

# Provider Newsletter



[providers.amerigroup.com](http://providers.amerigroup.com)

2016  
Quarter 2

## Medicaid

### Quality Improvement program

Learn more about our Quality Improvement programs by visiting the Provider Resources & Document section under the Quality Management heading of our website at <https://providers.amerigroup.com/TX>. We are also happy to send you a copy – call Provider Services at 1-800-454-3730.

### Distribution of clinical practice and preventive health guidelines

Clinical practice guidelines (CPG) are evidence-based measures known to be effective in improving health outcomes. Guideline effectiveness is determined through scientific evidence, professional standards or expert opinion. Amerigroup\* provides clinical care and preventive health guidelines to our network physicians that are based on current research and national standards. The [clinical practice guidelines](https://providers.amerigroup.com/TX) are available on our website at <https://providers.amerigroup.com/TX>.

### Timely communication is key to utilization management (UM)

To ensure our members receive quality care, it is vital that timely communication occur between the member's primary care provider or medical home and the specialist or ancillary provider to ensure the member receives thorough and seamless care.

To request a copy of the specific criteria/guidelines used for making UM decisions, please call 1-800-454-3730.

As a corporation and as individuals involved in UM decisions, we are governed by the following:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.

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

Amerivantage is an HMO plan with a contract with the State Medicare program. Enrollment in Amerivantage depends on contract renewal.  
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- We do not specifically 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
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization, or create barriers to care and service.

### **Member rights and responsibilities**

We want to keep you informed about our members' defined rights and responsibilities. These can be found in the [provider manual](#) on our website at <https://providers.amerigroup.com/TX> > Manuals & QRCs. If you would like us to mail you a copy, call Provider Services at 1-800-454-3730.

### **New Claims Status Listing Tool**

On April 16, 2016, a new Claims Status Listing Tool will be offered on the Amerigroup Payer Spaces on Availity. This application enables you to generate a list and view the status of multiple claims submitted to Amerigroup.

Besides your current claims status inquiry functionality on Availity, we will provide an added benefit with the Claims Status Listing Tool. With this tool, you can obtain a list of your claims submitted to Amerigroup for a specified period of time (span of up to 30 days) and up to two years back. You will have the opportunity to see the status of multiple claims in one report, if you choose, instead of looking them up one at a time.

#### **Here's how to access the Claims Status Listing Tool:**

- Log into the Availity Web Portal
- From the Availity Web Portal home page, select *Payer Spaces*
- Select the *Payer* from the list of payer options
- Select Applications, then select *Open* located below *Claims Status Listing Tool*

#### **My organization does not use Availity. What do I need to do?**

To initiate the registration process, have your primary controlling authority (PCA), a person who is authorized to sign on behalf of your organization, register. Click *Get Started* under the *Register Now* button and complete the online registration wizard.

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

For questions or additional registration assistance, call Availity Client Services at 1-800-282-4548, Monday through Friday, 5 a.m.-4 p.m., Pacific Time.



## Routine cervical cancer screening

We recently communicated with you regarding cervical cancer screening coverage for women younger than 21 years of age. This communication provides new coverage information on the frequency of cervical cancer screening of women at average risk. It does not address women with a history of prior abnormal results, precancerous cervical lesions, cervical cancer or those who are immunocompromised.

### Additional coverage information

As previously communicated, routine screening pap testing will not be reimbursed for women younger than 21 years of age. In addition, effective October 30, 2016, routine screening frequency for women age 21 to 65 will be reimbursed no more frequently than once every three years. Also, reimbursement for routine Pap testing for women 66 and older, with prior negative screening results, will be denied.

### Screening method and intervals

The U.S. Preventive Services Task Force<sup>1</sup>, the American College of Obstetricians and Gynecologists<sup>2</sup>, the American Cancer Society<sup>3</sup>, the American Society for Colposcopy and Cervical Pathology and the American Society for Clinical Pathology all agree that the optimal screening interval is not more frequently than every three years.

