Provider Newsletter

https://providers.amerigroup.com/tx

Amerigroup RealSolutions® in healthcare

2017
Quarter 2

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CMS emergency preparedness rule

On September 8, 2016, CMS finalized a rule to establish consistent emergency preparedness requirements for health care providers participating in Medicare and Medicaid, which includes providers with Amerigroup seeing Amerigroup Amerivantage (Medicare Advantage), STAR, STAR+PLUS, STAR Kids and CHIP members. The purpose is to increase patient safety during emergencies and establish a more coordinated response to natural and man-made disasters.

The CMS rule requires Medicare and Medicaid participating providers and suppliers to meet the following best practice standards:

	**1. Emergency plan**	Based on a risk assessment, develop an emergency plan using an all hazards approach that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters specific to the provider/supplier location.
	**2. Policies and procedures**	Develop and implement policies and procedures based on the plan and risk assessment.
	**3. Communication plan**	Develop and maintain a communication plan that complies with federal and state laws; patient care must be well coordinated within the facility, across health care providers, and with state and local public health departments and emergency systems.
	**4. Training and testing program**	Develop and maintain training and testing programs (including initial and annual trainings) as well as conduct drills and exercises or participate in an actual incident that tests the plan.

Important dates:

The regulation went into effect November 16, 2016. Health care providers and suppliers affected by this rule have one year from the effective date to comply and implement all regulations within their practice.

CMS emergency preparedness rule (cont.)

Impacted providers:

The following providers and suppliers are required to comply with the emergency preparedness rule:

- All-inclusive care for the elderly
- Ambulatory surgical centers
- Clinics, rehabilitation agencies and public health agencies as providers of outpatient physical therapy and speech-language pathology services
- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Critical access hospitals
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- Hospitals
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- Long-term care facilities
- Organ procurement organizations
- Psychiatric residential treatment facilities
- Religious nonmedical health care institutions
- Rural health clinics and federally qualified health centers
- Transplant centers

Note, while all 17 providers/suppliers are impacted, requirements may differ between types.

Additional information:

Amerigroup does not have any additional requirements beyond that required by CMS. If you have questions regarding the emergency preparedness rule or would like to view a list of specific requirements, please visit the CMS website (https://www.cms.gov > Medicare > Provider Enrollment & Certification > Survey & Certification - Emergency Preparedness).

TX-NL-0053-17

Utilization Management affirmative statement

Amerigroup, as a corporation and as individuals involved in Utilization Management (UM) decisions, is governed by the following statements:

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

TX-NL-0057-17

Screening for substance use disorders in pregnancy

As our nation struggles to deal with the serious health risks posed by the opioid epidemic, Amerigroup recognizes your role at the front lines of defense and supports you. Opioid misuse can have devastating effects on an individual's health, family and job as well as society as a whole. One of the most serious threats of the epidemic is to the unborn and newborns of women with substance use disorders (SUDs). Among the risks are preterm birth, low birth weight and neonatal abstinence syndrome/neonatal opioid withdrawal syndrome. Additionally, studies show long-term deficits in cognitive function, memory and behavior which are causes for concern for future generations.

Pregnancy offers women an opportunity to break patterns of unhealthy behaviors. As an OB provider, you have a unique opportunity to help break the pattern of opioid misuse and, thus, avoid health consequences for both mother and child. The first step is to identify, treat and/or refer to treatment those women who are using/abusing unhealthy substances. Screening, brief intervention and referral to treatment (SBIRT) is a widely accepted evidence-based practice that can help you identify, reduce and prevent misuses of unhealthy substances, including opioids.

An effective approach to screening is one that incorporates the practice into your routine prenatal care and flows naturally within the context of the prenatal interview. A short screening done as part of the patient history intake has been shown to accurately identify substance use and at-risk patients. Women who screen positive should be immediately engaged in a brief conversation that may or may not identify a need for treatment.

Evidence-based screening tools include:

- *Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)* — an eight-item questionnaire (www.integration.samhsa.gov > Clinical Practice > SBIRT > Screening > ASSIST).
- The *National Institute on Drug Abuse-Modified ASSIST* — a clinician's screening tool for drug use in general medical settings (https://www.drugabuse.gov/nmassist).

