Provider Newsletter

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Amerigroup
An Anthem Company

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Medical Policy update

Effective December 27, 2017, the Medical Policy and Technology Assessment Committee approved the following revision of the *DRUG.00017 Hyaluronan Injections in Joints Other Than the Knee* policy: Position statement revised from Medically Necessary to **Investigational and Not Medically Necessary** for hyaluronan injections for the treatment of temporomandibular joint disorders.

The Medical Policies and Clinical UM Guidelines Search is located online at https://medicalpolicies.amerigroup.com/search.

For questions regarding this *Medical Policy* update, please contact your Provider Relations representative.

TXPEC-2342-18

Amerigroup to conduct post-payment reviews of distinct procedural service modifiers

In accordance with CMS guidelines, Amerigroup conducts post-payment reviews of professional claims billed with modifiers for distinct procedural services. As part of these reviews, we may contact you with outlying billing practices to request additional documentation related to the services. If billing discrepancies are identified, we will provide you with a written report of our findings and initiate recoupment as appropriate. Findings may assist your office with quality improvement efforts.

For questions regarding post-payment reviews of distinct procedural service modifiers, contact Provider Services at 1-800-454-3730.

TX-NL-0099-18

2018 Utilization Management Affirmative Statement concerning utilization management decisions

The following statements govern Amerigroup, as a corporation and as individuals, involved in utilization management decisions:

- Utilization management decision making is based only on care appropriateness, and service and existence coverage.
- We do not reward practitioners or other individuals for issuing coverage or care denials. 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 benefit denials.
- We do not offer financial incentives to decision makers for utilization management determinations that encourage decisions resulting in underutilization or create barriers to care and service.

TXPEC-2362-18

Medical Policies and *Clinical Utilization Management Guidelines* update

Medical Policies update

On December 11, 2017, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Medical Policies* which are applicable to Amerigroup. These *Medical Policies* were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the below listing. The *Medical Policies* were made publicly available on the provider website on the publish date listed below. To search for specific policies, visit https://medicalpolicies.amerigroup.com/search. **Existing precertification requirements have not changed.**

On March 30, 2018, the clinical guidelines were made publicly available on the Amerigroup *Medical Policies* and *Clinical UM Guidelines* subsidiary website. To search for specific guidelines policies, visit https://medicalpolicies.amerigroup.com/search. **Existing precertification requirements have not changed.**

Please share this notice with other members of your practice and office staff.

Publish date	*Medical Policy* number	*Medical Policy*	New/ revised
12/27/2017	DRUG.00112	Gemtuzumab Ozogamicin (Mylotarg®)	New
12/27/2017	DRUG.00118	Copanlisib (Aliqopa®)	New
11/9/2017	MED.00123	Axicabtagene ciloleucel (Yescarta™)	New
11/9/2017	DME.00040	Automated Insulin Delivery Devices	Revised
12/27/2017	DRUG.00050	Eculizumab (Soliris®)	Revised
12/27/2017	DRUG.00071	Pembrolizumab (Keytruda®)	Revised
12/27/2017	DRUG.00075	Nivolumab (Opdivo®)	Revised
11/9/2017	DRUG.00081	Eteplirsen (Exondys 51™)	Revised
12/27/2017	DRUG.00109	Durvalumab (Imfinzi™)	Revised
12/27/2017	GENE.00011	Gene Expression Profiling for Managing Breast Cancer Treatment	Revised
11/9/2017	SURG.00089	Balloon and Self-Expanding Absorptive Sinus Ostial Dilation	Revised
12/27/2017	TRANS.00023	Hematopoietic Stem Cell Transplantation for Multiple Myeloma and Other Plasma Cell Dyscrasias	Revised
12/27/2017	TRANS.00024	Hematopoietic Stem Cell Transplantation for Select Leukemias and Myelodysplastic Syndrome	Revised
12/27/2017	TRANS.00027	Hematopoietic Stem Cell Transplantation for Pediatric Solid Tumors	Revised
12/27/2017	TRANS.00028	Hematopoietic Stem Cell Transplantation for Hodgkin Disease and Non-Hodgkin Lymphoma	Revised
12/27/2017	TRANS.00029	Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias	Revised
12/27/2017	TRANS.00030	Hematopoietic Stem Cell Transplantation for Germ Cell Tumors	Revised

