Provider Newsletter

Amerigroup
An Anthem Company

https://providers.amerigroup.com/tx

June 2020

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COVID-19 information from Amerigroup

Amerigroup is closely monitoring COVID-19 developments and how the novel coronavirus will impact our customers and provider partners. Our clinical team is actively monitoring external queries and reports from the Centers for Disease Control and Prevention (CDC) and the Texas Health and Human Services Commission (HHSC) to help us determine what action is necessary on our part. Amerigroup will continue to follow HHSC guidance policies.

For additional information, reference the *COVID-19 News and Resources* section on the homepage of our **website**.

TXPEC-3523-20/TXPEC-3523-20/AGPCARE-0423-20

Acquisition of Beacon Health Options

We completed acquisition of Beacon Health Options (Beacon),* a large behavioral health organization that serves more than 36 million people across the country. Bringing together our existing solid behavioral health business with Beacon's successful model and support services creates one of the most comprehensive behavioral health networks in the country. It's also an opportunity to offer best-in-class behavioral health capabilities and whole-person care solutions in new and meaningful ways to help people live their best lives.

From the standpoint of our customers and providers at this time, it's business as usual:

- Members should continue to call the customer service number on the back of their membership card or access their health plan's website for online self-service.
- Providers should continue to use the provider service contact information, websites and online self-service websites as part of their agreement with either Amerigroup Beacon.
- There will be no immediate changes to the way Amerigroup or Beacon manage their respective provider networks, contracts and fee arrangements. Amerigroup Washington, Inc. and Beacon provider networks, contracts and fee arrangements will remain separate at this time.

We know our providers continue to expect more of their health care partner, and at Amerigroup, we aim to deliver more in return.

For more details, please see the **press release**; additional details will be shared in future communications.

** Anthem, Inc. completed its acquisition of Beacon Health Options (Beacon). Beacon will operate as a wholly owned subsidiary of Anthem. Amerigroup is a wholly owned subsidiary of Amerigroup Corporation. Amerigroup Corporation is a wholly owned subsidiary of Anthem, Inc.*

TX-NL-0282-20

New behavioral health discharge call-in line

We value the strong and collaborative relationships we have with the providers in our network. As we continuously work to improve our process, we have a new option for providers to communicate with us. Effective April 1, 2020, behavioral health providers have a new discharge call-in line.

What is the impact of this change?

If a member is discharging from inpatient or residential treatment, providers may send the discharge information via the call-in line at **1-833-385-9055**. The call-in line is staffed from 8 a.m. to 8 p.m. ET, Monday through Friday. If all representatives are on calls, or if it's a weekend, the confidential voicemail will be initiated, allowing providers to leave discharge information.

Providers can also continue to submit information via fax or the **Availity Portal**.*

** Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup.*

TX-NL-0295-20

Provider collaboration and communication

Provider collaboration leads to well-informed treatment decisions. Providers work together to develop compatible courses of treatment, increasing the chances for positive health outcomes and avoiding adverse interaction.

Provider communication between a member's primary care provider or medical home and specialists, hospitals, home health agencies, and therapy providers is key to ensuring our members — your patients — receive quality care that is thorough and seamless. Each provider type is responsible for conducting timely provider-to-provider communication as appropriate. For additional information related to this requirement, visit **https://providers.amerigroup.com/ProviderDocuments/TXTX_CAID_ProviderManual.pdf.**

TX-NL-0293-20

Member Rights and Responsibilities Statement

The delivery of quality health care requires cooperation between patients, their providers and their health care benefit plans. One of the first steps is for patients and providers to understand their rights and responsibilities. Therefore, in line with our commitment to participating practitioners and members in our plans, Amerigroup has adopted a *Member Rights and Responsibilities Statement*, which is located within the provider manual. For additional information related to this requirement, visit **https://providers.amerigroup.com/ProviderDocuments/TXTX_CAID_ProviderManual.pdf.**

If you need a physical copy, call Provider Services at **1-800-454-3730**.

