Provider Newsletter

Amerigroup
An Anthem Company

https://providers.amerigroup.com/tx

December 2017

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The *Provider Newsletter* is now available bimonthly

Effective with this publication, your *Provider Newsletter* from Amerigroup will now be published on a bimonthly basis. The newsletter is an excellent source of important and necessary information about how to do business with us.

This change in frequency allows us to share important information with you sooner. This will also reduce the number of faxes and mailings we are required to send in order to notify you of important changes.

Below is the new bimonthly *Provider Newsletter* schedule for 2018. All publications will be posted on our provider website (https://providers.amerigroup.com/TX > Provider Resources & Documents > Newsletters — Current) by the first of the month. We will continue to notify you via fax when the newsletter is available.

- February 1, 2018
- April 1, 2018
- June 1, 2018
- August 1, 2018
- October 1, 2018
- December 1, 2018

For any questions about this change, please contact your local Provider Relations representative or Provider Services at 1-800-454-3730.

TX-NL-0081-17; SSO-NL-0025-17_NJ_NM_TN_TX_WA

Amerigroup adopts Milliman Care Guideline for inpatient rehabilitation and skilled nursing facility clinical reviews

Effective for dates of service on and after October 31, 2018, Amerigroup will transition from using the InterQual® Level of Care (LOC) Rehabilitation, LOC: Long-Term Acute Care and LOC: Subacute/Skilled Nursing Facility (SNF) criteria to using Milliman Recovery Facility Care guidelines for the review of prior authorization requests for inpatient rehabilitation and SNF services.

Please use one of the following methods to request PA:

- **Web:** https://www.availity.com
- **Fax:** 1-800-964-3627
- **Phone:** 1-800-454-3730

For questions, contact Provider Services at 1-800-454-3730.

TX-NL-0082-17

Care program available for STAR+PLUS members facing advanced illness

Effective October 1, 2017, Amerigroup is offering the Aspire Health program — a palliative care program — to STAR+PLUS members who are facing an advanced illness. The program allows members and their caregivers timely access to appropriate care 24 hours a day, seven days a week through the Aspire care management team. Aspire uses member claims data to identify and contact members who may benefit from this program. Members who choose to participate will receive in-home services as soon as possible.

Aspire does not replace the care of PCPs and specialists, and members enrolled in this program keep their PCP and other specialists and may continue to seek treatment. The Aspire clinical team will also consult regularly with PCPs and other specialists to discuss any significant changes to care plans or medications. If you have questions or need to contact Aspire regarding a member's care, you can reach them at 1-844-952-5591.

For additional information, visit https://providers.amerigroup.com/TX.

TX-NL-0079-17

Amerigroup to conduct postservice reviews of certain modifiers and services

Effective January 1, 2018, Amerigroup will conduct postservice reviews of professional claims billed with the following modifiers: 25, 62, 80, 81, 82, AS and 91. Additionally, Amerigroup will conduct postservice reviews of Evaluation and Management services billed during a global surgery period.

What is the impact of this change?

As part of the review, Amerigroup may contact providers to request additional documentation related to the services. If billing discrepancies are identified, Amerigroup will provide a written report of the findings to providers and initiate recoupments as appropriate. Findings may assist your office with quality improvement efforts.

TX-NL-0077-17

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

Medical Policies and *Clinical Utilization Management Guidelines* update

Medical Policies update

On August 3, 2017, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Medical Policies* applicable to Amerigroup. These policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the below listing.

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

CG-DRUG-29 Hyaluronan Injections in the Knee will be implemented as investigational and not medically necessary on December 1, 2017. RAD.00035 will be archived effective 09/15/2017. CG-MED-58 will be effective 09/15/2017.