Other screening tools can be found on the Substance Abuse and Mental Health Services Administration (SAMHSA) website (www.integration.samhsa.gov > Clinical Practice > SBIRT > Screening).

SBIRT is a covered benefit for STAR members. As an example, providers can use codes 99408 or H0049 to indicate SBIRT was provided. For more information on SBIRT reimbursement or coding, visit www.medicaid.gov > Medicaid > Data & Systems > Policy and Program Topics > The National Correct Coding Initiative in Medicaid or contact Provider Services at 1-800-454-3730.

The key to success in helping patients break the pattern of opioid misuse is the availability of and access to treatment.

While OB providers can — with appropriate training and certification — prescribe treatment for opioid dependence, Amerigroup understands you may not be comfortable providing this type of specialized care. To find treatment in your area, use the SAMHSA treatment locator tool at https://findtreatment.samhsa.gov or call the SAMHSA National Helpline at 1-800-662-HELP (4357)/TDD: 1-800-487-4889. Amerigroup is also available to assist you with referrals for treatment; for assistance, call Provider Services at 1-800-454-3730.

TX-NL-0058-17

Interactive Care Reviewer tool: Register and start using today!

Beginning mid-April, your practice can initiate online preauthorization requests for STAR members more efficiently and conveniently with our Interactive Care Reviewer (ICR) tool available through the Availity Web Portal. The ICR offers a streamlined process to request inpatient and outpatient procedures through the Availity Web Portal. There are no changes to the preauthorization capabilities on the provider website (https://providers.amerigroup.com/TX).

How do I gain access to the ICR?

You can access our ICR tool via the Availity Web Portal. If your organization has not yet registered for Availity, go to www.availity.com and select **Register** in the upper right-hand corner of the page. If your organization already has access to Availity, your Availity administrator can grant you access to "authorization and referral request" for submission capability and "authorization and referral inquiry" for inquiry capability. You can then find our tool under Patient Registration > Authorizations & Referrals. From this area, you can select the authorizations or authorization/referral inquiry option as appropriate.

Whom can I contact with questions?

For questions regarding our ICR tool, please contact Provider Services at 1-800-454-3730. For questions on accessing our tool via Availity, call Availity Client Services at 1-800-AVAILITY. Availity Client Services is available Monday-Friday from 8 a.m.-7 p.m. ET (excluding holidays) to answer your registration questions.

What benefits/efficiencies does the ICR provide?

- **You are automatically routed to our ICR.** Once the ICR is available, when you go to *Authorizations* in the Availity Web Portal, you are automatically routed to the ICR in order to begin your prior authorization request.
- **You can determine if prior authorization is needed.** For most requests, when you enter patient, service and provider details, you will receive a message indicating whether or not review is required.
- **You will have inquiry capability.** Ordering and servicing physicians and facilities can locate information on preauthorization requests for those they are affiliated with; this includes requests previously submitted via phone, fax, ICR or another online tool (e.g., AIM Specialty Health®).
- **The ICR is easy to use.** You can submit outpatient and inpatient requests for services online using the same, easy-to-use functionality.
- **The ICR reduces the need to fax.** The ICR allows text detail as well as images to be submitted along with the request. Therefore, you can submit requests online and reduce the need to fax medical records.
- **There is no additional cost to you.** The ICR is a no-cost solution that's easy to learn and even easier to use.
- **You can access the ICR tool almost anywhere.** You can submit your requests from any computer with internet access. (Note: We recommend you use Internet Explorer 11, Chrome, Firefox or Safari for optimal viewing.)
- **You receive a comprehensive view of all your preauthorization requests.** You have a complete view of all the utilization management requests you submitted online, including the status of your requests and specific views that provide case updates and a copy of associated letters.

TX-NL-0044-16

Level two and level three shower chairs to require prior authorization

Beginning July 1, 2017, level two and level three shower chairs require prior authorization (PA).

What is the impact of this change?

