

# Provider Newsletter



# Amerigroup

An Anthem Company

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

October 2019

## Table of Contents

### Medicaid:

Pharmacy benefit manager change	Page 2
Medical drug <i>Clinical Criteria</i> updates	Page 3
New clinical guideline: pneumatic compression devices	Page 3
Evaluation and management services — over-coded services	Page 4
MCG Care Guidelines update and customizations	Page 4
Prior authorization requirements	Page 5
<i>Medical Policies and Clinical Utilization Management Guidelines</i> update	Page 6

### Medicare-Medicaid Plan (MMP):

Pharmacy benefit manager change to IngenioRx	Page 8
Medical drug <i>Clinical Criteria</i> updates	Page 9
Aspire Telehealth Palliative Care program	Page 9
<i>Medical Policies and Clinical Utilization Management Guidelines</i> update	Page 10
Prior authorization requirements for continuous positive airway pressure supplies	Page 11
Prior authorization requirements	Page 12

### Medicare Advantage:

Pharmacy benefit manager change to IngenioRx	Page 13
Medicare preferred continuous glucose monitors	Page 14
MCG Care Guidelines update and customizations	Page 14
Medical drug <i>Clinical Criteria</i> updates	Page 14
Lowering health risks with no-cost statins	Page 15
Aspire Telehealth Palliative Care program	Page 15
Assisting your patients in managing the Donut Hole	Page 16
<i>Clinical Laboratory Improvement Amendments</i>	Page 17
Update: 2019 risk adjustment provider trainings	Page 18
Prior authorization requirements for continuous positive airway pressure supplies	Page 19
Prior authorization requirements	Page 20
<i>Medical Policies and Clinical Utilization Management Guidelines</i> update	Page 21

### Reimbursement Policies:

Drug Screen Testing	Page 24
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	Page 25
Modifier 62: Co-Surgeons	Page 25

## Pharmacy benefit manager change

Effective October 1, 2019, IngenioRx will become the pharmacy benefit manager (PBM) for prescription drugs, home delivery pharmacy\* and specialty pharmacy for our members. Because Amerigroup and IngenioRx are both Anthem, Inc. companies, your patients gain fast, easy access to their health and prescription benefits in one place.



### Transferring prescriptions

We will automatically transfer prescriptions to IngenioRx Home Delivery Pharmacy for patients currently using home delivery through Express Scripts Mail Order Pharmacy. For patients receiving specialty drugs as a pharmacy benefit from Accredo, we will automatically transfer prescriptions to IngenioRx Specialty Pharmacy. Patients filling prescriptions at a retail pharmacy can continue, in most cases, using their same retail pharmacy.

Prescriptions for controlled substances or compounded drugs currently being filled at Express Scripts Mail Order Pharmacy or other out-of-network, mail-order pharmacies or Accredo or other out-of-network specialty pharmacies cannot be transferred to another pharmacy under federal law. Patients currently receiving these medications will need a new prescription sent to IngenioRx Home Delivery Pharmacy or IngenioRx Specialty Pharmacy.

### More information coming soon

Be on the lookout for additional information regarding this transition to IngenioRx. If you have questions about this change, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

*\* Service not available in all markets.*

TX-NL-0237-19

## Medical drug *Clinical Criteria* updates

### Quarter one

On February 22, 2019, and March 14, 2019, the Pharmacy and Therapeutics (P&T) Committee approved changes to *Clinical Criteria* applicable to the medical drug benefit for Amerigroup. These policies were developed, revised or reviewed to support clinical coding edits.

Effective dates will be reflected in the [Clinical Criteria Q1 web posting](#).

TX-NL-0223-19

### Quarter two

On March 29, 2019, April 12, 2019, and May 1, 2019, the Pharmacy and Therapeutic (P&T) Committee approved changes to *Clinical Criteria* applicable to the medical drug benefit for Amerigroup. These policies were developed, revised or reviewed to support clinical coding edits.

Effective dates will be reflected in the [Clinical Criteria Q2 web posting](#).

TX-NL-0230-19

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

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

## New clinical guideline: pneumatic compression devices

Amerigroup will implement the following clinical guideline effective December 1, 2019, to support the review of outpatient pneumatic compression devices (PCDs) after outpatient orthopedic procedures.

Federal and state law, as well as state contract language and CMS guidelines, including definitions and specific contract provisions/exclusions, take precedence over these prior authorization rules and must be considered first when determining coverage. **Noncompliance with new requirements may result in denied claims.**

### CG-DME-46 Pneumatic Compression Devices for Prevention of Deep Vein Thrombosis of the Lower Limbs

This document addresses the use of PCDs for the prevention of deep vein thrombosis (DVT) of the lower limbs. This therapy involves the use of an inflatable garment and an electrical pneumatic pump. The garment is intermittently inflated and deflated with cycle times and pressures that vary between devices. PCDs are used in clinics, or can be purchased or rented for home use for prevention and treatment of a number of conditions. This document only addresses the home use of PCDs for post-outpatient orthopedic procedures.

**Note:** This document addresses devices for the prevention of DVT only. Pneumatic devices used in the treatment or prevention of lymphedema, venous insufficiency or therapy for musculoskeletal injuries are not addressed in this document, nor are devices for prevention of DVT post-major surgical procedures.

### Not medically necessary

The use of PCDs for prevention of thromboembolism of the lower-limbs following outpatient orthopedic surgery is considered not medically necessary for all indications.

TX-NL-0236-19

## Evaluation and management services — over-coded services

In an ongoing effort to ensure accurate claims processing and payment, Amerigroup is taking additional steps to verify the accuracy of payments



made to providers. Beginning on October 27, 2019, Amerigroup will 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.

Providers should report E&M services in accordance with the American Medical Association CPT® manual and CMS guidelines for billing E&M service codes ([Documentation Guidelines for Evaluation and Management](#)).

The level of service for E&M service codes is based primarily on the documented medical history, examination and medical decision-making. Counseling, coordination of care, the nature of the presenting problem and face-to-face interaction are considered contributing factors. The appropriate E&M level code should reflect and not exceed what is needed to manage the member's condition(s).

