

Provider Newsletter



Amerigroup

An Anthem Company

<https://providers.amerigroup.com/TX>

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Medicaid

Verifying and updating your provider information

Maintaining accurate provider information is critically important to ensure that our members have timely and accurate access to care.



Additionally, Amerigroup is required by Centers for Medicare & Medicaid Services (CMS) to include accurate information in provider directories for certain key provider data elements. To remain compliant with state requirements, providers are required to notify us of a change in address or practice status within 10 days of the effective date of the change.

Additional key data elements include physician name, phone number, hospital affiliations and medical group affiliations.

Notify us by sending changes, including effective date, using practice letterhead to txproviderrelations@amerigroup.com. Thank you for your help and continued efforts in keeping our records up to date.

TX-NL-0255-19

Revision to *Evaluation and Management Services — Over-Coded Services* postponed

Amerigroup previously communicated that as of October 27, 2019, we would assess selected claims for evaluation and management (E&M) services using an automated analytic solution to ensure payments are aligned with national industry coding standards. The target effective date has been delayed.



Amerigroup will send out a follow-up article to inform providers of the revised effective date and any additional details for the changes made. The update that was posted entitled *Evaluation and Management Services — Over-Coded Services* has been removed.

TX-NL-0264-19

InterQual 2019.1 update

Effective January 17, 2020, Memorial Hermann Hospital should use InterQual® 2019.1 criteria.

TX-NL-0258-19

Improving the patient experience

Are you looking for innovative ways to improve your patients' health care experiences?



Numerous studies have shown a patient's primary health care experience and, to some extent, their health care outcomes, are largely dependent upon health care provider and patient interactions. That's

why Amerigroup has an online learning site called *My Diverse Patients* that offers insight on how to communicate with your diverse patient population, including a course titled: [*What Matters Most: Improving the Patient Experience*](#). Learn more by visiting the course link or on the *My Diverse Patients* site at www.mydiversepatients.com.

TX-NL-0250-19

Medical drug *Clinical Criteria* updates

September 2019 update

On September 19, 2019, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the medical drug benefit for Amerigroup. These policies were developed, revised or reviewed to support clinical coding edits.

Effective dates are reflected in the [Clinical Criteria web posting](#).

TX-NL-0256-19

The *Clinical Criteria* is publicly available on our [provider website](#). Visit [Clinical Criteria](#) to search for specific policies.

Please submit your questions to [email](#).

Behavioral health services documentation

Behavioral health medical records

For behavioral health (BH) practitioners, helping patients is the top priority. Documenting each patient encounter accurately and efficiently is critical for BH practitioners to meet their patients' ongoing needs. Improperly documented records that are missing relevant information can yield insufficient services and unintended complications.

Federal laws, state laws and policies set forth by Amerigroup all mandate the proper documentation of medical services. These laws require practitioners to maintain the records necessary to fully disclose the extent of the services, care and supplies furnished to beneficiaries, as well as to support claims billed. Proper documentation helps to protect BH practitioners from challenges to furnished treatment and to avoid civil, criminal and administrative penalties and litigation.

General BH medical record documentation requirements

BH services must meet specific requirements for reimbursement. Documented services must:

- Meet the state's Medicaid and CHIP program rules.
- Reflect medical necessity and justify the treatment and clinical rationale.
- Reflect active treatment.
- Be complete, concise and accurate, including the face-to-face time spent with the patient.
- Be legible, signed with credentials and dated.
- Be maintained and available for review.
- Be coded correctly for billing purposes.



Prevent problems — self audit

BH practitioners have specific responsibilities when they accept reimbursement from a government program. They have a duty to ensure that the claims submitted to Federal health care programs are true and accurate, and ensure that their medical record documentation supports and justifies billed services. All practitioners' documentation is open to scrutiny by employers, Federal and state reviewers, and auditors. Practitioners can protect themselves and their practices by implementing an internal self auditing strategy and self-referral where appropriate.

