March 2021

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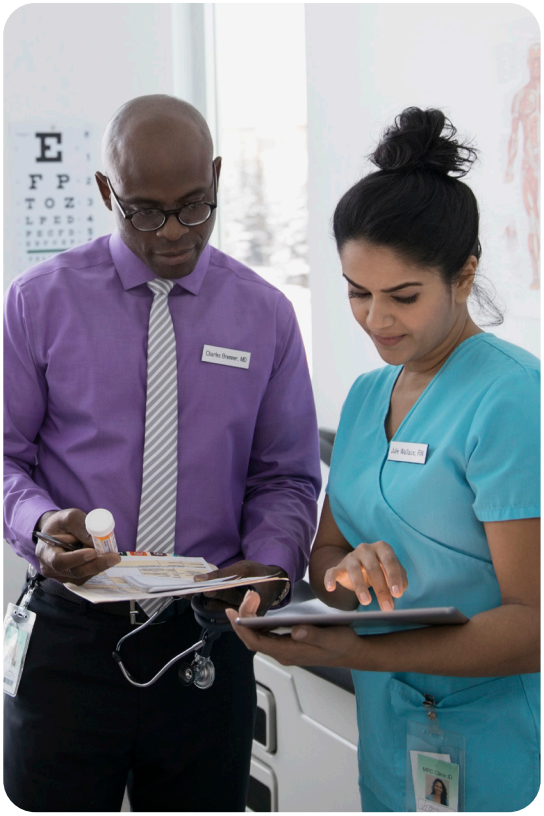
Access to more claim denial information is now self-service

Through predictive analytics, healthcare teams can now receive real-time solutions to claim denials.

Amerigroup is committed to providing digital first solutions. Healthcare teams can now use self-service tools to reduce the amount of time spent following up on claim denials. Through the application of predictive analytics, Amerigroup has the answers before you ask the questions. With an initial focus on claim-level insights, Amerigroup has streamlined claim denial inquiries by making the reasons for the claim denial digitally available. In addition to the reason for the denial, we supply you with the next steps needed to move the claim to payment. This eliminates the need to call for updates and experience any unnecessary delays waiting for the *EOP*.

Through the application of predictive analytics, Amerigroup has the answers before you ask the questions.

Access the *Claims Status Listing* on Payer Spaces from **https://providers.amerigroup.com** by using the Log In button or through the secure provider portal via **Availity**.* We provide a complete list of claims, highlight those claims that have proactive insights, provide a reason for the denial and the information needed to move the claim forward.



Claim resolution daily

Automated updates make it possible to refresh claims history daily. As you resolve claim denials, the claim status changes, other claims needing resolution are added and claims are resolved faster.

Amerigroup made it easier to update and supply additional information, too. While logged into the secure provider portal, you have the ability to revise your claim, add attachments, or eliminate it if filed in error. Even if you did not file the claim digitally, you can access the proactive insights. Predictive analytics supplies the needed claim denial information online — all in one place.

Predictive proactive issue resolution and near real-time digital claim denial information is another example of how Amerigroup is using digital technology to improve the healthcare experience. If you have questions, please reach out to your Provider Relations representative.

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

TX-NL-0358-20

Coding spotlight: Overview of the 2021 evaluation and management changes

Why are these changes necessary?

Changes are meant to simplify code selection criteria, make coding more clinically relevant, and to reduce documentation overload for office-based evaluation and management (E/M) services, while continuing to differentiate payment based on complexity of care.

Key elements of major revisions for 2021:

- Physicians may choose their documentation based on medical decision making (MDM) or total time (including non-face-to-face services).
- History and exam are still important parts of the notes and may contribute to both time and MDM, but they will no longer be scored for determining the level of the E/M visit.
- MDM criteria has moved away from simply adding up tasks to instead, focusing on tasks that affect the management of a patient's condition.
- Code 99201 was deleted.
- Codes 99202 to 99215 were revised.

