Provider Newsletter

Amerigroup
An Anthem Company

https://providers.amerigroup.com/tx

June 2018

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Complex Case Management program

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

Amerigroup is available to offer assistance in these difficult moments with our Complex Care Management program. Our care managers are part of an interdisciplinary team of clinicians and other resource professionals there to support members, families, primary care physicians and caregivers. The Complex Care Management process utilizes the experience and expertise of the Care Coordination team to educate and empower our members by increasing self-management skills. The Complex Care Management process can help members understand their illnesses and learn about care choices to ensure they have access to quality, 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 telephonically 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.

You can contact us by phone at 1-800-600-4441. Case Management business hours are Monday-Friday from 8 a.m.-5 p.m. Central time.

TX-NL-0092-17

Use Availity to 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 updating your information in Availity via https://www.availity.com. Thank you for your help and continued efforts in keeping our records up to date.

TX-NL-0092-17

Provider surveys

Each year we reach out to you to ask what we are doing well and how we can continue to improve our services. We use this feedback to continually improve our operations and strengthen our relationship with our providers.

Thank you for participating in our network, for providing quality health care to our members and for your timely completion of any surveys you receive.

TX-NL-0092-17

Miscellaneous durable medical equipment billing guidelines

Reminder:
Miscellaneous durable medical equipment (DME) procedure codes (such as E1399) cannot be used as an alternative to specific identified codes. Amerigroup conducts postpayment reviews to ensure the right codes for the right services are used. This applies to all claims for STAR and Amerigroup Amerivantage (Medicare Advantage) members.

In an effort to improve the provider experience, we continually evaluate coding and billing patterns. Recently, we identified trends related to the use of E1399 — DME, miscellaneous. This code is only intended for use when a more appropriate code is not available. When an appropriate code does exist, that code must be used regardless of your contracted rate. It is not appropriate to use E1399 for payment increases.

We continue to require prior authorization for the use of miscellaneous code E1399.

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

- Web: https://www.availity.com
- Fax: 1-888-235-8468
- Phone: 1-855-878-1785

As it is not our policy to inform providers of proper billing processes within prior authorization responses, authorization responses do not include code-specific details. If your service was approved but your claim was denied payment when billed using E1399, the incorrect code was used. You will need to update the authorization and the claim with the appropriate *HIPAA*-compliant HCPCS code.

Amerigroup will conduct postpayment reviews of code E1399 to ensure proper use. If it is determined a more appropriate code should have been used, we will notify you in writing and advise you of your appeal rights.

You can find additional information related to miscellaneous codes in the Unlisted, Unspecified or Miscellaneous Codes reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare > Coding > Unlisted, Unspecified or Miscellaneous Codes.

TX-NL-0114-18

Online registration processes for electronic remittance advices and electronic funds transfers

No action is required for providers already registered for electronic funds transfers (EFTs) and electronic remittance advices (ERAs).

Effective September 1, 2018, our provider disbursement processes are changing. These changes include the following:

- New EFT enrollment: Go to EnrollHub™, a Council for Affordable Quality Healthcare (CAQH) Solutions™ enrollment tool.
- New ERA-only enrollment and change management for existing ERA-only enrollments: These will be managed through Availity. Go to https://www.availity.com and select **Enrollments Center** in the *My Account Dashboard* on the home page. Select **ERA Enrollment** in the *Multi-Payer Enrollments* section. Then, simply follow the wizard and submit. After submitting, you will be notified by email that enrollment is complete and start receiving *835s* through Availity.
- Change Healthcare and PaySpan will no longer be used for EFT/ERA enrollment.
- Providers now have access to *Explanation of Payment* letters through our secure self-service provider website.
- Medicaid and Medicare remittance advices have been consolidated.

These enhancements offer providers streamlined reimbursement registration tools.

The following chart summarizes information about the new processes to enroll in EFT or ERA or to update EFT and ERA transaction information after September 1, 2018.

Process to enroll or update electronic transactions after September 1, 2018		
Type of transaction	**How to enroll, update, change or cancel**	**Contact to resolve issues**
EFT only	Use the CAQH EFT EnrollHub tool available at http://www.caqh.org/solutions/enrollhub.	CAQH Provider Help Desk 1-844-815-9763
ERA only	Register for ERAs at https://www.availity.com.	Availity 1-800-282-4548

Is registration required?

Providers are not obligated to register for either EFT or ERA and will continue to receive a paper check and remittance advice.

Is there a cost to providers for the changes to EFT and ERA?

