Provider Newsletter

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Amerigroup RealSolutions® in healthcare

2016
Quarter 4

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TX-NL-0040-16

December 2016
Revised January 11, 2017

New pregnancy notification process using the Availity Web Portal Benefit Look-up Tool

As you know, Amerigroup offers pregnant women several services and benefits through the Taking Care of Baby and Me® program. It is our goal to ensure all pregnant members are identified early in their pregnancy, so they can take full advantage of the education, support, resources and incentives Amerigroup provides throughout the prenatal and postpartum period.

We've partnered with Availity, the vendor supporting the Benefit Look-up Tool you may currently use in your OB office, to send us information about newly identified pregnant women. This new process, including HEDIS®* maternity attestation, will help providers connect patients with additional benefits as soon as possible. The reporting process includes a few simple steps.

How it works:

When an Amerigroup member of childbearing age visits the OB office, the office associate will be prompted to answer the question "Is the member pregnant?" during the eligibility and benefits inquiry process. If the response is "yes," Amerigroup will inquire about the due date and a *Maternity Attestation Form* will be generated for the OB office to complete. On this electronic form, the provider will enter other important information including the date of the first prenatal care visit, delivery date and postpartum visit date.

This new, user-friendly workflow will generate timely information that will help members, providers and Amerigroup improve birth outcomes with early intervention and ensure compliance with HEDIS benchmarks.

We will be working hard to ensure Amerigroup providers throughout Texas receive necessary training for this new workflow and that all questions are answered. If you have any specific questions regarding the new Availity maternity attestation in Texas, please feel free to reach out to Provider Services at 1-800-454-3730.

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

Provider FAQ — Availity Web Portal pregnancy notification and HEDIS attestation

What is the purpose of this new process?

As you know, Amerigroup offers pregnant women several services and benefits through the Taking Care of Baby and Me® program. It is our goal to ensure all pregnant women are identified early in their pregnancy so they can take full advantage of the education, support, resources and incentives Amerigroup provides throughout the prenatal and postpartum period.

This new, user-friendly workflow will generate timely information that will help you, your patients and Amerigroup improve birth outcomes with early intervention and will ensure compliance with HEDIS benchmarks.

When will the new pregnancy-related questions display?

When an OB/GYN office conducts an eligibility and benefits inquiry for an Amerigroup member 15-44 years of age in the Availity Web Portal, the system will display pregnancy-related questions. If the office confirms the patient is pregnant, a HEDIS *Maternity Attestation Form* will be generated. If the patient is not pregnant, the desired eligibility and benefits information will display and no further action is required.

Does the new HEDIS *Maternity Attestation Form* replace the need for an OB global authorization?

Responses provided in the Availity pregnancy notification system do not replace the need to submit a request for OB global authorization. A request for OB global authorization can be submitted by phone or fax as well as online through the secure provider self-service website that can be accessed through the Availity Web Portal.

How should the office reply when a patient presents as a transfer from another OB provider?

You should answer the pertinent pregnancy questions and complete the HEDIS *Maternity Attestation Form* as usual. Even though the first prenatal visit question typically relates to prenatal care in the first trimester or within 42 days of plan enrollment, you can simply enter the date you first provided prenatal care for the patient.

If a patient transfers out of our practice during her prenatal course, how should the office complete the HEDIS *Maternity Attestation Form*?

It is OK to leave the HEDIS attestation in a pending status as it provides Amerigroup with pertinent prenatal care information up to the point that the patient transfers out of the practice. The form will remain in place until it is automatically retired 19 months later.

If we have confirmed the patient is pregnant, but she suffers an early miscarriage or chooses to end the pregnancy, how will the office communicate this important information?

In this situation, you should select the option on the HEDIS *Maternity Attestation Form* that states "this pregnancy ended or the baby delivered prior to 20 weeks." This action will allow the office to close out and submit the HEDIS *Maternity Attestation Form* for this pregnancy.

Do I have to answer all the questions on the HEDIS *Maternity Attestation Form* all at once?

No, the workflow is designed so you may enter and save information as it becomes available during the pregnancy. After the delivery and postpartum visit dates are entered, you will be given the option to complete and submit the attestation. Until then, you may save the information you enter and continue on with other tasks.

Provider FAQ — Availity Web Portal pregnancy notification and HEDIS attestation continued

Is there an easy way for me to obtain a list of all patients for whom I need to enter prenatal or postpartum visit dates?

Your organization will receive two notifications to complete the HEDIS *Maternity Attestation Form*.

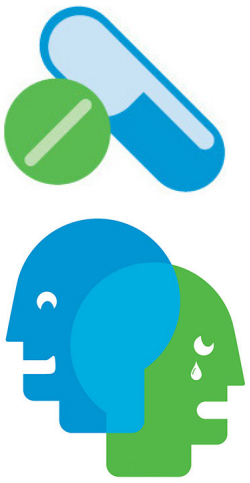
- In order to prompt you to complete the form and enter the first prenatal visit date, the first notification is posted at the time the form is created.
- In order to alert you to schedule the postpartum visit (if not already done) and to enter the postpartum visit date, the second notification is posted 14 days prior to the estimated due date.