Claims will be selected from providers who, based on a risk adjusted analysis, code higher level E&M services compared to their peers with similar risk-adjusted members. Individual claims will be identified as over-coded based on a claim specific risk adjusted analysis. If a claim is determined to be over coded, it will be reimbursed at the fee schedule rate for the appropriate level of E&M for the condition(s) identified. Providers whose coding patterns improve are eligible to be removed from the program.

If providers have medical record documentation to support reimbursement for the originally submitted E&M service, those medical records should be submitted for consideration.

TX-NL-0219-19

## MCG Care Guidelines update and customizations

The upgrade to the 23rd edition of the MCG Care Guidelines for Amerigroup has changed from May 24, 2019, to September 5, 2019. In addition, Amerigroup has customized some of the MCG criteria.

### Customizations to the 23rd Edition of the MCG Care Guidelines

Effective September 5, 2019, the following customizations will be implemented:



- Left Atrial Appendage Closure, Percutaneous (W0157) — customized to refer to SURG.00032 Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
- Spine, Scoliosis, Posterior Instrumentation, Pediatric (W0156) — customized to refer to Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines

Effective November 1, 2019, customizations will be implemented for Chemotherapy and Inpatient & Surgical Care (W0162) for adult patients. The customizations provide specific criteria and guidance on the following:

- Clinical indications for admission; examples will also be added for:
  - Aggressive hydration needs that cannot be managed in an infusion center
  - Prolonged marrow suppression
- Regimens that cannot be managed outpatient; examples will also be added

Providers can view a summary of the 23rd edition of the MCG Care Guidelines customizations [online](#) by selecting **Customizations to MCG Care Guidelines 23rd Edition (Publish date November 1, 2019)**.

TX-NL-0222-19

## Prior authorization requirements

Effective November 1, 2019, prior authorization (PA) requirements will change for 31 services. These services will require PA by Amerigroup for Medicaid, Medicare Advantage and Medicaid-Medicare Plan (MMP) members.



**Read more online.**

TX-NL-0226-19

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

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

- **Web:** <https://www.availity.com>
- **Fax:** Medicaid: 1-800-964-3627; MMP: 1-888-235-8468
- **Phone:** Medicaid: 1-800-454-3730; Medicare: 1-866-805-4589; MMP: 1-855-878-1785

Not all PA requirements are listed here. Detailed PA requirements are available to providers on our provider website (<https://providers.amerigroup.com/TX> > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool) and at <https://www.availity.com>. Providers may also call Provider Services for PA requirements.

## Medical Policies and Clinical Utilization Management Guidelines update

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



To view a guideline, visit [https://medicalpolicies.amerigroup.com/am\\_search.html](https://medicalpolicies.amerigroup.com/am_search.html).

### March 2019 update

#### Updates:

- CG-DME-44 — Electric Tumor Treatment Field (TTF) was revised to add the use of enhanced computer treatment planning software (such as NovoTal) as not medically necessary (NMN) in all cases.
- CG-MED-72 — Hyperthermia for Cancer Therapy was revised to clarify medically necessary (MN) and NMN statements addressing frequency of treatment.
- CG-SURG-09 — Temporomandibular Disorders was revised to clarify MN and NMN criteria and removed requirement for FDA approval of prosthetic implants. DC-NL-0177-19
- CG-SURG-30 — Tonsillectomy for Children with or without Adenoidectomy was revised to:
  - Spell out number of episodes of throat infections in MN criteria (A1, A2, A3).
  - Clarify criterion addressing parapharyngeal abscess (B4) to say two or more.
  - Add “asthma” as potential condition improved by tonsillectomy in MN criteria (C1b).
- The following AIM Specialty Health® updates took effect on September 28, 2019:
  - Advanced Imaging
    - Imaging of the Brain
    - Imaging of the Extremities
    - Imaging of the Spine

#### Medical Policies

On March 21, 2019, the Medical Policy and Technology Assessment Committee (MPTAC) approved several *Medical Policies* applicable to Amerigroup. These guidelines take effect October 10, 2019. View the full update online for a list of the policies.

#### Clinical UM Guidelines

On March 21, 2019, the MPTAC approved several *Clinical UM Guidelines* applicable to Amerigroup. These guidelines were adopted by the medical operations committee for members on May 7, 2019. These guidelines take effect October 10, 2019. View the full update online for a list of the guidelines.



**Read more online.**

TX-NL-0227-19

June 2019 update

Updates:

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

- \*DME.00037 — Added devices that combine cooling and vibration to the Investigational (INV) & not medically necessary (NMN) statement
- \*LAB.00027 — Added Mediator Release Test to INV&NMN statement.
- \*LAB.00033 — Clarified INV&NMN statement to include 4Kscore and AR-V7
- \*OR-PR.00003:
  - Clarified medically necessary (MN) position statement criteria 2-4
  - Added statement that use of prosthetic devices that combine both a microprocessor controlled knee and foot-ankle prosthesis is considered INV&NMN for all indications
- \*SURG.00011:
  - Added new MN and INV&NMN statements addressing amniotic membrane-derived products for conjunctival and corneal indications, including KeraSys and Prokera
  - Added new products to INV&NMN statement.
- \*SURG.00045:
  - Added erectile dysfunction, Peyronie's disease and wound repair to the INV&NMN statement
  - Revised title
- \*SURG.00121 — Added INV&NMN statement to address use of transcatheter tricuspid valve repair or replacement for all indications
- The following AIM Specialty Health® updates were approved on June 6, 2019:
  - Advanced Imaging:
    - Imaging of the Heart
    - Oncologic Imaging
    - Vascular Imaging
  - Proton Beam Therapy
  - Rehabilitative Therapies — Physical Therapy, Occupational Therapy and Speech Therapy (New)

Medical Policies

On June 6, 2019, the Medical Policy and Technology Assessment Committee (MPTAC) approved several *Medical Policies* applicable to Amerigroup. These guidelines take effect October 10, 2019. View the full update online for a list of the policies.

Clinical UM Guidelines

On June 6, 2019, the MPTAC approved several *Clinical UM Guidelines* applicable to Amerigroup. These guidelines were adopted by the medical operations committee for STAR members on July 5, 2019. These guidelines take effect October 10, 2019. View the full update online for a list of the guidelines.