There is no cost to providers from Amerigroup. Providers should inquire with trading partners and other vendors they work with to understand additional steps or any changes to services.

Information and changes to expect

Medicaid and Medicare claim payments and recoveries with claim adjudication beginning September 1, 2018, will be incorporated into one remittance advice for paper or electronic payments. Checks and EFTs from Amerigroup will also be combined. Medicaid and Medicare will be grouped separately on the paper remittance in a section for each product line:

- The back of the remittance advice will contain specific instructions on how to file Medicare appeals.
- Medicaid and Medicare claims are identified in the Claim Filing Indicator Code (CLP06 segment) on the *ERA/835* for Medicaid with MC and Medicare with **MB**, **MA** or **16.**
- Effective September 1, 2018, we will discontinue the email notification providers currently receive when an EFT and ERA is issued.
- The PDF versions of paper remittances are available on the provider self-service website. Both provider and clearinghouse *835s* continue to be received through the EDI process.
- More information about retrieving copies of remittance advices is available online. To access our tutorial, *Remittance Inquiry Process Guide*, go to our provider website and select the **Tutorials** drop-down menu under *Provider Resources & Documents*.
- Starting in 2018, more claim payments and remittance advices issued by Amerigroup will be made on a weekly basis to providers. Additionally, non-Federal Employee Program payments under $5 will be held for a maximum of 14 days to allow additional claims to combine to increase the overall payment amount.
- These changes will ensure efficiency and consistency between professional and facility claim payments.
- If you are a provider who receives paper claim checks or EFT payments from Amerigroup on a daily basis, you will be able to schedule posting on a weekly cycle after this change.
- The Automated Clearing House batch header is changing. The payee name that appears on the EFT statement is changing and will be easily identifiable. This change does not impact payment to you in any way. You will now see **Amerigroup TX5C**.

How do I access historical ERAs from Change Healthcare and PaySpan?

We are in the process of migrating all historical remittance advices to our self-service provider website. We will notify you when the migration is complete. Please continue to use Change Healthcare and PaySpan until that time.

TX-NL-0119-18

Coding Spotlight — Pregnancy

A provider's guide to diagnose and code for pregnancy

Pregnancy demonstrates a woman's amazing creative and nurturing powers while providing for the future. Early and regular prenatal care is vital to the health of the baby and the mother.

Pregnancy facts

- In 2016, 7.2 percent of women who gave birth smoked cigarettes during pregnancy. Prevalence of smoking during pregnancy was highest for women aged 20-24 (10.7 percent), followed by women aged 15-19 (8.5 percent) and 25-29 (8.2 percent).[1]
- Hypertensive disorders affect up to 10 percent of pregnancies in the United States.[2]
- Ectopic pregnancy affects 1-2 percent of all pregnancies and is responsible for 9 percent of pregnancy-related deaths in the United States.[3]

For detailed information on pregnancy coding (risk factors, HEDIS® quality measures for prenatal and postpartum care, and ICD 10-CM: general coding and documentation), please view the full pregnancy coding guide on our provider website.

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

Resources

1 Cigarette Smoking During Pregnancy: United States, 2016. Retrieved from https://www.cdc.gov/nchs/products/databriefs/db305.htm.

2 Hypertension in pregnancy. Retrieved from https://www.acog.org/Clinical-Guidance-and-Publications/Task-Force-and-Work-Group-Reports/Hypertension-in-Pregnancy.

3 Barash J.H., Buchanan E.M., Hillson C. Diagnosis and Management of Ectopic Pregnancy. Retrieved from https://www.aafp.org/afp/2014/0701/p34.html.

TX-NL-0104-18

Prenatal and postpartum outreach initiatives

At Amerigroup, we recognize that the relationship between a patient and her health care provider can lead to improved compliance with routine prenatal and postpartum care. With this in mind, we are requesting our network providers assist us in our prenatal and postpartum outreach initiatives. These initiatives target our newly pregnant and newly delivered members.

How can you help?

An Amerigroup associate may contact your office to schedule and/or confirm members' prenatal and/or postpartum appointments. We look forward to collaborating with your office as we assist our members/your patients in making and keeping these very important wellness visits.