You may access the work queue at any time by going to **Payer Spaces**. Next, select the payer title from the list. Then select **Amerigroup HEDIS Attestation for Maternity**.

How can I get additional help, support or training?

- Availity offers integrated help and on-demand training demonstrations (select **Help | Find Help** and search using the keyword "maternity").
- You can launch a training demo from associated help topics as well as the HEDIS attestation for maternity work queue.
- If you have technical difficulties related to the HEDIS attestation for maternity workflow, contact Availity at 1-800-282-4548.
- If you have specific member concerns, please contact Provider Services at 1-800-454-3730.

Behavioral Health Medication Management program



The Amerigroup Behavioral Health (BH) Medication Management program addresses the specific needs of STAR members using medications prescribed for their BH. Our goal is to improve the quality of care provided to our members and promote medication adherence. We focus on age appropriate use of medications, thus reducing the use of unnecessary medications.

The outreach and education programs also support providers and members on BH-related HEDIS measures that use medication utilization as a quality measurement tool such as:

- Antidepressant Medication Management (AMM)
- Follow-up Care for Children Prescribed ADHD Medication (ADD)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)
- Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

If you have questions, please call Pharmacy Operations at 1-800-719-4871. Note, calls will be answered and/or returned Monday-Friday from 8:30 a.m.-4 p.m. ET.

Reducing preterm births through cervical length screening

In our continuing efforts to improve pregnancy outcomes and prevent preterm births (PTBs), Amerigroup is announcing our endorsement of the American College of Obstetricians and Gynecologists (ACOG) and Society for Maternal Fetal Medicine (SMFM) guidelines on cervical length (CL) screening and progesterone treatment.[1]

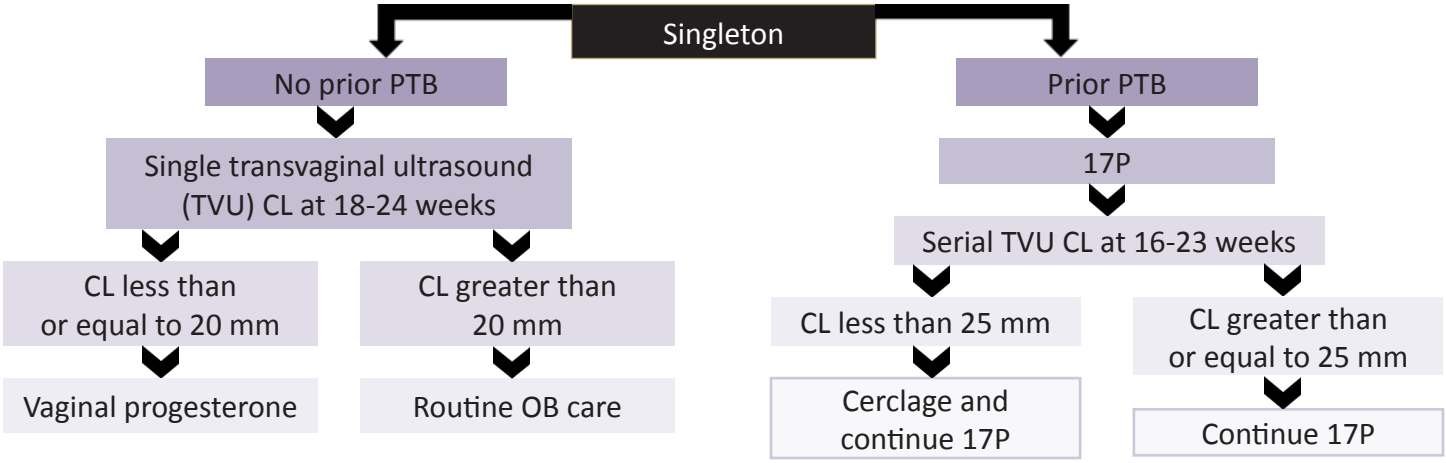
As you know, the risk factor most consistently predictive of PTBs is a prior PTB.[2] Women with this risk factor are currently treated with alpha-hydroxyprogesterone caproate (17P) by intramuscular injection weekly from 16-36 weeks; however, less than 10 percent of spontaneous PTBs occur in women with a prior history.

We have a tremendous opportunity to address this by screening CL and treating with progesterone. Shortened CL before 24 weeks is now recognized to be a second strongly predictive risk factor for PTBs in singleton pregnancies.[3] Using this evidence-based strategy, we can improve our efforts by identifying and treating at-risk women who might not be otherwise identified.

