Provider Newsletter

https://providers.amerigroup.com/tx

Amerigroup RealSolutions® in healthcare

2017
Quarter 1

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Clarification on medical director peer-to-peer process

Amerigroup knows your time is important, and we want to make the peer-to-peer process easy for you. Therefore, we now allow your office staff to call on your behalf to schedule a peer review with our medical director.

If you received a denial or notification that a case is under review and you would like to discuss the case with our medical director, please call 1-800-839-6275, ext. 57768 or 817-861-7768. Be ready to provide the following information:

- Name of person/physician our medical director needs to call
- Contact number
- Convenient time for a return call
- Authorization/reference number for the case
- Member's name, DOB and Amerigroup ID number

If you or your office staff reach our voicemail, please leave the name of the best contact person and his or her phone number so that our representatives can reach out for additional information.

Our medical director will make every effort to call you back within one business day.

Please note, if the notification you received indicates the case was denied, you may contact us within two business days of receipt of the notification to set up a peer-to-peer review for possible reconsideration. After two business days, the case will need to follow the appeal process outlined in the denial letter received.

TX-NL-0050-17

Additional information on ClaimCheck® upgrade to ClaimsXten™

Amerigroup 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 and select Claims Status.

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

TX-NL-0048-17

Interactive Care Reviewer tool: Register and start using today!

Beginning March 18, 2017, your practice can initiate online preauthorization requests for STAR members more efficiently and conveniently with our Interactive Care Reviewer (ICR) tool available through the Availity Web Portal. The ICR offers a streamlined process to request inpatient and outpatient procedures through the Availity Web Portal. There are no changes to the preauthorization capabilities on the provider website (https://providers.amerigroup.com/TX).

How do I gain access to the ICR?

You can access our ICR tool via the Availity Web Portal. If your organization has not yet registered for Availity, go to www.availity.com and select **Register** in the upper right-hand corner of the page. If your organization already has access to Availity, your Availity administrator can grant you access to "authorization and referral request" for submission capability and "authorization and referral inquiry" for inquiry capability. You can then find our tool under Patient Registration > Authorizations & Referrals. From this area, you can select the authorizations or authorization/referral inquiry option as appropriate.

Whom can I contact with questions?

For questions regarding our ICR tool, please contact Provider Services at 1-800-454-3730. For questions on accessing our tool via Availity, call Availity Client Services at 1-800-AVAILITY. Availity Client Services is available Monday-Friday from 8 a.m.-7 p.m. ET (excluding holidays) to answer your registration questions.

What benefits/efficiencies does the ICR provide?

- **You are automatically routed to our ICR.** Once the ICR is available, when you go to Authorizations in the Availity Web Portal, you are automatically routed to the ICR in order to begin your prior authorization request.
- **You can determine if prior authorization is needed.** For most requests, when you enter patient, service and provider details, you will receive a message indicating whether or not review is required.
- **You will have inquiry capability.** Ordering and servicing physicians and facilities can locate information on preauthorization requests for those they are affiliated with; this includes requests previously submitted via phone, fax, ICR or another online tool (e.g., AIM Specialty Health®).
- **The ICR is easy to use.** You can submit outpatient and inpatient requests for services online using the same, easy-to-use functionality.
- **The ICR reduces the need to fax.** The ICR allows text detail as well as images to be submitted along with the request. Therefore, you can submit requests online and reduce the need to fax medical records.
- **There is no additional cost to you.** The ICR is a no-cost solution that's easy to learn and even easier to use.
- **You can access the ICR tool almost anywhere.** You can submit your requests from any computer with internet access. (Note: We recommend you use Internet Explorer 11, Chrome, Firefox or Safari for optimal viewing.)
- **You receive a comprehensive view of all your preauthorization requests.** You have a complete view of all the utilization management requests you submitted online, including the status of your requests and specific views that provide case updates and a copy of associated letters.

TX-NL-0044-16

Behavioral health provider survey

Amerigroup is committed to finding the best ways possible to support our members and providers, and you can help! We are looking to identify areas of expertise or services for which you are licensed and have at least two years of clinical experience. To make the collection of this information easy, we have created a short online survey; all you need to do is follow the link/instructions below. The information collected will be used to help us locate services for members more efficiently.

The *Behavioral Health Areas of Expertise Profile* is designed to capture informational data only. While not all services listed are covered benefits in your state, having complete information on what our providers offer will be valuable should changes occur. Neither your provider application/credentialing nor your provider contract will be impacted or changed based on the information you supply on the profile. Any changes or amendments to credentialing or a provider contract must be requested through Provider Relations.

You can access the online survey below:

- Behavioral health facilities
- Behavioral health individual practitioners and medical groups

You may also access the survey via the provider website (https://providers.amerigroup.com/TX > Provider Resources & Documents > Behavioral Health > Behavioral Health Facility Survey or Behavioral Health Practitioner Survey).

For your convenience, you can include up to five locations per survey. For behavioral health facility practitioners, if you have more than five locations, please complete an additional survey for the remaining locations. For behavioral health individual practitioners, please complete one survey for every practitioner in your organization.