Effective July 1, 2017, Amerigroup requires PA for level two and level three shower chairs for STAR, STAR Kids, STAR+PLUS and CHIP members. Federal and state law as well as specific state 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.**

PA requirements will be added to the following:

- E0240

Note, in the event HCPCS or modifiers change, Amerigroup will continue to require PA for level two and three shower chairs.

To request PA, contact us by phone (1-800-454-3730) or fax (1-800-964-3627).

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers on the provider self-service website (https://providers.amerigroup.com/TX > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool).

TX-NL-0052-17

Tetanus vaccine billing guidelines reminder

Effective for dates of service on and after January 1, 2016, Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) requires providers administering a tetanus vaccine for an open wound or laceration to bill with codes 90696, 90697, 90698, 90700, 90702, 90714, 90715 or 90723 in addition to the administration code (90471 and/or 90472) and the appropriate diagnosis to indicate an open wound or laceration. Tetanus vaccines administered in the ER should be billed with appropriate revenue codes (0250 or 0636 for the vaccine and 0771 for the administration).

Note, if a tetanus vaccine is administered for a reason other than an open wound or laceration and the member has pharmacy benefits, the member's Medicare Part D plan should be billed; this applies to the vaccine and the administration charges. To bill the member's Medicare Part D plan, you may use TransactRX — a clearinghouse for claim submissions. Claims can be submitted on their website (www.transactrx.com) or by calling TransactRX Customer Service at 1-866-522-3386. There is no charge to providers who use electronic funds deposit to receive payment. There is a service fee of $2.50 for check payments.

For more information, review the *Vaccine and Vaccine Administration Payments Under Medicare Part D* factsheet on the CMS website (https://www.CMS.gov > Outreach & Education > Medicare > Medicare Learning Network® (MLN) Homepage > Publications > Vaccine and Vaccine Administration Payments Under Medicare Part D).

TXD-NL-0047-17

Prior authorization required for continuous interstitial glucose monitoring

Effective August 1, 2017, Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) requires prior authorization (PA) for continuous interstitial glucose monitoring. Federal and state law as well as state contract language and CMS 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.**

PA requirements will be added to the following procedure codes:

- A9276: sensor — invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system (one unit = one-day supply)
- A9277: transmitter — external, for use with interstitial continuous glucose monitoring system
- A9278: receiver (monitor) — external, for use with interstitial continuous glucose monitoring system

To request PA, contact us via one of the methods below:

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

Not all PA requirements are listed here. Detailed PA requirements are available to providers on the provider self-service website (https://providers.amerigroup.com/TX > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool). Providers may also call Provider Services at 1-855-878-1785.

TXDPEC-0328-17

Prior authorization requirements for Part B drug: Spinraza (nusinersen)

On September 1, 2017, prior authorization (PA) requirements will change for the Part B injectable/infusible drug Spinraza (nusinersen) covered by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan). Federal and state law, as well as state contract language and CMS 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.**

PA requirements will be added to the following code which is billed with not otherwise classified (NOC) HCPCS J-code J3490:

- Spinraza (nusinersen) — for the treatment of children and adults with spinal muscular atrophy, a rare and often fatal genetic disease affecting muscle strength and movement (J3490)

Please note, this drug is currently billed under the NOC J-code J3490. Since this code includes drugs that are NOC, if the authorization is denied for medical necessity, the plan's denial will be for the drug and not the HCPCS.

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

- Phone: 1-855-878-1785
- Fax: 1-888-235-8468
- Web: Interactive Care Reviewer tool via https://www.availity.com

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers on the provider self-service website (https://providers.amerigroup.com/TX > Quick Tools > Precertification Lookup Tool). Providers may also call Provider Services at 1-855-878-1785 for PA requirements.

TXD-NL-0048-17

Prior authorization requirements for the Part B injectable/infusible drug: Exondys 51 (eteplirsen)

On July 1, 2017, prior authorization (PA) requirements will change for the Part B injectable/infusible drug Exondys 51 (eteplirsen) covered by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan). Federal and state law, as well as state contract language and CMS 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.**

PA requirements will be added to the following drugs billed with not otherwise classified (NOC) HCPCS J-codes J3490 and J3590:

- Exondys 51 (eteplirsen) — for treatment of Duchenne muscular dystrophy in patients with confirmed mutation of the dystrophin gene amenable to exon 51 skipping (C9484, J3490 and J3590)

Please note, this drug is currently billed under the NOC J-codes J3490 and J3590. Since this code includes drugs that are NOC, if the authorization is denied for medical necessity, the plan's denial will be for the drug and not the HCPCS.