ACOG and SMFM have collaborated to promote an algorithm to aid in this endeavor. Amerigroup endorses this strategy of CL screening and treating with progesterone.[4] We support universal CL screening at 18-24 weeks.[5] CL screening by ultrasound is considered the gold standard and makes other measuring methods and devices medically unnecessary.[6]

We encourage you to obtain a CL measurement with your patient's ultrasound at 18-24 weeks as shown in the included algorithm. If, in addition to an abdominal scan, a vaginal approach is necessary to obtain this measurement, please add modifier 52 to the vaginal ultrasound billing code. Please refer to the ultrasound policy found on the provider website for appropriate diagnosis codes for your member. We believe this will help you continue to provide high quality, evidence-based prenatal care to your patients.[7]

Algorithm based on the ACOG recommendation:



1 "Progesterone and Preterm Birth Prevention: Translating Clinical Trials Data into Clinical Practice." American Journal of Obstetrics and Gynecology 206 (2012): 376-386.
2 J.D Iams, R.L. Goldenberg, P.J. Meis, et al. "The Length of the Cervix and the Risk of Spontaneous Premature Delivery." New England Journal of Medicine 334 (1996): 567-572.
3 S.S. Hassan, R. Romero, D. Vidyadhari, et al. "Vaginal Progesterone Reduces the Rate of Preterm Birth in Women with a Sonographic Short Cervix: a Multi-Center, Randomized, Double-Blind, Placebo-Controlled Study." Ultrasound Obstetrics and Gynecology 38 (2011): 18-31.
4 S. Campbell. "Universal Cervical Length Screening and Vaginal Progesterone Prevents Early Preterm Births, Reduces Neonatal Morbidity and is Cost Saving: Doing Nothing is No Longer an Option." Ultrasound Obstetrics and Gynecology 38 (2011): 1-9.
5 "Letter to Secretary Burwell." American College of Obstetricians and Gynecologists and Society for Maternal Fetal Medicine (2014).
6 "American Institute of Ultrasound in Medicine Practice Guideline for the Performance of Obstetric Ultrasound Examinations." Journal of Ultrasound Medicine 32 (2013): 1083-1101.
7 R. Romero, K. Nicolaides, A. Conde-Agudelo, et al. "Vaginal Progesterone in Women with an Asymptomatic Sonographic Short Cervix in the Midtrimester Decreases Preterm Delivery and Neonatal Morbidity: a Systematic Review and Meta-analysis of Individual Patient Data." American Journal of Obstetrics and Gynecology 206 (2012): 124.

Does your patient understand what you just told them?

Though members may hear the information you present to them, they may not grasp it all. Help our members understand their plan of care with simple steps like:

- Have them repeat back information such as what the medication is for, when they take the medication, how much medication they take, when they are to follow up again, etc.
- Use common terms for medical procedures or treatments to ensure the member understands their medical condition, knows the signs and symptoms to look for, and knows when to call you.
- Encourage your patients to ask questions.
- Allow time to listen.

Questions to ask members at each appointment:

- Do you understand your treatment plan?
- What would keep you from following your treatment plan?
- Do you know who to contact if you have a medical question anytime of the day including weekends?
- What other concerns do you have not related to this visit?
- Is there anything else you would like for me to know?

For more information, refer to the following resources:

- *Plain Language: A Promising Strategy for Clearly Communicating Health Information and Improving Health Literacy* issue brief from the U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion: https://health.gov/communication/literacy > Reports and research > Plain Language: A Promising Strategy for Clearly Communicating Health Information and Improving Health Literacy (2005)
- *Health Literacy Basics* quick guide from the U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion: http://health.gov/communication/literacy > Tools for improving health literacy > Quick Guide to Health Literacy
- Texas Health Steps™ — Motivational Interviewing training from the Texas Department of State Health Services and the Texas Health and Human Services Commission: www.txhealthsteps.com/cms/?q=catalog/course/1999
- 5 Myths physicians believe about patient experience from the Advisory Board: https://www.advisory.com/-/media/Advisory-com/Research/PEC/Resources/Posters/5-myths-physicians-believe-about-patient-engagement.pdf

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Provider Website Survey

Amerigroup relies on your feedback to improve and strengthen our processes and operations. Our *Provider Website Survey* is a new tool to evaluate the effectiveness of our Medicaid provider websites. Input about your experience with our website is essential to our goal of efficient and effective provider resources. We will use your survey responses to better understand your experiences and continue to improve our site. Providing exceptional service to our providers is one of our strongest commitments.

Thank you in advance for taking the time to complete this brief survey. To access the survey, go to https://www.surveymonkey.com/r/7PHY5BL.

Elective one and two vessel coronary artery bypass graft to require prior authorization

Effective January 1, 2017, elective one and two vessel coronary artery bypass graft (CABG) will require prior authorization (PA).

Amerigroup will require PA for the elective one and two vessel CABG beginning January 1, 2017. Please refer to the provider self-service website for detailed PA requirements (https://providers.amerigroup.com/TX > 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:

- 33510 — coronary artery bypass, vein only; single coronary venous graft
- 33511 — coronary artery bypass, vein only; two coronary venous grafts
- 33517 — coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (list separately in addition to code for primary procedure)
- 33518 — coronary artery bypass, using venous graft(s) and arterial graft(s); two venous grafts (list separately in addition to code for primary procedure)
- 33530 — reoperation, coronary artery bypass procedure or valve procedure, more than one month after original operation (list separately in addition to code for primary procedure)
- 33533 — coronary artery bypass, using arterial graft(s); single arterial graft
- 33534 — coronary artery bypass, using arterial graft(s); two coronary arterial grafts

To request PA, contact us via phone (1-800-454-3730), fax (1-800-964-3627) or the provider website.

