Provider Newsletter

Amerigroup
An Anthem Company

https://providers.amerigroup.com/tx

October 2020

Table of Contents

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

Social determinants of health support expanding with GroundGame Health

Effective October 1, 2020, Amerigroup will integrate community health workers (CHWs) used by GroundGame Health (GGH)* into our current care management program.

Referrals into the program are completed via provider direct referrals or ad hoc referrals from the Amerigroup Case Management team.

Provider direct referrals will include members with the following situations:

- Identified social determinants of health needs including, but not limited to:
  - Living environment
  - Transportation
  - Food insecurity issues
  - Financial issues
  - Social isolation, etc.
- Hospital readmissions
- A readmission risk score of more than 24

GGH provides an extra layer of support by using CHWs as an extension of care management to help members navigate the complex health care system. PCHP makes an initial outreach to identified members to determine the appropriate level of services a member may need, but they do not provide any clinical services, replace case management from Amerigroup, or replace the care and care management provided by PCPs and specialists. Note: There is no requirement that members participate in this program, and members have the opportunity to opt out of the program as they choose.

A GGH CHW may reach out to your practice to introduce themselves and establish a relationship with the physician(s) at your practice based on referrals received. CHWs may also discuss developing a mechanism by which to share information regarding patients who have been identified for complex care services.

The CHW may also broaden the impact of case management by focusing on action plan developments in various ways, such as helping members fill prescriptions, scheduling appointments and arranging rides to the doctor. CHWs can even accompany members to appointments when appropriate and provide connections to meal delivery services that may be available to them.

To learn more about GGH, please visit **https://groundgamehealth.org**. If you have questions regarding GGH, CHWs and complex care services, please call **1-866-739-6323** or email physicianreferral@preferredchp.com.

** GroundGame Health is an independent company providing contracting services on behalf of Amerigroup.*

TXPEC-3783-20

Patient360 enhancement for medical providers

Patient360 is a real-time dashboard you can access through the Availity* Portal that gives you a full 360° view of your Amerigroup patient's health and treatment history and will help you facilitate care coordination. You can drill down to specific items in a patient's medical record to retrieve demographic information, care summaries, claims details, authorization details, pharmacy information and care management-related activities.

What's new:

Medical providers now have the option available to include feedback for Amerigroup patients who have gaps in care. Your practice can locate these care gaps in the *Active Alerts* section on the Member Care Summary page of the Patient360 application.

Once you have completed all the required fields on the Availity Portal to access Patient360, you will land on the *Member Summary* page of the application. To provide feedback, select the **Clinical Rules Engine (CRE)** within the *Active Alerts* section. This will open the *Care Gap Alert Feedback Entry* window. You can choose the feedback menu option that applies to your patient's care gap.

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

TX-NL-0319-20

Are you using Patient360 for the first time?

You can easily access Patient360 on the Availity Portal.

First, you need to be assigned to a Patient360 role, which your Availity administrators can locate within the *Clinical Roles* options.

Once you have the Availity role assignment, navigate to Patient360 through the Availity Portal by selecting the application on Amerigroup *Payer Spaces* or by choosing the **Patient360** link located on the patient's benefits screen.

Do you need a job aid to help you get started?

The **Patient360 Navigation Overview** illustrates the steps to access Patient360 through the Availity Portal and offers instructions on how to provide feedback for your patients who are displaying a Care Gap Alert. This reference is available for you to access online through the **Custom Learning Center**.

1. From the Availity home page, select Payer Spaces > Amerigroup payer tile > Applications > Custom Learning Center.
2. Select **Resources** from the menu located on the upper left corner of the page.
   (To use the catalog filter to narrow the results, select **Payer Spaces** from the *Category* menu.)
3. Select **Download** to view and/or print the reference guide.

Provider Chat — A fast, easy way to have your questions answered

You now have a new option to have questions answered quickly and easily. With Amerigroup Chat, providers can have a real-time, online discussion through a new digital service, available through **Payer Spaces on Availity**.*

Provider Chat offers:

- Faster access to Provider Services for all questions.
- Real-time answers to your questions about prior authorization and appeals status, claims, benefits, eligibility, and more.
- An easy to use platform that makes it simple to receive help.
- The same high level of safety and security you have come to expect with Amerigroup.

Chat is one example of how Amerigroup is using digital technology to improve the health care experience, with the goal to save you valuable time. To get started, access the service through **Payer Services on Availity**.

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TXPEC-3935-20

Coding spotlight: providers guide to coding for behavioral health disorders

Behavioral health disorders are classified in Chapter 5 of the *ICD-10-CM*

Behavioral health disorders are commonly under-reported on claims. Many Amerigroup members may have behavioral disorders that are not properly managed. Health care providers can assist by taking detailed histories and coding behavioral health issues properly on claims. Below are the ICD-10-CM coding guidelines for behavioral health conditions.

