December 2021
Provider Services: 800-454-3730
https://provider.amerigroup.com/MD

Amerigroup

Provider Newsletter

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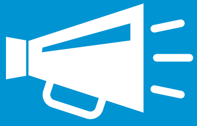
MD-NL-0492-21



COVID-19 information from Amerigroup Community Care

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 Maryland Department of Health (MDH) to help us determine what action is necessary on our part. Amerigroup will continue to follow MDH guidance policies.

For additional information, reference the *COVID-19 Updates* section of our **website**.

MDPEC-2081-20

Experience the difference — Provider service

Based on your feedback, Amerigroup Community Care redesigned our approach to provider service. Through this improved approach, we will be your most trusted advocate in the healthcare industry. Our new service model was designed to create an improved provider experience when doing business with us and ensure we support you in delivering high-quality healthcare to our members. Here is how we will better support you.

Easier self-service:

- Most questions and issues can be resolved by using self-service tools that are available 24/7 using the **Availity Portal**.* This includes claim payment disputes, provider data updates, claims status, verification of member benefits and eligibility, view claims status, submit and view prior authorization requests, and more.
- Use the ***Practice Profile Update Form*** to submit changes or additions to your information.
- Download our ***Quick Reference Guide*** that has resources related to the most common topics that may be able to help resolve your request.

Faster access to Provider Services:

- We have increased our focus to resolve issues and requests to our Provider Services on your first attempt.
- You can now use **Availity's secure live chat** function to conveniently chat with a Provider Services representative on most issues and requests.
- Call the number on the back of your patient's ID card or dial **800-454-373**0 during normal business hours.
- If Provider Services is unable to help, you can request follow-up from your Provider Experience representative.
- You can also send a message to your Provider Experience representative by using the *Contact Us* form on the **contact us page**.

We will continue to work hard on reducing your administrative burden and operational issues, allowing you more time to focus on the care you provide patients and our members.

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

MD-NL-0495-21

Medicaid enrollment reminder

The *21st Century Cures Act*, a federal law enacted by Congress, requires all Medicaid managed care network providers to be enrolled in state Medicaid programs. Providers must enroll separately with each state in which they practice.

All billing and rendering providers submitting claims to Amerigroup Community Care are required to maintain active enrollment in the Maryland Medicaid program. Providers enroll through the electronic Provider Revalidation and Enrollment Portal (ePREP), managed by the Maryland Department of Health. **Failure to enroll and maintain an active status with ePREP may result in future claims denial.** Please enroll and/or verify active status with ePREP at **https://eprep.health.maryland.gov**. For more information, contact the Maryland Department of Health at **844-4MD-PROV (844-463-7768)** or visit **https://health.maryland.gov/mmcp/Pages/ePREP.aspx**.

Medicaid providers will use ePREP as a one-stop shop for new enrollment, re-enrollment, revalidation, and provider/demographic updates (e.g., license updates, changes of ownership, address changes).

How to enroll

Providers must **sign up** with a username and password. For help navigating, you can contact the ePREP Call Center at **844-4MD-PROV (844-463-7768)**, Monday through Friday, 7 a.m. to 7 p.m. (except state holidays).

Resources are also available at the **Maryland Department of Health website**.

MD-NL-0482-21

How to change PCP assignment of a member

Reminder, in order to be paid for a member visit, the primary care physician (PCP) seen must be the assigned PCP of the member or a PCP in the Amerigroup Community Care network under the same TIN as the assigned PCP. Providers can change a member's assigned PCP with the member's consent.

The member or provider can change the assigned PCP leading up to and on the date of the visit using the PCP change form located on the **provider website**.

Important things to note:

- The form must be faxed on or before the date of the visit, reflected as the "date of request."
- All fields must be completed for the form to be processed timely.
- The new PCP must be an in-network PCP.

Members can also call Member Services toll free at **800-600-4441** to speak to a representative prior to their appointment.