TXPEC-3371-19



Read more online.

Resources to support your diverse patient panel

As patient panels grow more diverse and needs become more complex, providers and office staff need more support to help address patients' needs. Amerigroup wants to help.

Cultural competency resources

We have cultural competency resources available on our provider website. Leveraging content created by the Industry Collaboration Effort Cultural and Linguistic Workgroup, the *Cultural Competency Training* and the *Caring for Diverse Populations Toolkit* have enhanced content.

<i>Cultural Competency Training includes:</i>	<i>Caring for Diverse Populations Toolkit includes:</i>
<ul style="list-style-type: none">■ Enhanced content regarding culture including language and the impact on health care.■ A cultural competency continuum that can help providers assess their level of cultural competency.■ Guidance on working effectively with interpreters.■ Comprehensive content on serving patients with disabilities.	<ul style="list-style-type: none">■ Comprehensive information on working with diverse patients and effectively supporting culture, language and disabilities in health care delivery.■ Tools and resources to help mitigate barriers including materials that can be printed and made available for patients in your office.■ Guidance on regulations and standards for cultural and linguistic services.

In addition, providers can access <https://mydiversepatients.com> for tools and resources that are accessible from any smartphone, tablet or desktop. Providers will find free continuing medical education courses that cover topics relevant to providing culturally competent care and services for diverse individuals.

Prevalent non-English languages (based on population data)

Like you, Amerigroup wants to effectively serve the needs of diverse patients. It's important for us all to be aware of the cultural and linguistic needs of our communities, so we are sharing recent data about the prevalent non-English languages spoken by five percent or 1,000 individuals in Texas. (Source: American Community Survey, 2016 American Community Survey 5-Year Estimates, Table B16001, generated 10/03/2018)

- Prevalent non-English languages in TX:
 - Spanish
 - Vietnamese



Language support services

As a reminder, Amerigroup provides language support services for our members with limited English proficiency (LEP) or hearing, speech or visual impairments. Please see the provider manual at <https://providers.amerigroup.com/TX> for details on the available services and how to access them.

TX-NL-0253-19

Medicare-Medicaid Plan

Pharmacy benefit manager change to IngenioRx

Earlier this year, Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) announced the launch of IngenioRx, our new pharmacy benefits manager (PBM). Effective January 1, 2020, IngenioRx started serving our Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) members' prescription drug coverage.

With the transition to the new PBM, Amerigroup STAR+PLUS MMP members will receive new ID cards containing all the information needed to process claims and access member services. Members will need to use their new ID cards to fill prescriptions beginning January 1, 2020.



Transferring prescriptions

Mail order

Members who fill mail order prescriptions will need to fill their prescriptions with IngenioRx beginning January 1, 2020. We will automatically transfer member mail order prescriptions to IngenioRx home delivery pharmacy for members currently using Express Scripts Mail Order Pharmacy. Members will receive further instructions by mail on initiating IngenioRx home delivery pharmacy services.

Specialty pharmacy

Members who now fill their specialty drugs with Express Scripts' Accredo will have a few choices of specialty pharmacy providers. Members may:

- Keep Accredo as their specialty pharmacy.
- Transfer their specialty pharmacy prescriptions to the new IngenioRx Specialty Pharmacy.
- Select another participating specialty pharmacy.

Members will receive information by mail about their specialty pharmacy options, including further

instructions on initiating IngenioRx specialty pharmacy.

Retail pharmacy

It is expected that most members will be able to continue using their current retail pharmacy. In the event a member's retail pharmacy is not in the new pharmacy network, we will notify the member directly.

Controlled substances and compound prescriptions

Prescriptions for controlled substances, currently filled by Express Scripts Mail Order Pharmacy, cannot be transferred to another pharmacy under federal law. Members currently receiving these medications, who will use IngenioRx for their mail order provider, will need a new prescription



Read more online.

sent to IngenioRx. Compound prescriptions are

Healthcare Quality Patient Assessment Form and Patient Assessment Form

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) offers the *Healthcare Quality Patient Assessment Form (HQPAF)/Patient Assessment Form (PAF)*. This article focuses on key tips that may help participating providers successfully close out their 2019 HQPAF/PAF.