The Utilization Review team will utilize the InterQual Procedures criteria for CABG requests.

Update to the ClaimsCheck® upgrade to ClaimsXten™

Earlier this year, Amerigroup announced plans for an upgrade from ClaimsCheck to McKesson's next generation claim auditing software, ClaimsXten. Due to the complexity of the software conversion, along with the expansion of software functionality that is now available, the target effective date has been moved from November 1, 2016, to April 30, 2017.

With the new software functionality, edits will be applied with greater accuracy. The new software functionality will also allow for greater flexibility with rule development and configuration.

For additional details regarding this software update, please refer to the original communication posted at https://providers.amerigroup.com/TX > Provider Resources & Documents > Newsletters > Provider News Issue 3 2016.

Continuous interstitial glucose monitoring to require prior authorization

Effective March 1, 2017, continuous interstitial glucose monitoring will require prior authorization (PA).

For dates of service on or after March 1, 2017, PA will be required for continuous interstitial glucose monitoring 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:

- 95250: ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours — sensor placement, hook-up, calibration of monitor, patient training, removal of sensor and printout of recording
- 95251: ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours — interpretation and report

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).

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 submitted 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 and select your state
- Under Provider Resources & Documents, select Quick Tools and then select 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.

Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5®) updates

In an effort to keep our providers well-informed of changes occurring in the behavioral health community, we wanted to share some updates from the DSM-5.

When transitioning from the DSM-IV-TR to the DSM-5, the provider community moved from use of a multiaxial system to the current use of a nonaxial system upon diagnosis. While the information included in the diagnosis remains much the same, the axes are not included in DSM-5.

Although formatted differently, the same information is found within the DSM-5 diagnostic system. DSM-5 combines DSM-IV-TR axes I-III diagnoses into one list, as shown in Table 1.

Table 1: DSM-5 diagnosis:

DSM-IV multiaxial system	DSM-5 nonaxial system
Axis I: clinical disorder (d/o) and other conditions that are focus of treatment **Axis II:** personality d/o and mental retardation Axis III: general medical conditions	Combined attention to clinical disorders, including personality disorders and intellectual disability, other conditions that are the focus of treatment, and medical conditions.
Axis IV: psychosocial and environmental stressors	Reason for visit and psychosocial and contextual factors via expanded list of V codes and Z codes.
Axis V: Global Assessment of Functioning (GAF)	Disability included in notation. World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) included as option.

Additional conditions and problems relevant to the presenting symptoms, diagnoses and treatment are also listed as ICD-10-CM Z codes. These can be found in the section of DSM-5 entitled Other Conditions That May Be a Focus of Clinical Attention. In addition, Axis V GAF was removed from DSM-5. Alternatively, WHODAS 2.0 is included in section III of DSM-5.

We understand that our providers depend upon diagnoses for guiding treatment recommendations, identifying prevalence rates for mental health service planning, identifying patient groups for clinical and basic research, and documenting important public health information. As the understanding of mental disorders and their treatments has evolved, medical, scientific and clinical professionals have focused on the characteristics of specific disorders and their implications for treatment and research. Clinical training and experience are needed to use the DSM-5 for determining a diagnosis. The diagnostic criteria identify symptoms, behaviors, cognitive functions, personality traits, physical signs and syndrome combinations; the durations require clinical expertise in order to differentiate psychiatric disorders from normal life variations and transient responses to stress.

***Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5®)* updates continued**

Revisions to the DSM-5 may continue to take place. In September 2016, updates were made to the codes used for the diagnoses listed in Table 2. Detailed information about these updates may be viewed in an online supplement published by the American Psychiatric Association located at http://psychiatryonline.org. Select **View the DSM-5® Update (September 2016)**.

Table 2:

Disorder	Codes effective October 1, 2016
Avoidant/Restrictive Food Intake Disorder	F50.89
Binge-Eating Disorder	F50.81
Disruptive Mood Dysregulation Disorder	F34.81
Excoriation (Skin-Picking) Disorder	F42.4
Gender Dysphoria in Adolescents and Adults	F64.0
Hoarding Disorder	F42.3
Obsessive-Compulsive Disorder	F42.2
Other Specified Depressive Disorder	F32.89
Other Specified Feeding or Eating Disorder	F50.89
Other Specified Obsessive-Compulsive and Related Disorder	F42.8
Pica, in adults	F50.89
Premenstrual Dysphoric Disorder	F32.81
Social (Pragmatic) Communication Disorder	F80.82
Unspecified Obsessive-Compulsive and Related Disorder	F42.9

Some resources that may best help you include:

- *American Medical Association, Professional Edition CPT* (current procedural terminology), 2016.
- American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Arlington, VA, American Psychiatric Association, 2013.
- *ICD-10-CM and ICD-10-PCS Coding Handbook 2016*.

