Provider Newsletter

Amerigroup
An Anthem Company

https://providers.amerigroup.com/TX

August 2019

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Prepayment clinical validation review process

Effective with dates of service on or after September 5, 2019, Amerigroup will update our audit process for claims with modifiers used to bypass claim edits. Modifier reviews will be conducted through a prepayment clinical validation review process. Claims with modifiers such as -25, -59, -57, LT/RT and other anatomical modifiers will be part of this review process.

In accordance with published reimbursement policies that document proper usage and submission of modifiers, the clinical validation review process will evaluate the proper use of these modifiers in conjunction with the edits they are bypassing (such as NCCI). Clinical analysts who are registered nurses and certified coders will review claims pended for validation, along with any related services, to determine whether it is appropriate for the modifier to bypass the edit.

If you believe a claim denial should be reviewed, please follow the applicable provider appeal process (outlined with the denial notification) and include medical records that support the usage of the modifier applied when submitting your appeal.

TX-NL-0200-19

Unspecified diagnosis code update

Amerigroup previously communicated that as of July 1, 2018, we now require unspecified diagnosis codes to be used only when an established diagnosis code does not exist to describe the diagnosis for our members. Our goal is to align with ICD-10-CM requirements, using more specific diagnosis codes when available and appropriate. This includes codes that ICD-10-CM provides with laterality specifying whether the condition occurs on the left, right or is bilateral. The target effective date has been delayed for implementing the corresponding code edit. However, providers are encouraged to ensure their billing staff is aware of the required specificity in reporting ICD-10-CM diagnosis codes to prevent future denials.

Amerigroup will be sending out a follow-up article to inform providers of when to expect this requirement to go-live and any additional details for the changes made.

TX-NL-0201-19

AIM Specialty Health programs may require documentation

Currently, providers submit various pre-service requests to AIM Specialty Health® (AIM). As part of our ongoing quality improvement efforts, for outpatient diagnostic imaging services, cardiac procedures and sleep studies. AIM may request documentation to support the clinical appropriateness of certain requests.

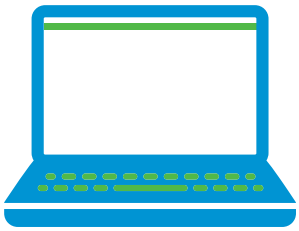
When requested, providers should verify information by submitting documentation from the medical record and/or participating in a pre-service consultation with an AIM physician reviewer. If medical necessity is not supported, the request may be denied as not medically necessary.

TX-NL-0210-19

Coming soon: electronic attachments

As we prepare for the potential regulatory-proposed standards for electronic attachments, Amerigroup will be implementing X12 275 electronic attachment transactions (version 5010) for claims.

Standard electronic attachments will bring value to you by eliminating the need for mailing paper records and reducing processing time overall.



Amerigroup and Availity will pilot electronic data interchange batch electronic attachments with previously selected providers. Both solicited and unsolicited attachments will be included in our pilots.

Attachment types

Solicited attachments:
The provider sends a claim, and the payer determines there is not enough information to process the claim. The payer will then send the provider a request for additional information (currently done via letter). The provider can then send the solicited attachment transaction, with the documentation requested, to process the claim.

Unsolicited attachment:
When the provider knows that the payer requires additional information to process the claim, the provider will then send the X12 837 claim with the Paper Work Included segment tracking number. Then, the provider will send the X12 275 attachment transaction with the additional information and include the tracking number that was sent on the claim for matching.

What you can do

As we prepare for this change, you can help now by having conversations with your clearinghouse and/or electronic health care records vendor to determine their ability to set up the X12 275 attachment transaction capabilities.

In addition, you should be on the lookout for additional information and details about working with Amerigroup and Availity to send attachments via electronic batch.

TX-NL-0212-19

New service types added to Availity

Enhancements have been made to the Availity Portal that will now allow you to access more service types when using the Eligibility and Benefits Inquiry tool and will also allow us to share even more valuable information with you electronically.

