Provider Newsletter

Amerigroup
An Anthem Company

https://providers.amerigroup.com/tx

November 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

Coding spotlight: tips and best practices for compliance

Need for coding compliance

Coding compliance refers to the process of ensuring that the coding of diagnosis, procedures and data complies with all coding rules, laws and guidelines.

All provider offices and health care facilities should have a compliance plan. Internal controls in the reimbursement, coding, and payment areas of claims and billing operations are often the source of fraud and abuse, and have been the focus of government regulations.

Compliance plan benefits:

- More accurate payment of claims
- Fewer billing mistakes
- Improved documentation and more accurate coding
- Less chance of violating state and federal requirements including self-referral and anti-kickback statutes.

Compliance programs can show the provider practice is making an effort to submit claims appropriately and send a signal to employees that compliance is a priority.

Read more online.

TX-NL-0334-20

Provider transparency update

A key goal of the provider transparency initiatives of Amerigroup is to improve quality while managing health care costs.

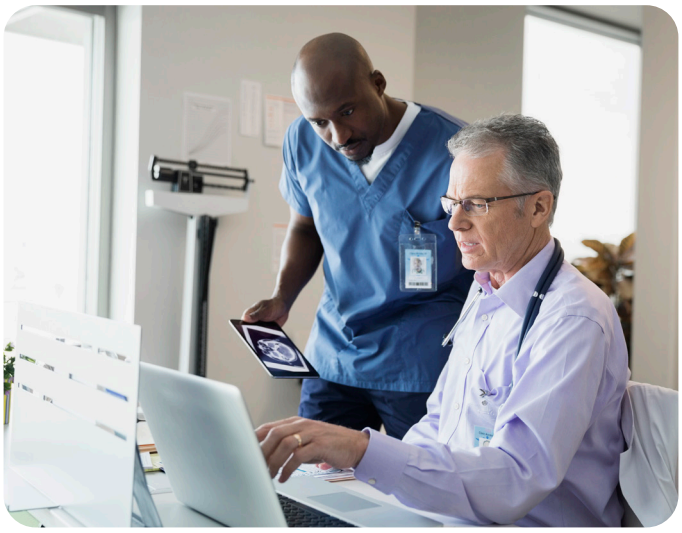
One of the ways this is accomplished is through our value-based programs (for example, the Provider Quality Incentive Program, the Provider Quality Incentive Program Essentials, Risk and Shared Savings, etc.), known as the Programs.

Value-Based Program Providers (also known as Payment Innovation Providers) in our various value-based programs receive quality, utilization and/or cost data, reports and information about other health care providers (Referral Providers). The Value-Based Program Providers can use that information in selecting Referral Providers for their patients covered under the Programs. If a Referral Provider is higher quality and/or lower cost, this component of the Programs should result in the provider getting more referrals from Value-Based Program Providers. If Referral Providers are lower quality and/or higher cost, the converse should be true.

Providing this type of data, including comparative cost information, to Value-Based Program Providers helps them make more informed decisions about managing health care costs, and maintaining and improving quality of care. It also helps them succeed under the terms of the Programs.

Amerigroup will share data on which we relied in making these quality/cost/utilization evaluations upon request and will discuss it with Referral Providers, including any opportunities for improvement. If you have questions or need support, please refer to your local market representative or care consultant.

TX-NL-0336-20



CAHPS education for providers

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is an annual standardized survey conducted to assess consumer experience with their health care services and health plan. Providers and their staff play a key role in the member experience. Several questions specific to the member's experience with their provider are included in the CAHPS survey. Education about the CAHPS survey, the importance of focusing on the patient experience and ways to improve the patient experience are included in the *Provider Orientation* and available by visiting **https://providers.amerigroup.com/TX** under the *Training Programs* section.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

TX-NL-0333-20

Aspire Health telehealth palliative care program for Medicaid members in need of telephonic palliative care

The Aspire Health* telehealth program provides an additional layer of telephonic support to patients facing a serious illness. The program is focused on helping ensure patients understand their diagnosis, facilitating conversations with patients and their families around the patient's goals of care, and helping ensure patients receive care aligned with their goals and values.