TX-NL-0235-19





## MCG Care Guidelines update and customizations

View the [article](#) in the Medicaid section.

TX-NL-0222-19

## Prior authorization requirements

View the [article](#) in the Medicaid section.

TX-NL-0226-19

## Pharmacy benefit manager change to IngenioRx

Effective January 1, 2020, IngenioRx will become our new pharmacy benefit manager (PBM) and will start managing prescription coverage for your Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) patients. IngenioRx PBM services will include handling your patients' prescriptions for mail order and specialty pharmacy medications.

### Transferring prescriptions



We will automatically transfer prescriptions to IngenioRx Home Delivery Pharmacy for patients currently using Express Scripts Mail Order Pharmacy. Members will receive instructions for initializing IngenioRx Home Delivery Pharmacy later this year. For patients receiving specialty drugs from Accredo, we will automatically transfer prescriptions to IngenioRx Specialty Pharmacy. Most patients will be able to fill their prescriptions at their same retail pharmacy outlet. If your patient's pharmacy will not be available, we will notify your patient by letter and include a list of three alternative pharmacies near his or her home.

Prescriptions for controlled substances currently being filled at Express Scripts Mail Order Pharmacy or Accredo cannot be transferred to another pharmacy under federal law. Patients currently receiving these medications will need a new prescription sent to IngenioRx Home Delivery Pharmacy or IngenioRx Specialty Pharmacy.

For providers	Then
Who use ePrescribing	There are no changes — Simply select IngenioRx.
Who do not use ePrescribing	<p>You should send your mail order and specialty prescriptions to IngenioRx. IngenioRx will begin accepting prescriptions January 1, 2020. Please consider the days' supply of the prescription when making these requests.</p> <ul style="list-style-type: none"><li>■ <b>IngenioRx Mail Order Pharmacy new prescriptions:</b><ul style="list-style-type: none"><li>■ Phone: 1-833-203-1742</li><li>■ Fax: 1-800-378-0323</li></ul></li><li>■ <b>IngenioRx Specialty Pharmacy:</b><ul style="list-style-type: none"><li>■ Prescriber phone: 1-833-262-1726</li><li>■ Prescriber fax: 1-833-263-2871</li></ul></li></ul>

You can confirm whether your patient has transitioned to IngenioRx through the Availity Portal. Your patient's PBM information can be located in the *Patient Information* section of their patient profile as part of the Eligibility and Benefits inquiry.

TXD-NL-0152-19



## Medical drug *Clinical Criteria* updates

### 2018 Quarter four

On August 17, 2018, October 9, 2018, and November 16, 2018, the Pharmacy and Therapeutic (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 [MMP Clinical Criteria Updates](#).

TXD-NL-0155-19

### 2019 Quarter one

On February 22, 2019, and March 14, 2019, the Pharmacy and Therapeutic (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 will be reflected in the [MMP Clinical Criteria Web Posting Q1 2019](#).

TXD-NL-0156-19

### 2019 Quarter two

On March 29, 2019, April 12, 2019, and May 1, 2019, the Pharmacy and Therapeutic (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 will be reflected in the [MMP Clinical Criteria Web Posting Q2 2019](#).

TXD-NL-0157-19

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

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

## Aspire Telehealth Palliative Care program

### Aspire Health for Medicare-Medicaid Plan members in need of phone palliative care

The Aspire Telehealth Palliative Care program provides an additional layer of phone support to patients facing a serious illness. The program is focused on:

- Helping patients understand their diagnosis.
- Facilitating conversations with patients and their families around their goals of care.
- Ensuring patients receive care aligned with their goals and values.

The program begins with an initial 30-60 minute telephonic assessment by a specially trained Aspire Health social worker. The conversation in this initial call focuses on building rapport and completing a comprehensive assessment. This assessment includes understanding the patient's perception of their illness and current treatment plan. Follow-up calls occur every 2-4 weeks, typically lasting 15-45 minutes, with the exact frequency based on a patient's individual need. Aspire Health's social workers are supported by a 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 24 hours a day, 7 days a week on-call support. The average patient is enrolled in the program for 6-8 months with some of the key goals 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 advanced care planning documents and/or a transition to hospice when appropriate.

More information is available at [www.aspirehealthcare.com](http://www.aspirehealthcare.com) or by calling the 24/7 Patient & Referral Hotline at 1-844-232-0500.

TXD-NL-0158-19

## Medical Policies and Clinical Utilization Management Guidelines update

The *Medical Policies* and *Clinical Utilization Management (UM) Guidelines* below were developed or revised to support clinical coding edits, effective November 14, 2019. Several policies and guidelines were revised to provide clarification only and are not included. Existing precertification requirements have not changed. Please note: The *Medical Policies* and *Clinical UM Guidelines* below are followed in the absence of Medicare guidance.



To view a guideline, visit [https://medicalpolicies.amerigroup.com/am\\_search.html](https://medicalpolicies.amerigroup.com/am_search.html).

### June 2019 update

#### Updates:

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

- \*DME.00037 — Added devices that combine cooling and vibration to the Investigational (INV) & not medically necessary (NMN) statement
- \*LAB.00027 — Added Mediator Release Test to INV&NMN statement.
- \*LAB.00033 — Clarified INV&NMN statement to include 4Kscore and AR-V7
- \*OR-PR.00003:
  - Clarified medically necessary (MN) position statement criteria 2-4
  - Added statement that use of prosthetic devices that combine both a microprocessor controlled knee and foot-ankle prosthesis is considered INV&NMN for all indications
- \*SURG.00011:
  - Added new MN and INV&NMN statements addressing amniotic membrane-derived products for conjunctival and corneal indications, including KeraSys and Prokera
  - Added new products to INV&NMN statement.
- \*SURG.00045:
  - Added erectile dysfunction, Peyronie's disease and wound repair to the INV&NMN statement
  - Revised title
- \*SURG.00121 — Added INV&NMN statement to address use of transcatheter tricuspid valve repair or replacement for all indications

- The following AIM Specialty Health<sup>®</sup> updates were approved on June 6, 2019:
  - Advanced Imaging:
    - Imaging of the Heart
    - Oncologic Imaging
    - Vascular Imaging
  - Proton Beam Therapy
  - Rehabilitative Therapies — Physical Therapy, Occupational Therapy and Speech Therapy (New)

#### Medical Policies

On June 6, 2019, the Medical Policy and Technology Assessment Committee (MPTAC) approved several *Medical Policies* applicable to Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan). View the full update online for a list of the policies.