Clinical Utilization Management Guidelines update

On December 11, 2017, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Clinical Utilization Management (UM) Guidelines* which are applicable to Amerigroup. These clinical guidelines were developed or revised to support clinical coding edits. Several guidelines were revised to provide clarification only and are not included in the below listing. The *Clinical UM Guidelines* on this list represent the *Clinical UM Guidelines* adopted by the Medical Operations Committee for the Government Business Division on March 30, 2018. To see the full utilization management guidelines on the website, visit https://medicalpolicies.amerigroup.com/search.

On March 30, 2018, the clinical guidelines were made publicly available on the Amerigroup *Medical Policies* and *Clinical UM Guidelines* subsidiary website. To search for specific guidelines policies, visit https://medicalpolicies.amerigroup.com/search. **Existing precertification requirements have not changed.**

Please share this notice with other members of your practice and office staff.

Update to clinical guideline, CG-MED-39, Central (Hip or Spine) Bone Density Measurement and Screening for Vertebral Fractures Using Dual Energy X-Ray Absorptiometry (CG-MED 39), was published March 30, 2018.

Effective March 30, 2018, this clinical guideline will apply to Medicaid lines of business.

The clinical indication section specific to female screening of osteoporosis was revised to reflect that an initial (baseline) central (hip or spine) bone density measurement is considered medically necessary when conducted in postmenopausal individuals 65 years of age or older.

The guideline also identifies other clinical indications when initial and repeat central bone mineral density measurements are medically necessary.

Publish date	*Clinical UM Guideline* number	*Clinical UM Guideline* title	New/ revised
12/27/2017	CG-DME-40	Electrical Bone Growth Stimulation	New
12/27/2017	CG-DME-41	Ultraviolet Light Therapy Delivery Devices for Home Use	New
12/27/2017	CG-DRUG-65	Tumor Necrosis Factor Antagonists	New
12/27/2017	CG-DRUG-66	Panitumumab (Vectibix®)	New
12/27/2017	CG-DRUG-68	Bevacizumab (Avastin®) for Non-Ophthalmologic Indications	New
12/27/2017	CG-DRUG-69	Ustekinumab (Stelara®)	New
12/27/2017	CG-DRUG-70	Eribulin mesylate (Halaven®)	New
12/27/2017	CG-DRUG-71	Ziv-aflibercept (Zaltrap®)	New
12/27/2017	CG-DRUG-72	Pertuzumab (Perjeta®)	New
12/27/2017	CG-DRUG-73	Denosumab (Prolia®, Xgeva®)	New
12/27/2017	CG-DRUG-74	Canakinumab (Ilaris®)	New
12/27/2017	CG-DRUG-75	Romiplostim (Nplate®)	New
12/27/2017	CG-DRUG-76	Plerixafor Injection (Mozobil™)	New
12/27/2017	CG-DRUG-77	Radium Ra 223 Dichloride (Xofigo®)	New
12/27/2017	CG-DRUG-78	Antihemophilic Factors and Clotting Factors	New