Your response is critical in helping us match your services to our members' needs. If you have questions about completing the survey or would like a paper copy of the survey, please contact Provider Relations.

TX-NL-0051-17

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 for STAR and CHIP 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 (1-800-454-3730), fax (1-800-964-3627) or the provider website (https://providers.amerigroup.com/TX).

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

TX-NL-0043-16

Prior authorization requirements for new injectable/infusible drugs: Istodax (romidepsin), Ixempra (ixabepilone), Doxil (doxorubicin), Torisel (temsirolimus) and Inflectra (infliximab-dyyb)

Effective February 1, 2017, Istodax (romidepsin), Ixempra (ixabepilone), Doxil (doxorubicin), Torisel (temsirolimus) and Inflectra (infliximab-dyyb) will require prior authorization (PA) under the medical benefit.

What is the impact of this change?

For dates of service on or after February 1, 2017, PA will be required for five injectable/ infusible drugs covered by Amerigroup for STAR members. These drugs are Istodax (romidepsin), Ixempra (ixabepilone), Doxil (doxorubicin), Torisel (temsirolimus) and Inflectra (infliximab-dyyb). **Noncompliance with new requirements may result in denied claims.**

PA requirements will be added to the codes below:

- Istodax (romidepsin) — J9315
- Ixempra (ixabepilone) — J9207
- Doxil (doxorubicin) — Q2049 and Q2050
- Torisel (temsirolimus) — J9330
- Inflectra (infliximab-dyyb) — Q5102

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/TX > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool). Providers may also call Provider Services at 1-800-454-3730 for PA requirements if they are not able to access the website.

TX-NL-0027-16

Notification process reminder

Effective March 12, 2017, failure to obtain precertification for STAR and CHIP members and failure to notify Amerigroup 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/TX > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool).

TX-NL-0051-17

Intracardiac electrophysiological studies and catheter ablation to require prior authorization

Effective April 1, 2017, intracardiac electrophysiological studies and catheter ablation will require prior authorization (PA). All requests with dates of service beginning on or after April 1, 2017, must be reviewed by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) for PA.

Please refer to the provider self-service tool for detailed authorization requirements.
To locate the provider self-service tool, go to https://providers.amerigroup.com > select your state > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool.

Noncompliance with new requirements may result in denied claims. PA requirements will be added to the following codes: 93600, 93602, 93609, 93610, 93612, 93615, 93616, 93618, 93619, 93620, 93624, 93631, 93640, 93641, 93642, 93644, 93650, 93653, 93654, 93656 and 93660.

Please use one of the following methods to request PA:

- Phone: 1-800-454-3730
- Fax: 1-800-964-3627
- Web: https://providers.amerigroup.com

Federal and state law, state contract language, CMS guidelines and definitions, as well as specific contract provisions and exclusions take precedence over these PA rules and must be considered first when determining coverage.

If you have any questions, please call Provider Services at 1-855-878-1785.

TXD-NL-0027-16

Epidermal growth factor receptor testing to require prior authorization

Effective June 1, 2017, epidermal growth factor receptor (EGFR) testing requires prior authorization (PA) for Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) members.

What is the impact of this change?

Beginning June 1, 2017, Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) requires PA for EGFR testing for Amerigroup STAR+PLUS MMP 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 this new requirement may result in denied claims.**

PA requirements will be added to the following code:

- 81235 — EGFR (e.g., nonsmall cell lung cancer) gene analysis, common variants (e.g., exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)

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/TX > Quick Tools > Precertification Lookup Tool). Providers may also call Provider Services at 1-855-878-1785 for PA requirements if they are not able to access the website.

TXD-NL-0029-16

Additional information on ClaimCheck® upgrade to ClaimsXten™

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) 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 1-855-878-1785 and select option two prompt.

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

TXD-NL-0033-17

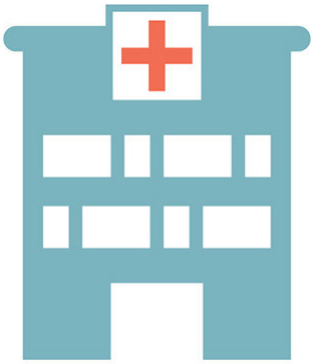
Hospital observation service limits

This information is a correction to the previous hospital observation service limits newsletter article published in September 2016. Observation services with less than eight hours will be considered a bundled service. Observation services billed over 72 hours will be considered as exceeding limits. This pertains to both contracted and noncontracted providers.

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.

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



TXDPEC-0294-16

Launch of the Retrospective Medical Record Review Program

Risk adjustment is the method used by CMS to adjust the capitated payment made to Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) based on demographic characteristics and health status (represented by diagnosis data and disease interactions) of each Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) 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 STAR+PLUS MMP 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 STAR+PLUS MMP 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 you need to know:

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 STAR+PLUS MMP?

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 STAR+PLUS MMP members targeted?

A. No, Amerigroup STAR+PLUS MMP 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.

Launch of the Retrospective Medical Record Review Program continued

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.)
- Onsite 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 onsite 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 STAR+PLUS MMP 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-Medicaid Plan 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.