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

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

Effective date	*Medical Policy* number	*Medical Policy* title	New or revised
8/17/2017	DRUG.00111	Guselkumab (Tremfya™)	New
9/27/2017	LAB.00035	Multi-biomarker Disease Activity Blood Tests for Rheumatoid Arthritis	New
8/17/2017	DRUG.00040	Abatacept (Orencia®)	Revised
8/17/2017	DRUG.00058	Pharmacotherapy for Hereditary Angioedema	Revised
8/17/2017	DRUG.00071	Pembrolizumab (Keytruda®)	Revised
8/17/2017	DRUG.00082	Daratumumab (DARZALEX™)	Revised
8/17/2017	DRUG.00099	Cerliponase Alfa (Brineura™)	Revised
8/17/2017	DRUG.00107	Avelumab (Bavencio®)	Revised
8/17/2017	GENE.00011	Gene Expression Profiling for Managing Breast Cancer Treatment	Revised
8/17/2017	MED.00051	Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry	Revised
8/17/2017	MED.00081	Cognitive Rehabilitation	Revised
8/17/2017	RAD.00035	Coronary Artery Imaging: Contrast-Enhanced Coronary Computed Tomography Angiography (CCTA), Fractional Flow Reserve derived from Computed Tomography (FFRCT), Coronary Magnetic Resonance Angiography (MRA), and Cardiac Magnetic Resonance Imaging (MRI)	Revised
8/17/2017	RAD.00066	Multiparametric Magnetic Resonance Fusion Imaging Targeted Prostate Biopsy	Revised
8/17/2017	SURG.00055	Cervical Total Disc Arthroplasty	Revised
8/17/2017	SURG.00121	Transcatheter Heart Valve Procedures	Revised

Clinical Utilization Management Guidelines update

On August 3, 2017, the MPTAC approved the following *Clinical Utilization Management (UM) Guidelines* applicable to Amerigroup. These clinical guidelines were developed or revised to support clinical coding edits. Several guidelines were revised to provide clarification only and are not included in the following listing. This list represents the *Clinical UM Guidelines* adopted by the Medical Operations Committee for the Government Business Division on August 24, 2017.

On August 3, 2017, the clinical guidelines were made publicly available on the Amerigroup *Medical Policies* and *Clinical UM Guidelines* subsidiary website. Visit https://medicalpolicies.amerigroup.com/search to search for specific guidelines.

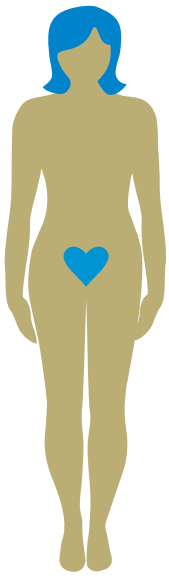
Existing precertification requirements have not changed. Please share this notice with other members of your practice and office staff.

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

Effective date	*Clinical UM Guideline* number	*Clinical UM Guideline* title	New or revised
9/27/2017	CG-ADMIN-02	Clinically Equivalent Cost Effective Services – Targeted Immune Modulators	New
9/27/2017	CG-MED-57	Cardiac Stress Testing with Electrocardiogram (ECG)	New
8/17/2017	CG-ANC-06	Ambulance Services: Ground; Non Emergent	Revised
8/17/2017	CG-SURG-27	Sex Reassignment Surgery	Revised

TXPEC-2152-17

Update to coverage guideline for cervical cancer screening and human papillomavirus testing (CG-MED-53)



Effective January 1, 2018, coverage guideline CG-MED-53 that applies to cervical cancer screening and human papillomavirus (HPV) testing will be updated.

Important items to note:

- Cervical cancer screening with cytology, with or without HPV testing, for women under 21 years of age is considered not medically necessary with the exception of women who are chronically immunosuppressed (i.e., organ transplant recipients or seropositive for HIV).
- Cervical cancer screening with HPV testing, alone or in combination with cytology, for women younger than 30 years of age is considered not medically necessary with the exception of women who are chronically immunosuppressed.
- There is no change to the medical necessity criteria for cervical cancer screening with cytology and without HPV testing for women ages 21-65 years of age.

If you have questions about this communication, received it in error or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

TX-NL-0075-17

New review process for not otherwise classified drug codes

Effective February 1, 2018, Amerigroup is implementing a new review process for not otherwise classified (NOC) drug codes. Our Reimbursement Policy for "Unlisted or Miscellaneous Codes" requires NOC drug codes be submitted with the correct national drug code (NDC). As a large number of NOC drug claims do not contain the NDC, we will review claims to ensure the presence of a NDC, and claims without an NDC will be denied.