***Medical Policies* and *Clinical Utilization Management Guidelines* update (cont.)**

Publish date	*Clinical UM Guideline* number	*Clinical UM Guideline* title	New/ revised
12/27/2017	CG-DRUG-79	Siltuximab (Sylvant®)	New
12/27/2017	CG-DRUG-80	Cabazitaxel (Jevtana®)	New
12/27/2017	CG-DRUG-81	Tocilizumab (Actemra®)	New
12/27/2017	CG-GENE-01	Janus Kinase 2 (JAK2) V617F Gene Mutation Assay	New
12/27/2017	CG-GENE-02	Analysis of KRAS Status	New
12/27/2017	CG-GENE-03	BRAF Mutation Analysis	New
12/27/2017	CG-GENE-04	Molecular Marker Evaluation of Thyroid Nodules	New
12/27/2017	CG-MED-61	Preoperative Testing for Low Risk Invasive Procedures and Surgeries	New
12/27/2017	CG-MED-62	Resting Electrocardiogram Screening in Adults	New
12/27/2017	CG-MED-63	Treatment of Hyperhidrosis	New
12/27/2017	CG-MED-64	Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)	New
12/27/2017	CG-MED-65	Manipulation Under Anesthesia of the Spine and Joints other than the Knee	New
12/27/2017	CG-MED-66	Cryopreservation of Oocytes or Ovarian Tissue	New
12/27/2017	CG-MED-67	Melanoma Vaccines	New
12/27/2017	CG-MED-68	Therapeutic Apheresis	New
12/27/2017	CG-SURG-61	Cryosurgical Ablation of Solid Tumors Outside the Liver	New
12/27/2017	CG-SURG-62	Radiofrequency Ablation to Treat Tumors Outside the Liver	New
12/27/2017	CG-SURG-63	Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure	New
12/27/2017	CG-SURG-65	Recombinant Human Bone Morphogenetic Protein	New
12/27/2017	CG-SURG-66	Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)	New
12/27/2017	CG-SURG-67	Treatment of Osteochondral Defects	New
12/27/2017	CG-SURG-68	Surgical Treatment of Femoracetabular Impingement Syndrome	New
12/27/2017	CG-SURG-69	Meniscal Allograft Transplantation of the Knee	New
12/27/2017	CG-DRUG-38	Pemetrexed Disodium (Alimta®)	Revised
12/27/2017	CG-DRUG-50	Paclitaxel, Protein-Bound (Abraxane®)	Revised
12/27/2017	CG-DRUG-61	Gonadotropin Releasing Hormone Analogs for the Treatment of Non-Oncologic Indications	Revised
12/27/2017	CG-MED-21	Anesthesia Services and Moderate (“Conscious”) Sedation	Revised
11/9/2017	CG-MED-55	Level of Care: Advanced Radiologic Imaging	Revised

Prior authorization (PA) requirements

Elotuzumab

Effective May 1, 2018, PA is required for elotuzumab to be covered by Amerigroup.

PA requirements will be added to the following:

- J9176 — injection, elotuzumab, 1 mg

TX-NL-0093-17

Eight injectable drugs

Effective June 1, 2018, PA is required for eight injectable drugs to be covered by Amerigroup.

PA requirements will be added to the following:

- J0565 — injection, bezlotoxumab, 10 mg
- J1428 — injection, eteplirsen, 10 mg
- J2326 — injection, nusinersen, 0.1 mg
- J2350 — injection, ocrelizumab, 1 mg
- J9022 — injection, atezolizumab, 10 mg
- J9023 — injection, avelumab, 10 mg
- J9285 — injection, olaratumab, 10 mg
- Q2040 — Tisagenlecleucel

TX-NL-0096-18

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.**

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

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

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the provider self-service tool at https://www.availity.com. Providers who are unable to access Availity can use the Precertification Lookup Tool on our website (https://providers.amerigroup.com/TX > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool) or call Provider Services at 1-800-454-3730 for PA requirements.

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) to conduct post-payment reviews of distinct procedural service modifiers

In accordance with CMS guidelines, Amerigroup STAR+PLUS MMP conducts post-payment reviews of professional claims billed with modifiers for distinct procedural services. As part of these reviews, we may contact you with outlying billing practices to request additional documentation related to the services. If billing discrepancies are identified, we will provide you with a written report of our findings and initiate recoupment as appropriate. Findings may assist your office with quality improvement efforts.