The program begins with an initial 30- to 60-minute telephonic assessment by a specially trained Aspire social worker with the conversation focused on building rapport and completing a comprehensive assessment, including understanding the patient's perception of his or her illness and current treatment plan. Follow-up calls occur every 2 to 4 weeks, typically lasting 15 to 45 minutes, with the exact frequency based on a patient's individual need. Aspire's social worker is supported by Aspire's full interdisciplinary team of board-certified palliative care physicians, nurses and chaplains who provide additional telephonic support to patients and their families as needed. Patients enrolled in the telehealth program have access to Aspire's 24/7 on-call support. The average patient is enrolled in the program 6 to 8 months, with key outcomes being the ability for patients to *teach-back* their current medical situation, articulate their health and quality-of-life goals, and establish a future care plan through either the completion of advance care planning documents and/or a transition to hospice when appropriate.

More information is available at **www.aspirehealthcare.com** or by calling the 24/7 Patient & Referral Hotline at **1-844-232-0500**.

** Aspire Health is an independent company providing telephonic palliative care services on behalf of Amerigroup.*

TX-NL-0326-20

New guidelines for sports/school physicals and annual checkups

Effective September 1, 2020, Amerigroup will allow participating PCP providers to perform sports/school physicals. This is a value-added service for STAR and CHIP members 4 through 19 years old, STAR Kids 0 through 20 years old and is limited to one sports/school physical every 12 months.

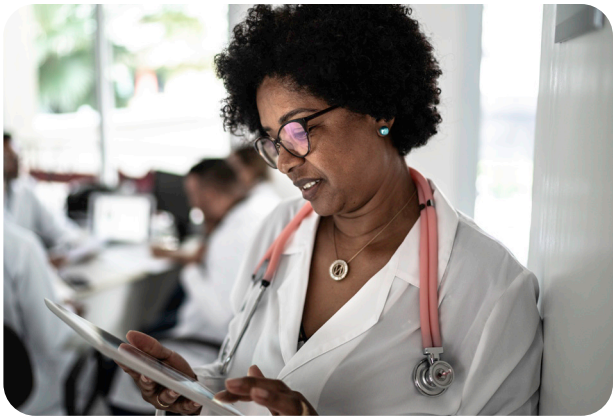
If the member is due for a Texas Health Steps checkup or CHIP well-child checkup, the provider should complete both the sports/school physical and all the components required for the annual checkup.

Providers may bill and receive reimbursement for both services. However, a sports/school physical is not a reason for an exception-to-periodicity checkup. To bill for a sports/school physical, use CPT® code 99212 and diagnosis code Z02.5. No additional modifier is needed.

TX-NL-0329-20

Attention: updated laboratory fee schedule

Effective January 1, 2021, Amerigroup will update the *Reference Laboratory Fee Schedule* for Amerigroup. This change is applicable to providers who are reimbursed, either in whole or in part, based on the fee schedule for laboratory services.



What is the impact of this change?

The actual impact to any particular provider will depend on the codes most frequently billed by that provider.

The updated fee schedule will be available on the **Availity Portal*** on the effective date of January 1, 2021.

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

TX-NL-0288-20

Prior authorization requirements

Effective December 1, 2020, prior authorization (PA) requirements will change for HCPCS code 55899. This will be reviewed using MED.00132: Adipose-derived Regenerative Cell Therapy and Soft Tissue Augmentation Procedures. This code will require PA by Amerigroup for members.

PA requirements will be added to the following:

- 55899 — Unlisted procedure, male genital system

TX-NL-0331-20

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, 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. PA requirements are available to contracted providers by accessing the Provider Self-Service Tool at **https://www.availity.com** or **https://provider.amerigroup.com/TX** > Login. Contracted and noncontracted providers who are unable to access Availity* may call Provider Services at **1-800-454-3730** for assistance with PA requirements.

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Digital transactions cut administrative tasks in half

Introducing the Amerigroup *Digital Provider Engagement Supplement* to the provider manual

Using the secure Availity Portal* or EDI submissions (via Availity), administrative tasks can be reduced by more than 50% when filing claims with or without attachments, checking statuses, verifying eligibility and benefits, and when submitting prior authorizations electronically. In addition, it could not be easier. Through self-service functions, you can accomplish digital transactions all at one time, all in one place. If you are not already registered, just go **here** for EDI information or **here** for the secure Availity Portal.

Get payments faster

By eliminating paper checks, electronic funds transfer (EFT) is a digital payment solution that deposits payments directly into your account. It is safe, secure and will deliver payments to you faster. Electronic remittance advice (ERA) is completely searchable and downloadable from the Availity Portal or the *EDI 835* remittance, which meets all *HIPAA* mandates — eliminating the need for paper remittances.

Member ID cards go digital

Members who are transitioning to digital member ID cards will find it is easier for them and you. The ID card is easily emailed directly to you for file upload, eliminating the need to scan or print. In addition, the new digital member ID card can be directly accessed via Availity. Providers should begin accepting the digital member ID cards when presented by the member.