The scope of review will include both professional and facility claims for Medicaid members. The NOC drug codes listed below will suspend and be routed for review. Note, to ensure billed drugs are a benefit and covered per our medical policies or state policies, Amerigroup may request that you submit medical records.

NOC drug codes and descriptions as of May 4, 2017:	
A9150	Nonprescription drug
A9152	Single vitamin/mineral/trace element — oral, per dose, not otherwise specified (NOS)
A9153	Multiple vitamins (with or without minerals and trace elements) — oral, per dose, NOS
C9399	Unclassified drug or biological
J1566	Immune globulin injection — intravenous, lyophilized, NOS (500 mg)
J1599	Immune globulin injection — intravenous, nonlyophilized, NOS (500 mg)
J3490	Unclassified drug
J3590	Unclassified biological
J7199	Hemophilia clotting factor — NOC
J7599	Immunosuppressive drug — NOC
J7699	NOC drugs — inhalation solution administered through durable medical equipment (DME)
J7799	NOC drugs — drugs (other than inhalation drugs) administered through DME
J7999	Compounded drug — NOC
J8498	Antiemetic drug — rectal/suppository, NOC
J8499	Prescription drug — oral, nonchemotherapeutic, NOS
J8597	Antiemetic drug — oral, NOS
J8999	Prescription drug — oral, chemotherapeutic, NOS
J9999	Antineoplastic drugs — NOC
S5000	Prescription drug — generic
S5001	Prescription drug — brand name
90749	Unlisted vaccine/toxoid

TX-NL-0076-17

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) adopts Milliman Care Guideline for inpatient rehabilitation and skilled nursing facility clinical reviews

Effective for dates of service on and after March 1, 2018, Amerigroup STAR+PLUS MMP will transition from using the InterQual® Level of Care (LOC) Rehabilitation and LOC: Subacute/ Skilled Nursing Facility (SNF) criteria to using Milliman Recovery Facility Care guidelines for the review of prior authorization requests for inpatient rehabilitation and SNF services. This change only applies to Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) members.

Providers can call Provider Services at 1-855-878-1785 to request prior authorization review for these services. Additionally, providers may initiate an online request at https://www.availity.com.

For questions, contact Provider Services at 1-855-878-1785.

TXD-NL-0068-17

Update to provider payment frequency

Starting in 2018, more claim payments and remittance advices issued by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) will be made on a **weekly basis** to providers. Additionally, non Federal Employee Program (FEP) payments under $5 will be held for a maximum of 14 days to allow for additional claims to combine to increase the payment amount.

This change is being made for efficiency and to ensure consistency between professional and facility claim payments for commercial, FEP, Medicare and Medicaid members. Please note, this will not affect payments made from our national account system.

If you are a provider that receives paper claim checks or electronic fund transfer payments from Amerigroup STAR+PLUS MMP on a daily basis, you will be able to schedule posting on a weekly cycle after this change.

TXD-NL-0010-17

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

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

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

TXD-NL-0009-16

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees.

Prior authorization (PA) requirements for Part B drugs

On December 1, 2016, PA requirements will change for three new, Part B injectable/infusible drugs covered by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) for STAR+PLUS MMP members.

Prior authorization requirements will be added to the codes below:

- **Istodax (Romidepsin):**
  for treatment of cutaneous Tcell lymphoma and peripheral Tcell lymphoma after receiving at least one prior systemic therapy; additional indications include Sezary syndrome and mycosis fungoides (J9315)
- **Ixempra (Ixabepilone):**
  for use with capecitabine in the treatment of metastatic or locally advanced breast cancer that is resistant to an anthracycline and a taxane for whose cancer is taxane resistant and for whom further anthracycline therapy is contraindicated; Ixempra is also approved as monotherapy for the treatment of metastatic or locally advanced breast cancer that is resistant or refractory to anthracyclines, taxanes and capecitabine (J9207)

Drugs billed with not otherwise classified (NOC) HCPCS J-code (J3490 and J3590):

- **Taltz (Ixekizumab):**
  for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy (unlisted, no J-code established at this time)

Please note, one of these drugs is currently billed under the NOC J-code J3490 and J3590. Since this code includes all drugs NOC, the plan's denial will be for the drug and not the HCPCS.