The goal of these outreach initiatives is to increase patient compliance, improve health outcomes for our members and encourage our network providers to collaborate with us in maintaining the highest possible prenatal and postpartum quality measures. To be HEDIS® compliant, the initial prenatal visit occurs within the first trimester (or within 42 days of enrollment) and a postpartum appointment takes place 21-56 days after delivery. **Follow-up appointments that occur one to two weeks following a cesarean section or greater than 56 days after delivery are not recognized as reportable postpartum visits by HEDIS.**

If you have questions regarding our prenatal and postpartum outreach initiatives, please email Erica Henry, RN at MPOP_Support@anthem.com.

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TX-NL-0123-18

Services requiring prior authorization

All programs require prior authorization (PA) for all covered specialty medications, where allowable by state. The scope of this notice includes both professional and facility requests for Medicaid business.

Specialty medications that are reported with not otherwise classified (NOC) designation codes and C codes may also require PA before services are provided.

Regardless of whether PA is required, all services must be medically necessary to be covered. Even if PA is not required, to avoid a claim denial based on medical necessity, Amerigroup encourages providers to review our medical necessity criteria prior to rendering nonemergent services. Medical necessity criteria can be accessed by visiting https://providers.amerigroup.com/TX to view the most current *Medical Policies* and *Clinical Utilization Management Guidelines*.

If no specific policy is available, the medical necessity review of a drug may be conducted using *Medical Policy ADMIN.00006: Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy* or *Clinical Utilization Management Guideline* and/or *Clinical Utilization Management Guideline CG-DRUG-01: Off-Label Drug and Approved Orphan Drug Use*.

Clinical review of specialty medications is in addition to services currently requiring PA. Providers are responsible for verifying eligibility and benefits for Amerigroup members before providing services. We recommend providers visit https://providers.amerigroup.com/TX to review the list of services and service categories currently requiring PA, with a reminder that the list of services requiring PA will be updated as needed. For clarification regarding whether a specific code or service requires PA, call the number listed below. Except in an emergency, failure to obtain PA may result in denial of reimbursement.

Again, please be reminded that the list of services requiring PA will be updated as needed.

Providers are strongly encouraged to revisit the G*overnment Business Division Reimbursement Policy Unlisted or Miscellaneous Codes* policy, which states NOC codes must be submitted with the correct national drug code (NDC) for proper claim payment. If the required NDC data elements are missing or invalid for the procedure code on a claim line, the claim will be denied.

TX-NL-0109-18

Requesting PA

To request PA, report a medical admission or for questions regarding PA, providers may use one of the following methods:

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

Prior authorization (PA) requirements

Mylotarg (gemtuzumab ozogamicin)

Effective July 1, 2018, PA requirements will change for Mylotarg (gemtuzumab ozogamicin) to be covered by Amerigroup through the medical benefit.

PA requirements will be added to the following:

- Mylotarg (gemtuzumab ozogamicin) — a humanized anti-CD33 monoclonal antibody for the treatment of acute myeloid leukemia and acute promyelocytic leukemia (J9203)

TX-NL-0098-18

Electrical stimulation device

Effective August 1, 2018, PA requirements will change for electrical stimulation devices.

PA requirements will be added to the following:

- Electrical stimulation device used for cancer treatment, includes all accessories, any type (E0766)

TX-NL-0103-18

Darzalex (daratumumab)

Effective August 1, 2018, PA requirements will change for the injectable drug Darzalex (daratumumab) for Medicaid members.

PA requirements will be added to the following:

- Darzalex (daratumumab) — injection, 10 mg (J9145)

TX-NL-0113-18

Cabazitaxel (Jevtana)

Effective September 1, 2018, PA requirements will change for the injectable drug Cabazitaxel (Jevtana) to be covered by Amerigroup.

PA requirements will be added to the following:

- Cabazitaxel (Jevtana) — injection, 1 mg (J9043)

TX-NL-0115-18

Chimeric antigen receptor T-cell therapy

Chimeric antigen receptor T-cell (CAR T) therapy, including immunotherapy and all inpatient stays, will continue to require PA regardless of place of service or if billed with an unlisted code.

PA requirements will be added to the following:

- Tisagenlecleucel (brand name: Kymriah™), up to 250 million CAR-positive viable T-cells, including leukapheresis and dose-preparation procedures, per infusion (Q2040)
- Axicabtagene Ciloleucel, up to 200 million autologous anti-CD19 CAR T-cells, including leukapheresis and dose-preparation procedures, per infusion (new code effective April 1, 2018) (Q2041)

TX-NL-0100-18

PA requirements (cont.)

Lower extremity vascular intervention

Effective July 1, 2018, PA requirements will change for lower extremity vascular intervention.