TX-NL-0292-20

2020 affirmative statement concerning utilization management decisions

All associates who make utilization management (UM) decisions are required to adhere to the following principles:

- UM decision making is based only on appropriateness of care and service and existence of coverage.
- We do not specifically reward practitioners or other individuals for issuing denials of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denials of benefits.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization or create barriers to care and service.

TX-NL-0286-20

MCG Care Guidelines — 24th edition

Effective August 1, 2020, Amerigroup will upgrade Medicaid and CHIP plans to the 24th edition of MCG Care Guidelines for the following modules: Inpatient Surgical Care (ISC), General Recovery Care (GRC), Chronic Care (CC), Recovery Facility Care (RFC) and Behavioral Health Care (BHC). The tables highlight new guidelines and changes that may be considered more restrictive.

Read more online.

TX-NL-0283-20

Important information about utilization management

Our utilization management (UM) decisions are based on medical necessity of the requested care and services, as well as the member's coverage according to their benefit plan. We do not reward providers or other individuals for issuing denials of coverage, service or care. Nor do we make decisions about hiring, promoting or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in underutilization. Our medical policies are available on our **provider website**.

You can request a free copy of our UM criteria from Provider Services at **1-800-454-3730**. To access UM criteria online, go to **https://providers.amerigroup.com/QuickTools/Pages/MedicalPolicies.aspx**. Providers can discuss a UM denial decision with a physician reviewer by calling us at the number listed.

We are staffed with clinical professionals who coordinate our members' care and are available 24/7 to accept precertification requests. Secured voicemail is available during off-business hours and a clinical professional will return your call within the next business day. Our staff will identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.

You can submit precertification requests through the **Availity Portal*** at **https://www.availity.com**.

Have questions about utilization decisions or the UM process?

Our Clinical team is available at **1-800-454-3730**, Monday through Friday, from 8 a.m. to 5 p.m.

For any physician peer-to-peer discussions regarding a request that is being reviewed by our medical directors, someone from your office can call **1-817-861-7768** and set up a time for a medical director to call you to discuss the case. For BH requests that are being reviewed, you can call **1-757-473-2737, ext. 106-128-2008** and schedule an appointment for a discussion.

UM fax numbers:	
DME, pain management injections, nonemergent ambulance services, home health nursing (private duty nursing, skilled nursing visits and home health aide) (excludes long-term support services)	**1-866-249-1271**
Therapy requests (speech, occupational and physical therapy)	**1-844-756-4608**
Inpatient/outpatient surgeries, back and spine procedures, and other general requests	**1-800-964-3627**
Inpatient behavioral health (BH)	**1-877-434-7578**
Outpatient BH	**1-866-877-5229**
STAR Kids long-term services and supports/personal attendant services	**1 -844-756-4604**

STAR+PLUS long-term services and supports/personal attendant services – fax numbers by service area:	
Austin	**1-877-744-2334**
El Paso	**1-888-822-5790**
Houston/Beaumont	**1-888-220-6828**
Lubbock	**1-888-822-5761**
San Antonio	**1-877-820-9014**
Tarrant/West Rural Service Area	**1-888-562-5160**

Phone numbers:	
Urgent requests	**1-800-454-3730**
Cardiology, genetic testing, radiation oncology, radiology (high-tech), sleep studies (**AIM Specialty Health**®*)	**1-800-714-0040**
Access2Care* to set up nonemergent transportation (other than ambulance)	**1-855-295-1636**

** Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup. AIM Specialty Health is an independent company providing some utilization review services on behalf of Amerigroup. Access2Care is an independent company providing transportation services on behalf of Amerigroup.*

TX-NL-0291-20

Complex Case Management program

Managing illness can be a daunting task for our members. It's not always easy for patients to understand test results, to know how to obtain essential resources for treatment, or to know whom to contact with questions and concerns.