Population	Recommended screening
Women younger than 21 years	No screening
Women aged 21-29 years	Cervical Pap alone every three years
Women aged 30-65 years	Human papillomavirus (HPV) and cervical Pap co-testing every five years or cervical Pap alone every three years
Women older than 65 years	No screening is necessary after adequate negative prior screening results
Women who underwent total hysterectomy (with no residual cervix)	No screening is necessary

We encourage you to adopt this medical society and industry recommendation in the interest of improving patient quality and reducing harm from unnecessary follow up.

1. United States Preventive Services Task Force. Cervical Cancer. March 2012.

2. American College of Obstetricians and Gynecologists. Practice Bulletin Number 157: Screening for Cervical Cancer. Obstet Gynecol. 2016; 127:e1-20.

3. Saslow D, Solomon D, Lawson HW, et al. American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer. CA Cancer J Clin 2012; 62:147-72.

## How do you contact our medical directors?

If you received notification that a case is under review by our medical director, or you received a denial notification and you would like to discuss the case with our Medical Director, your staff can call our dedicated physician peer-to-peer phone line for inpatient and outpatient requests.

The dedicated peer-to-peer phone number is 1-800-839-6275, ext. 57768, or 1-817-861-7768. When your staff calls, they should be prepared to provide the member identification number, reference number, and the physician's name and contact number so the Medical Director can return your call.

For cases that are under review, our Medical Director will call back within one business day to discuss the case. If you are calling about a denial notification you have received, you must contact us within two business days from the date the case was denied in order to have the case reviewed for reconsideration and to set-up the physician peer to peer call.

## Amerivantage

### Dual Eligible Special Needs Plans (D-SNP) training required

In 2016, Amerigroup is offering Dual Eligible Special Needs Plans (D-SNPs) to people who are eligible for both Medicare and Medicaid benefits or who are qualified Medicare beneficiaries (QMBs) in CA. D-SNPs provide enhanced benefits to people eligible for both Medicare and Medicaid. These plans are \$0 premium plans. Some include a combination of supplemental benefits such as hearing, dental, vision as well as transportation to doctors' appointments. Some D-SNP plans also may include a card or catalog for purchasing over-the-counter items.

D-SNPs are a kind of Medicare Advantage plan that are approved by Medicare and also contract with the state Medicaid agency. Providers who see Amerigroup Medicare Advantage members in CA are "in network" and available to see Amerigroup D-SNP members effective Jan. 1, 2016, unless they have opted out of participating with the D-SNP plan.

**Providers should understand that D-SNP members are protected from all balance billing.** Amerigroup D-SNPs are "zero cost share" plans, meaning we only enroll dual-eligible beneficiaries (people eligible for both Medicare and Medicaid) who have Medicare cost sharing protection under their Medicaid benefits. The provider may not seek payments for cost sharing from dual-eligible members for health care services. Providers cannot bill D-SNP members for services not reimbursed by Medicaid or Amerigroup's D-SNP plan, nor can providers balance bill for the difference between what has been paid and the billed charges.

Providers who are contracted for D-SNP plans are required to take annual training to keep up-to-date on plan benefits and requirements, including coordination of care and Model of Care elements. Providers contracted for our D-SNP plans received notices in January that contained information for online training, either through scheduled WebEx sessions or through [self-paced training](#) on our [provider portal](#). Every provider contracted for our D-SNP plans is required to complete an attestation stating that they have completed the annual training. These attestations are located at the end of the self-paced training document and can be completed by individual providers or at the group level with one signature along with a roster of providers that participate within the group.

To take the self-paced training, please go to the Training Programs link at <https://providers.amerigroup.com/pages/home.aspx> under your state.