TXD-NL-0005 -16

On February 1, 2018, prior authorization (PA) requirements will change for Part B injectable/infusible drugs Renflexis (infliximab-abda), Rituxan Hyclea (rituximab/hyaluronidase) and Zilretta (triamcinolone acetonide SR) covered by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan).

PA requirements will be added to the following codes, some of which are billed with not otherwise classified (NOC) HCPCS J-codes J3490, J3590, J9999 and C9399:

- **Renflexis (infliximab-abda):**
  for the treatment of Crohn's disease, pediatric Crohn's disease, ulcerative colitis, rheumatoid arthritis (in combination with methotrexate), ankylosing spondylitis, psoriatic arthritis and plaque psoriasis (Q5102)
- **Rituxan Hyclea (rituximab/hyaluronidase):**
  for the treatment of chronic lymphoid leukemia, diffused large B-cell lymphoma and follicular lymphoma (J3490, J3590, J9999 and C9399 — unlisted, no J-code established at this time)
- **Zilretta (triamcinolone acetonide SR):**
  extended-release formulation for the treatment of osteoarthritis in the knees (J3490)

Since these codes include drugs that are NOC, if the authorization is denied for medical necessity, the plan's denial will be for the drug and not the HCPCS.

TXD-NL-0007-17

PA requirements for Part B drugs (cont.)

On March 1, 2018, Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) PA requirements will change for certain Part B injectable/infusible drugs covered by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan).

Prior authorization requirements will be added to the following Part B drugs:

- **Aliqopa (copanlisib injection):** for the treatment of adults with relapsed follicular lymphoma who have received at least two prior treatments (J9999)
- **Cinvanti (aprepitant injection):** for the treatment of chemotherapy-induced nausea and vomiting (J3490, J3590)
- **Opsiria (sirolimus injection):** for the treatment of uveitis and works by blocking an enzyme called "mammalian target of rapamycin" (J3490, J3590)

Please note: The above drugs are currently billed under the Not Otherwise Classified (NOC) HCPCS codes J3490, J3590 and J9999; they are unlisted because no J code has been established at this time. Since these codes include other Part B drugs that are NOC, if the authorization is denied for medical necessity, the plan's denial will be for the drug and not the HCPCS code.

TXD-NL-0069-17

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.**

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

- **Web:** Interactive Care Reviewer tool via https://www.availity.com
- **Fax:** 1-888-235-8468
- **Phone:** 1-855-878-1785

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the provider self-service tool at https://www.availity.com. Providers who are unable to access Availity can use the Precertification Lookup Tool on our website (https://providers.amerigroup.com/TX > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool) or call Provider Services at 1-855-878-1785 for PA requirements.

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) to conduct postservice reviews of certain modifiers and services

Effective January 1, 2018, Amerigroup STAR+PLUS MMP will conduct postservice reviews of professional claims billed with the following modifiers: 25, 62, 80, 81, 82, AS and 91. Additionally, Amerigroup STAR+PLUS MMP will conduct postservice reviews of Evaluation and Management services billed during a global surgery period.

What is the impact of this change?

As part of the review, Amerigroup STAR+PLUS MMP may contact providers to request additional documentation related to the services. If billing discrepancies are identified, Amerigroup STAR+PLUS MMP will provide a written report of the findings to providers and initiate recoupments as appropriate. Findings may assist your office with quality improvement efforts.

What if I need assistance?

For more information about postservice reviews, contact Provider Services at 1-855-878-1785.

TXD-NL-0008-17

New Medication Electronic Prior Authorization Request Tool effective January 1, 2018

What is electronic prior authorization (ePA)?

- ePA offers providers the ability to complete prior authorization (PA) requests for medications via a web portal.
- How do ePA cases differ from phone/fax cases?
- ePA cases are simply initiated differently from other PA cases. Once an ePA case is submitted, it follows the same process as phone/fax cases.
- This electronic alternative allows providers a self-service option for initiating and managing PA requests.
- If the necessary information to meet clinical criteria is submitted during the ePA process, an immediate approval decision can be completed and communicated back to the provider.

Why ePA?