Dates and tips to remember:

- Amerigroup STAR+PLUS MMP encourages you to review your patient population as soon as possible. You can help patients schedule an in-office visit. These appointments help the patient manage chronic conditions, which impact the health status of the patient.
- At the conclusion of each office visit with the patient, providers who are participating in the HQPAF/PAF program are asked to complete and return a HQPAF/PAF. The form should be completed based on information collected during the visit. Participating providers may continue to use the 2019 version of the HQPAF/PAF for encounters taking place on or before December 31, 2019. Amerigroup STAR+PLUS MMP will accept the 2019 version of the HQPAF/PAF for 2019 encounters until midnight on January 31, 2020. Important note: HQPAF/PAF for 2019 dates of service that are rejected due to provider error and corrected by the provider may be submitted through March 31, 2020.
- If not already submitted, participating providers are required to submit an [Account Setup Form \(ASF\)](#), W9 and a completed [direct deposit enrollment](#) by March 31, 2020. Participating providers should call 1-877-751-9207 if they have questions regarding this requirement. Failure by a participating provider to comply with this requirement will result in forfeiture of the provider payment for submitted 2019 HQPAF/PAF program, if applicable.



If you have any questions about the PAF or HQPAF programs, please call 1-877-751-9207 from 8:30 a.m.-6:30 p.m. Central time Monday-Friday.

TXD-NL-0171-19

Medical drug Clinical Criteria updates

August 2019 update

On August 16, 2019, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the medical drug benefit for Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan). These policies were developed, revised or reviewed to support clinical coding edits.

Effective dates are reflected in the [Clinical Criteria web posting](#).

TXD-NL-0174-19

September 2019 update

On September 19, 2019, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the medical drug benefit for Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan). These policies were developed, revised or reviewed to support clinical coding edits.

Effective dates are reflected in the [Clinical Criteria web posting](#).

TXD-NL-0172-19

The *Clinical Criteria* is publicly available on our [provider website](#). Visit [Clinical Criteria](#) to search for specific policies.

Please submit your questions to [email](#).

Medical Policies and Clinical Utilization Management Guidelines update

The *Medical Policies, Clinical Utilization Management (UM) Guidelines* and *Third-Party Criteria* 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. Please refer to Medicaid guidelines for coverage and reimbursement information.

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

August 2019 update

Notes/updates:

Updates marked with an asterisk (*) denote that the criteria may be perceived as more restrictive.