PA requirements will be added to the following:

- Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty (37220)
- Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (37221)
- Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty (37224)
- Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed (37225)
- Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (37226)
- Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (37227)
- Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty (37228)
- Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed (37229)
- Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (37230)
- Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (37231)

TX-NL-0101-18

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
- Phone: 1-800-454-3730

Not all PA requirements are listed here. Detailed PA requirements are available to contracted and noncontracted providers on our provider website (https://providers.amerigroup.com/TX > Quick Tools > Precertification Lookup Tool). Providers may also call us at 1-800-454-3730 for PA requirements.

Prenatal and postpartum outreach initiatives

At Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan), we recognize that the relationship between a patient and his or her health care provider can lead to improved compliance with routine prenatal and postpartum care. With this in mind, we are requesting our network providers assist us in our prenatal and postpartum outreach initiative. These initiatives target our newly pregnant and newly delivered members.

How can you help?

An associate with Amerigroup STAR+PLUS MMP may contact your office to schedule and/or confirm members' prenatal and/or postpartum appointments. We look forward to collaborating with your office as we assist our members/your patients in making and keeping these very important wellness visits.

The goal of these outreach initiatives is to increase patient compliance, improve health outcomes for our members and encourage our network providers to collaborate with us in maintaining the highest possible prenatal and postpartum quality measures. To be HEDIS® compliant, the initial prenatal visit occurs within the first trimester (or within 42 days of enrollment) and a postpartum appointment takes place 21-56 days after delivery. **Follow-up appointments that occur one to two weeks following a cesarean section or greater than 56 days after delivery are not recognized as reportable postpartum visits by HEDIS.**

If you have questions regarding our prenatal and postpartum outreach initiative, please email Erica Henry, RN at MPOP_Support@anthem.com.

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TXD-NL-0089-18

Miscellaneous durable medical equipment billing guidelines

Reminder:
Miscellaneous durable medical equipment (DME) procedure codes (such as E1399) cannot be used as an alternative to specific identified codes. Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) conducts postpayment reviews to ensure the right codes for the right services are used.

In an effort to improve the provider experience, we continually evaluate coding and billing patterns. Recently, we identified trends related to the use of E1399 — DME, miscellaneous. This code is only intended for use when a more appropriate code is not available. When an appropriate code does exist, that code must be used regardless of your contracted rate. It is not appropriate to use E1399 for payment increases.

We continue to require prior authorization for the use of miscellaneous code E1399.

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

- Web: https://www.availity.com
- Fax: 1-888-235-8468
- Phone: 1-855-878-1785

As it is not our policy to inform providers of proper billing processes within prior authorization responses, authorization responses do not include code-specific details. If your service was approved but your claim was denied payment when billed using E1399, the incorrect code was used. You will need to update the authorization and the claim with the appropriate *HIPAA*-compliant HCPCS code.

Amerigroup will conduct postpayment reviews of code E1399 to ensure proper use. If it is determined a more appropriate code should have been used, we will notify you in writing and advise you of your appeal rights.

You can find additional information related to miscellaneous codes in the Unlisted, Unspecified or Miscellaneous Codes reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Texas MMP > Coding > Unlisted, Unspecified or Miscellaneous Codes.

TXD-NL-0086-18

Online registration processes for electronic remittance advices and electronic funds transfers

No action is required for providers already registered for electronic funds transfers (EFTs) and electronic remittance advices (ERAs).

Effective September 1, 2018, our provider disbursement processes are changing. These changes include the following:

- New EFT enrollment: Go to EnrollHub™, a Council for Affordable Quality Healthcare (CAQH) Solutions™ enrollment tool.
- New ERA-only enrollment and change management for existing ERA-only enrollments: These will be managed through Availity. Go to https://www.availity.com and select **Enrollments Center** in the *My Account Dashboard* on the home page. Select **ERA Enrollment** in the *Multi-Payer Enrollments* section. Then, simply follow the wizard and submit. After submitting, you will be notified by email that enrollment is complete and start receiving *835s* through Availity.
- Change Healthcare and PaySpan will no longer be used for EFT/ERA enrollment.
- Providers now have access to *Explanation of Payment* letters through our secure self-service provider website.
- Medicaid, Medicare and Medicare-Medicaid Plan (MMP) remittance advices have been consolidated.

These enhancements offer providers streamlined reimbursement registration tools.

The following chart summarizes information about the new processes to enroll in EFT or ERA or to update EFT and ERA transaction information after September 1, 2018.