Prior authorization requirements for new injectable/infusible drugs — Istodax (Romidepsin), Ixempra (Ixabepilone) and Taltz (Ixekizumab)

On December 1, 2016, prior authorization 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. These drugs include: Istodax (Romidepsin), Ixempra (Ixabepilone) and Taltz (Ixekizumab). Federal and state law, as well as state contract language and CMS guidelines, including definitions and specific contract provisions/exclusions, take precedence over these prior authorization rules and must be considered first when determining coverage. Noncompliance with new requirements may result in denied claims.

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.

Not all prior authorization requirements are listed here. Detailed prior authorization requirements are available to contracted providers on the provider self-service website (https://providers.amerigroup.com/TX > Quick Tools > Precertification Lookup Tool). Noncontracted providers may call Provider Services at 1-855-878-1785 for prior authorization requirements.

Prior authorization requirements for new injectable/infusible drugs: Inflectra (infliximab-dyyb) and Cinqair (reslizumab)

On January 1, 2017, prior authorization requirements will change for two new, Part B injectable/infusible drugs covered by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) for STAR+PLUS MMP members. These drugs include: Inflectra (infliximab-dyyb) and Cinqair (reslizumab). Federal and state law, as well as state contract language and CMS guidelines, including definitions and specific contract provisions/exclusions, take precedence over these prior authorization rules and must be considered first when determining coverage. Noncompliance with new requirements may result in denied claims.

Prior authorization requirements will be added to the code below:

- Inflectra (infliximab-dyyb): for treatment of moderate to severely active Crohn's disease, ulcerative colitis, rheumatoid arthritis, ankylosing spondylitis and psoriatic arthritis (Q5102)

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

- Cinqair (reslizumab): for add-on maintenance treatment of patients with severe asthma with an eosinophilic phenotype (unlisted, no J code established at this time)

Please note, this drug is currently billed under the NOC J-code J3490/J3590. Since this code includes 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.

Not all prior authorization requirements are listed here. Detailed prior authorization 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 prior authorization requirements.

Prior authorization requirements for new injectable/infusible drugs: Tecentriq (atezolizumab injection)

On January 1, 2017, prior authorization requirements will change for Tecentriq (atezolizumab injection) — a new, Part B injectable/infusible drug covered by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) for 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 prior authorization rules and must be considered first when determining coverage.Noncompliance with new requirements may result in denied claims.

Prior authorization requirements will be added to the code below.

Drugs billed with not otherwise classified (NOC) HCPCS J-code J3590/J9999:

- Tecentriq (atezolizumab injection): for treatment of individuals with locally advanced or metastatic urothelial cancer who had disease progression during or following platinum-containing chemotherapy or whose disease progressed within 12 months of neoadjuvant treatment with platinum-containing chemotherapy (unlisted, no J code established at this time)

Please note, this drug is currently billed under the NOC J-code J3590/J9999. Since this code includes all drugs NOC, if the authorization is denied for medical necessity, the plan's denial will be for the drug and not the HCPCS.

Not all prior authorization requirements are listed here. Detailed prior authorization 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 prior authorization requirements.

Prior authorization requirements for new injectable/infusible drugs: Emend (fosaprepitant), Aloxi (palonosetron) and Afstyla (antihemophilic)

On January 1, 2017, prior authorization 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. (Note, this applies to outpatient services only.) These drugs include: Emend (fosaprepitant), Aloxi (palonosetron) and Afstyla (antihemophilic). Federal and state law, as well as state contract language and CMS guidelines, including definitions and specific contract provisions/exclusions, take precedence over these prior authorization rules and must be considered first when determining coverage. Noncompliance with new requirements may result in denied claims.

Prior authorization requirements will be added to the codes below:

- Emend (fosaprepitant): for prevention of acute or delayed nausea and vomiting associated with initial and repeat courses of moderate to high emetogenic cancer therapy (J1453)
- Aloxi (palonosetron): for prevention of acute or delayed nausea and vomiting associated with initial and repeat courses of moderate to high emetogenic cancer therapy, as well as for prevention of postoperative nausea and vomiting when used within 24 hours following surgery (J2469)

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

- Afstyla (antihemophilic factor recombinant, single chain):
  - Used as a long-acting recombinant factor VIII replacement for patients with hemophilia A (unlisted, no J-code established at this time)
  - Used for on-demand treatment and control of bleeding episodes, as well as perioperative management of bleeding (unlisted, no J-code established at this time)

Please note, one of these drugs is currently billed under the NOC J-code (J3490). Since this code includes all drugs NOC, if the authorization is denied for medical necessity, the plan's denial will be for the drug and the HCPCS. This update to the 2016 prior authorization requirement applies to all the Medicare-Medicaid plans.

Not all prior authorization requirements are listed here. Detailed prior authorization requirements are available to contracted providers on the provider self-service website (https://providers.amerigroup.com/TX > Quick Tools > Precertification Lookup Tool). Noncontracted providers may call Provider Services at 1-855-878-1785 for prior authorization requirements.