## Amerigroup STAR+PLUS MMP

### Quality programs support patient safety, health improvement

Below is an outline of our quality programs:

#### **Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) Quality Improvement (QI) Program**

The QI Program supports the special needs of all Amerigroup STAR+PLUS MMP members by evaluating the quality, safety, and appropriateness of medical and behavioral health care and services offered by Amerigroup STAR+PLUS MMP. The program reviews care provided to all demographic groups, races, ethnicities, special needs populations, care settings, and types of services through continuous quality improvement processes.

#### **Readmissions Quality Improvement Project (QIP)**

The Readmissions QIP is a 3-year initiative focused on improving care transitions and care coordination to reduce behavioral health-related, potentially preventable hospital admissions and readmissions. It includes post-discharge follow-up calls focused on medication adherence, member education, and hospital to home transitions.

#### **Chronic Care Improvement Program (CCIP)**

The CCIP is a 5-year initiative for Amerigroup STAR+PLUS MMP members to improve their cardiovascular health and reduce their risk of a heart attack or stroke by helping ensure our members understand and control their blood pressure. The CCIP supports the national Million Hearts initiative.

#### **You can help by carrying out the following actions:**

- Schedule post-hospital follow-up discharge appointments within the first week, as well as routine follow-up appointments
- Educate members and their families about the care process to ensure clear understanding about their condition and treatment plans
- Conduct blood pressure monitoring at each office visit
- Provide member education on healthy lifestyles such as healthy nutrition, physical activity, smoking cessation, and stress reduction
- Conduct medication reconciliation
- Encourage medication adherence

### Medicare Part B prior authorization reminder

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) would like to remind providers to contact the STAR-PLUS MMP Part B Specialty Pharmacy department for injectable and infusion drugs requiring preauthorization prior to rendering services or the expiration of current authorizations.

As a reminder, effective May 1, 2016, all oncology and oncology-supportive specialty drugs that require prior authorization will be reviewed for medical necessity by AIM.

The STAR-PLUS MMP Part B Specialty Pharmacy department can be faxed at 1-800-359-5781.

For oncology and oncology supportive specialty drugs, AIM can be reached by:

- Phone: 1-800-554-0580 or 1-800-714-0040
- Provider Portal: [www.providerportal.com](http://www.providerportal.com)

Injectable and infusion drugs requiring prior authorization are available to contracted providers by accessing the Provider Self-Service Tool within Availity. Noncontracted providers should contact the health plan.

### **AIM to review oncology and oncology supportive specialty drugs for medical necessity**

Effective May 1, 2016, all oncology and oncology supportive specialty drugs that require prior authorization for Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) members will be reviewed for medical necessity through AIM's provider portal or by contacting AIM at 1-800-554-0580.

Prior authorization requirements can also be reviewed online at Availity.com.

Providers may be familiar with and participating in the Cancer Care Quality Program (CCQP) administered by AIM. Effective May 1, 2016, CCQP reviews and prior authorizations will be performed by the same review team. The STAR+PLUS MMP specialty pharmacy team will no longer review oncology and oncology supportive drugs for medical necessity for members effective May 1, 2016.

### **AIM to conduct MMP medical necessity reviews for vascular ultrasound procedures**

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) is collaborating with AIM Specialty Health to conduct medical necessity reviews for vascular ultrasound management for our STAR+PLUS MMP (Medicare-Medicaid Plan) members.

Effective July 1, 2016, AIM will accept prior authorization requests for a number of vascular ultrasound screening and diagnostic procedures. To submit your request, go to the AIM **ProviderPortal<sup>SM</sup>** at [www.aimspecialtyhealth.com](http://www.aimspecialtyhealth.com). From the dropdown menu, select Amerigroup Medicare Advantage. For additional assistance, you may also call AIM toll-free at 1-800-714-0040, Monday to Friday, 7 a.m. to 7 p.m. Central Time. Effective July 1, 2016, AIM will accept prior authorization requests for Screening and Diagnostic Ultrasound requests for the codes found [here](#).