- *GENE.00023 — Gene Expression Profiling of Melanomas
 - Expanded Scope to include testing for the diagnosis of melanoma
 - Updated investigational and not medically necessary (INV&NMN) statement to include suspicion of melanoma
- *GENE.00046 — Prothrombin G20210A (Factor II) Mutation Testing
 - Revised title
 - Expanded scope and position statement to include all prothrombin (factor II) variations
- *MED.00110 — Growth Factors, Silver-based Products and Autologous Tissues for Wound Treatment and Soft Tissue Grafting
 - Revised title
 - Added new INV&NMN statements addressing Autologous adipose-derived regenerative cell therapy and use of autologous protein solution
- *SURG.00052 — Intradiscal Annuloplasty Procedures (Percutaneous Intradiscal Electrothermal Therapy [IDET], Percutaneous Intradiscal Radiofrequency Thermocoagulation [PIRFT] and Intradiscal Biacuplasty [IDB])
 - Revised title
 - Combined the three INV&NMN statements into a single statement
 - Added Intraosseous basivertebral nerve ablation to the INV&NMN statement
- *TRANS.00035 — Mesenchymal Stem Cell Therapy for the Treatment of Joint and Ligament Disorders, Autoimmune, Inflammatory and Degenerative Diseases
 - Revised title
 - Expanded Position Statement to include non-hematopoietic adult stem cell therapy
- *CG-ANC-07 — Inpatient Interfacility Transfers
 - Added NMN statements regarding admission and subsequent care at the receiving facility
- *CG-DME-46 — Pneumatic Compression Devices for Prevention of Deep Vein Thrombosis of the Extremities
 - Revised title
 - Expanded Scope
 - Revised MN statement to include upper extremities
- The following AIM Specialty Health® updates were approved:
 - *Spine Surgery
 - *Radiation Oncology-Brachytherapy Brachytherapy, intensity modulated radiation therapy (IMRT), stereotactic body radiation therapy (SBRT) and stereotactic radiosurgery (SRS) treatment guidelines
 - Sleep Disorder Management Diagnostic & Treatment Guidelines
 - Advanced Imaging
 - Imaging of the Heart: Cardiac CT for Quantitative Evaluation of Coronary Calcification
 - *Imaging of the Abdomen and Pelvis
- MCG Customization for Repair of Pelvic Organ Prolapse (W0163) — Updated Coding Section

Medical Policies and Clinical UM Guidelines update (cont.)

Medical Policies

On August 22, 2019, the Medical Policy and Technology Assessment Committee (MPTAC) approved several *Medical Policies* applicable to Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan). These guidelines take effect December 27, 2019. View the update online for a list of the policies.



Read more online.

Clinical UM Guidelines

On August 22, 2019, the MPTAC approved several *Clinical UM Guidelines* applicable to Amerigroup STAR+PLUS MMP. These guidelines were adopted by the medical operations committee for Amerigroup STAR+PLUS MMP members on September 26, 2019. These guidelines take effect December 27, 2019. View the update online for a list of the guidelines.

TXD-NL-0169-19

Medicare Advantage

Introducing two new Medicare Advantage special needs plans for 2020

As we continue our efforts to provide high-quality, member-focused health plans for Medicare Advantage beneficiaries, Amerigroup Community Care is offering an Institutional Special Needs Plan (I-SNP) and a Chronic Special Needs Plan (C-SNP) in 2020. These special needs plans provide members with the benefits of integrated care and case management through a holistic approach while promoting continuity of care and preserving provider choice.

MEMBER



Read more online.

AGPCRNL-0079-19

Medical drug *Clinical Criteria* updates

August 2019 update

On August 16, 2019, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the medical drug benefit for Amerigroup Community Care. These policies were developed, revised or reviewed to support clinical coding edits.

Effective dates are reflected in the [Clinical Criteria web posting](#).

AGPCRNL-0071-19

September 2019 update

On September 19, 2019, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the medical drug benefit for Amerigroup Community Care. These policies were developed, revised or reviewed to support clinical coding edits.

Effective dates are reflected in the [Clinical Criteria web posting](#).

AGPCRNL-0077-19

The *Clinical Criteria* is publicly available on our [provider website](#). Visit [Clinical Criteria](#) to search for specific policies.

Please submit your questions to [email](#).

Benefits update for Special Supplemental Benefits for the Chronically Ill

Amerigroup Community Care filed a number of supplemental benefits under new guidelines released by the Centers for Medicare & Medicaid Services (CMS). The guidelines, known as Special Supplemental Benefits for the Chronically Ill (SSBCI), allow Medicare Advantage (MA) plans to offer expanded benefits/services, provided they have a reasonable expectation of improving or maintaining the health or overall function of the enrollee as it relates to the chronic condition or illness.

New benefits filed under the new SSBCI guideline include nutrition benefits (Healthy Nutrition, Prescribed Nutrition), a pest control benefit and a benefit providing support to our members with service dogs through the *Americans with Disabilities Act*. Not all benefits are available on every MA plan.