Prior authorization requirements for new injectable/infusible drugs: Cuvitru, Ocrevus and Lutathera

On March 1, 2017, prior authorization (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. These drugs include Cuvitru (immune globulin), Ocrevus (ocrelizumab) and Lutathera (octreotate Lu-177 DOTA Tyr-3). Federal and state law, as well as state contract language and CMS guidelines, including definitions and specific contract provisions/exclusions, take precedence over these precertification rules and must be considered first when determining coverage. Noncompliance with new requirements may result in denied claims.

PA requirements will be added to the following drugs billed with not otherwise classified (NOC) HCPCS J codes (J3490, J3590 and J9999):

- Ocrevus (ocrelizumab): for treatment of primary progressive multiple sclerosis and relapsing-remitting multiple sclerosis (unlisted, no J code established at this time) (J3490)
- Cuvitru (immune globulin): for treatment of primary immunodeficiency in adults and children 2 years of age and older, primarily administered via pump (unlisted, no J code established at this time) (J3590)
- Lutathera (octreotate Lu-177 DOTA Tyr-3): for treatment of neuroendocrine tumors in patients who have progressed on traditional somatostatin analogues (unlisted, no J code established at this time) (J9999)

Please note, these drugs are currently billed under the NOC J codes J3490, J3590 and J9999. Since this code includes 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.

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.

Prior authorization requirements for new injectable/infusible drugs: Doxil (doxorubicin)and Sustol (granisetron)

On February 1, 2017, prior authorization requirements will change for two new, Part B injectable/infusible drugs covered by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) for STAR+PLUS MMP members. These drugs are Doxil (doxorubicin) and Sustol (granisetron). Federal and state law, as well as state contract language and CMS guidelines, including definitions and specific contract provisions/exclusions, take precedence over these prior authorization rules and must be considered first when determining coverage. Noncompliance with new requirements may result in denied claims.

Prior authorization requirements will be added to the code below:

- Doxil (doxorubicin): for treatment of ovarian cancer after failure of platinum-based chemotherapy; AIDS-related kapoli sarcoma after failure of prior systemic chemotherapy or intolerance to such therapy; multiple myeloma when used in combination with bortezomib and have received on prior therapy; Doxil may also be used for breast cancer, Hodgkin's lymphoma, non-Hodgkin's lymphoma, sarcomas of soft tissue and uterine neoplasms (Q2049 and Q2050)

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

- Sustol (granisetron): indicated in combination with other antiemetic in adults for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of moderately emetogenic chemotherapy or anthracycline and cyclophosphamide combination chemotherapy (unlisted, no J code established at this time)

Please note, this drug is currently billed under the NOC J-code J3490 and J3590. Since this code includes 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.

Not all prior authorization requirements are listed here. Detailed prior authorization 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 prior authorization requirements if they are not able to access the website.

Prior authorization requirements for new injectable/infusible drugs: Erelzi (etanercept), Amjevita (adalimumab), Voretigene neparvovec, Nanacog (recombinant factor IX) and Lartruvo (olaratumab)

On April 1, 2017, prior authorization (PA) requirements will change for five new, Part B injectable/infusible drugs covered by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) for STAR+PLUS MMP members. These drugs include Erelzi (etanercept), Amjevita (adalimumab), Voretigene neparvovec, Nanacog (recombinant factor IX) and Lartruvo (olaratumab). Federal and state law, as well as state contract language and CMS guidelines, including definitions and specific contract provisions/exclusions, take precedence over these precertification rules and must be considered first when determining coverage. Noncompliance with new requirements may result in denied claims.

PA requirements will be added to the following drugs billed with not otherwise classified (NOC) HCPCS J codes (J3590 and J9999):

- Erelzi (etanercept): for treatment of rheumatoid arthritis, ankylosing spondylitis, juvenile idiopathic arthritis, psoriatic arthritis and plaque psoriasis (unlisted, no J code established at this time) (J3590)
- Amjevita (adalimumab): for treatment of Crohn's disease, ulcerative colitis, rheumatoid arthritis, ankylosing spondylitis, juvenile idiopathic arthritis, psoriatic arthritis, plaque psoriasis, noninfective uveitis and hidradenitis suppurativa (unlisted, no J code established at this time) (J3590)
- Voretigene neparvovec: for treatment of inherited retinal disease for which there is no current treatment; the disease is caused by mutations in the RPE65 gene (unlisted, no J code established at this time) (J3590)
- Nanacog (recombinant factor IX): for the treatment of hemophilia B (unlisted, no J code established at this time) (J3590)
- Lartruvo (olaratumab): a platelet-derived growth factor antagonist, in combination with doxorubicin, for the treatment of soft tissue sarcoma not amenable to curative treatment with radiotherapy or surgery (unlisted, no J code established at this time) (J9999)

Please note, these drugs are currently billed under the NOC J codes J3590 and J9999. Since this code includes 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.