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers on the provider self-service website (https://providers.amerigroup.com/TX > Quick Tools > Precertification Lookup Tool). Providers may also call Provider Services at 1-855-878-1785 for PA requirements.

TXD-NL-0037-17

Billing changes for 2017 home health agencies

For dates of service on and after January 1, 2017, Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) will provide separate payment to home health agencies (HHAs) for disposable negative pressure wound therapy (NPWT) device claims for members who receive home health services for which payment is made under the Medicare-Medicaid Plan home health benefit. In addition to billing a claim with type of bill 32X, HHAs must enter a claim with type of bill 34X, HCPCS code 97607 or 97608, and the appropriate revenue code (042X, 043X or 0559) in order to receive separate payment for NPWT.

For dates of service on or after January 1, 2017, G0163 and G0164 will be retired and replaced with the following new G codes:

- G0493: skilled services of a registered nurse (RN) for the observation and assessment of a patient's condition — each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)
- G0494: skilled services of a licensed practical nurse (LPN) for the observation and assessment of a patient's condition — each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)
- G0495: skilled services of an RN to train and/or educate a patient or family member in the home health or hospice setting — each 15 minutes
- G0496: skilled services of an LPN to train and/or educate a patient or family member in the home health or hospice setting — each 15 minutes

For more information, contact Provider Services at 1-855-878-1785.

TXD-NL-0042-17

Utilization Management affirmative statement

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- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Amerigroup STAR+PLUS MMP does not specifically reward practitioners or other individuals for issuing denials of coverage or care.
- Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support denials of benefits.
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TXD-NL-0046-17

CMS emergency preparedness rule

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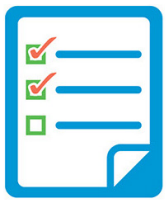
The CMS rule requires Medicare-Medicaid plan participating providers and suppliers to meet the following common and well-known industry best practice standards:

	**1. Emergency plan**	Based on a risk assessment, develop an emergency plan using an all hazards approach that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters specific to the provider/supplier location.
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Important dates:

The regulation went into effect November 16, 2016. Health care providers and suppliers affected by this rule have one year from the effective date to comply and implement all regulations within their practice.

CMS emergency preparedness rule (cont.)

Impacted providers:

The following providers and suppliers are required to comply with the emergency preparedness rule:

- All-inclusive care for the elderly
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- Transplant centers

Note, while all 17 providers/suppliers are impacted, requirements may differ between types.

Additional information:

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) does not have any additional requirements beyond that required by CMS. If you have questions regarding the emergency preparedness rule or would like to view a list of specific requirements, please visit the CMS website (https://www.cms.gov > Medicare > Provider Enrollment & Certification > Survey & Certification - Emergency Preparedness).

TXD-NL-0038-17

High-Risk Medication Report

High-Risk Medication Reports are reviewed to monitor the use of high-risk medications in the elderly by CMS as a patient safety initiative.

To ensure providers are aware of high-risk medications prescribed to Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) members, we fax a list of high-risk medication claims to providers each week. Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) also distributes a monthly report to prescribers detailing the number of their patients on high-risk medications and the number of high-risk medications prescribed year-to-date. We also contact members who have filled prescriptions for high-risk medications and suggest they discuss the prescription with their provider and ask if there is a safer alternative drug.

If you receive a *High-Risk Medication Report*, please review it and help us support safe medication choices. Alternatives to these high-risk medications are listed on our provider website.

If you have questions about this communication, received this fax in error or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-855-878 -785.