#### Clinical UM Guidelines

On June 6, 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 (Medicare-Medicaid Plan) members on July 5, 2019. View the full update online for a list of the guidelines.



**Read more online.**

TXD-NL-0154-19

## Prior authorization requirements for continuous positive airway pressure supplies

Effective December 1, 2019, Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) will begin requiring prior authorization for the below listed continuous positive airway pressure (CPAP) supplies. These prior authorizations will be managed through AIM Specialty Health® (AIM), a specialty health benefits company. Amerigroup STAR+PLUS MMP has an existing relationship with AIM in the administration of other medical management programs.

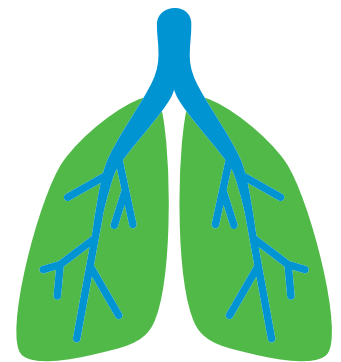
AIM will follow the Amerigroup STAR+PLUS MMP clinical hierarchy for medical necessity determination. Amerigroup STAR+PLUS MMP makes coverage determinations based on CMS national coverage determinations, local coverage determinations, other coverage guidelines, and instructions issued by CMS and state benefit requirement changes. Where the existing guidance provides insufficient clinical detail, AIM will make a determination of medical necessity using an objective, evidence-based process. The AIM Clinical Guidelines that have been adopted by Amerigroup STAR+PLUS MMP to review for medical necessity are located at <http://www.aimspecialtyhealth.com/marketing/guidelines/185/index.html>.

Not all prior authorization requirements are listed here. Detailed prior authorization requirements are available to providers on our provider website (<https://providers.amerigroup.com/TX> > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool) and at <https://www.availity.com>. Providers may also call us at 1-855-878-1785 for requirements.

### Prior authorization requirements

For services that are scheduled on or after December 1, 2019, providers must contact AIM to obtain prior authorization for the services detailed below. Providers are strongly encouraged to verify that a prior authorization has been obtained before scheduling and performing services.

- A4604 — Tubing with heating element
- A7046 — Water chamber for humidifier, replacement, each
- A7027 — Combination Oral/Nasal Mask used with positive airway pressure device, each
- A7030 — Full Face Mask used with positive airway pressure device, each
- A7031 — Face Mask Cushion, Replacement for Full Face Mask
- A7034 — Nasal Interface (mask or cannula type), used with positive airway pressure device, with/without head strap
- A7035 — Headgear
- A7036 — Chinstrap
- A7037 — Tubing
- A7039 — Filter, nondisposable
- A7044 — Oral Interface for Positive Airway Pressure Therapy
- A7045 — Replacement Exhalation Port for PAP Therapy
- A7028 — Oral Cushion, Replacement for Combination Oral/Nasal Mask, each
- A7029 — Nasal Pillows, Replacement for Combination Oral/Nasal Mask, pair
- A7032 — Replacement Cushion for Nasal Application Device
- A7033 — Replacement Pillows for Nasal Application Device, pair
- A7038 — Filter, disposable



TXD-NL-0153-19

## Prior authorization requirements

Beginning December 1, 2019, prior authorization (PA) requirements will change for some codes covered for Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) members.

### PA requirements will be added to the following:

- T1019 — Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)
- C9740 — Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants
- E0953 — Wheelchair accessory, lateral thigh or knee support, any type including fixed mounting hardware
- E1031 — Rollabout chair, any and all types with castors 5 inches or greater
- E1090 — High-strength lightweight wheelchair, detachable arms, desk or full-length, swing-away detachable footrests
- E1130 — Standard wheelchair, fixed full-length arms, fixed or swing-away detachable footrests
- E1140 — Wheelchair, detachable arms, desk or full-length, swing-away detachable footrests
- E1260 — Lightweight wheelchair, detachable arms (desk or full-length) swing-away detachable footrest
- E1285 — Heavy-duty wheelchair, fixed full-length arms, swing-away detachable footrest
- E1290 — Heavy-duty wheelchair, detachable arms (desk or full-length) swing-away detachable footrest
- E2207 — Wheelchair accessory, crutch and cane holder
- E2378 — Power wheelchair component, actuator, replacement only
- K0039 — Leg strap, H style

TXD-NL-0150-19

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

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

- Fax: 1-888-235-8468
- Phone: 1-855-878-1785

Not all PA requirements are listed here. PA requirements are available to contracted and noncontracted providers on our provider website (<https://providers.amerigroup.com/TX> > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool). Providers may also call us at 1-855-878-1785 for PA requirements.

# Medicare Advantage



## Medical drug Clinical Criteria updates

View the [article](#) in the Medicaid section.

TX-NL-0223-19

## Prior authorization requirements

View the [article](#) in the Medicaid section.

TX-NL-0226-19

## Pharmacy benefit manager change to IngenioRx

Effective January 1, 2020, IngenioRx will become our new pharmacy benefit manager (PBM) and will start managing prescription coverage for your Medicare Advantage individual and group retiree plan patients. IngenioRx PBM services will include handling your patients' prescriptions for mail order and specialty pharmacy medications.

### Transferring prescriptions



We will automatically transfer prescriptions to IngenioRx Home Delivery Pharmacy for patients currently using Express Scripts Mail Order Pharmacy. Members will receive instructions for initializing IngenioRx Home Delivery Pharmacy later this year. For patients receiving specialty drugs from Accredo, we will automatically transfer prescriptions to IngenioRx Specialty Pharmacy. Most patients will be able to fill their prescriptions at their same retail pharmacy outlet. If your patient's pharmacy will not be available, we will notify your patient by letter and include a list of three alternative pharmacies near his or her home.