- ePA is speedy, simple and smart.
- It saves time; submitting ePA requests is faster than phone/fax requests, and there is no paperwork to manage.
- It is easy to use; 70 percent of physicians already ePrescribe, and ePA is the next step.
- The ability to receive automatic approvals with ePA expedites the process and, subsequently, fosters a positive member experience.

How do I submit an ePA?

- Visit the CoverMyMeds website (https://www.covermymeds.com).
- Through your electronic medical records tool, utilize the ePA functionality if it exists.

How do I receive assistance if I have issues or questions with ePA through CoverMyMeds?

- For assistance, reach out to CoverMyMeds via one of the following methods:
  - **Online:** https://www.covermymeds.com/main/help
  - **Phone:** 1-866-452-5017
  - **Chat:** Select the **Click to Chat with CoverMyMeds** box in the bottom, right-hand corner of the CoverMyMeds website. Note, you don't need to be logged in to access this feature.

TXD-NL-0002-17

Network delegation for home health care services

Amerigroup will delegate its provider network for Home Health Care Services for most of our Medicare Advantage individual products to myNEXUS in 2018.

We want to ensure the transition is as seamless as possible for our members. If you are not currently contracted with myNEXUS and wish to continue providing Home Health Care services to Medicare Advantage individual members, please contact myNEXUS using one of the options below:

To stay current with delegation dates and learn more, visit the myNEXUS Contracting wesite (https://www.mynexuscare.com/contracting).

- **Email:** contracting@mynexuscare.com
- **Phone:** 1-844-411-9622

SSO-NL-0034-17

Medicare Advantage members to receive gift cards diabetic retinal eye exams

To encourage Medicare Advantage members to receive screening for diabetic retinal disease, eligible members H3240 NJ HMO/ SNP Amerigroup and H5817 TX HMO/ SNP Amerigroup will receive Visionary Rewards, an offer for a $50 VISA gift card for completing a retinal or dilated eye exam in 2017. The goal of the incentive is to improve HEDIS®/ Star measure (CDC-DRE) and improve member health outcomes while reducing cost of care through early detection and improving member satisfaction.

SSO-NL-0029-17

Liability assignment for eye refraction and self-administered drugs

Amerigroup would like to clarify liability assignment related to Statutorily Non-Covered Services of Eye Refraction (procedure code 92015) and Self-Administered Drug (procedure code A9270) when the service is denied on Medicare Advantage individual and group-sponsored claims.

For the liability assessment to be assigned appropriately, we require that the G modifier(s) be submitted on the claim form and the Notice of Denial of Medical Coverage letter be obtained prior to the service rendered.

When the Notice of Denial of Medical Coverage letter is obtained, please submit both the GX and GY modifier on the claim.

This billing process is different from traditional Medicare, which only requires a GY modifier be appended to the procedure code.

The Centers for Medicare & Medicaid Services considers providers contracted with Amerigroup for Medicare Advantage as plan "agents;" therefore, related CMS regulations must be followed. Due to this, a GY modifier only submitted on the claim form will not ensure the correct liability assignment for the denied service.

SSO-NL-0031-17

Amerigroup Texas, Inc. is a D-SNP plan with a Medicare contract and a contract with the State Medicaid program. Enrollment in Amerigroup Texas, Inc. depends on contract renewal.

Facility global surgical package billing policy updated effective January 1, 2018

Amerigroup Global Surgical Package reimbursement policy has been updated effective January 1, 2018 to include facility services. Unless the facility's contract indicates otherwise, Amerigroup will not separately reimburse a facility for typical postoperative care rendered during the global surgical period.

Amerigroup will begin enforcing this policy January 1, 2018 for individual and group-sponsored Medicare Advantage claims.

Please refer to the Medicare Advantage Global Surgical Package reimbursement policy.