For questions regarding post-payment reviews of distinct procedural service modifiers, contact Provider Services at 1-855-878-1785.

TXD-NL-0002-18

2018 Utilization Management Affirmative Statement concerning utilization management decisions

The following statements govern Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan), as a corporation and as individuals, involved in utilization management decisions:

- Utilization management decision making is based only on care appropriateness, and service and existence coverage.
- We do not reward practitioners or other individuals for issuing coverage or care denials. 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 benefit denials.
- We do not offer financial incentives to decision makers for utilization management determinations that encourage decisions resulting in underutilization or create barriers to care and service.

TXDPEC-1004-18

Prior authorization (PA) requirements

Varubi (rolapitant) and Fasenra (benralizumab)

Effective May 1, 2018, PA is required for Part B injectable/infusible drugs Varubi® (rolapitant) and Fasenra® (benralizumab) to be covered by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan).

PA requirements will be added to the following:

- Varubi (rolapitant) — for the prevention of delayed chemotherapy induced nausea and vomiting in combination with other antiemetic agents, including highly emetogenic chemotherapy (unlisted, no J code established at this time; J3490, J3590)
- Fasenra (benralizumab) — for the add-on maintenance treatment of patients with severe asthma ages 12 and older and with eosinophilic phenotype (unlisted, no J code established at this time; J3490, J3590)

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

TXD-NL-0079-17

Rebinyn (factor IX, glycopegylated), Fibryna (human fibrinogen) and Hemlibra (emicizumab-kxwh)

On June 1, 2018, PA is required for Part B injectable/infusible drugs Rebinyn (factor IX, glycopegylated), Fibryna (human fibrinogen) and Hemlibra (emicizumab-kxwh) to be covered by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan).

PA requirements will be added to the following:

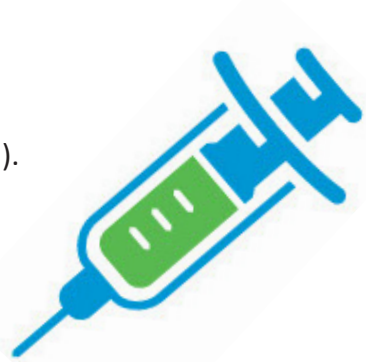
- Rebinyn (factor IX, glycopegylated) — a DNA-derived coagulation factor IX concentrate that temporarily increases plasma levels of factor IX and can temporarily correct the coagulation defect in patients with hemophilia B (J7195)
- Fibryna (human fibrinogen) — a human fibrinogen concentrate indicated for the treatment of acute bleeding episodes in adults and adolescents with congenital fibrinogen deficiency, including afibrinogenemia and hypofibrinogenemia. Fibryna is not indicated for dysfibrinogenemia (J7178)
- Hemlibra (emicizumab-kxwh) — approved by the FDA as a prophylactic medicine used to prevent or reduce the frequency of bleeding episodes in adults and children with hemophilia A with factor VIII inhibitors. It is given once a week subcutaneously (unlisted, no J code established at this time; C9399, J3490, J3590, J7199 and J9999)

Please note, one of the drugs noted above is currently billed under not otherwise classified (NOC) HCPCS J-codes (C9399, J3490, J3590, J7199 and J9999). Since these codes include all drugs that are NOC, if the authorization is denied for medical necessity, the plan's denial will be for the drug and not the HCPCS code.

TXDPEC-0994-18

PA requirements (cont.)

Brineura, Tremfya and Zinplava



Effective June 1, 2018, PA is required for injectable drugs Brineura, Tremfya and Zinplava to be covered by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan).