Prescriptions for controlled substances currently being filled at Express Scripts Mail Order Pharmacy or Accredo cannot be transferred to another pharmacy under federal law. Patients currently receiving these medications will need a new prescription sent to IngenioRx Home Delivery Pharmacy or IngenioRx Specialty Pharmacy.

For providers	Then
Who use ePrescribing	There are no changes — Simply select IngenioRx.
Who do not use ePrescribing	<p>You should send your mail order and specialty prescriptions to IngenioRx. IngenioRx will begin accepting prescriptions January 1, 2020. Please consider the days' supply of the prescription when making these requests.</p> <ul style="list-style-type: none"><li>■ <b>IngenioRx Mail Order Pharmacy new prescriptions:</b><ul style="list-style-type: none"><li>■ Phone: 1-833-203-1742</li><li>■ Fax: 1-800-378-0323</li></ul></li><li>■ <b>IngenioRx Specialty Pharmacy:</b><ul style="list-style-type: none"><li>■ Prescriber phone: 1-833-262-1726</li><li>■ Prescriber fax: 1-833-263-2871</li></ul></li></ul>

You can confirm whether your patient has transitioned to IngenioRx through the Availity Portal. Your patient's PBM information can be located in the *Patient Information* section of their patient profile as part of the eligibility and benefits inquiry.

AGPCRN-0048-19

## Medicare preferred continuous glucose monitors



On January 1, 2020, Amerigroup will implement a preferred edit on Medicare-eligible continuous glucose monitors (CGMs). Currently, there are two CGM systems covered by CMS under the Medicare Advantage Part D (MAPD) benefit; these are Dexcom

and Freestyle Libre. The preferred CGM for Medicare Advantage Part D individual members covered by Amerigroup will be Freestyle Libre. This edit will only affect members who are newly receiving a CGM system. Members will need to obtain their CGM system from a retail or mail order pharmacy — not a durable medical equipment (DME) facility. For Dexcom coverage requests, call 1-833-293-0661.

AGPCRNL-0057-19

## MCG Care Guidelines update and customizations

Effective November 1, 2019, customizations will be implemented for Chemotherapy and Inpatient & Surgical Care (W0162) for adult patients. The customizations provide specific criteria and guidance on the following:



- Clinical indications for admission; examples will also be added for:
  - Aggressive hydration needs that cannot be managed in an infusion center
  - Prolonged marrow suppression
- Regimens that cannot be managed outpatient; examples will also be added

Providers can view a summary of the 23rd edition of the MCG Care Guidelines customizations [online](#) by selecting **Customizations to MCG Care Guidelines 23rd Edition**.

AGPCRNL-0041-19

## Medical drug *Clinical Criteria* updates

### Quarter one

On February 22, 2019, and March 14, 2019, the Pharmacy and Therapeutics (P&T) Committee approved changes to *Clinical Criteria* applicable to the medical drug benefit for Amerigroup. These policies were developed, revised or reviewed to support clinical coding edits.

Effective dates will be reflected in the [Clinical Criteria Q1 web posting](#).

AGPCRNL-0042-19

### Quarter two

On March 29, 2019, April 12, 2019 and May 1, 2019, the Pharmacy and Therapeutic (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 will be reflected in the [Clinical Criteria Q2 web posting](#).

AGPCRNL-0038-19

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

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



## Lowering health risks with no-cost statins

Statin medications can assist your patients in lowering their cholesterol levels, reducing cardiovascular risk and low-density lipoprotein (LDL) reduction.

When evaluating your patients as candidates for statin medications, implement treatment protocols based on the *American College of Cardiology/American Heart Association 2018 Guideline on the Management of Blood Cholesterol*:

- Cardiovascular risk reduction benefits of statin therapy go beyond cardiovascular risk and LDL reduction.
- Patients with an LDL-C less than 70 should have statin therapy evaluated and individualized based on other cardiovascular risk factors.
- Patients aged less than 75 years and at risk for cardiovascular disease are recommended to have a high-intensity statin. Moderate-intensity statin therapy is recommended if the patient has a contraindication or experienced statin-associated side effects.

### Ensuring your patients adhere to their prescribed statin amounts

Several barriers, financial and physical, may prevent your patients from adhering to their prescribed statin use.

Remind your patients of the importance of using their prescribed medications. Communicate to your patients:

- The benefits of the medication.
- The potential for side effects:
  - Try a lower dose or a different statin to manage any experienced side effects.

**Prescribe low-cost generics to eliminate cost as a barrier and inform patients of statin medications available for \$0 for up to a 90-day supply.**

### List of statin medications available for free with an up to 90-day supply

The following medications are available at no cost:

- Simvastatin
- Lovastatin
- Atorvastatin
- Pravastatin
- Rosuvastatin

AGPCRN-0051-19

## Aspire Telehealth Palliative Care program

### Aspire Health for Medicare members in need of telephonic palliative care

The Aspire Telehealth Palliative Care program provides an additional layer of phone support to patients facing a serious illness. The program is focused on:

- Helping patients understand their diagnosis.
- Facilitating conversations with patients and their families around their goals of care.
- Ensuring patients receive care aligned with their goals and values.

The program begins with an initial 30-60 minute telephonic assessment by a specially trained Aspire Health social worker. The conversation in this initial call focuses on building rapport and completing a comprehensive assessment. This assessment includes understanding the patient's perception of their illness and current treatment plan. Follow-up calls occur every 2-4 weeks, typically lasting 15-45 minutes, with the exact frequency based on a patient's individual need. Aspire Health's social workers are supported by a full interdisciplinary team of board-certified palliative care physicians, nurses, and chaplains who provide additional phone support to patients and their families as needed. Patients enrolled in the telehealth program have access to 24/7 on-call support. The average patient is enrolled in the program for 6-8 months with some of the key goals 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 advanced care planning documents and/or a transition to hospice when appropriate.

More information is available at [www.aspirehealthcare.com](http://www.aspirehealthcare.com) or by calling the 24/7 Patient & Referral Hotline at 1-844-232-0500.

AGPCRN-0059-19



## Assisting your patients in managing the Donut Hole



### The Medicare Part D coverage gap

The coverage gap, also referred to as the Donut Hole, is one of the four Medicare Part D payments stages your patients will progress through. This is the payment stage where your patients will spend the most in out-of-pocket drug costs.