To comply with CMS guidance, Amerigroup must ascertain that the member meets the criteria defined by CMS for being chronically ill. In some cases, information will be available in patient records. In other cases, Amerigroup will need to contact providers to ensure that member has a qualifying condition and that, as the member's physician, they concur this benefit meets the standards of helping improve or maintain the member's condition.

Amerigroup encourages our members to consult with their physician when selecting a benefit. As some of these benefits are elective and include other options, providers may be able to help their patients make the most appropriate benefit choice for their needs.

For more information on SSBCI, visit the CMS website at <https://go.cms.gov/36iC952>.

AGPCRNL-0083-19

Healthcare Quality Patient Assessment Form and Patient Assessment Form

Amerigroup Community Care offers the *Healthcare Quality Patient Assessment Form (HQPAF)/Patient Assessment Form (PAF)*. This article focuses on key tips that may help participating providers successfully close out their 2019 HQPAF/PAF.

Dates and tips to remember:

- Amerigroup encourages you to review your patient population as soon as possible. You can help patients schedule an in-office visit. These appointments help the patient manage chronic conditions, which impact the health status of the patient.
- At the conclusion of each office visit with the patient, providers who are participating in the HQPAF/PAF program are asked to complete and return a HQPAF/PAF. The form should be completed based on information collected during the visit. Participating providers may continue to use the 2019 version of the HQPAF/PAF for encounters taking place on or before December 31, 2019. Amerigroup will accept the 2019 version of the HQPAF/PAF for 2019 encounters until midnight on January 31, 2020. Important note: HQPAF/PAF for 2019 dates of service that are rejected due to provider error and corrected by the provider may be submitted through March 31, 2020.
- **If not already submitted, participating providers are required to submit** an [Account Setup Form \(ASF\)](#), W9 and a completed [direct deposit enrollment](#) by March 31, 2020. Participating providers should call 1-877-751-9207 if they have questions regarding this requirement. Failure by a participating provider to comply with this requirement will result in forfeiture of the provider payment for submitted 2019 HQPAF/PAF program, if applicable.



If you have any questions about the PAF or HQPAF programs, please call 1-877-751-9207 from 9:30 a.m.-7:30 p.m. Eastern time, Monday-Friday.

AGPCRN-0075-19

New CMS requirement: Hospitals must use Medicare Outpatient Observation Notice

CMS requires that all hospitals and critical access hospitals (CAHs) provide written notification and an oral explanation to individuals receiving observation services as outpatients for more than 24 hours.

Hospitals should use the Office of Management and Budget-approved standardized *Medicare Outpatient Observation Notice (MOON)*, form CMS-10611. **All hospitals and CAHs are still required to provide this statutorily required notification.** The notice and accompanying instructions are available at <https://go.cms.gov/391jZH9>.

The MOON was developed to inform all Medicare beneficiaries, including Amerigroup Community Care members, when they are an outpatient receiving observation services, and are not an inpatient of the hospital or CAH. The notice must include the reasons the individual is an outpatient receiving observation services and the implications of receiving outpatient services, such as required Medicare cost-sharing and post-hospitalization eligibility for Medicare coverage of skilled nursing facility services.

Hospitals and CAHs must deliver the notice no later than 36 hours after observation services are initiated or sooner if the individual is transferred, discharged or admitted.



AGPCARE-0338-19

2020 Medicare risk adjustment provider trainings

The Medicare Risk Adjustment Regulatory Compliance team at Amerigroup Community Care offers two provider training programs regarding Medicare risk adjustment and documentation guidelines. Information for each training is outlined below.



Medicare Risk Adjustment and Documentation Guidance (general)

- **When:** This training is offered the first Wednesday of each month from 1 p.m.-2 p.m. ET.
- **Learning objective:** This onboarding training will provide an overview of Medicare risk adjustment, including the risk adjustment factor and the hierarchical condition category (HCC) model with guidance on medical record documentation and coding.
- **Credits:** This live activity, Medicare Risk Adjustment and Documentation Guidance, from January 8, 2020-December 2, 2020, has been reviewed and is acceptable for up to one prescribed credit(s) by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

For those interested in joining us, [register](#) for one of the monthly training sessions.