Process to enroll or update electronic transactions after September 1, 2018		
Type of transaction	**How to enroll, update, change or cancel**	**Contact to resolve issues**
EFT only	Use the CAQH EFT EnrollHub tool available at http://www.caqh.org/solutions/enrollhub.	CAQH Provider Help Desk 1-844-815-9763
ERA only	Register for ERAs at https://www.availity.com.	Availity 1-800-282-4548

Is registration required?

Providers are not obligated to register for either EFT or ERA and will continue to receive a paper check and remittance advice.

Is there a cost to providers for the changes to EFT and ERA?

There is no cost to providers from Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan). Providers should inquire with trading partners and other vendors they work with to understand additional steps or any changes to services.

Information and changes to expect

Medicaid, Medicare and MMP claim payments and recoveries with claim adjudication beginning September 1, 2018, will be incorporated into one remittance advice for paper or electronic payments. Checks and EFTs from Amerigroup STAR+PLUS MMP will also be combined. Medicaid and Medicare will be grouped separately on the paper remittance in a section for each product line:

- The back of the remittance advice will contain specific instructions on how to file Medicare appeals.
- Medicaid and Medicare claims are identified in the Claim Filing Indicator Code (CLP06 segment) on the *ERA/835* for Medicaid with MC and Medicare with **MB**, **MA** or **16.**
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- This change will ensure efficiency and consistency between professional and facility claim payments.
- If you are a provider who receives paper claim checks or EFT payments from Amerigroup STAR+PLUS MMP on a daily basis, you will be able to schedule posting on a weekly cycle after this change.
- The Automated Clearing House batch header is changing. The payee name that appears on the EFT statement is changing and will be easily identifiable. This change does not impact payment to you in any way. You will now see **Amerigroup TX5C**.

TXD-NL-0088-18

Prior authorization (PA) requirements

Mylotarg (gemtuzumab ozogamicin) and Mvasi (bevacizumab-awwb)

Effective July 1, 2018, PA requirements will change for the Part B injectable/infusible drugs Mylotarg (gemtuzumab ozogamicin) and Mvasi (bevacizumab-awwb) covered by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan).

PA requirements will be added to the following:

- Mylotarg (gemtuzumab ozogamicin) — a humanized anti-CD33 monoclonal antibody for the treatment of acute myeloid leukemia and acute promyelocytic leukemia (J9203)
- Mvasi (bevacizumab-awwb) — for the treatment of metastatic colorectal cancer, nonsmall cell lung cancer, glioblastoma, metastatic renal cell carcinoma and cervical cancer as well as several eye conditions (J3590 — unlisted code, no J-code established at this time)

Please note, one of the drugs noted above is currently billed under the not otherwise classified (NOC) HCPCS J-code J3590. Since this code includes all drugs that are NOC, if the authorization is denied for medical necessity, the plan's denial will be for the drug and not the HCPCS code.

TXD-NL-0001-18

Cardiovascular services

Effective August 1, 2018, PA requirements will change for cardiovascular services for Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) members.

PA requirements will be added to the following:

- Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values (93285)
- Implantation of patient-activated cardiac event global recorder (33282)

TXD-NL-0084-18

Electrical stimulation device

Effective August 1, 2018, PA requirements will change for electrical stimulation devices.

PA requirements will be added to the following:

- Electrical stimulation device used for cancer treatment, includes all accessories, any type (E0766)

TXD-NL-0081-18

Trelstar (triptorelin)

Effective August 1, 2018, PA requirements will change for the Part B injectable/infusible drug Trelstar (triptorelin) to be covered by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan).

PA requirements will be added to the following:

- Trelstar (triptorelin) — for the palliative treatment of advanced prostate cancer and the treatment of central precocious puberty (J3315)

TXD-NL-0085-18

PA requirements (cont.)

ZEVALIN (ibritumomab tiuxetan) and Eptacog (recombinant factor VIIa)

Effective August 1, 2018, PA requirements will change for the Part B injectable/infusible drugs ZEVALIN® (ibritumomab tiuxetan) and Eptacog (recombinant factor VIIa) to be covered by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan).

PA requirements will be added to the following:

- ZEVALIN (ibritumomab tiuxetan) — for treatment of relapsed or refractory low-grade or follicular B-cell non-Hodgkin's lymphoma (NHL) or previously untreated follicular NHL (J9999)
- Eptacog Beta (recombinant factor VIIa): for treatment of hemophilia A and B who have developed antibodies to factor VIII and IX (J3490, J3590)

Please note, one of the drugs listed above is currently billed under the not otherwise classified (NOC) HCPCS J-code J3490 or J3590. Since these codes include all drugs that are NOC, if the authorization is denied for medical necessity, the plan's denial will be for the drug and not the HCPCS code.