TXD-NL-0030-16

FX modifier and tetanus vaccine

Payment reduction for X-rays taken using film:

Effective for dates of service on or after January 1, 2017, Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) follows the CMS requirement in which providers must use the FX bill modifier when billing for X-rays using film. A payment reduction of 20 percent will apply to the technical component (and the technical component of the global fee) for X-ray services provided using film for which payment is made under the *Medicare Physician Fee Schedule*.

Claims for tetanus vaccinations:

Effective January 1, 2016, tetanus vaccine 90703 is no longer accepted by Medicare. Effective for dates of service on and after January 1, 2016, providers administering a tetanus vaccine for an open wound or laceration should bill using 90696, 90697, 90698, 90700, 90702, 90714, 90715 or 90723 in addition to a 90471 and/or 90472 administration code and the appropriate diagnosis code to indicate an open wound or laceration. Claims should be submitted to Amerigroup STAR+PLUS MMP.

If a tetanus vaccine is administered for a reason other than a puncture wound or laceration and the member has pharmacy benefits, bill the member's Medicare Part D plan. This applies to the vaccine and the administration charges.

To bill the Medicare Part D plan, you may use TransactRX, a clearinghouse for claims submission. To use TransactRX, please contact the clearinghouse via their website (www.transactrx.com) or call Customer Service at 1-866-522-3386. Physicians, facilities, health clinics and pharmacies may use this clearinghouse to process Part D claims. There is no cost to providers who use electronic funds deposit to receive payment; however, there is a service fee of $2.50 for check payments on claims.

TXDPEC-0927-16

Prior authorization for outpatient radiation therapy services

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) requires prior authorization (PA) for outpatient radiation therapy services for Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) members.

What is the impact of this change?

Providers should continue to request PA for the radiation therapy modalities and services listed below:

- Intensity-modulated radiation therapy
- 3-D conformal/external beam radiation therapy
- Brachytherapy
- Proton beam therapy
- Stereotactic body radiation therapy and stereotactic radiosurgery

The type of review needed will determine the PA steps that should be taken:

- Planning: PA is administered by contacting Amerigroup STAR+PLUS MMP via the Availity Web Portal.
- Planning and delivery: PA is administered by AIM Specialty Health® (AIM).
- Delivery: PA is administered by AIM.

If you are only requesting PA for planning codes, and you are not yet ready to request PA for delivery codes or the radiation therapy is being performed as part of an inpatient admission, you may request approval by contacting Amerigroup STAR+PLUS MMP at 1-855-878-1785 or through the provider website, https://providers.amerigroup.com/TX.

AIM reviews PAs for planning and delivery services under the umbrella of radiation therapy modalities. They evaluate certain treatment plans against clinical appropriateness criteria to ensure the care aligns with established medical best practices and Medicare/Medicaid guidelines as appropriate.

If you are ready to deliver any of the services listed above, please contact AIM. To submit your request, go to the AIM ProviderPortal at www.aimspecialtyhealth.com. For additional assistance, contact AIM toll free at 1-800-714-0040 Monday-Friday from 8 a.m.-8 p.m. ET.

TXD-NL-0032-16

Additional information on ClaimCheck® upgrade to ClaimsXten™

Amerigroup Community Care previously announced plans to upgrade from ClaimCheck® to the ClaimsXten auditing system in the second quarter of 2017.

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SSO-NL-0013-17

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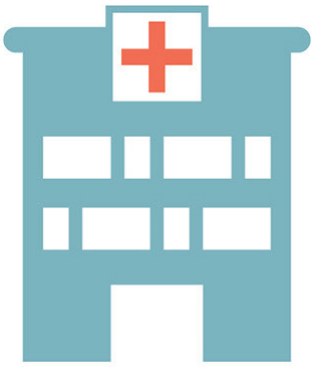

SSO-NL-0008-16

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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.

Launch of the Retrospective Medical Record Review Program continued

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 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.

TX-NL-0025-16

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.

TX-NL-0019-16

Policy Update

Modifier 91: Repeat Clinical Diagnostic Laboratory Test

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

Amerigroup 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.

TX-NL-0020-16

Policy Update

Reimbursement for Reduced and Discontinued Services

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

Amerigroup 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.

TX-NL-0016-16

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:

- For participating providers and facilities:
  - 95 days from Date of Service (DOS), date of discharge, or receipt of State Assigned ID (TPI - Texas Provider Identifier)
  - 365 days from DOS for Nursing Facility; 95 days from DOS for Nursing Facility add-on services
- For nonparticipating providers and facilities:
  - 95 days from Date of Service (DOS), date of discharge, or receipt of State Assigned ID (TPI - Texas Provider Identifier)
  - 365 days from DOS for Nursing Facility; 95 days from DOS for Nursing Facility add-on services.
  - 365 days for out-of-state providers

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 rejected or 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. Claims for services billed to a third party payor as primary must be submitted within 95 days of notice of action by the 3rd party (or 365 day filing time limit if applicable to type of claims and later).

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

TX-NL-0018-16

Policy Update — Amerivantage

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:

- 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 > Medicaid/Medicare.

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): 70 percent
- Modifier 55 (postoperative management only): 20 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.

TX-NL-0026-16

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