You may have already noticed new additions to service types, including:

- Medically related transportation.
- Long-term care.
- Acupuncture.
- Respite care.
- Dermatology.
- Sleep study therapy (found under diagnostic medical).
- Allergy testing.

Note, although there is an extensive list of available benefit types available when submitting an eligibility and benefits request, these types do vary by payer.

Here are some important points to remember when selecting service types:

- The benefit/service type field is populated with the last benefit type you selected. If you don't see a specific benefit in the results, submit a new request and select the specific benefit type/service code.
- You have the ability to inquire about 50 patients at one time using the Add Multiple Patients feature.

TX-NL-0204-19

Pharmacy management information

Need up-to-date pharmacy information?

Log in to our provider website to access our formulary, prior authorization forms, *Preferred Drug List* and process information.

Have questions about the formulary or need a paper copy?

Call our Pharmacy department at 1-800-454-3730. Our Member Services representatives serve as advocates for our members. To reach Member Services for STAR Kids, call 1-800-756-4600. For all others, please call 1-800-600-4441.

TX-NL-0215-19

Update your information

We continually update our provider directories to ensure that your current practice information is available to our members. At least 30 days prior to making any changes to your practice — including updating your address and/or phone number, adding or deleting a physician from your practice, closing your practice to new patients, etc. — please notify us by sending changes using practice letterhead to txproviderrelations@amerigroup.com.

Thank you for your help and continued efforts in keeping our records up-to-date.

TX-NL-0215-19

Medical Policies and *Clinical Utilization Management Guidelines* update

The *Medical Policies* and *Clinical Utilization Management (UM) Guidelines* below were developed and/or revised to support clinical coding edits. Note, several policies and guidelines were revised to provide clarification only and are not included. Existing precertification requirements have not changed. Note, not all of the services and codes referenced within these guidelines are reimbursed under Medicaid or CHIP. Please refer to Medicaid or CHIP guidelines for coverage and reimbursement information.

To view a guideline, visit https://medicalpolicies.amerigroup.com/am_search.html.

Updates:

- **MED.00110 — Growth Factors, Silver-based Products and Autologous Tissues for Wound Treatment and Soft Tissue Grafting** was revised to add bioengineered autologous skin-derived products (e.g., SkinTE) as investigational and not medically necessary.
- **MED.00126 — Fractional Exhaled Nitric Oxide and Exhaled Breath Condensate Measurements for Respiratory Disorders** was revised to add Nasal Nitric Oxide as investigational and not medically necessary in the diagnosis and monitoring of asthma and other respiratory disorders.
- **SURG.00037 — Treatment of Varicose Veins (Lower Extremities)** was revised:
  - To replace "nonsurgical management" with "conservative therapy" in the medically necessary criteria
  - To add sclerotherapy used in conjunction with a balloon catheter (e.g., catheter-assisted vein sclerotherapy [KAVS] procedure) as investigational and not medically necessary
- **TRANS.00035 — Mesenchymal Stem Cell Therapy for the Treatment of Joint and Ligament Disorders, Autoimmune, Inflammatory and Degenerative Diseases** (previous title: Mesenchymal Stem Cell Therapy For Orthopedic Indications)
  - Includes the revised position statement: "Mesenchymal stem cell therapy is considered investigational and not medically necessary (INV&NMN) for the treatment of joint and ligament disorders caused by injury or degeneration as well as autoimmune, inflammatory and degenerative diseases."
  - Expands the document's scope to address non-FDA approved uses of mesenchymal stem cell therapy
- The following **AIM Specialty Health® updates** took effect on January 24, 2019:
  - Advanced Imaging
    - Imaging of the Heart
    - Imaging of the Head and Neck
  - Arterial Ultrasound
  - Joint Surgery
  - Sleep Disorder Management Diagnostic and Treatment

Medical Policies

On January 24, 2019, the Medical Policy and Technology Assessment Committee (MPTAC) approved several *Medical Policies* applicable to Amerigroup. These guidelines take effect 30 days from posting. View the full update online for a list of the policies.