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.

Prior authorization requirement change for three drugs: interferon gamma-1b (Actimmune®), mecasermin (Increlex®) and azacitidine (Vidaza®)

On February 1, 2017, prior authorization requirements will change for three drugs covered by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) for STAR+PLUS MMP members. These drugs are interferon gamma-1b (Actimmune), mecasermin (Increlex) and azacitidine (Vidaza). Federal and state law, as well as state contract language and CMS guidelines, including definitions and specific contract provisions/exclusions, take precedence over these prior authorization rules and must be considered first when determining coverage. Noncompliance with new requirements may result in denied claims.

Prior authorization requirements will be added to the codes below:

- J9216 — injection, interferon gamma-1b (Actimmune), 3 million units
- J2170 — injection, mecasermin (Increlex), 1 mg
- J9025 — injection, azacitidine (Vidaza), 1 mg

Not all prior authorization requirements are listed here. Detailed prior authorization 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 prior authorization requirements if they are not able to access the website.

Help ensure members receive a comprehensive medication review

CMS requires that Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) offer a comprehensive medication review (CMR) as part of the Medication Therapy Management (MTM) program. A CMR is offered to members with three or more chronic diseases who are receiving at least eight maintenance medications.

Amerigroup STAR+PLUS MMP utilizes trained pharmacists to contact our qualifying members. Prescription claims data is reviewed to identify members being treated for three or more chronic diseases from six core chronic conditions. Amerigroup STAR+PLUS MMP also encourages retail pharmacists to help members complete a CMR.

Ask STAR+PLUS MMP members if they have received a letter or postcard inviting them to participate in a MTM program and encourage them to complete the medication review. The interactive consultation is followed by a written medication summary provided to the member. Members are encouraged to bring the summary to their provider appointments to facilitate discussion. The CMR will help ensure STAR+PLUS MMP members understand their medication regimen, the importance of taking their medications as prescribed and possible interactions.

If the member has three or more chronic diseases from the six core chronic conditions listed below, is taking multiple prescriptions and has not already participated in the MTM program, ask the STAR+PLUS MMP member to contact one of our trained pharmacists at 1-844-866-3730 to complete the medication review.

Hepatitis C	Dyslipidemia
Chronic heart failure	Hypertension
Diabetes	Respiratory disease (such as asthma, chronic obstructive pulmonary disease or chronic lung disorders)

Elective one and two vessel coronary artery bypass graft to require prior authorization

Effective February 1, 2017, Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) will require prior authorization (PA) for elective one and two vessel coronary artery bypass graft (CABG) procedures. Noncompliance with new requirements may result in denied claims.

PA requirements will be added to the following codes:

- 33510 — coronary artery bypass, vein only; single coronary venous graft
- 33511 — coronary artery bypass, vein only; two coronary venous grafts
- 33517 — coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (list separately in addition to code for primary procedure)
- 33518 — coronary artery bypass, using venous graft(s) and arterial graft(s); two venous grafts (list separately in addition to code for primary procedure)
- 33530 — reoperation, coronary artery bypass procedure or valve procedure, more than one month after original operation (list separately in addition to code for primary procedure)
- 33533 — coronary artery bypass, using arterial graft(s); single arterial graft
- 33534 — coronary artery bypass, using arterial graft(s); two coronary arterial grafts

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

For the Medicaid markets, the Utilization Review team will utilize the InterQual Procedures Criteria for CABG requests.

In absence of an existing national coverage determination or local coverage determination, the Medicare markets will utilize the InterQual Procedures Criteria for CABG requests.

Not all PA requirements are listed here. For more information, go to https://providers.amerigroup.com/TX > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool. You may also call Provider Services at 1-855-878-1785.

Prior authorization requirement change for Torisel® (temsirolimus)

On March 1, 2017, Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) will change prior authorization requirements for Torisel® (temsirolimus) for 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 prior authorization rules and must be considered first when determining coverage. Noncompliance with new requirements may result in denied claims.

Prior authorization requirements will be added to the following code:

- J9330 — Torisel® (temsirolimus)

Not all prior authorization requirements are listed here. Detailed prior authorization 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 prior authorization requirements if they are not able to access the provider website.

Clarification — requesting authorization for certain arterial duplex imaging procedures

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

We understand the need for arterial duplex imaging procedures may not be identified until patients have undergone a physiologic study or cardiac catheterization. For these cases, please contact AIM to request a clinical appropriateness review no later than 10 business days after you perform these procedures and before you submit a claim.

Please note, failure to contact AIM for review within the 10-day postservice window will result in a denial of payment.

Impacted codes are as follows:

CPT code	Brief description
93925	Dup-scan lxtr art/artl bpgs compl bi study
93926	Dup-scan lxtr art/artl bpgs uni/lmtd study
93930	Dup-scan uxtr art/artl bpgs compl bi study
93931	Dup-scan uxtr art/artl bpgs uni/lmtd study

To submit a review request, visit the AIM website (aimspecialtyhealth.com).