PA requirements will be added to the following:

- Brineura — injection, cerliponase alfa, 1 mg (C9014)
- Tremfya — injection, guselkumab, 1 mg (C9029)
- Zinplava — injection, bezlotoxumab, 10 mg (J0565)

TXDPEC-0995-18

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.**

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

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

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the provider self-service tool at https://www.availity.com. Providers who are unable to access Availity can use the Precertification Lookup Tool on our website (https://providers.amerigroup.com/TX > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool) or call Provider Services at 1-855-878-1785 for PA requirements.

Improve member medication regimen

Amerigroup Community Care and the Centers for Medicare & Medicaid Services consider medication review and reconciliation a top priority to help ensure members take their medications safely. Our pharmacists use medication review and reconciliation to help members understand what medications they are taking, why they are taking them, how they should be taking their medication and to answer any questions or concerns they have about their medication regimen.

Amerigroup may contact you to discuss members' medications as part of either the Medication Therapy Management (MTM) or the Medication Reconciliation Post Discharge (MRPD) programs:

- The MTM program starts with a letter welcoming members to participate in a private medication review with one of our pharmacists over the phone. This free service gives members the opportunity to ask questions about the medicines they are taking and to review prescription and over-the-counter drugs to prevent drug reactions, and helps members get the most benefit from their medications at the lowest cost. At the end of the discussion, your patient is encouraged to share a written summary of their medication list and any medication-related concerns with you.
- Medication Reconciliation Post Discharge is a HEDIS® and Centers for Medicare & Medicaid star ratings measure for 2018. The MRPD program helps members with their medications after they have been discharged from an inpatient hospital stay. Amerigroup pharmacists will work with you and the member to identify and correct any medication related problems to reduce the risk of readmission. To complete this measure per HEDIS specifications, it is necessary to include the appropriate documentation in the member's chart. The medication reconciliation post-discharge HEDIS measure medical record documentation must include the following:
  - Date medication reconciliation was performed
  - Notation stating that current medication and discharge medication lists were reviewed
  - Signature of prescribing care provider, clinical pharmacist or registered nurse who performed medication reconciliation
  - If medications were provided at discharge, please include the member's next steps such as:
    - Take new medications as prescribed.
    - Discontinue all discharge medications.
  - Notation if no medications were prescribed at discharge

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

SSO-NL-0042-18_NJ_NM_TX_WA

Medical Policies and *Clinical Utilization Management Guidelines* update

Medical Policies

The Amerigroup Community Care Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Medical Policies*. These *Medical Policies* were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the below listing. The *Medical Policies* were made publicly available on the provider website on the effective date listed below.

Visit *Medical Policies* and *Clinical Utilization Management (UM) Guidelines* to search for specific policies. **Existing precertification requirements have not changed.**

Please share this notice with other members of your practice and office staff.

Effective date	*Medical Policy* Number	*Medical Policy*	New/ revised
12/27/2017	DRUG.00112	Gemtuzumab Ozogamicin (Mylotarg®)	New
12/27/2017	DRUG.00118	Copanlisib (Aliqopa®)	New
11/9/2017	MED.00123	Axicabtagene ciloleucel (Yescarta™)	New
11/9/2017	DME.00040	Automated Insulin Delivery Devices	Revised
12/27/2017	DRUG.00050	Eculizumab (Soliris®)	Revised
12/27/2017	DRUG.00071	Pembrolizumab (Keytruda®)	Revised
12/27/2017	DRUG.00075	Nivolumab (Opdivo®)	Revised
11/9/2017	DRUG.00081	Eteplirsen (Exondys 51™)	Revised
12/27/2017	DRUG.00109	Durvalumab (Imfinzi™)	Revised
12/27/2017	GENE.00011	Gene Expression Profiling for Managing Breast Cancer Treatment	Revised
11/9/2017	SURG.00089	Balloon and Self-Expanding Absorptive Sinus Ostial Dilation	Revised
12/27/2017	TRANS.00023	Hematopoietic Stem Cell Transplantation for Multiple Myeloma and Other Plasma Cell Dyscrasias	Revised
12/27/2017	TRANS.00024	Hematopoietic Stem Cell Transplantation for Select Leukemias and Myelodysplastic Syndrome	Revised
12/27/2017	TRANS.00027	Hematopoietic Stem Cell Transplantation for Pediatric Solid Tumors	Revised
12/27/2017	TRANS.00028	Hematopoietic Stem Cell Transplantation for Hodgkin Disease and Non-Hodgkin Lymphoma	Revised
12/27/2017	TRANS.00029	Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias	Revised
12/27/2017	TRANS.00030	Hematopoietic Stem Cell Transplantation for Germ Cell Tumors	Revised