MD-NL-0483-21

Urinary tract infection toolkits are on the way

To support the health of our members, Amerigroup Community Care is sending urinary tract infection (UTI) toolkits to select members who were seen in the ER for a UTI.

This useful kit contains:

- A water bottle to help your patient stay hydrated.
- UTI test strips with instructions on use if having symptoms. These are test strips that are also available over the counter.
- Basic instructions on how to use the toolkit and reasons to seek care.

Amerigroup members may reach out to you when they receive their toolkit.

MD-NL-0473-21

LiveChair collaboration

Amerigroup Community Care and LiveChair* are collaborating to reach Amerigroup members in Baltimore City, Baltimore County, Prince George's County, and Montgomery County.

LiveChair is a barbershop and salon network in African American and Latinx communities that provides education to clientele on Medicaid benefits, chronic disease prevention, and links Amerigroup members to PCPs to improve health outcomes.

LiveChair provides barbers and salons with information and education on prevention messaging to share with clientele as well as their technology platform to schedule appointments, and provide health information reminders through the LiveChair phone app.

This innovative approach to reaching out to members continues to evolve as we engage some of our most critical community partners to improve health!

For more information, contact Dr. Stephen Noble at **stephen@livechair.com**.

** LiveChair is an independent company providing barbershop network services on behalf of Amerigroup Community Care.*

MD-NL-0475-21

Good news: non-payment remittance advice enhancements are here

We have enhanced your ability to search, review, and download a copy of the remittance advice on Availity* when there is not an associated payment. For remit advice with payment, you can continue to search with the Check/EFT number.

Below are images reflecting the scenarios that have been enhanced:

Paper remittance

ZERO AMOUNT -- THIS IS NOT A CHECK

DATE 07/14/21

PROVIDER NAME

ADDRESS

ALTERNATE PAYEE REMITTANCE ADVICE

PROVIDER-NPI IDS XXXXX

TAX ID NO XXXXX

CHECK NUMBER: 9999999999

0.00 IRS WITHHELD

0.00 STATE WITHHELD

Electronic remittance advice (ERA/835)

Check Details

Check/EFT Number 9999999999-2019

Check/EFT Date 11/18/2019

Check Amount $0.00

What has changed?

Non-payment number display in the Check Number and Check/EFT Number fields:	
Old — There were two sets of numbers for the same remittance advice. The paper remittance displayed 10 bytes (9999999999 or 99########) and the corresponding 835 (ERA) displayed 27 bytes (9999999999 — [year] #############).	**Enhancement** — The updated numbering sequence for the paper remittance and corresponding 835 (ERA) now contain the same 10-digit number beginning with 9 (9XXXXXXXXX). Each non-payment remittance issued will be assigned a unique number.
Searching for non-payment remittance:	
Old — When using *Remit Inquiry* to locate paper remittance, the search field required a date range and tax ID to locate a specific remittance due to same number scenario (10 bytes (9999999999) being used for every non-payment remittance.	**Enhancement** — Once the unique ERA non-payment remittance number is available, it can be entered in the check number field in *Remit Inquiry*. This new way of assigning check numbers provides a faster and simplified process to find the specific remittance.

The way your organization receives remittances and payments has not changed; we have simply enhanced the numbering for the non-pay remittances. These changes do not impact previously issued non-payment remittance advice.

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

MD-NL-0459-21

Provider administered drugs

To better serve the members of Amerigroup Community Care, and to ensure members' benefits are optimized, members who are taking certain provider administered drugs through their pharmacy benefit will be directed to access them exclusively under their medical benefit. Impacted members will receive a letter advising of the change in drug coverage. The below list of provider administered drugs will be covered under the medical benefit for dates of service December 1, 2021, and beyond:

HCPCS or CPT® code(s)	Drug
J0256	ARALAST NP
Q5121	AVSOLA
J9023	BAVENCIO
J0490	BENLYSTA
J0179	BEOVU
J0598	CINQAIR
J0586	DYSPORT
J9217	ELIGARD
J1325	EPOPROSTENOL SODIUM
J0178	EYLEA
J0180	FABRAZYME
J0517	FASENRA
J1325	FLOLAN
J0257	GLASSIA
J9173	IMFINZI
Q5103	INFLECTRA
J1290	KALBITOR
J9271	KEYTRUDA
J9119	LIBTAYO
J2778	LUCENTIS
J0221	LUMIZYME
J9217	LUPRON DEPOT (1-MONTH)

HCPCS or CPT® code(s)	Drug
J9217	LUPRON DEPOT (3-MONTH)
J1950	LUPRON DEPOT (3-MONTH)
J9217	LUPRON DEPOT (4-MONTH)
J9217	LUPRON DEPOT (6-MONTH)
J2503	MACUGEN
J1726	MAKENA
Q5107	MVASI
J0587	MYOBLOC
J7307	NEXPLANON
J2182	NUCALA
C9494	OCREVUS
J9299	OPDIVO
J0256	PROLASTIN-C
J0897	PROLIA
J1745	REMICADE
J3285	REMODULIN
Q5104	RENFLEXIS
J9312	RITUXAN
J0596	RUCONEST
Q5119	RUXIENCE

HCPCS or CPT® code(s)	Drug
J2354	SANDOSTATIN LAR DEPOT
J1602	SIMPONI ARIA
J1930	SOMATULINE DEPOT
C9483	TECENTRIQ
J3315	TRELSTAR
J3315	TRELSTAR MIXJECT
J0490	TREPROSTINIL
J3316	TRIPTODUR
Q5115	TRUXIMA
J2323	TYSABRI
J1325	VELETRI
J0588	XEOMIN
J0897	XGEVA
J0775	XIAFLEX
J9228	YERVOY
J0256	ZEMAIRA
Q5118	ZIRABEV
J9202	ZOLADEX
J3489	RECLAST
Q2051	ZOLEDRONIC ACID
J3487	ZOLEDRONIC ACID
J3489	ZOMETA

We appreciate your support and look forward to your assistance in ensuring that our Amerigroup members' drug benefit coverage is provided in a clinically appropriate fashion. If you have questions, please contact your local Network Relations representative.

MD-NL-0467-21/MD-NL-0488-21

Medical drug benefit *Clinical Criteria* updates

On August 20, 2021, the Pharmacy and Therapeutics (P&T) Committee approved several *Clinical Criteria* applicable to the medical drug benefit for Amerigroup Community Care. These policies were developed, revised, or reviewed to support clinical coding edits.

Read more online.

MD-NL-0478-21

Visit the ***Clinical Criteria* website** to search for specific policies. If you have questions or would like additional information, reach out via **email**.

Prepayment clinical validation review process

Effective with dates of service on or after September 5, 2019, Amerigroup Community Care updated our audit process for claims with modifiers used to bypass claim edits. Modifier reviews are now conducted through a prepayment clinical validation review process. Claims with modifiers such as -25, -59, -57, LT/RT, and other anatomical modifiers will be part of this review process.

In accordance with published **reimbursement policies** that document proper usage and submission of modifiers, the clinical validation review process will evaluate the proper use of these modifiers in conjunction with the edits they are bypassing (such as the National Council on Compensation Insurance). Clinical analysts who are registered nurses and certified coders will review claims pended for validation, along with any related services, to determine whether it is appropriate for the modifier to bypass the edit.

If you believe a claim denial should be reviewed, please follow the applicable provider appeal process (outlined with the denial notification) and include medical records that support the usage of the modifier applied when submitting your appeal.

MD-NL-0484-21

Updates to AIM Specialty Health Advanced Imaging *Clinical Appropriateness Guidelines*

Effective for dates of service on and after March 13, 2022, the following updates will apply to the listed AIM Specialty Health® (AIM)* Advanced Imaging *Clinical Appropriateness Guidelines*. As part of the AIM guideline annual review process, these updates are focused on advancing efforts to drive clinically appropriate, safe, and affordable healthcare services.