For additional assistance, contact AIM at 1-800-714-0040, Monday-Friday from 7 a.m.-7 p.m. CT.

Continuous interstitial glucose monitoring to require prior authorization

Effective April 1, 2017, Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) will require prior authorization (PA) for continuous interstitial glucose monitoring. Noncompliance with new requirements may result in denied claims.

PA requirements will be added to the following codes:

- 95250: ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours — sensor placement, hook-up, calibration of monitor, patient training, removal of sensor and printout of recording
- 95251: ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours — interpretation and report

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.

Not all PA requirements are listed here. For more information, go to https://providers.amerigroup.com/TX > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool. You may also call Provider Services at 1-855-878-1785.

Transitional care management services eligibility

Upon discharge from an inpatient hospital setting, STAR+PLUS MMP members are not eligible to receive transitional care management (TCM) services for a period of 30 days. Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) determines the discharge date based on the date the member received their discharge evaluation and management (E&M) visit. TCM services will be denied by Amerigroup STAR+PLUS MMP if the discharge E&M visit is not received before the TCM service.

These billing instructions apply to all individual Medicare Advantage plans including dual special needs plans and Medicare-Medicaid plans.

For more information on TCM services, refer to the CMS Transitional Care Management Services Fact Sheet available online at https://www.CMS.gov > Outreach & Education > Find Resources > MLN Products > Publications > search for Transitional Care Management Services Fact Sheet.

Update to the ClaimsCheck® upgrade to ClaimsXten™

Earlier this year, Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) announced plans for an upgrade from ClaimsCheck to McKesson's next generation claim auditing software, ClaimsXten. Due to the complexity of the software conversion, along with the expansion of software functionality that is now available, the target effective date has been moved from November 1, 2016, to April 30, 2017.

With the new software functionality, edits will be applied with greater accuracy. The new software functionality will also allow for greater flexibility with rule development and configuration.

For additional details regarding this software update, please refer to the original communication posted at https://providers.amerigroup.com/TX > Newsletters > Provider News Issue 2 2016.

HCPCS codes required for rural health clinic claims

All claims for STAR+PLUS MMP members from rural health clinics with dates of service on or after April 1, 2016, must contain an appropriate HCPCS code for each service line along with a revenue code. This pertains to contracted and noncontracted providers.

These billing instructions apply to all individual and group-sponsored Medicare Advantage plans including dual special needs plans and Medicare-Medicaid plans.

HCPCS codes required for rural health clinic claims

All claims for Amerigroup Amerivantage (Medicare Advantage) members from rural health clinics with dates of service on or after April 1, 2016, must contain an appropriate HCPCS code for each service line along with a revenue code. This pertains to contracted and noncontracted providers.

These billing instructions apply to all individual and group-sponsored Medicare Advantage plans including dual special needs plans and Medicare-Medicaid plans.

Clarification — requesting authorization for certain arterial duplex imaging procedures

Amerigroup Community Care is collaborating with AIM Specialty Health (AIM) to conduct medical necessity reviews for vascular ultrasound management for Amerigroup Amerivantage (Medicare Advantage) members.

We understand the need for arterial duplex imaging procedures may not be identified until patients have undergone a physiologic study or cardiac catheterization. For these cases, please contact AIM to request a clinical appropriateness review no later than 10 business days after you perform these procedures and before you submit a claim.

Please note, failure to contact AIM for review within the 10-day postservice window will result in a denial of payment.

Impacted codes are as follows:

CPT code	Brief description
93925	Dup-scan lxtr art/artl bpgs compl bi study
93926	Dup-scan lxtr art/artl bpgs uni/lmtd study
93930	Dup-scan uxtr art/artl bpgs compl bi study
93931	Dup-scan uxtr art/artl bpgs uni/lmtd study

To submit a review request, visit the AIM website (aimspecialtyhealth.com).

For additional assistance, contact AIM at 1-800-714-0040, Monday-Friday from 7 a.m.-7 p.m. CT.

New Policy - Medicaid
Corrected Claims
(Policy 16-001, effective 05/15/2017)

Amerigroup allows reimbursement for a Corrected Claim within 120 days of the last payment notification (Explanation of Payment [EOP]/ Remittance Advice [RA]). Providers resubmitting paper claims for corrections must clearly mark the claim "**Corrected Claim**." Corrected Claims submitted electronically must have the applicable frequency code. Failure to mark the claim appropriately may result in denial of the claim as a duplicate.

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

New Policy - Amerivantage
Corrected Claims
(Policy 16-001, effective 05/15/2017)

Amerigroup allows reimbursement for a Corrected Claim when received within the applicable timely filing requirements of the original claim. The Corrected Claim must be received within the timely filing limit due to the initial claim not being considered a clean claim. Amerigroup follows the standard of:

- Within 12 months during the timely filing period for participating and nonparticipating providers and facilities

Providers resubmitting paper claims for corrections must clearly mark the claim "**Corrected Claim**." Corrected Claims submitted electronically must have the applicable frequency code. Failure to mark the claim appropriately may result in denial of the claim as a duplicate.

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