TXD-NL-0041-17

HCPCS codes allow for payment for coordinating behavioral health services

We would like to remind providers seeing Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) members of the collaborative care, case management (CM) and cognitive assessment HCPCS codes that went into effect on January 1, 2017. CMS approved these codes for services provided under the psychiatric collaborative care model, which supports integration of behavioral health (BH) care into primary care treatment. The codes allow payment for efforts to coordinate and integrate BH services, including key services of CM, for patients receiving BH treatment and psychiatric consultation by primary care treatment teams. The collaborative care codes introduced in 2017 include the following:

HCPCS code:	Description:
G0502	Initial psychiatric collaborative CM (first 70 minutes in the first calendar month of BH care manager activities) in consultation with a psychiatric consultant and directed by the treating physician or other qualified health care professional (QHCP) with the following required elements: ■ Outreach to and engagement in treatment of a patient directed by the treating physician or other QHCP ■ Initial assessment of the patient including administration of validated rating scales with the development of an individualized treatment plan ■ Review by the psychiatric consultant with modifications of the plan if recommended ■ Entering patient in a registry and tracking patient follow-up and progress using the registry with appropriate documentation and participation in weekly caseload consultation with the psychiatric consultant ■ Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies
G0503	Subsequent psychiatric collaborative CM (first 60 minutes in a subsequent month of BH care manager activities) in consultation with a psychiatric consultant and directed by the treating physician or other QHCP with the following required elements: ■ Tracking patient follow-up and progress using the registry with appropriate documentation ■ Participation in weekly caseload consultation with the psychiatric consultant ■ Ongoing collaboration with and coordination of the patient's mental health (MH) care with the treating physician or other QHCP and any other treating MH providers ■ Additional review of progress and recommendations for changes in treatment as indicated including medications based on recommendations provided by the psychiatric consultant ■ Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies ■ Monitoring of patient outcomes using validated rating scales ■ Relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment
G0504	Initial or subsequent psychiatric collaborative CM (each additional 30 minutes in a calendar month of BH care manager activities) in consultation with a psychiatric consultant and directed by the treating physician or other QHCP (List separately in addition to code for primary procedure.) *(Note, G0504 should be used in conjunction with G0502 or G0503.)*

HCPCS codes allow for payment for coordinating behavioral health services (cont.)

HCPCS code:	Description:
G0507	CM services for BH conditions (at least 20 minutes of clinical staff time per calendar month) directed by a physician or other QHCP with the following required elements: ■ Initial assessment or follow-up monitoring including the use of applicable validated rating scales ■ BH care planning in relation to BH/psychiatric health problems including revision for patients who are not progressing or whose status changes ■ Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation ■ Continuity of care with a designated member of the care team
G0505	Cognitive/functional assessment and care planning

For more information, visit the CMS website at https://www.CMS.gov > Newsroom > search for "Medicare finalizes substantial improvements that focus on primary care, mental health, and diabetes prevention" from November 2016.

TXD-NL-0045-17

New place of service code for telehealth

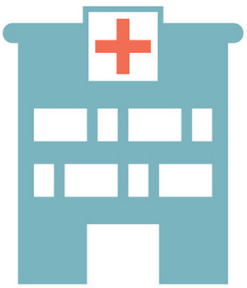
Effective January 1, 2017, Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) will follow CMS in implementing the new place of service (POS) code for telehealth — POS code 02. This code is for use by physicians or practitioners delivering telehealth services from a distant site.

When billing for telehealth services, providers must bill with POS code 02 and continue to bill with modifier GT (for telehealth services via interactive audio and video telecommunication systems) or GQ (for telehealth services via an asynchronous telecommunications system). Telehealth services not billed with POS code 02 will be denied.

To view a list of telehealth services, visit https://www.CMS.gov > Medicare > Telehealth > List of Telehealth Services.

TXD-NL-0040-17

New CMS requirement — Hospitals must use the *Medicare Outpatient Observation Notice*



CMS requires that all hospitals and critical access hospitals (CAHs) provide written and verbal notification to inform Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) members that they are receiving observation services on an outpatient basis for more than 24 hours.

All hospitals and CAHs are required to provide this statutory notification no later than March 8, 2017. Hospitals should use the standardized *Medicare Outpatient Observation Notice (MOON) (CMS-10611)* approved by the Office of Management and Budget. The *MOON* and accompanying instructions are available on the CMS website at https://www.CMS.gov > Medicare > Medicare - General Information > Beneficiary Notices Initiative (BNI).