SSO-NL-0033-17

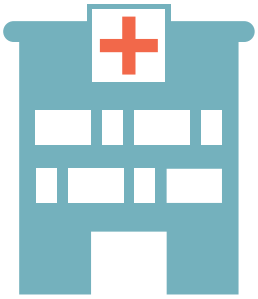
Include NPI on surgical procedure UB04 bills

In October 2017, Amerigroup will edit for operating provider NPI when a surgical procedure code is billed for members having an individual Medicare Advantage or MMP plan. A surgical procedure code is a code within the range of 10021-69990 but excluding 10035, 10036, 15780-15783, 15786-15789, 15792, 15793, 20527, 20550-20553, 20555, 20612, 20615, 29581-29584, 36406, 36410, 36415, 36416, 44705, 47531, 47532, 50430, 50431, 59425, 59426, 59430, 62302-62305, 62320-62327, 62367-62370, 69209, 69210. When a surgical procedure code is billed, the operating provider's NPI must be billed in box 77 on the facility *UB04 CMS 1450 Claim Form* for outpatient services. If a surgical procedure code is billed without an operating provider NPI, the claim will be denied for missing NPI.

SSO-NL-0030-17

Critical access hospitals (CAH) reimbursed at Medicare rate

Effective May 26, 2017, Amerigroup began using a rate database, sourced from CMS-published Medicare hospital cost reports, of CAH inpatient, swing bed and outpatient rates to price claims from non-contracted CAHs for individual Medicare Advantage and MMP members. Consequently, Amerigroup usually will not need a Medicare Administrative Contractor (MAC) rate letter to process claims from non-contracted CAHs for individual Medicare Advantage and MMP members. However, Amerigroup will require a MAC rate letter in the situations noted below. We look forward to handling your claims in a more timely manner with this process change.



Amerigroup still will require a MAC rate letter or additional information from CAHs in the following situations.

- Non-contracted CAHs must submit a MAC rate letter for claims for Medicare Advantage group-sponsored members.
- Contracted CAHs compensated using Medicare rates must continue to submit MAC rate letters to their Amerigroup network managers as required by contract.
- All CAHs should update Amerigroup regarding a change in status in Method (from I to II or II to I). Note that Method II reimbursement applies to contracted CAHs only if specified in contract.

SSO-NL-0032-17

Help ensure Medicare Part D members receive a comprehensive medication review

The Centers for Medicare & Medicaid Services require that plans with Medicare Part D benefits offer a Comprehensive Medication Review (CMR) as part of the Medication Therapy Management (MTM) program. A CMR is offered to members who have three or more chronic diseases and who are receiving eight or more maintenance medications. Amerigroup employs SinfoniaRx to contact our qualifying individual and group-sponsored Medicare Part D members to complete the interactive consultation. The CMR consists of a consultation followed by a written medication summary to help educate and support provider recommendations for medication adherence. Please ask these members if they have received a letter or postcard inviting them to participate in a CMR.

SSO-NL-0028-17

Improve Medicare Advantage members' medication adherence with 90-day prescriptions

To help improve medication adherence among Medicare Advantage members, Amerigroup will fax providers prescribing a 30-day supply of oral diabetic medications, RAS antagonists and statins to promote the use of 90-day prescriptions. Ninety-day prescriptions help improve the adherence of our Medicare Advantage members by having them travel to their pharmacy less often. When medically appropriate, we request that you convert the member's prescription to a 90-day supply to improve patient adherence and outcomes without compromising the quality of care. Please note that we do not intend to transfer these prescriptions to a mail-order or specialty pharmacy. The member will obtain the 90-day supply medication at the same pharmacy where he or she previously obtained the 30-day supply prescription.

SSO-NL-0026-17

Amerigroup to conduct postservice reviews of certain modifiers and services

Beginning in the fourth quarter of 2017, Amerigroup will conduct postservice reviews of professional claims billed with the following modifiers: 25, 62, 80, 81, 82, AS and 91. Additionally, Amerigroup will conduct postservice reviews of Evaluation and Management services billed during a global surgery period.

What is the impact of this change?

As part of the review, Amerigroup may contact providers to request additional documentation related to the services. If billing discrepancies are identified, Amerigroup will provide a written report of the findings to providers and initiate recoupments as appropriate. Findings may assist your office with quality improvement efforts.

SSO-NL-0024-17_NJ-NM-TN-TX-WA

Complete *OptiNet*® assessments for out-of-state office locations; drop-down menu changed

Contracted providers with Amerigroup who render services to Medicare Advantage members in other state counties that are contiguous to their home state should complete the ***Opti****Net* registration. The ***Opti****Net* program has expanded to include these providers who render services in other state counties contiguous to their home state; these providers should register by January 1, 2018.