Changes to time documentation

Time will now be defined as the total time spent by the provider (both face-to-face and time spent on non-face-to-face activities related to this patient's visit performed on the same day as the visit). This may include the services listed below, but should not include time spent on separately billable services (such as X-ray interpretation). Effective January 1, 2021:

- The total time spent must be documented clearly by the provider for the E/M level to be determined by time and does not include ancillary staff time.
- Time will no longer need to be dominated by counseling.
- All time used for leveling the E/M must be on the same day of the face-to-face visit.

Read more online.

TX-NL-0370-20

MCG Care Guidelines 24th edition customization

Effective June 1, 2021, the following new customizations will be implemented:

- **Gastrointestinal Bleeding, Upper (W0170, previously ORG M-180)** – Customized the Clinical Indications for admission to inpatient care by revising the hemoglobin; systolic blood pressure; pulse; melena; orthostatic hypotension; and BUN criteria.
- **Gastrointestinal Bleeding, Upper Observation Care (W0171, previously OCG OC-021)** – Customized the Clinical Indications for observation care by revising the systolic blood pressure and hemoglobin criteria and adding melena or hematochezia and suspected history of bleeding.

Access a detailed summary of customizations online: **Customizations to MCG Care Guidelines 24th Edition** (**https://medpol.providers.amerigroup.com/green-provider/medical-policies-and-clinical-guidelines** > Other Criteria > MCG > Customizations to the MCG Care Guidelines 24th Edition.)

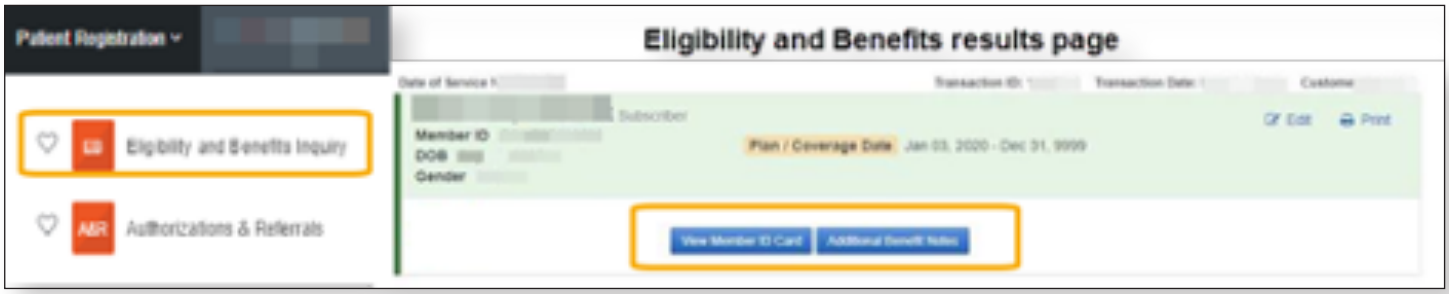
TX-NL-0363-20

Availity Portal eligibility and benefits provides both additional benefit notes and digital member ID Cards

New: additional benefit detail

Now, you can select **Additional Benefit Notes**, on the Availity* Portal *Eligibility and Benefits* results screen to find more descriptive benefit information.

Benefits are listed in alphabetical order, making it easier to search for specific benefits. Capabilities include full benefit descriptions, vendor information associated with the benefit and the option for the provider to print out the benefit information.



Digital member ID cards

The digital member ID card allows easy, low-touch access to view additional information or confirm basic membership details

When conducting an eligibility and benefits inquiry for our members, simply select **View Member ID Card** on the *Eligibility and Benefits* results page. Note: The Availity Portal requires you to enter the member's ID number, as well as a date of birth or the member's first and last name into the search options in order to submit an eligibility and benefits inquiry.

Try both of these valuable tools today!