TXD-NL-0044-17

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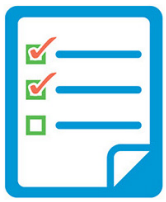	**1. Emergency plan**	Based on a risk assessment, develop an emergency plan using an all hazards approach that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters specific to the provider/supplier location.
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SSO-PEC-0880-17

New program offers benefits for end-stage renal disease patients

This year, Amerigroup Community Care began offering Amerivantage ESRD (HMO-POS SNP) — a Medicare Advantage chronic care-special needs plan specifically designed for members with end-stage renal disease (ESRD). The plan offers medical coverage (Parts A and B), prescription drug coverage (Part D) tailored to ESRD patients and an out-of-network option. Additional benefits include:

- Preventive and comprehensive dental coverage.
- Transportation to medical appointments (48 one-way trips).
- Annual eyewear allowance.
- Over-the-counter allowance.

Note, Amerivantage ESRD (HMO-POS SNP) is an open-access plan, so there is no requirement to receive a referral. However, for coordination of overall care and referral guidance, Amerigroup encourages members to talk to their primary physician. Amerigroup does require prior authorization for some services.

DaVita VillageHealth* is working with Amerivantage ESRD (HMO-POS SNP) members to help coordinate care and medical services among their health care providers. All members are assigned a registered nurse or nurse practitioner who will facilitate communication between you, the member's other doctors, the member's family and the member.

Paper claims submissions for Amerivantage ESRD (HMO-POS SNP) members should be sent to the address below:
Amerigroup Community Care
P.O. Box 61010
Virginia Beach, VA 23466-1010

If you have any questions regarding Amerivantage ESRD (HMO-POS SNP), please call our dedicated line (1-877-269-5660).

** DaVita VillageHealth, an independent company, is a subsidiary of DaVita Inc. and provides case management services on behalf of Amerigroup.*

SSO-NL-0015-17

Policy Update — Medicaid Maternity Services

(Policy 14-001, effective 11/01/17)

Amerigroup allows reimbursement for prenatal care, deliveries and two postpartum visits as individual services. Amerigroup will not reimburse for duplicate or otherwise overlapping services during the course of the pregnancy.

What's New?

We have updated the Maternity Services Reimbursement Policy to include outcome of delivery/weeks of gestation information. You are required to use the appropriate diagnosis code on professional delivery service claims to indicate the outcome of delivery. Diagnosis codes that indicate the applicable gestational weeks of pregnancy are required on all professional delivery service claims and are recommended for all other pregnancy-related claims.

Failure to report the appropriate diagnosis code will result in denial of the claim.

For market-specific information, refer to the Maternity Services Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

TX-NL-0046-17

Policy Update — Amerivantage Maternity Services

(Policy 14-001, effective 11/01/17)

Amerigroup allows reimbursement for global obstetrical codes once per period of a pregnancy (defined as 279 days) when appropriately billed by a single provider or provider group reporting under the same federal Tax Identification Number (TIN). If a provider or provider group reporting under the same TIN does not provide all antepartum, delivery and postpartum services, global obstetrical codes may not be used and providers are to submit for reimbursement only the elements of the obstetric package that were actually provided. Amerigroup will not reimburse for duplicate or otherwise overlapping services during the course of the pregnancy.

What's New?

We have updated the Maternity Services Reimbursement Policy to include outcome of delivery/weeks of gestation information. You are required to use the appropriate diagnosis code on professional delivery service claims to indicate the outcome of delivery. Diagnosis codes that indicate the applicable gestational weeks of pregnancy are required on all professional delivery service claims and are recommended for all other pregnancy-related claims.

Failure to report the appropriate diagnosis code will result in denial of the claim.