### Reducing drug costs Tier 6 medications

While there are programs that can assist financially during the coverage gap (such as the Medicare Extra Help program and Medicare's Coverage Gap Discount Program), your patients may still have difficulties covering their drug costs.

Reminding your patients to never stop taking medications or making any changes to their medications without first consulting you is important. By prescribing Tier 6 medications, you may be able to reduce total drug costs for your patients with these lower-cost generic medications.

**These following medications are available on Tier 6, which are available for \$0, even while your patients are in the coverage gap stage of Medicare Part D.**

#### Blood pressure medications:

Benazepril (Lotensin®)	5 mg, 10 mg, 20 mg, 40 mg
Enalapril (Vasotec®)	2.5 mg, 5 mg, 10 mg, 20 mg
Fosinopri	10 mg, 20 mg, 40 mg
Irbesartan (Avapro®)	75 mg, 150 mg, 300 mg
Lisinopril (Prinivil® or Zestril®)	2.5 mg, 5 mg, 10 mg, 20 mg, 30 mg, 40 mg
Losartan (Cozaar®)	25 mg, 50 mg, 100 mg
Quinapril (Accupril®)	10 mg, 20 mg, 40 mg
Ramipril (Altace®)	1.25 mg, 2.5 mg, 5 mg, 10 mg
Trandolapril:	1 mg, 2 mg, 4 mg
Benazepril-HCTZ (Lotensin HCT®)	5-6.25 mg, 10-12.5 mg, 20-12.5 mg, 20-25mg
Enalapril-HCTZ (Vaseretic®)	5-12.5 mg, 10-25 mg
Lisinopril-HCTZ (Zestoretic® or Prinizide®)	10-12.5 mg, 20-12.5 mg, 20-25 mg
Losartan-HCTZ (Hyzaar®)	50-12.5 mg, 100-12.5 mg, 100-25 mg
Valsartan-HCTZ (Diovan HCT®)	80-12.5 mg, 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg

#### Diabetes medications:

Metformin (Glucophage®)	500 mg, 850 mg, 1000 mg
Metformin ER (Glucophage XR®)	500 mg, 750 mg
Glimepiride (Amaryl®)	1 mg, 2 mg, 4 mg
Glipizide (Glucotrol®)	5 mg, 10 mg
Glipizide ER (Glucotrol XL®)	2.5 mg, 5 mg, 10 mg
Glipizide-metformin:	2.5-250 mg, 2.5-500 mg, 5-500 mg

#### Osteoporosis medications:

Alendronate (Fosamax®)	5 mg, 10 mg, 35 mg, 40 mg, 70 mg
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#### Cholesterol medications:

Atorvastatin (Lipitor®)	10 mg, 20 mg, 40 mg, 80 mg
Lovastatin (Mevacor®)	10 mg, 20 mg, 40 mg
Pravastatin (Pravachol®)	10 mg, 20 mg, 40 mg, 80 mg
Rosuvastatin (Crestor®)	5mg, 10 mg, 20 mg, 40 mg*
Simvastatin (Zocor®)	5 mg, 10 mg, 20 mg, 40 mg, 80 mg

\* Rosuvastatin was added to Tier 6 in June

AGPCRNL-0050-19

## Clinical Laboratory Improvement Amendments

Claims that are submitted for laboratory services subject to the *Clinical Laboratory Improvement Amendments of 1988 (CLIA)* statute and regulations require additional information to be considered for payment.

To be considered for reimbursement of clinical laboratory services, a valid *CLIA* certificate identification number must be reported on a *1500 Health Insurance Claim Form (CMS-1500)* or its electronic equivalent effective July 1, 2015. The *CLIA* certificate identification number must be submitted in one of the following manners:

Claim format and elements	CLIA number location options	Referring provider name and NPI number location options	Servicing laboratory physical location
<b>CMS-1500 (formerly HCFA-1500)</b>	Must be represented in field 23	Submit the referring provider name and NPI number in fields 17 and 17b, respectively.	Submit the servicing provider name, full physical address and NPI number in fields 32 and 32A, respectively, if the address is not equal to the billing provider address. The servicing provider address must match the address associated with the <i>CLIA</i> ID entered in field 23.
<b>HIPAA 5010 837 Professional</b>	Must be represented in the 2300 loop, REF02 element, with qualifier of X4 in REF01	Submit the referring provider name and NPI number in the 2310A loop, NM1 segment.	Physical address of servicing provider must be represented in the 2310C loop if not equal to the billing provider address and must match the address associated with the <i>CLIA</i> ID submitted in the 2300 loop, REF02.

Providers who have obtained a *CLIA Waiver* or *Provider Performed Microscopy Procedure* accreditation must include the QW modifier when any *CLIA* waived laboratory service is reported on a *CMS-1500* claim form in order for the procedure to be evaluated to determine eligibility for benefit coverage.

Laboratory procedures are only covered and, therefore, payable if rendered by an appropriately licensed or certified laboratory having the appropriate level of *CLIA* accreditation for the particular test performed. Thus, any claim that does not contain the *CLIA* ID, has an invalid ID, has a lab accreditation level that does not support the billed service code and/or does not have complete servicing provider demographic information will be considered incomplete and rejected or denied beginning November 1, 2019.

AGPCRNL-0049-19

## Update: 2019 risk adjustment provider trainings

Our Medicare Risk Adjustment Regulatory Compliance team offers two provider training programs regarding Medicare risk adjustment guidelines. Information for each training is outlined below. The Medicare Risk Adjustment Regulatory Compliance team developed the following two provider trainings. This update outlines the training series:



### Medicare risk adjustment and documentation guidance (general)

- **When** — offered the first Wednesday of each month from December 5, 2018, to November 6, 2019 at 1-2 p.m. Eastern time
- **Learning objective** — This 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.
- **Credit** — This activity has been reviewed and is acceptable for up to one prescribed credit by the American Academy of Family Physicians.

If you are 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.

### Medicare risk adjustment, documentation and coding guidance (condition specific)

- **When** — offered on the fourth Wednesday of every other month from January 23, 2019 to November 27, 2019 from noon-1 p.m. Eastern time
- **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.
- **Credit** — This live series activity has been reviewed and is acceptable for credit by the American Academy of Family Physicians.