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TX-NL-0367-20

Medicare-Medicaid Plan

Access to more claim denial information is now self-service

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

TX-NL-0358-20

MCG Care Guidelines 24th edition customization

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

TX-NL-0363-20/TXD-NL-0201-20

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.

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.

- *GENE.00055 – Gene Expression Profiling for Risk Stratification of Inflammatory Bowel Disease (IBD) Severity
  - Gene expression profiling for risk stratification of inflammatory bowel disease (IBD) severity, including use of PredictSURE IBD, is considered investigational and not medically necessary for all indications
- *LAB.00037 – Serologic Testing for Biomarkers of Irritable Bowel Syndrome (IBS)
  - Serological testing for biomarkers of irritable bowel syndrome (for example, CdtB and anti-vinculin), using tests such as, IBSDetex, ibs-smart or IBSchek, is considered investigational and not medically necessary for screening, diagnosis or management of irritable bowel syndrome, and for all other indications
- *DME.00011 – Electrical Stimulation as a Treatment for Pain and Other Conditions: Surface and Percutaneous Devices
  - Revised scope to only include non-implantable devices and moved content addressing implantable devices to SURG.00158
  - Added “non-implantable” to bullet point on percutaneous neuromodulation therapy
  - Added percutaneous electrical nerve field stimulation (PENFS) as investigational and not medically necessary for all indications
- *SURG.00062 – Vein Embolization as a Treatment for Pelvic Congestion Syndrome and Varicocele
  - Expanded scope to include percutaneous testicular vein embolization for varicocele and added embolization of the testicular (spermatic) veins as investigational and not medically necessary as a treatment of testicular varicocele
- *CG-LAB-15 – Red Blood Cell Folic Acid Testing
  RBC folic acid testing is considered not medically necessary in all cases
- *CG-LAB-16 – Serum Amylase Testing
  - Serum amylase testing is considered not medically necessary for acute and chronic pancreatitis and all other conditions
- *CG-GENE-04 – Molecular Marker Evaluation of Thyroid Nodules
  - Added the Afirma Xpression Atlas as not medically necessary
- SURG.00158 – Implantable Peripheral Nerve Stimulation Devices as a Treatment for Pain
  - A new *Medical Policy* was created from content contained in DME.00011.
  - There are no changes to the policy content.
  - Publish date is December 16, 2020.
- CG-GENE-21 – Cell-Free Fetal DNA-Based Prenatal Testing
  - A new *Clinical Guideline* was created from content contained in GENE.00026.
  - There are no changes to the guideline content.
  - Publish date is December 16, 2020.

Medical Policies

On November 5, 2020, the medical policy and technology assessment committee (MPTAC) approved several *Medical Policies* applicable to Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan). These guidelines take effect May 8, 2021.

Clinical UM Guidelines

On November 5, 2020, the MPTAC approved several *Clinical UM Guidelines* applicable to Amerigroup STAR+PLUS MMP. These guidelines were adopted by the medical operations committee for Amerigroup STAR+PLUS MMP members on November 19, 2020. These guidelines take effect May 8, 2021.

Read more online.

TXD-NL-0207-21

Access to more claim denial information is now self-service

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

TX-NL-0358-20

MCG Care Guidelines 24th edition customization

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

TX-NL-0363-20/AGPCRNL-0158-20

Medical Policies and *Clinical Utilization Management Guidelines* update

View the **article** in the Medicare-Medicaid Plan section.

TXD-NL-0207-21/AGPCRNL-0167-21

DME checklist of information needed from providers

Amerigroup Community Care wants to help ensure Medicare Advantage members receive the DME they are eligible to receive under CMS guidelines as soon as that equipment is needed. When requesting DME for your patients, our members, please include the needed information to give our physiatrist and other clinical reviewers a complete picture of your patients' status and needs. This will help ensure a timely response from Amerigroup; reduce the need for additional phone calls, faxes, emails and appeals; and deliver the requested DME to your patients as soon as possible.

Read more online.

AGPCRNL-0166-21