Amerigroup is available to offer assistance in these difficult areas with our Complex Case Management program. Our care managers are part of an interdisciplinary team of clinicians and other resource professionals there to support members, families, primary care providers and caregivers. The Complex Case Management process provides education to our members which helps our members understand their illnesses and empowers our members by increasing their self-management skills. Case Management can help our members learn about care choices to ensure they have access to quality and efficient health care.

Members or caregivers can refer themselves or family members by calling the Member Services number located on their ID card. They will be transferred to a team member based on the immediate need. Physicians can refer their patients by contacting us by phone or through electronic means. We can help with transitions across levels of care so that patients and caregivers are better prepared and informed about health care decisions and goals. Members can opt in and opt out of the Case Management program at any time.

You can contact us by phone at **1-800-454-3730** or by fax at **1-866-249-1185**. For OB Case Management, fax to **1-866-249-1180**. Case Management business hours are Monday through Friday, from 8 a.m. to 5 p.m. Central time.

TX-NL-0290-20

Follow-Up After Hospitalization for Mental Illness

We understand providers are committed to providing our members with quality care, including follow-up appointments after a behavioral health (BH) inpatient stay. Since regular monitoring, follow-up appointments and making necessary treatment recommendations or changes are all part of quality care, we would like to provide an overview of the related HEDIS® measure.

The Follow-Up After Hospitalization for Mental Illness (FUH) HEDIS measure evaluates members 6 years and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner.

Two areas of importance for this HEDIS measure are:

- The percentage of BH inpatient discharges for which the member received follow-up within seven days after discharge.
- The percentage of BH inpatient discharges for which the member received follow-up within 30 days after discharge.

On a regular basis, we continue to monitor if these two consecutive follow-up appointments are recommended and scheduled during the inpatient stay as part of discharge planning by the eligible BH facilities (such as psychiatric hospitals, freestanding mental health facilities and acute care hospitals with psychiatric units), as well as by practicing BH providers.

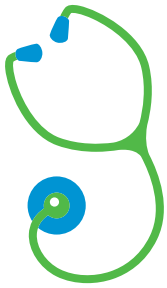
Read more online.

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

TX-NL-0289-20

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 or CHIP. Please refer to Medicaid/CHIP guidelines for coverage and reimbursement information.



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

Notes/updates:

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

- *SURG.00028 — Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH)
  - Revised scope of document to only address benign prostatic hyperplasia (BPH)
  - Revised medically necessary criteria for transurethral incision of the prostate by adding "prostate volume less the 30 mL"
  - Added transurethral convective water vapor thermal ablation in individuals with prostate volume less than 80 mL and waterjet tissue ablation as medically necessary indication
  - Moved transurethral radiofrequency needle ablation from medically necessary to not medically necessary section
  - Moved placement of prostatic stents from standalone statement to combined not medically necessary statement
- *SURG.00037 — Treatment of Varicose Veins (Lower Extremities)
  - Added the anterior accessory great saphenous vein (AAGSV) as medically necessary for ablation techniques when criteria are met
  - Added language to the medically necessary criteria for ablation techniques addressing variant anatomy
  - Added limits to retreatment to the medically necessary criteria for all procedures
- *SURG.00047 — Transendoscopic Therapy for Gastroesophageal Reflux Disease, Dysphagia and Gastroparesis
  - Expanded scope to include gastroparesis
  - Added gastric peroral endoscopic myotomy or peroral pyloromyotomy as investigational and not medically necessary
- *SURG.00097 — Vertebral Body Stapling and Tethering for the Treatment of Scoliosis in Children and Adolescents
  - Expanded scope of document to include vertebral body tethering
  - Added vertebral body tethering as investigational and not medically necessary
- *CG-LAB-14 — Respiratory Viral Panel Testing in the Outpatient Setting
  - Clarified that respiratory viral panel (RVP) testing in the outpatient setting is medically necessary when using limited panels involving five targets or less when criteria are met
  - Added RVP testing in the outpatient setting using large panels involving six or more targets as not medically necessary
- *CG-MED-68 — Therapeutic Apheresis
  - Added diagnostic criteria to the condition "chronic inflammatory demyelinating polyradiculoneuropathy" (CIDP) when it is treated by plasmapheresis or immunoadsorption
- The following AIM Specialty Clinical Appropriateness Guidelines have been approved, to view an AIM guideline, visit the **AIM Specialty Health®** page**:
  - *Joint Surgery
  - *Advanced Imaging — Vascular Imaging