When documenting behavioral mood disorders, the following descriptors apply:	
Type:	Depressive, manic, or bipolar disorder
Episode:	Single or recurrent
Status:	Partial or full remission; identify most recent episode as manic, depressed, or mixed
Severity:	Mild, moderate, severe, or with psychotic elements

Read more online.

TX-NL-0321-20

Medical drug *Clinical Criteria* updates

May 2020 update

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

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

TX-NL-0318-20

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

Please submit your questions to **email**.

Prior authorization requirements

Effective November 1, 2020, prior authorization (PA) requirements will change for E0482. The medical codes listed below will require PA for Medicaid and CHIP members.

PA requirements will be added to the following:

- E0482 — Cough stimulating device, alternating positive and negative airway pressure

TX-NL-0325-20

Effective September 1, 2020, prior authorization (PA) requirements will change for 0200T and 0201T. The medical codes listed below will require PA for Medicaid and CHIP members.

PA requirements will be added to the following:

- 0200T — Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, one or more needles
- 0201T — Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, two or more needles

TX-NL-0320-20

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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Medical Policies and *Clinical Utilization Management Guidelines* update

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

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

Notes/updates:

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

- CG-DME-46 — Pneumatic Compression Devices for Prevention of Deep Vein Thrombosis of the Extremities in the Home Setting
  - Expanded scope of document and revised Medically Necessary statement
- CG-DME-47 — Noninvasive Home Ventilator Therapy for Respiratory Failure
  - Revised Medically Necessary and Discussion/General Information sections
- CG-GENE-02 — Analysis of RAS Status
  - Clarified scope of document and revised the Not Medically Necessary and Coding sections
- CG-MED-64 — Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)
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- MED.00004 —Technologies for the Evaluation of Skin Lesions (including Dermatoscopy, Epiluminescence Microscopy, Videomicroscopy, Ultrasonography)
  - Revised the Not Medically Necessary, Rationale and Coding sections

Medical Policies

On November 7, 2019, February 20, 2020 and May 14, 2020, the Medical Policy and Technology Assessment Committee (MPTAC) approved several *Medical Policies* applicable to Amerigroup. These guidelines take effect September 12, 2020. View the update online for a list of the policies.

Clinical UM Guidelines

On November 7, 2019, February 20, 2020 and May 14, 2020, the MPTAC approved several *Clinical UM Guidelines* applicable to Amerigroup. These guidelines were adopted by the medical operations committee for Amerigroup members on November 28, 2019, April 23, 2020 and May 25, 2020. These guidelines take effect September 12, 2020. View the update online for a list of the guidelines.

Read more online.

TX-NL-0322-20

Update: Notice of changes to the AIM musculoskeletal program

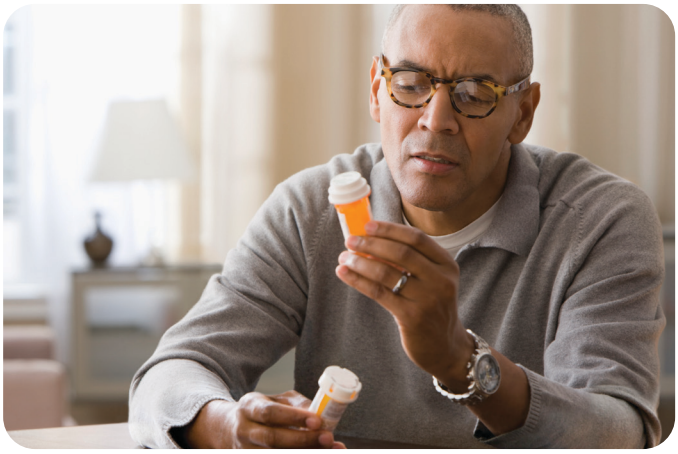
As you know, AIM Specialty Health® (AIM)* administers the musculoskeletal utilization review program for Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) members, which includes the medical necessity review of certain surgeries of the spine, joints and interventional pain treatment. For certain surgeries, the review also includes a consideration of the level of care.

Effective December 1, 2020, two joint codes (29871 and 29892) will be incorporated into the AIM Level of Care Guideline for Musculoskeletal Surgery and Procedures. According to the clinical criteria for level of care, which is based on clinical evidence as outlined in the AIM guideline, it is generally appropriate to perform these two procedures in a hospital outpatient setting. To avoid additional clinical review for these surgeries, providers requesting prior authorization should either choose **hospital observation** admission as the site of service or **Hospital Outpatient Department (HOPD)**.

Read more online.

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

TXD-NL-0195-20



Medical drug *Clinical Criteria* updates

May 2020 update

On May 15, 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**.

TXD-NL-0194-20

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

Please submit your questions to **email**.

Social determinants of health support expanding with GroundGame Health

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

TXPEC-3783-20/AGPCARE-0534-20

Patient360 enhancement for medical providers

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

TX-NL-0319-20

Update: Notice of changes to the AIM musculoskeletal program

As you know, AIM Specialty Health® (AIM)* administers the musculoskeletal program for Medicare Advantage members, which includes the medical necessity review of certain surgeries of the spine, joints and interventional pain treatment. For certain surgeries, the review also includes a consideration of the level of care.