Note: Dates may be modified due to holiday scheduling.

Medicare Risk Adjustment, Documentation and Coding Guidance (condition specific)

- **When:** This training is offered on the third Wednesday of every other month from noon-1 p.m. ET.
- **Learning objective:** This is a collaborative learning event with Enhanced Personal Health Care to provide in-depth disease information training pertaining to specific conditions, including an overview of their corresponding HCCs and guidance on documentation and coding.
- **Credits:** An application for CME credit has been filed with the American Academy of Family Physicians. Determination of credit is pending.

For those interested in joining us for this six-part training series, please see the list of topics and scheduled training dates below:

1. [Session one: Red flag HCCs, part one](#) — January 15, 2020
 - Training will cover HCCs most commonly reported in error as identified by CMS, including chronic kidney disease (stage five), ischemic or unspecified stroke, cerebral hemorrhage, aspiration and specified bacterial pneumonias, unstable angina, other acute ischemic heart disease, and end-stage liver disease.
2. [Session two: Red flag HCCs, part two](#) — March 18, 2020
 - Training will cover HCCs most commonly reported in error as identified by CMS, including atherosclerosis of the extremities with ulceration or gangrene, myasthenia gravis/myoneural disorders and Guillain-Barre syndrome, drug/alcohol psychosis, lung and other severe cancers, and diabetes with ophthalmologic or unspecified manifestation.
3. [Session three: Neoplasms](#) — May 20, 2020
4. [Session four: Acute, chronic and status conditions](#) — July 15, 2020
5. [Session five: Diabetes mellitus and other metabolic disorders](#) — September 16, 2020
6. [Session six: TBD](#)
(This Medicare risk adjustment webinar will cover the critical topics and updates that surface during the year.) — November 18, 2020

AGPCRNL-0078-19

Medical Policies and Clinical Utilization Management Guidelines update

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

August 2019 update

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Medical Policies

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Read more online.

Clinical UM Guidelines

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AGPCRNL-0074-19

Prior authorization requirements

CardioMEMS

Effective April 1, 2020, prior authorization (PA) requirements will change for the following CardioMEMS™ services to be covered by Amerigroup Community Care.



Read more online.

PA requirements will be added to the following codes:

- Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components (93264)
- Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30 days, including at least weekly downloads of pulmonary artery pressure recordings, interpretation(s), trend analysis and report(s) by a physician or other qualified health care professional (93264)
- Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed (33289)

AGPCRNL-0085-19

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:

- Web: <https://www.availity.com>

Not all PA requirements are listed here. PA requirements are available to contracted providers through the Availity Portal (<https://www.availity.com>). Providers may also call the Provider Services number on the back of the member's ID card for PA requirements.

Reimbursement Policies

Policy Update — Medicaid

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Effective 05/01/2020)

Currently, Amerigroup includes Early and Periodic Screening, Diagnosis and Treatment (EPSDT) component services in the reimbursement of preventive medicine evaluation and management (E&M) visits unless they are appended with Modifier 25 to indicate a significant, separately identifiable E&M service by the same physician on the same date of service.



However, effective May 1, 2020, the following EPSDT component services will be separately reimbursable from the preventive medicine E&M visit:

- Hearing screening with or without the use of an audiometer or other electronic device
- Vision screening

For additional information, refer to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) reimbursement policy at <https://providers.amerigroup.com/TX> > Quick Tools > Reimbursement Policies > [Medicaid/Medicare](#) > Prevention.

TX-NL-0224-19

Policy Update — Medicare-Medicaid Plan Modifier 62: Co-Surgeons (Effective 05/01/2020)

Effective May 1, 2020, Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) has updated the Modifier 62: Co-Surgeons reimbursement policy to expand the current policy's language, adding that Amerigroup STAR+PLUS MMP does not consider surgeons performing different procedures during the same surgical session as co-surgeons, and Modifier 62 is not required.