Clinical UM Guidelines

On January 24, 2019, the MPTAC approved several *Clinical UM Guidelines* applicable to Amerigroup. These guidelines were adopted by the medical operations committee for Amerigroup members on March 28, 2019. These guidelines take effect 30 days from posting. View the full update online for a list of the guidelines.

Read more online.

TX-NL-0211-19

Prior authorization requirements

Hyperbaric oxygen and supervision of hyperbaric oxygen therapy

Effective October 1, 2019, prior authorization (PA) requirements will change for hyperbaric oxygen and supervision of hyperbaric oxygen therapy to be covered for Amerigroup members.

PA requirements will be added to the following:

- Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval (G0277)
- Physician attendance and supervision of hyperbaric oxygen therapy, per session (99183)

TX-NL-0216-19

Durable medical equipment

Effective December 1, 2019, prior authorization (PA) requirements will change for the codes listed below. The listed codes will require PA by Amerigroup for STAR members.

PA requirements will be added to the following:

- All lower extremity prosthesis — shank foot system with vertical loading pylon (L5987)
- Gait trainer, pediatric size — anterior support, includes all accessories and components (E8002)
- Wheelchair, pediatric size — tilt-in-space, folding, adjustable, without seating system (E1234)
- Wheelchair, pediatric size — tilt-in-space, rigid, adjustable, without seating system (E1233)
- Transport chair, pediatric size (E1037)
- Multi-positional patient transfer system with integrated seat, operated by care giver (E1035)
- Wheelchair accessory — ventilator tray, gimbaled (E1030)
- Water circulating heat pad with pump (E0217)

TX-NL-0218-19

Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, including definitions and specific contract provisions/exclusions, take precedence over these PA rules and must be considered first when determining coverage. **Noncompliance with new requirements may result in denied claims.**

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

- Web: https://www.availity.com
- Fax: 1-800-964-3627; 1-866-249-1271 (DME)
- Phone: 1-800-454-3730

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the Precertification Lookup Tool at https://www.availity.com via https://providers.amerigroup.com/TX. Contracted and noncontracted providers who are unable to access the Availity Portal can call Provider Services at 1-800-454-3730.

Prepayment clinical validation review process

View the article in the Medicaid section.

TX-NL-0200-19

AIM Specialty Health programs may require documentation

View the article in the Medicaid section.

TX-NL-0210-19

Coming soon: electronic attachments

View the article in the Medicaid section.

TX-NL-0212-19

New service types added to Availity

View the article in the Medicaid section.

TXD-NL-0140-19

Unspecified diagnosis code update

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) previously communicated that as of July 1, 2018, we now require unspecified diagnosis codes to be used only when an established diagnosis code does not exist to describe the diagnosis for Amerigroup STAR+PLUS MMP members. Our goal is to align with ICD-10-CM requirements, using more specific diagnosis codes when available and appropriate. This includes codes that
ICD-10-CM provides with laterality specifying whether the condition occurs on the left, right or is bilateral. The target effective date has been delayed for implementing the corresponding code edit. However, providers are encouraged to ensure their billing staff is aware of the required specificity in reporting ICD-10-CM diagnosis codes to prevent future denials.

Amerigroup STAR+PLUS MMP will be sending out a follow-up article to inform providers of when to expect this requirement to go-live and any additional details.

TXD-NL-0138-19

Hearing Care Solutions began service June 6, 2019

As of June 6, 2019, Hearing Care Solutions (HCS) began serving members enrolled in Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan). Members may contact HCS at 1-855-312-2545 to arrange for an appointment with a provider in the HCS network. Providers interested in joining the HCS network may call 1-877-583-2842.

TXD-NL-0149-19

Prepayment clinical validation review process

View the article in the Medicaid section.

TX-NL-0200-19

Unspecified diagnosis code update

View the article in the Medicaid section.