### **Effective November 1, 2016 ClaimsCheck<sup>®</sup> upgrade to ClaimsXten<sup>™</sup>**

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) appreciates your participation in our network. Amerigroup STAR+PLUS MMP uses ClaimCheck 10.2, a comprehensive nationally recognized code auditing system, to ensure consistent physician and facility reimbursement by automatically evaluating provider claims in accordance with accepted industry coding standards. The purpose of this update is to notify you that we are upgrading ClaimCheck 10.2 to ClaimsXten, McKesson's next generation code auditing system.



As with ClaimCheck 10.2, ClaimsXten uses rules derived from a combination of CMS coding guidelines, AMA/CPT, Specialty Society guidelines and Amerigroup policy. The upgrade will become effective November 1, 2016.

### **What is ClaimsXten?**

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

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

### **Why are we upgrading from ClaimCheck 10.2 to ClaimsXten?**

We periodically update our claims logic to:

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

### **How will the upgrade to ClaimsXten affect you?**

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

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

Other procedures and categories that are reviewed include:

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

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

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



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

<b>Rule</b>	<b>Provider type</b>	<b>Description</b>
New patient code for established patient	Professional	Audits for claim lines containing a new patient E&M code when another claim line containing any E&M code was billed within a three-year period.
Duplicate line items	Professional	Audits for claim lines that match a previously submitted claim line on a different claim for the same member, provider, procedure, modifier, date of service, quantity and billed amount.

If you have questions regarding ClaimsXten edits that you receive on your explanation of payment, please call the Provider Services at 1-800-454-3730 and select the appropriate prompt.



## Reimbursement Policies

### **New Policy**

#### **Medical Recalls**

*(Policy 06-111, effective 10/01/2016)*

Amerigroup does not allow reimbursement for repair or replacement of items due to a medical recall. The following are applicable items:

- Durable medical equipment
- Supplies
- Prosthetics
- Orthotics
- Drugs/vaccines

Amerigroup will allow reimbursement of medically necessary procedures to remove and replace recalled or replaced devices. Amerigroup will not be responsible for the full cost of a replaced device if an inpatient or outpatient facility is receiving a partial or full credit for a device due to recall. Payment will be reduced by the amount of the device credit.

For additional information, refer to the Medical Recalls policy at <https://providers.amerigroup.com>.

### **New Policy**

#### **Multiple Procedure Payment Reduction**

*(Policy 15-002, effective 10/01/2016)*

When services are performed on the same date of service during the same patient encounter, and are performed by the same physician or health care professional with the same National Provider Identifier (NPI) or multiple providers in the same group practice with the same group NPI, the following will be subject to Multiple Procedure Payment Reductions (MPPR):

- Cardiovascular procedures
- Ophthalmology procedures

“Always therapy” services are not subject to Multiple Procedure Payment Reductions.

For additional information, refer to the Multiple Procedure Payment Reduction policy at <https://providers.amerigroup.com>.



## **Policy Reminder**

### **Facility Take Home DME and Medical Supplies**

*(Policy 06-081, originally effective 12/22/2009)*

Amerigroup does not allow reimbursement of Durable Medical Equipment (DME) and medical supplies dispensed by a facility for take-home use under the inpatient or outpatient hospital benefit. Facility claims submitted for DME and medical supplies billed with revenue codes denoting take-home use will be denied.

To be considered for reimbursement, claims for take-home DME and medical supplies should be submitted by a DME/supply vendor. Reimbursement is based on the:

- Contract or negotiated rate for participating vendors
- Out-of-network fee schedule or negotiated rate for non-participating vendors

Amerigroup allows reimbursement of facility claims for medical supplies dispensed to the member at discharge and billed with revenue codes other than take-home for the following items:

- Crutches
- Medical supplies for no more than 72 hours if the provider was not able to obtain supplies from a vendor by discharge

For additional information, refer to the Facility Take Home DME and Medical Supplies reimbursement policy at <https://providers.amerigroup.com>.