Clinical UM Guidelines

Effective date	*Clinical UM Guideline* Number	*Clinical UM Guideline* Title	New/ revised
12/27/2017	CG-DME-40	Electrical Bone Growth Stimulation	New
12/27/2017	CG-DME-41	Ultraviolet Light Therapy Delivery Devices for Home Use	New
12/27/2017	CG-DRUG-65	Tumor Necrosis Factor Antagonists	New
12/27/2017	CG-DRUG-66	Panitumumab (Vectibix®)	New
12/27/2017	CG-DRUG-68	Bevacizumab (Avastin®) for Non-Ophthalmologic Indications	New
12/27/2017	CG-DRUG-69	Ustekinumab (Stelara®)	New
12/27/2017	CG-DRUG-70	Eribulin mesylate (Halaven®)	New
12/27/2017	CG-DRUG-71	Ziv-aflibercept (Zaltrap®)	New
12/27/2017	CG-DRUG-72	Pertuzumab (Perjeta®)	New
12/27/2017	CG-DRUG-73	Denosumab (Prolia®, Xgeva®)	New
12/27/2017	CG-DRUG-74	Canakinumab (Ilaris®)	New
12/27/2017	CG-DRUG-75	Romiplostim (Nplate®)	New
12/27/2017	CG-DRUG-76	Plerixafor Injection (Mozobil™)	New
12/27/2017	CG-DRUG-77	Radium Ra 223 Dichloride (Xofigo®)	New
12/27/2017	CG-DRUG-78	Antihemophilic Factors and Clotting Factors	New
12/27/2017	CG-DRUG-79	Siltuximab (Sylvant®)	New
12/27/2017	CG-DRUG-80	Cabazitaxel (Jevtana®)	New
12/27/2017	CG-DRUG-81	Tocilizumab (Actemra®)	New
12/27/2017	CG-GENE-01	Janus Kinase 2 (JAK2) V617F Gene Mutation Assay	New
12/27/2017	CG-GENE-02	Analysis of KRAS Status	New
12/27/2017	CG-GENE-03	BRAF Mutation Analysis	New
12/27/2017	CG-GENE-04	Molecular Marker Evaluation of Thyroid Nodules	New
12/27/2017	CG-MED-60	Anesthesia During Cataract Surgery	New
12/27/2017	CG-MED-61	Preoperative Testing for Low Risk Invasive Procedures and Surgeries	New
12/27/2017	CG-MED-62	Resting Electrocardiogram Screening in Adults	New
12/27/2017	CG-MED-63	Treatment of Hyperhidrosis	New
12/27/2017	CG-MED-64	Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)	New
12/27/2017	CG-MED-65	Manipulation Under Anesthesia of the Spine and Joints other than the Knee	New
12/27/2017	CG-MED-66	Cryopreservation of Oocytes or Ovarian Tissue	New
12/27/2017	CG-MED-67	Melanoma Vaccines	New