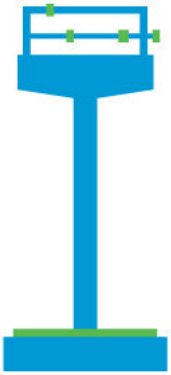
For additional information, refer to the Maternity Services Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

PEC-ALL-2382-17

Policy Update — Medicaid & Amerivantage

Modifier 63: Procedure Performed on Infants Less Than 4 kg

(Policy 06-015, effective 09/15/2017)



Currently, Amerigroup allows additional reimbursement of 120 percent for surgery on neonates and infants up to a present body weight of 4 kg. Effective September 15, 2017, Amerigroup will allow reimbursement for surgery on neonates and infants up to a present body weight of 4 kg when billed with Modifier 63 at 100 percent of the applicable fee schedule or contracted/negotiated rate. Please note, the neonate weight should be documented clearly in the report for the service.

Assistant surgeon and/or multiple procedure rules and fee reductions apply when

- An assistant surgeon is used
- Multiple procedures are performed on neonates or infants less than 4 kg in the same operative session

Key Definition

Modifier 63: Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding Modifier 63 to the procedure.

In applicable circumstances, Amerigroup does **not** allow reimbursement for Modifier 63. To view these circumstances, please refer to the Modifier 63: Procedure Performed on Infants Less Than 4 kg Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

TX-NL-0036-16

Policy Notice — Amerigroup STAR+PLUS MMP Reimbursement Policy bulletin

Effective October 1, 2017, Reimbursement Policies will become effective and located on the Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) provider website. For policy-specific information, go to https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > TX MMP Reimbursement Polices.

These policies will serve as a guide to assist you in accurate claim submission and to outline the basis for reimbursement if the service is covered by the Amerigroup STAR+PLUS MMP benefit plan. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. Proper billing and submission guidelines are required along with the use of industry-standard, compliant codes on all claim submissions.

Code and clinical editing

Amerigroup STAR+PLUS MMP applies code and clinical editing guidelines to evaluate claims for accuracy and adherence to accepted national industry standards and plan benefits. We utilize sophisticated software products to ensure compliance with standard code edits and rules. These products increase consistency of payment for providers by ensuring correct coding and billing practices. Editing sources include but are not limited to the CMS National Correct Coding Initiative, Amerigroup Medical Policies and MMP *Clinical Utilization Management Guidelines*. Amerigroup STAR+PLUS MMP is committed to working with you to ensure timely processing and payment of claims.

Amerigroup STAR+PLUS MMP does not apply clinical editing guidelines to state-defined local procedure codes.

TXD-NL-0043-17

Policy Update — Amerivantage Inpatient Readmissions Update

(Policy 13-001)

In an effort to identify clinically related readmissions to the same facility, licensed clinical staff will review at the time of an inpatient authorization the clinical information submitted regarding the medical treatment and management of an admission that occurred within 2 30 days from a previous admission to the same facility. If an admission is believed to be related, a medical director will contact the admitting physician to confirm that the clinical information is accurate. If the second admission is determined to be clinically related, we will not reimburse for an additional admission as this is considered a continuation of the episode of care. This process will be implemented June 2017.

What's New?

Based on the information above, the Inpatient Readmissions Reimbursement Policy has been updated. Amerigroup Community Care will utilize information indicating clinically related readmissions, clinical criteria and/or licensed clinical medical review for readmissions from day 2-day 30 for the second admission determination. For additional information, please refer to the Inpatient Readmissions Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

SS0-NL-0016-17

Policy Update — Amerigroup STAR+PLUS MMP Inpatient Readmissions Update

(Policy 13-001)

In an effort to identify clinically related readmissions to the same facility, licensed clinical staff will review at the time of an inpatient authorization the clinical information submitted regarding the medical treatment and management of an admission that occurred within 2 30 days from a previous admission to the same facility. If an admission is believed to be related, a medical director will contact the admitting physician to confirm that the clinical information is accurate. If the second admission is determined to be clinically related, we will not reimburse for an additional admission as this is considered a continuation of the episode of care.

What's New?

Based on the information above, the Inpatient Readmissions Reimbursement Policy has been updated. Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) will utilize information indicating clinically related readmissions, clinical criteria and/or licensed clinical medical review for readmissions from day 2-day 30 for the second admission determination. For additional information, please refer to the Inpatient Readmissions Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > TX MMP.