Amerigroup makes going digital easy with the *Digital Provider Engagement Supplement*

From our digital member ID cards, EDI transactions, application programming interfaces and direct data entry, we cover everything you need to know in the *Digital Provider Engagement Supplement* to the provider manual, available by going to **https://providers.amerigroup.com/TX** > Provider Resources & Documents > Training Programs > Provider Digital Engagement, and on the secure **Availity Portal**. The supplement outlines our provider expectations, processes and self-service tools across all electronic channels for Medicaid and Medicare, including medical, dental and vision benefits.

The *Digital Provider Engagement Supplement* to the provider manual is another example of how Amerigroup is using digital technology to improve the health care experience. We are asking providers to go digital with Amerigroup so we can realize our mutual goals of reducing administrative burden and increasing provider satisfaction and collaboration. Read the *Digital Provider Engagement Supplement* now by going to **https://providers.amerigroup.com/TX** > Provider Resources & Documents > Training Programs > Provider Digital Engagement, and go digital with Amerigroup.

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TX-NL-0341-20

Medicare-Medicaid Plan

COVID-19 information from Amerigroup

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

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

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TX-NL-0288-20

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TX-NL-0288-20/AGPCRNL-0104-20

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TX-NL-0341-20/ GPCRNL-0139-20

Medical drug *Clinical Criteria* updates

June 2020 update

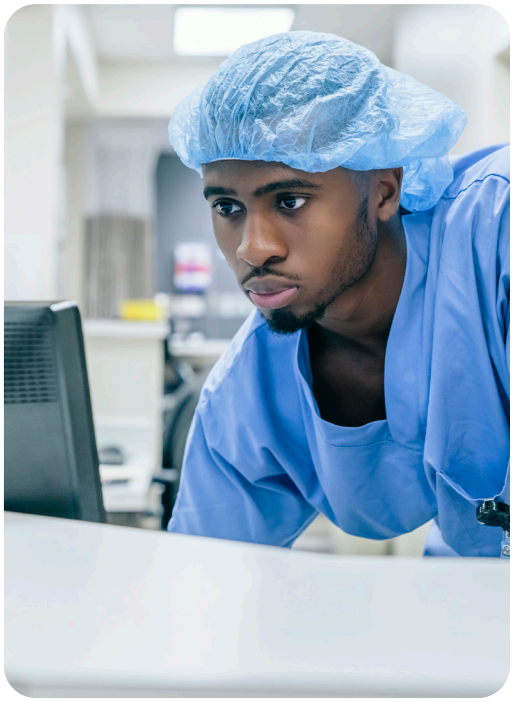
On February 21, 2020, May 15, 2020, and June 18, 2020, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the medical drug benefit for Amerigroup Community Care. These policies were developed, revised or reviewed to support clinical coding edits.

Effective dates are reflected in the **Clinical Criteria web posting**.

AGPCRNL-0133-20

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

Please submit your questions to **email**.



FDA approvals and expedited pathways used — new molecular entities

Amerigroup Community Care reviews the activities of the FDA's approval of drugs and biologics on a regular basis to understand the potential effects for both our providers and members.

The FDA approves new drugs/biologics using various pathways of approval. Recent studies on the effectiveness of drugs/biologics going through these different FDA pathways illustrates the importance of clinicians being aware of the clinical data behind a drug or biologic approval in making informed decisions.

Approval pathways the FDA uses for drugs/biologics	
Standard Review	The Standard Review process follows well-established paths to make sure drugs/biologics are safe and effective when they reach the public. From concept to approval and beyond, FDA performs these steps: reviews research data and information about drugs and biologics before they become available to the public, watches for problems once drugs and biologics are available to the public, monitors drug/biologic information and advertising, and protects drug/biologic quality. **To learn more about the Standard Review process, go here.**
Fast Track	Fast Track is a process designed to facilitate the development and expedite the review of drugs/biologics to treat serious conditions and fill an unmet medical need. **To learn more about the Fast Track process, go here.**
Priority Review	A Priority Review designation means FDA's goal is to take action on an application within six months. **To learn more about the Priority Review process, go here.**
Breakthrough Therapy	A process designed to expedite the development and review of drugs/biologics that may demonstrate substantial improvement over available therapy. **To learn more about the Breakthrough Therapy process, click here.**
Orphan Review	Orphan Review is the evaluation and development of drugs/biologics that demonstrate promise for the diagnosis and/or treatment of rare diseases or conditions. **To learn more about the Orphan Review process, click here.**
Accelerated Approval	These regulations allowed drugs/biologics for serious conditions that filled an unmet medical need to be approved based on a surrogate endpoint. **To learn more about the Accelerated Approval process, click here.**

New molecular entities approvals — January to August 2020

Certain drugs/biologics are classified as new molecular entities (NMEs) for purposes of FDA review. Many of these products contain active ingredients that have not been approved by FDA previously, either as a single ingredient drug or as part of a combination product; these products frequently provide important new therapies for patients.