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

1. **Red flag HCCs, part one** — [Register](#) for recording of live session.  
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, and end-stage liver disease. Recording will play upon registration..
2. **Red Flag HCCs, part two** — [Register](#) for recording of live session.  
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, and diabetes with ophthalmologic or unspecified manifestation. Recording will play upon registration.
3. **Opioids and more: substance abuse and dependence** — Recording will play upon [registration](#).
4. **Acute, chronic and status conditions** — Recording will play upon [registration](#).
5. **Diabetes mellitus and other metabolic disorders** — September 25, 2019; [register](#)
6. **Behavioral health** — November 27, 2019; [register](#)

AGPCRN-0054-19

## Prior authorization requirements for continuous positive airway pressure supplies

Effective December 1, 2019, Amerigroup will begin requiring prior authorization for the below listed continuous positive airway pressure (CPAP) supplies. These prior authorizations will be managed through AIM Specialty Health® (AIM), a specialty health benefits company. Amerigroup has an existing relationship with AIM in the administration of other medical management programs.

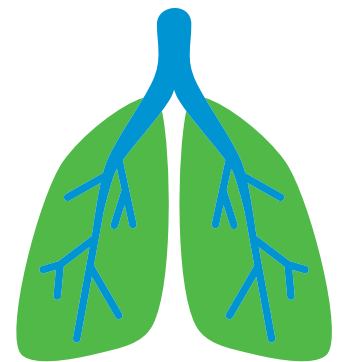
AIM will follow the Amerigroup clinical hierarchy for medical necessity determination. Amerigroup makes coverage determinations based on CMS national coverage determinations, local coverage determinations, other coverage guidelines, and instructions issued by CMS and legislative benefit changes. Where the existing guidance provides insufficient clinical detail, AIM will make a determination of medical necessity using an objective, evidence-based process.

Detailed prior authorization requirements are available to contracted providers by accessing the Provider Self-Service Tool at <https://www.availity.com>. Contracted and noncontracted providers may call Provider Services at the phone number on the back of the member's ID card for prior authorization requirements or additional questions as needed. The Clinical Guidelines that have been adopted by Amerigroup to review for medical necessity are located at <http://www.aimspecialtyhealth.com/marketing/guidelines/185/index.html>.

### Prior authorization requirements

For services that are scheduled on or after December 1, 2019, providers must contact AIM to obtain prior authorization for the services detailed below. Providers are strongly encouraged to verify that a prior authorization has been obtained before scheduling and performing services.

- A4604 — Tubing with heating element
- A7046 — Water chamber for humidifier, replacement, each
- A7027 — Combination Oral/Nasal Mask used with positive airway pressure device, each
- A7030 — Full Face Mask used with positive airway pressure device, each
- A7031 — Face Mask Cushion, Replacement for Full Face Mask
- A7034 — Nasal Interface (mask or cannula type), used with positive airway pressure device, with/without head strap
- A7035 — Headgear
- A7036 — Chinstrap
- A7037 — Tubing
- A7039 — Filter, nondisposable
- A7044 — Oral Interface for Positive Airway Pressure Therapy
- A7045 — Replacement Exhalation Port for PAP Therapy
- A7028 — Oral Cushion, Replacement for Combination Oral/Nasal Mask, each
- A7029 — Nasal Pillows, Replacement for Combination Oral/Nasal Mask, pair
- A7032 — Replacement Cushion for Nasal Application Device
- A7033 — Replacement Pillows for Nasal Application Device, pair
- A7038 — Filter, disposable



AGPCRNL-0053-19

# Prior authorization requirements

Beginning December 1, 2019, prior authorization (PA) requirements will change for some codes covered by Amerigroup for Medicare Advantage members.

## PA requirements will be added to the following:

- T1019 — Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)
- C9740 — Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants
- E0953 — Wheelchair accessory, lateral thigh or knee support, any type including fixed mounting hardware
- E1031 — Rollabout chair, any and all types with castors 5 inches or greater
- E1090 — High-strength lightweight wheelchair, detachable arms, desk or full-length, swing-away detachable footrests
- E1130 — Standard wheelchair, fixed full-length arms, fixed or swing-away detachable footrests
- E1140 — Wheelchair, detachable arms, desk or full-length, swing-away detachable footrests
- E1260 — Lightweight wheelchair, detachable arms (desk or full-length) swing-away detachable footrest
- E1285 — Heavy-duty wheelchair, fixed full-length arms, swing-away detachable footrest
- E1290 — Heavy-duty wheelchair, detachable arms (desk or full-length) swing-away detachable footrest
- E2207 — Wheelchair accessory, crutch and cane holder
- E2378 — Power wheelchair component, actuator, replacement only
- K0039 — Leg strap, H style

AGPCRNL-0043-19

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

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

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

Not all PA requirements are listed here. Detailed prior authorization requirements are available to contracted providers by accessing the Provider Self-Service Tool at <https://www.availity.com>. Contracted and noncontracted providers who are unable to access the Availity Portal may call the number on the back of your patient's Amerigroup ID card for PA requirements.

## Medical Policies and Clinical Utilization Management Guidelines update

The *Medical Policies* and *Clinical Utilization Management (UM) Guidelines* below were developed and/or revised to support clinical coding edits. Note, several policies and guidelines were revised to provide clarification only and are not included. Existing precertification requirements have not changed. For markets with carved-out pharmacy services, the applicable listings below are informational only. Please note: The *Medical Policies* and *Clinical UM Guidelines* below are followed in the absence of Medicare guidance.



To view a guideline, visit <https://providers.amerigroup.com/TX>.