Medical Policies

On November 7, 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 update online for a list of the policies.

Read more online.

Clinical UM Guidelines

On November 7, 2019, the MPTAC approved several *Clinical UM Guidelines* applicable to Amerigroup. These guidelines were adopted by the medical operations committee for Amerigroup members on November 25, 2019. These guidelines take effect 30 days from posting. View the update online for a list of the guidelines.

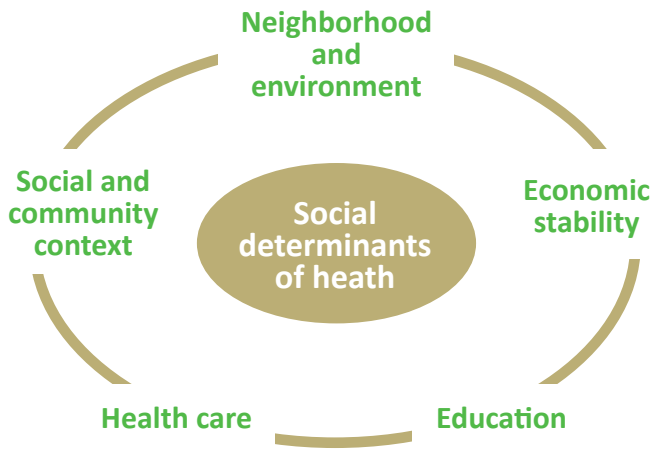
*** AIM Specialty Health is a separate company providing utilization review services on behalf of Amerigroup.*

TX-NL-0294-20

Coding spotlight — provider's guide to code social determinants of health

What are social determinants of health (SDOH)?

The World Health Organization (WHO) defines SDOH as "conditions in which people are born, grow, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequalities." Capturing SDOH is becoming a necessary element of documentation.



Read more online.

TX-NL-0287-20

Acquisition of Beacon Health Options

View the **article** in the Medicaid section.

TX-NL-0282-20

New behavioral health discharge call-in line

View the **article** in the Medicaid section.

TX-NL-0295-20

2020 affirmative statement concerning utilization management decisions

View the **article** in the Medicaid section.

TX-NL-0286-20/TXD-NL-0184-20

MCG Care Guidelines — 24th edition

Effective August 1, 2020, we will upgrade the Amerigroup Amerivantage (Medicare Advantage) and Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) programs to the 24th edition of MCG Care Guidelines for the following modules: Inpatient Surgical Care (ISC), General Recovery Care (GRC), Chronic Care (CC), Recovery Facility Care (RFC) and Behavioral Health Care (BHC). The tables highlight new guidelines and changes that may be considered more restrictive.

Read more online.

TXD-NL-0183-20

Optum to collect medical records for risk adjustment

Risk adjustment is the process by which the Centers for Medicare & Medicaid Services (CMS) reimburses health plans, based on the health status of their members. Risk adjustment was implemented to pay health plans more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (age and gender) as well as health status.

In 2020, Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) will work with Optum,* who is working with Ciox Health,* to request medical records with dates of service for the target year 2019 through present day.

Jaime Marcotte, Medicare Retrospective Risk Program Lead, is managing this project. If you have any questions regarding this program, please contact Jaime at jaime.marcotte@anthem.com or **1-843-666-1970**.

Additional information, including an FAQ, will be available on the **provider website** under *News & Announcements*.