TXD-NL-0049-17

Policy Update — Amerivantage Multiple Radiology Payment Reduction

(Policy 12-002, effective 09/15/2015)

Amerigroup Community Care allows reimbursement for multiple diagnostic imaging procedures. Multiple diagnostic imaging procedures with the exception of CT scan services will be subject to a Multiple Procedure Payment Reduction when services are performed by the same physician or health care professional with the same NPI on the same date of service during the same patient encounter.

The global and technical component (TC) of certain diagnostic imaging procedures will reimburse at 100 percent of the physician fee schedule or negotiated amount for the service with the highest TC payment. Payment is made at 50 percent for the TC of subsequent services furnished by the same physician to the same patient in the same session on the same day.

A reduced allowance for the second and subsequent procedures will not apply when multiple imaging procedures are billed appended with Modifier 59.

For additional information, please refer to the Multiple Radiology Payment Reduction Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

SSO-PEC-0873-17

Policy Update — Amerivantage Modifier FX and Reimbursement Policy Update

CMS has added a new Modifier FX, used to indicate X-rays that are taken using film. Reimbursement will be subject to a 20 percent reduction of the applicable fee schedule and/or contracted/negotiate rate. Amerigroup will begin following CMS Modifier FX reimbursement guidelines effective September 15, 2017.

Modifier FX (X-ray taken using film) has been added to our reimbursement modifiers list. This modifier is applicable to Medicare Advantage Plans only. For additional information, refer to Modifier Usage Reimbursement Policy (Exhibit A) at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

SSO-NL-0017-17

Policy Update — Amerigroup STAR+PLUS MMP Modifier FX and Reimbursement

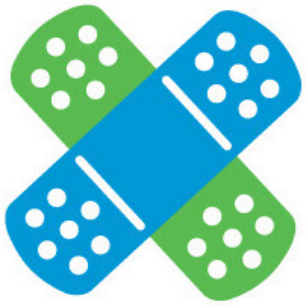
CMS has added a new Modifier FX, used to indicate X-rays that are taken using film. Reimbursement will be subject to a 20 percent reduction of the applicable fee schedule and/or contracted/ negotiate rate. Amerigroup STAR+PLUS (Medicare-Medicaid Plan) will begin following CMS Modifier FX reimbursement guidelines effective September 15, 2017.

Modifier FX (X-ray taken using film) has been added to our reimbursement modifiers list. This modifier is applicable to Amerigroup STAR+PLUS MMP only. For additional information, refer to Modifier Usage Reimbursement Policy (Exhibit A) at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > TX MMP.

TXD-NL-0050-17

Policy Update — Amerivantage Modifier 22: Increased Procedural Service

(Policy 07-020, effective 11/01/17)



Amerigroup allows reimbursement for procedure codes appended with Modifier 22. Reimbursement is based on 120% of the fee schedule or contracted/negotiated rate when the procedure or service is greater than what is usually required for the listed procedure.

Refer to Modifier 22: Increased Procedural Service Reimbursement Policy for more information at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

SSO-NL-0010-17

Policy Update — Medicaid Assistant at Surgery (Modifiers 80/81/82/AS)

(Policy 06-005, effective 10/15/2017)

Amerigroup allows reimbursement for one assistant surgeon when eligible procedures are billed with Modifiers 80 and AS. Effective October 15, 2017, Amerigroup observes Modifier KX in addition to Modifiers AS, 80, 81 and 82.

Amerigroup will also reimburse Modifiers 81 and 82. Assistant surgeon services are eligible for reimbursement as follows:

- Modifier 80: 16 percent
- Modifier 81: 16 percent
- Modifier 82: 16 percent
- Modifier AS: 13.6 percent

When multiple procedures are performed where only some of the procedures are eligible for assistant at surgery reimbursement, only assistant at surgery services for the eligible procedures will be considered for reimbursement. The same multiple procedure fee reductions and clinical edits apply to both the assistant at surgery and the primary surgeon.

For additional information, refer to the Assistant at Surgery (Modifiers 80/81/82/AS) Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

TX-NL-0060-16