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AGPCRNL-0125-20

Medical drug *Clinical Criteria* updates

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

AGPCRNL-0124-20

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

Please submit your questions to **email**.

Provider transparency update

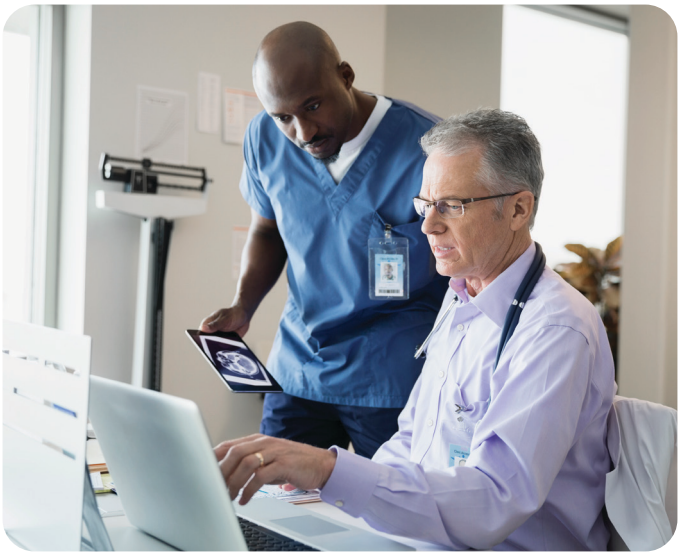
A key goal in our provider transparency initiative is to improve quality while managing health care costs.

One of the ways we do that is by offering value-based programs including Freestanding Patient Centered Care (FPCC), Medicare Advantage Enhanced Personal Health Care Essentials and so on (known as the Programs).

Value-based program providers (also known as payment innovation providers) in our programs receive quality, utilization and/or cost data, reports, and information about the health care providers (referral providers) to whom the providers may refer their Amerigroup Community Care patients. If a referral provider is higher quality and/or lower cost, this component of the Programs should result in the provider receiving more referrals from value-based program providers. The converse should be true if referral providers are lower quality and/or higher cost.

Providing this type of data to value-based program providers (including comparative cost information) helps them make more informed decisions about managing health care costs, maintain/improve quality of care and succeed under the terms of the Programs.

Additionally, employers and group health plans (or their representative/vendors) may also be given data about value-based program providers or referral providers to better understand how their health care dollars are being spent and how their health benefits plans are being administered. This will give them the opportunity to educate their employees and plan members about the benefits of using higher quality and/or lower cost health care providers.



Upon request, Amerigroup will share the data used to make these quality/cost/utilization evaluations and will discuss it with referral providers, including any opportunities for improvement.

AGPCRNL-0131-20

Evaluation and management services correct coding

Amerigroup Community Care continues to be dedicated to delivering access to quality care for our members, providing higher value to our customers and helping improve the health of our communities. In an ongoing effort to promote accurate claims processing and payment, Amerigroup is taking additional steps to assess selected claims for evaluation and management (E/M) services submitted by professional providers.

Beginning on December 1, 2020, we will be using an analytic solution to facilitate a review of whether coding on these claims is aligned with national industry coding standards.

Providers should report E/M services in accordance with the American Medical Association (AMA) CPT® manual and CMS guidelines for billing E/M service codes: Documentation Guidelines for Evaluation and Management. The appropriate level of service 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 time are considered contributing factors. The coded service should reflect and not exceed that needed to manage the member's condition(s).

Claims will be selected from providers who are identified as coding at a higher E/M level as compared to their peers with similar risk-adjusted members. Prior to payment, Amerigroup may review E/M claims to determine, in accordance with correct coding requirements and/or reimbursement policy as applicable, whether the E/M code level submitted is higher than the E/M code level supported on the claim.

If the E/M code level submitted is higher than the E/M code level supported on the claim, Amerigroup reserves the right to:

- Deny the claim and request resubmission of the claim with the appropriate E/M level;
- Pend the claim and request documentation supporting the E/M level billed; and/or
- Adjust reimbursement to reflect the lower E/M level supported by the claim.

The maximum level of service for E/M codes will be based on the complexity of the medical decision-making, and reimbursed at the supported E/M code level and fee schedule rate.

This initiative will not impact every level four or five E/M claim. Providers whose coding patterns improve and are no longer identified as an outlier are eligible to be removed from the program.

Providers that 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 (including submission of such documentation with the dispute).

AGPCRNL-0126-20

Prior authorization requirements

On January 1, 2021, Amerigroup Community Care prior authorization (PA) requirements will change for a number of codes.

Read more online.

AGPCRNL-0130-20

On January 1, 2021, Amerigroup prior authorization (PA) requirements will change for a number of codes.

Read more online.

AGPCRNL-0132-20

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

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Read more online.

AGPCRNL-0127-20