** Optum is an independent company providing medical record review services on behalf of Amerigroup STAR+PLUS MMP. Ciox Health is an independent company providing medical record review services on behalf of Amerigroup STAR+PLUS MMP.*

TXD-NL-0186-20

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.

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

Medical Policies

On February 20, 2020, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Medical Policies* applicable to Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan).

Publish Date	*Medical Policy* #	*Medical Policy* Title	New or Revised
2/27/2020	GENE.00011	Gene Expression Profiling for Managing Breast Cancer Treatment	Revised
2/27/2020	SURG.00103	Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)	Revised

TXD-NL-0187-20

Acquisition of Beacon Health Options

View the **article** in the Medicaid section.

TX-NL-0282-20

New behavioral health discharge call-in line

View the **article** in the Medicaid section.

TX-NL-0295-20

Medical drug *Clinical Criteria* updates

February 2020 update

On November 15, 2019, and February 21, 2020, 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-0109-20

The *Clinical Criteria* is publicly available on our **provider website**. Visit ***Clinical Criteria*** to search for specific policies.

Please submit your questions to **email**.

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:** Offered the first Wednesday of each month from 1 p.m. to 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, to 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 to learn how providers play a critical role in facilitating the risk adjustment process, register for one of the monthly training sessions at https://bit.ly/2z4A81e.

*Note: Dates may be modified due to holiday scheduling.

Medicare Risk Adjustment, Documentation and Coding Guidance (Condition Specific)

- **When:** Offered on the third Wednesday of every other month at noon to 1 p.m. ET
- **Learning objective:** This is a collaborative learning event with Enhanced Personal Health Care (EPHC) to provide in-depth disease information pertaining to specific conditions, including an overview of their corresponding hierarchical condition categories (HCC), with guidance on documentation and coding.
- **Credits:** This live series activity, Medicare Risk Adjustment Documentation and Coding Guidance, from January 15, 2020, to November 18, 2020, has been reviewed and is acceptable for credit 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 for this six-part training series, please see the list of topics and scheduled training dates below:

- Red Flag HCCs, part one: Training will cover HCCs most commonly reported in error as identified by CMS (chronic kidney disease stage 5, ischemic or unspecified stroke, cerebral hemorrhage, aspiration and specified bacterial pneumonias, unstable angina and other acute ischemic heart disease, end-stage liver disease)
  (Recording will play upon registration.)
  https://bit.ly/3ae9znc
- Red Flag HCCs, part two: Training will cover HCCs most commonly reported in error as identified by CMS (atherosclerosis of the extremities with ulceration or gangrene, myasthenia gravis/myoneural disorders and Guillain-Barre syndrome, drug/alcohol psychosis, lung and other severe cancers, diabetes with ophthalmologic or unspecified manifestation)
  (Recording will play upon registration.)
  https://bit.ly/3abKg52
- Neoplasms
  (*Recording link will be available later in 2020.*)
- Acute, Chronic and Status Conditions
  (July 15, 2020)
  https://bit.ly/2ygZfNR
- Diabetes Mellitus and Other Metabolic Disorders
  (September 16, 2020)
  https://bit.ly/2XQ9hjZ
- TBD — This Medicare Risk Adjustment webinar will cover the critical topics and updates that surface during the year (November 18, 2020)
  https://bit.ly/2xxjhUj

AGPCRNL-0106-20

Updates to *Sleep Disorder Management Clinical Appropriateness Guideline*

Effective for dates of service on and after August 16, 2020, the following updates will apply to the AIM Specialty Health®* (AIM) *Sleep Disorder Management Clinical Appropriateness Guideline*.