TXD-NL-0080-18

Chimeric antigen receptor T-cell therapy

Chimeric antigen receptor T-cell (CAR T) therapy, including immunotherapy and all inpatient stays, will continue to require PA regardless of place of service or if billed with an unlisted code.

PA requirements will be added to the following:

- Tisagenlecleucel (brand name: Kymriah™), up to 250 million CAR-positive viable T-cells, including leukapheresis and dose-preparation procedures, per infusion (Q2040)
- Axicabtagene Ciloleucel, up to 200 million autologous anti-CD19 CAR T-cells, including leukapheresis and dose-preparation procedures, per infusion (new code effective April 1, 2018) (Q2041)

TXD-NL-0004-18

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.**

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There is no cost to providers from Amerigroup. Providers should inquire with trading partners and other vendors they work with to understand additional steps or any changes to services.

Information and changes to expect

Medicaid and Medicare claim payments and recoveries with claim adjudication beginning September 1, 2018, will be incorporated into one remittance advice for paper or electronic payments. Checks and EFTs from Amerigroup will also be combined. Medicaid and Medicare will be grouped separately on the paper remittance in a section for each product line:

- The back of the remittance advice will contain specific instructions on how to file Medicare appeals.
- Medicaid and Medicare claims are identified in the Claim Filing Indicator Code (CLP06 segment) on the *ERA/835* for Medicaid with MC and Medicare with **MB**, **MA** or **16.**
- Effective September 1, 2018, we will discontinue the email notification providers currently receive when an EFT and ERA is issued.
- The PDF versions of paper remittances are available on the provider self-service website. Both provider and clearinghouse *835s* continue to be received through the EDI process.
- More information about retrieving copies of remittance advices is available online. To access our tutorial, *Remittance Inquiry Process Guide*, go to our provider website and select the **Tutorials** drop-down menu under *Provider Resources & Documents*.
- Starting in 2018, more claim payments and remittance advices issued by Amerigroup will be made on a weekly basis to providers. Additionally, non-Federal Employee Program payments under $5 will be held for a maximum of 14 days to allow additional claims to combine to increase the overall payment amount.
- These changes will ensure efficiency and consistency between professional and facility claim payments.
- If you are a provider who receives paper claim checks or EFT payments from Amerigroup on a daily basis, you will be able to schedule posting on a weekly cycle after this change.
- The Automated Clearing House batch header is changing. The payee name that appears on the EFT statement is changing and will be easily identifiable. This change does not impact payment to you in any way. You will now see **Amerigroup TX5C**.

How do I access historical ERAs from Change Healthcare and PaySpan?

We are in the process of migrating all historical remittance advices to our self-service provider website. We will notify you when the migration is complete. Please continue to use Change Healthcare and PaySpan until that time.

TX-NL-0019-18

Miscellaneous durable medical equipment billing guidelines

Reminder:
Miscellaneous durable medical equipment (DME) procedure codes (such as E1399) cannot be used as an alternative to specific identified codes. Amerigroup conducts postpayment reviews to ensure the right codes for the right services are used. This applies to all claims for STAR and Amerigroup Amerivantage (Medicare Advantage) members.

In an effort to improve the provider experience, we continually evaluate coding and billing patterns. Recently, we identified trends related to the use of E1399 — DME, miscellaneous. This code is only intended for use when a more appropriate code is not available. When an appropriate code does exist, that code must be used regardless of your contracted rate. It is not appropriate to use E1399 for payment increases.

We continue to require prior authorization for the use of miscellaneous code E1399.

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

- Web: https://www.availity.com
- Fax: 1-888-235-8468
- Phone: 1-855-878-1785

As it is not our policy to inform providers of proper billing processes within prior authorization responses, authorization responses do not include code-specific details. If your service was approved but your claim was denied payment when billed using E1399, the incorrect code was used. You will need to update the authorization and the claim with the appropriate *HIPAA*-compliant HCPCS code.

Amerigroup will conduct postpayment reviews of code E1399 to ensure proper use. If it is determined a more appropriate code should have been used, we will notify you in writing and advise you of your appeal rights.

You can find additional information related to miscellaneous codes in the Unlisted, Unspecified or Miscellaneous Codes reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare > Coding > Unlisted, Unspecified or Miscellaneous Codes.

TX-NL-0114-18