Assistant surgeon and/or multiple procedures rules and fee reductions apply if a co-surgeon acts as an assistant in performing additional procedure(s) during the same surgical session.

Please note that assistant surgeon rules do not apply to procedures appropriately billed with Modifier 62.

Please visit <https://providers.amerigroup.com/TX> > Provider Resources & Documents > Quick Tools > Reimbursement Policies > Texas MMP > Coding to view the Modifier 62: Co-Surgeons reimbursement policy for additional information regarding percentages and reimbursement criteria.

TXD-NL-0145-19

Policy Update —

Medicaid

Multiple and Bilateral Surgery: Professional and Facility Reimbursement

(Policy 06-010, effective 05/01/20)

The current policy states: Amerigroup allows reimbursement to professional providers and facilities for multiple and bilateral surgery. Reimbursement is based on multiple and bilateral procedure rules in accordance with contracts and/or state guidelines for applicable surgical procedures performed at the same session by the same provider.

Effective May 1, 2020, the following updates have been made to the policy:

- Amerigroup allows reimbursement to professional providers and facilities for multiple and bilateral surgery. Reimbursement is based on multiple and bilateral procedure rules in accordance with contracts and/or state guidelines for applicable surgical procedures performed on the same day by the same provider to the same patient.
- Amerigroup also added language under the Multiple Surgery section to state that a single procedure will be subject to a multiple procedure reduction when submitted with multiple units.

Visit <https://providers.amerigroup.com/TX> > Provider Resources & Documents > Quick Tools > Reimbursement Policies > Coding to view the Multiple and Bilateral Surgery reimbursement policy for additional information regarding percentages and reimbursement criteria.

TX-NL-0245-19

Policy Update —

Medicare-Medicaid Plan

Multiple and Bilateral Surgery: Professional and Facility Reimbursement

(Policy 06-010, effective 05/01/20)

The current policy states: Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) allows reimbursement to professional providers and facilities for multiple and bilateral surgery. Reimbursement is based on multiple and bilateral procedure rules in accordance with contracts and/or state guidelines for applicable surgical procedures performed at the same session by the same provider.

Effective May 1, 2020, the following updates have been made to the policy:

- Amerigroup STAR+PLUS MMP allows reimbursement to professional providers and facilities for multiple and bilateral surgery. Reimbursement is based on multiple and bilateral procedure rules in accordance with contracts and/or state guidelines for applicable surgical procedures performed on the same day by the same provider to the same patient.
- Amerigroup STAR+PLUS MMP also added language under the Multiple Surgery section to state that a single procedure will be subject to a multiple procedure reduction when submitted with multiple units.

Visit <https://providers.amerigroup.com/TX> > Provider Resources & Documents > Quick Tools > Reimbursement Policies > Texas MMP > Coding to view the Multiple and Bilateral Surgery reimbursement policy for additional information regarding percentages and reimbursement criteria.

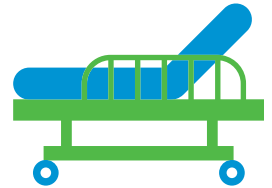
TXD-NL-0161-19

Policy Update — Medicare Advantage

Multiple and Bilateral Surgery: Professional and Facility Reimbursement

(Policy 06-010, effective 05/01/20)

Amerigroup Community Care allows reimbursement to professional providers and facilities for multiple and bilateral surgery. Effective May 1, 2020, reimbursement is based on multiple and bilateral procedure rules in accordance with contracts and/or state guidelines for applicable surgical procedures performed on the same day by the same provider to the same patient.



Visit <https://providers.amerigroup.com> to view the Multiple and Bilateral Surgery reimbursement policy for additional information regarding percentages and reimbursement criteria.

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