Sleep Disorder Management Clinical Appropriateness Guideline updates by section:

- Bi-Level Positive Airway Pressure (BPAP) Devices:
  - Change in BPAP FiO2 from 45 to 52 mmHg based on strong evidence and alignment with Medicare requirements for use of BPAP
- Multiple Sleep Latency Testing and/or Maintenance of Wakefulness Testing:
  - Style change for clarity
  - Code changes: none

As a reminder, ordering and servicing providers may submit prior authorization (PA) requests to AIM by:

- Accessing AIM's ***Provider****Portal*℠ directly at **providerportal.com**. Online access is available 24/7 to process orders in real time, and is the fastest and most convenient way to request PA.
- Accessing AIM via the **Availity Portal**.*
- Calling the AIM Contact Center at **1-800-714-0040** from 7 a.m. to 7 p.m. ET.

What if I need assistance?

If you have questions related to guidelines, email AIM at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current and upcoming guidelines **here**.

** AIM Specialty Health is an independent company providing some utilization review services on behalf of Amerigroup Community Care. Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup Community Care.*

AGPCRNL-0110-20

Amerigroup Community Care working with Optum to collect medical records for risk adjustment

Risk adjustment is the process by which the Centers for Medicare & Medicaid Services (CMS) reimburses Medicare Advantage plans, based on the health status of their members. Risk adjustment was implemented to pay Medicare Advantage plans more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (age and gender) as well as health status.

In 2020, Amerigroup will work with Optum,* who is working with Ciox Health,* to request medical records with dates of service for the target year 2019 through present day.

Jaime Marcotte, Medicare Retrospective Risk Program Lead, is managing this project. If you have any questions regarding this program, please contact Jaime at jaime.marcotte@anthem.com or **1-843-666-1970**.

Additional information, including an FAQ, will be available by visiting the provider website, selecting your state and going to the **News & Announcements** section.

** Optum and Ciox Health are independent companies providing medical record review services on behalf of Amerigroup Community Care.*

AGPCRNL-0105-20

Modifier use reminders

Billing for patient treatment can be complex, particularly when determining whether modifiers are required for proper payment. Amerigroup Community Care reimbursement policies and correct coding guidelines explain the appropriate use of coding modifiers. We would like to highlight the appropriate use of some commonly used modifiers.

Things to remember

- Review the *CPT® Surgical Package Definition* found in the current year's *CPT Professional Edition*. Use modifiers such as 25 and 59 only when the services are not included in the surgical package.
- Review the current *CPT Professional Edition Appendix A — Modifiers* for the appropriate use of modifiers 25, 57 and 59.
- When an evaluation and management (E&M) code is reported on the same date of service as a procedure, the use of the modifier 25 should be limited to situations where the E&M service is "above and beyond" or "separate and significant" from any procedures performed the same day.
- When appropriate, assign anatomical modifiers (Level II HCPCS modifiers) to identify different areas of the body that were treated. Proper application of the anatomical modifiers helps ensure the highest level of specificity on the claim and show that different anatomic sites received treatment.
- Use modifier 59 to indicate that a procedure or service was distinct or independent of other non-E&M services performed on the same date of service. The modifier 59 represents services not normally performed together, but which may be reported together under the circumstances.

If you feel that you have received a denial after appropriately applying a modifier under correct coding guidelines, please follow the normal claims dispute process and include medical records that support the use of the modifier(s) when submitting claims for consideration.

Amerigroup will publish additional articles on correct coding in provider communications.

AGPCRNL-0097-20

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.

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

Medical Policies

On February 20, 2020, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Medical Policies* applicable to Amerigroup Community Care.

Publish Date	*Medical Policy* #	*Medical Policy* Title	New or Revised
2/27/2020	GENE.00011	Gene Expression Profiling for Managing Breast Cancer Treatment	Revised
2/27/2020	SURG.00103	Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)	Revised

AGPCRNL-0108-20

Prior authorization requirements

Effective June 1, 2020, prior authorization (PA) requirements will change for several services to be covered for Amerigroup Community Care members.

Read more online.

AGPCRNL-0100-20

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 by accessing the Provider Self-Service Tool at Availity* at **https://providers.amerigroup.com** > Login. Call the Provider Services number on the back of the member's ID card for PA requirements.

** Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup Community Care.*