All participating providers who provide imaging services, including X-rays and ultrasounds as noted above, must complete the registration. Providers who do not register, who score less than 76 or who do not complete the survey will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only.

The provider registration is available online at www.providerportal.com. Please note that the drop-down menu selection for participating Medicare Advantage providers has changed. Select Medicare Advantage/Medicaid from the drop-down menu. This drop-down is changing from Amerigroup MA.

If you have questions or need help completing the registration, please call AIM Customer Service at 1-800-252-2021 Monday-Friday 8 a.m. to 7 p.m. ET or send an email to Assessment@AIMSpecialtyHealth.com.

If you have already completed an ***Opti****Net* assessment, please ensure that you keep your registration up to date. Expiring data could lead to a negative impact in your modality scores.

SSO-NL-0027-17

Policy Update — Amerigroup STAR+PLUS MMP
Multiple Radiology Payment Reduction
(Policy 12-002, effective 03/15/18)

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) allows reimbursement for multiple diagnostic imaging procedures. Multiple diagnostic imaging procedures will be subject to a Multiple Procedure Payment Reduction when services are performed by the same provider with the same NPI on the same date of service during the same patient encounter. CT scan services are not subject to a multiple procedure payment reduction.

The global, professional component and technical component of diagnostic imaging procedures will reimburse at 100 percent of the contracted/negotiated rate for each Professional Component and Technical Component service with the highest payment. Reimbursement of subsequent services is based on:

- 95 percent for the professional component of subsequent services furnished by the same provider to the same patient in the same session on the same day.
- 50 percent for the technical component of subsequent services furnished by the same provider to the same patient in the same session on the same day.

A reduced allowance for the second and subsequent procedures will not apply when multiple imaging procedures are billed appended with Modifier 59.

For additional information, please refer to the Multiple Radiology Payment Reduction reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > TX MMP.

TXD-NL-0006-17

Policy Update — Medicaid Portable/Mobile/Handheld Radiology Services

(Policy 06-160, effective 03/15/18)

Amerigroup allows reimbursement for portable/mobile radiology services when furnished in a residence used at the patient's home and if ordered by a physician and performed by qualified portable radiology suppliers. Portable/mobile radiology studies should not be performed for routine purposes or for reasons of convenience. Reimbursement is based on the applicable fee schedule or contracted/negotiated rate for the radiological service and transportation and setup components with the use of applicable modifiers.

Note: Portable radiology suppliers must be licensed or registered to perform services as required by applicable state laws.

Transportation and Setup

Amerigroup allows reimbursement for transportation and setup of portable radiology equipment when transported to the member's residence. Transportation costs are payable when the portable X-ray equipment used was actually transported to the location where the X-ray was taken. Reimbursement for the setup cost of portable radiology equipment is not separately reimbursable.

Handheld Radiology

The use of handheld radiology instruments is allowed. Reimbursement will be part of the physician's professional service, and no additional charge will be paid. The technical components for handheld radiology are not separately reimbursable.

For additional information, refer to Portable/Mobile/Handheld Radiology Services at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

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Policy Update — Amerivantage Portable/Mobile/Handheld Radiology Services

(Policy 06-160, effective 03/15/18)

Amerigroup allows reimbursement for portable/mobile radiology services when furnished in a residence used as the patient's home and if ordered by a physician and performed by qualified portable radiology suppliers. Portable/mobile radiology studies should not be performed for reasons of convenience. Amerigroup allows preventive screenings performed by portable/mobile radiology studies for routine purposes. Reimbursement is based on the applicable fee schedule or contracted/negotiated rate for the radiological service and transportation and setup components with the use of applicable modifiers.

Note: Portable radiology suppliers must be licensed or registered to perform services as required by applicable state laws.

Transportation and Setup

Amerigroup allows reimbursement for transportation and setup of portable radiology equipment when transported to the member's residence. Transportation costs are payable when the portable X-ray equipment used was actually transported to the location where the X-ray was taken.

Handheld Radiology

The use of handheld radiology instruments is allowed. Reimbursement will be part of the physician's professional service, and no additional charge will be paid. The technical components for handheld radiology are not separately reimbursable.

For additional information, refer to the Portable/Mobile/Handheld Radiology Services Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

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