***Medical Policies* and *Clinical Utilization Management Guidelines* updated (cont.)**

Effective date	*Clinical UM Guideline* Number	*Clinical UM Guideline* Title	New/ revised
12/27/2017	CG-MED-68	Therapeutic Apheresis	New
12/27/2017	CG-SURG-61	Cryosurgical Ablation of Solid Tumors Outside the Liver	New
12/27/2017	CG-SURG-62	Radiofrequency Ablation to Treat Tumors Outside the Liver	New
12/27/2017	CG-SURG-63	Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure	New
12/27/2017	CG-SURG-65	Recombinant Human Bone Morphogenetic Protein	New
12/27/2017	CG-SURG-66	Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)	New
12/27/2017	CG-SURG-67	Treatment of Osteochondral Defects	New
12/27/2017	CG-SURG-68	Surgical Treatment of Femoracetabular Impingement Syndrome	New
12/27/2017	CG-SURG-69	Meniscal Allograft Transplantation of the Knee	New
12/27/2017	CG-DRUG-38	Pemetrexed Disodium (Alimta®)	Revised
12/27/2017	CG-DRUG-50	Paclitaxel, Protein-Bound (Abraxane®)	Revised
12/27/2017	CG-DRUG-61	Gonadotropin Releasing Hormone Analogs for the Treatment of Non-Oncologic Indications	Revised
12/27/2017	CG-MED-21	Anesthesia Services and Moderate (“Conscious”) Sedation	Revised
11/9/2017	CG-MED-55	Level of Care: Advanced Radiologic Imaging	Revised

New Policy — Amerigroup STAR+PLUS MMP Inpatient Readmissions

(Policy 13-001, effective 07/01/18)

Effective July 1, 2018, Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) does not allow separate reimbursement for claims that have been identified as a readmission to the same or different hospital for the same, similar or related condition. Amerigroup STAR+PLUS MMP uses the following standards:

- Readmission up to 30-days from discharge
- Same diagnosis or diagnoses that fall into the same grouping

Amerigroup STAR+PLUS MMP will utilize clinical criteria and/or licensed clinical medical review for readmissions from day 2 to day 30 in order to determine the reason for the second admission.

Readmissions occurring on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition are considered part of the original admission and should be combined. Amerigroup STAR+PLUS MMP considers a readmission to the same or different hospital for the same, similar or related condition on the same date of service to be a continuation of initial treatment. Amerigroup STAR+PLUS MMP defines same day as services rendered within a 24-hour period (from time of discharge to time of readmission) for participating providers.

Exclusions

- Admissions for the medical treatment of cancer, primary psychiatric disease and rehabilitation care
- Planned readmissions
- Patient transfers from one acute care hospital to another
- Patient discharged from the hospital against medical advice

This policy only affects those facilities reimbursed for inpatient services by a diagnosis-related group methodology.

For additional information, refer to the Inpatient Readmissions reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > TX MMP.

TXD-NL-0003-18

Policy Update — Medicaid Unlisted, Unspecified or Miscellaneous Codes

(Policy 06-004, effective 07/01/2018)

As of July 1, 2018, Amerigroup requires unspecified diagnosis codes be used only when an established diagnosis code does not exist to describe the diagnosis. Reimbursement is based on review of the unspecified diagnosis code on an individual claim basis. If the claim must have an unspecified diagnosis code, and there is a corresponding left, right or bilateral diagnosis, then a description supporting the use of the unspecified diagnosis code must be provided.

For additional information, please review the Unlisted, Unspecified or Miscellaneous Codes reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

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Policy Update — Amerigroup STAR+PLUS MMP Unlisted, Unspecified or Miscellaneous Codes

(Policy 06-004, effective 07/01/18)

As of July 1, 2018, Amerigroup STAR+PLUS MMP requires unspecified diagnosis codes be used only when an established diagnosis code does not exist to describe the diagnosis. Reimbursement is based on review of the unspecified diagnosis code on an individual claim basis. If the claim must have an unspecified diagnosis code and there is a corresponding left, right, or bilateral diagnosis, then a description supporting the use of the unspecified diagnosis code must be provided.

For additional information, please review the Unlisted, Unspecified or Miscellaneous Codes reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > TX MMP.

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