### January 2019 update

#### Updates:

- MED.00110 — Growth Factors, Silver-Based Products and Autologous Tissues for Wound Treatment and Soft Tissue Grafting was revised to add bioengineered autologous skin-derived products (for example, SkinTE) as investigational and not medically necessary.
- MED.00126 — Fractional Exhaled Nitric Oxide and Exhaled Breath Condensate Measurements for Respiratory Disorders was revised to add nasal nitric oxide as investigational and not medically necessary in the diagnosis and monitoring of asthma and other respiratory disorders.
- SURG.00037 — Treatment of Varicose Veins (Lower Extremities) was revised to replace “non-surgical management” with “conservative therapy” in the medically necessary criteria and to add sclerotherapy used in conjunction with a balloon catheter (for example, KAVS procedure) as investigational and not medically necessary.
- TRANS.00035 — Mesenchymal Stem Cell Therapy for the Treatment of Joint and Ligament Disorders, Autoimmune, Inflammatory and Degenerative Diseases (Previous title: Mesenchymal Stem Cell Therapy For Orthopedic Indications) was revised to expand the scope to address non-FDA-approved uses of mesenchymal stem cell therapy; the position statement has been revised to the following: “Mesenchymal stem cell therapy is considered INV & NMN for the treatment of joint and ligament disorders caused by injury or degeneration as well as autoimmune, inflammatory and degenerative diseases.”
- The following AIM Specialty Health® updates took effect on January 24, 2019:
  - Advanced Imaging (imaging of the heart and imaging of the head and neck),
  - Arterial Ultrasound
  - Joint Surgery

#### Medical Policies

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

#### Clinical UM Guidelines

On January 24, 2019, the MPTAC approved several *Clinical UM Guidelines* applicable to Amerigroup. These guidelines were adopted by the medical operations committee for Amerigroup Amerivantage (Medicare Advantage) members on March 28, 2019. View the full update online for a list of the guidelines.



**Read more online.**

AGPCRNL-0028-19



March 2019 update

Updates:

- CG-DME-44 — Electric Tumor Treatment Field was revised to add the use of enhanced computer treatment planning software (such as NovoTal) as not medically necessary (NMN) in all cases.
- CG-MED-72 — Hyperthermia for Cancer Therapy was revised to clarify medically necessary (MN) and NMN statements addressing frequency of treatment.
- CG-SURG-09 — Temporomandibular Disorders was revised to clarify MN and NMN criteria and removed requirement for FDA approval of prosthetic implants.
- CG-SURG-30 — Tonsillectomy for Children With or Without Adenoidectomy was revised to:
  - Spell out number of episodes of throat infections in MN criteria (A1, A2, A3).
  - Clarify criterion addressing parapharyngeal abscess (B4) to say “two or more.”
  - Add “asthma” as potential condition improved by tonsillectomy in MN criteria (C1b).
- GENE.00043 — Genetic Testing of an Individual’s Genome for Inherited Diseases was revised to remove investigational and NMN statement and all other language and coding related to Corus CAD testing. Corus CAD testing is now addressed in GENE.00050.
- The following AIM Specialty Health® updates took effect on September 28, 2019:
  - Advanced Imaging
    - Imaging of the brain
    - Imaging of the extremities
    - Imaging of the spine

Medical Policies

On March 21, 2019, the Medical Policy and Technology Assessment Committee (MPTAC) approved several *Medical Policies* applicable to Amerigroup. These guidelines take effect September 16, 2019. View the full update online for a list of the policies.

Clinical UM Guidelines

On March 21, 2019, the MPTAC approved several *Clinical UM Guidelines* applicable to Amerigroup. These guidelines were adopted by the medical operations committee for Amerigroup Amerivantage (Medicare Advantage) members on May 7, 2019. These guidelines take effect September 16, 2019. View the full update online for a list of the guidelines.



AGPRNL-0046-19\_TX



June 2019 update

Updates:

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

- \*DME.00037 — added devices that combine cooling and vibration to the investigational and not medically necessary statement
- \*LAB.00027 — added Mediator Release Test to investigational and not medically necessary statement
- \*LAB.00033 — clarified investigational and not medically necessary statement to include 4Kscore and AR-V7
- \*OR-PR.00003:
  - Clarified medically necessary position statement criteria 2-4
  - Added statement that use of prosthetic devices that combine both a microprocessor controlled knee and foot-ankle prosthesis is considered investigational and not medically necessary for all indications
- \*SURG.00011:
  - Added new medically necessary and investigational and not medically necessary statements addressing amniotic membrane-derived products for conjunctival and corneal indications, including KeraSys and Prokera
  - Added new products to investigational and not medically necessary statement
- \*SURG.00045:
  - Added erectile dysfunction, Peyronie's disease and wound repair to the investigational and not medically necessary statement
  - Revised title
- \*SURG.00121 — added investigational and not medically necessary statement to address use of transcatheter tricuspid valve repair or replacement for all indications
- The following AIM Specialty Health® updates were approved on June 6, 2019:
  - Advanced Imaging:
    - Imaging of the Heart
    - Oncologic Imaging
    - Vascular Imaging
  - Proton Beam Therapy
  - Rehabilitative Therapies — Physical Therapy, Occupational Therapy and Speech Therapy (New)

Medical Policies

On June 6, 2019, the Medical Policy and Technology Assessment Committee (MPTAC) approved several *Medical Policies* applicable to Amerigroup. View the full update online for a list of the policies.

Clinical UM Guidelines

On June 6, 2019, the MPTAC approved several *Clinical UM Guidelines* applicable to Amerigroup. These guidelines were adopted by the medical operations committee for Medicare Advantage members on July 5, 2019. View the full update online for a list of the guidelines.



Read more online.

AGPCRNL-0055-19

# Reimbursement Policies

## New Policy: Update — Medicaid & Medicare Advantage Drug Screen Testing

(Policy 19-001, effective 11/01/19)

The effective date of this policy has been updated from 10/1/19.



Amerigroup allows reimbursement for all definitive drug classes and presumptive drug testing on the same day. Effective November 1, 2019, definitive drug testing may be done to confirm the results of a negative presumptive test or to identify substances when there is no presumptive test available. Provider documentation in the member's

medical records should reflect that the test was properly ordered and support that the order was based on the result of the presumptive test.

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

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

TX-NL-0198-19-A

## New Policy: Update — Medicare-Medicaid Plan Drug Screen Testing

(Policy 19-001, effective 11/01/19)

The effective date of this policy has been updated from 10/1/19.

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

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

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

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

TXD-NL-0135-19-A

## Policy Update — Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) (Policy 06-0149, effective 01/01/19)

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 January 1, 2019, 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 (Policy 06-010, effective 1/01/2020)

Effective January 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