TX-NL-0201-19

AIM Specialty Health programs may require documentation

View the article in the Medicaid section.

TX-NL-0210-19

Coming soon: electronic attachments

View the article in the Medicaid section.

TX-NL-0212-19

New service types added to Availity

View the article in the Medicaid section.

TX-NL-0204-19

Special needs plans — provider training required

Amerigroup offers special needs plans (SNPs) to people eligible for both Medicare and Medicaid benefits or who are qualified Medicare Advantage beneficiaries. SNPs provide enhanced benefits to people eligible for both Medicare and Medicaid. These include supplemental benefits such as hearing, dental, vision and transportation to medical appointments. Some SNPs include a card or catalog for purchasing over-the-counter items. SNPs do not charge premiums. As you are aware, CMS regulations protect SNP members from balance billing.

Providers who are contracted for SNPs are required to take annual training to stay current on plan benefits and requirements, including coordination-of-care and model-of-care elements. Providers contracted for our SNPs received notices in the first quarter of 2019 containing information for online, self-paced training through our training site hosted by SkillSoft. Each provider contracted for our SNPs is required to complete this annual training and select the attestation stating they have completed the training. Attestations can be completed by individual providers or at the group level with one signature.

AGPCRNL-0033-19

New Policy — Medicaid and Medicare Advantage Drug Screen Testing

(Policy 19-001, effective 10/01/19)

Amerigroup allows reimbursement for all definitive drug classes and presumptive drug testing on the same day. Effective October 1, 2019, definitive drug testing may be done to confirm the results of a negative presumptive test or to identify substances when there is no presumptive test available. Provider documentation in the member's medical records should reflect that the test was properly ordered and support that the order was based on the result of the presumptive test.

In the event a reference lab (POS = 81) performs both presumptive and definitive tests on the same date of service, records should reflect that the ordering/treating provider issued a subsequent order for definitive testing based on the results of the presumptive tests.

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

TX-NL-0198-19

New Policy — Medicare-Medcaid Plan Drug Screen Testing

(Policy 19-001, effective 10/01/19)

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) allows reimbursement for presumptive and definitive drug screening services. In certain circumstances, Amerigroup STAR+PLUS MMP allows reimbursement for presumptive drug testing by instrumented chemistry analyzers and definitive drug screening services for the same member provided on the same day by a reference laboratory.

Definitive drug testing may be done to confirm the results of a negative presumptive test or to identify substances when there is no presumptive test available. Provider documentation in the member's medical records should reflect that the test was properly ordered and support that the order was based on the result of the presumptive test.

In the event a reference lab (POS = 81) performs both presumptive and definitive tests on the same date of service, records should reflect that the ordering/treating provider issued a subsequent order for definitive testing based on the results of the presumptive tests.

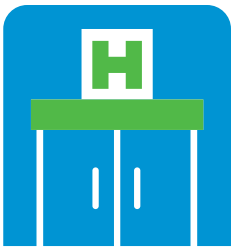
For additional information, refer to the Drug Screen Testing reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > TX MMP.

TXD-NL-0135-19

New Policy — Medicare Advantage

Emergency Department: Level of Evaluation and Management Services

(Policy 19-002, effective 09/01/19)



Effective September 1, 2019, Amerigroup Community Care classifies the intensity/complexity of facility emergency department (ED) interventions used for services rendered with an evaluation and management (E&M) code level. E&M services will be reimbursed based on this classification at the highest E&M level supported on the claim. Facilities must utilize appropriate CPT/HCPCS and revenue codes for all services rendered during the ED encounter.

Please refer to the Emergency Department: Level of Evaluation and Management Services reimbursement policy for additional details at https://providers.amerigroup.com/TX.

Providers who feel that the level of reimbursement should be reconsidered can file a claims dispute in accordance with the terms of their contract. Claims disputes require a statement as to why the intensity/complexity would require a different level of reimbursement as well as the medical records, which should clearly document the facility interventions performed and referenced in that statement.

TX-NL-0213-19