Amerigroup reviews the FDA-approved NMEs on a regular basis. To facilitate the decision-making process, we are providing a list of NMEs approved from January to August 2020, along with the FDA approval pathway utilized.

Read more online.

AGPCRNL-0138-20

AIM Specialty Health Musculoskeletal program expansion update

As previously communicated, AIM Specialty Health® (AIM)* planned to expand their Musculoskeletal program to perform medical necessity reviews for certain elective surgeries of the small joint for Medicare Advantage members. **However, this expansion has been postponed until further notice.**

If you have questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com.

AGPCRNL-0134-20

Transition to AIM Specialty Health *Rehabilitative Service Clinical Appropriateness Guidelines*

Amerigroup Community Care previously communicated that AIM Specialty Health®* (AIM) would transition the *Clinical Criteria* for Medical Necessity Review of Certain Rehabilitative Services to AIM *Rehabilitative Service Clinical Appropriateness Guidelines* as part of the AIM Rehabilitation Program beginning October 1, 2020. Please be aware that this transition has been delayed. **The new transition date will be in December 1, 2020.**

AGPCRNL-0136-20

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

Policy Update — Medicare Advantage Emergency Department: Leveling of Evaluation and Management Services

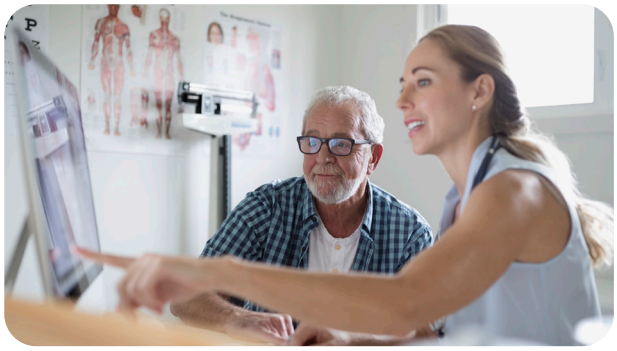
Effective January 15, 2021, Amerigroup Community Care classifies with an Evaluation and Management (E&M) code level the intensity/complexity of emergency department (ED) interventions a facility uses to furnish all services indicated on the claim. E&M services will be reimbursed based on this classification. Facilities must use appropriate *HIPAA* compliant codes for all services rendered during the ED encounter. If the E&M code level submitted is higher than the E&M code level supported on the claim, we reserve the right to perform one of the following:

- Deny the claim and request resubmission at the appropriate level or request the provider submit documentation supporting the level billed.
- Adjust reimbursement to reflect the lower ED E&M classification.
- Recover and/or recoup monies previously paid on the claim in excess of the E&M code level supported.

Providers who believe their medical record documentation supports reimbursement for the originally submitted level for the E&M service will be able to follow the dispute resolution process in accordance with the terms of their contract. Claims disputes require a statement providing the reason the intensity/complexity would require a different level of reimbursement, and the medical records which should clearly document the facility interventions performed and referenced in that statement.

For additional information, please review the Emergency Department: Leveling of Evaluation and Management Services reimbursement policy at **https://providers.amerigroup.com**. Under Quick Tools, select Reimbursement Policies > Medicaid.

AGPCARE-0623-20



Policy Update — Medicare Advantage Nurse Practitioner and Physician Assistant Services, Professional

(effective 04/24/20)

This update is to inform you that there is now a separate and specific professional reimbursement policy to reference for Nurse Practitioner and Physician Assistant Services.

Amerigroup Community Care continues to allow reimbursement for services provided by nurse practitioner (NP) and physician assistant (PA) providers. Unless provider, state, federal or CMS contracts and/or requirements indicate otherwise, reimbursement is based upon all of the following:

- Service is considered a physician's service
- Service is within the scope of practice
- A payment reduction consistent with CMS

Services furnished by the NP or PA should be submitted with their own NPI.

For additional information, please review the Nurse Practitioner and Physician Assistant Services, Professional reimbursement policy at **https://providers.amerigroup.com**. Under Quick Tools, select Reimbursement Policies > Medicare.

AGPCRNL-0129-20