Imaging of the Brain:

- Acoustic neuroma — removed indication for CT brain and replaced with CT temporal bone
- Meningioma — new guideline establishing follow-up intervals
- Pituitary adenoma — removed allowance for CT following nondiagnostic MRI in macroadenoma
- Tumor, not otherwise specified — added indication for management; excluded surveillance for lipoma and epidermoid without suspicious features

Imaging of the Head and Neck:

- Parathyroid adenoma — specified scenarios where surgery is recommended based on American Association of Endocrine Surgeons guidelines
- Temporomandibular joint dysfunction — specified duration of required conservative management

Imaging of the Heart:

- Coronary CT angiography — removed indication for patients undergoing evaluation for transcatheter aortic valve implantation/replacement who are at moderate coronary artery disease risk

Imaging of the Chest:

- Pneumonia — removed indication for diagnosis of COVID-19 due to availability and accuracy of lab testing
- Pulmonary nodule — aligned with Lung-RADS for follow-up of nodules detected on lung cancer screening CT

Imaging of the Abdomen and Pelvis:

- Uterine leiomyomata — new requirement for ultrasound prior to MRI; expanded indication beyond uterine artery embolization to include most other fertility-sparing procedures
- Intussusception — removed as a standalone indication
- Jaundice — added requirement for ultrasound prior to advanced imaging in pediatric patients
- Sacroiliitis — defined patient population in whom advanced imaging is indicated (predisposing condition or equivocal radiographs)
- Azotemia — removed as a standalone indication
- Hematuria — modified criteria for advanced imaging of asymptomatic microhematuria based on AUA guideline

Oncologic Imaging:

- National Comprehensive Cancer Network (NCCN) recommendation alignments for breast cancer, Hodgkin and Non-Hodgkin lymphoma, neuroendocrine tumor, melanoma, soft tissue sarcoma, testicular cancer, and thyroid cancers.
- Cancer screening — new age parameters for pancreatic cancer screening; new content for hepatocellular carcinoma screening
- Breast cancer — clinical scenario clarifications for diagnostic breast MRI and PET/CT

As a reminder, ordering and servicing providers may submit prior authorization requests to AIM via:

- AIM's **ProviderPortal**SM directly. Online access is available 24/7 to process orders in real-time and is the fastest and most convenient way to request authorization.
- The **Availity*** Portal.
- Phone at **800-714-0040**, Monday through Friday from 8 a.m. to 8 p.m. ET.

If you have questions related to guidelines, email AIM at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current and upcoming guidelines **online**.

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

MD-NL-0485-21

Clinical Laboratory Improvement Amendments

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

To be considered for reimbursement of clinical laboratory services, a valid *CLIA* certificate identification number must be reported on a *1500 Health Insurance Claim Form (CMS-1500*) or its electronic equivalent as of November 1, 2019. The *CLIA* certificate identification number must be submitted in one of the following manners:

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

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

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

MDPEC-2724-21

Durable medical equipment prior authorization requirement changes

Effective December 1, 2021, prior authorization (PA) requirements will change for the codes listed below. These medical codes will require PA by Amerigroup Community Care for HealthChoice members. 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:

- 97605 — Negative pressure wound therapy (for example, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
- 97606 — Negative pressure wound therapy (for example, vacuum assisted drainage collection), utilizing DME, including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters
- 97607 — Negative pressure wound therapy, (for example, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
- 97608 — Negative pressure wound therapy, (for example, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters
- A6550 — Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories
- A9272 — Wound suction, disposable, includes dressing, all accessories and components, any type, each
- E0637 — Combination sit-to-stand frame/table system, any size including pediatric, with seat lift feature, with or without wheels
- E0638 — Standing frame/table system, one position (for example, upright, supine or prone stander), any size including pediatric, with or without wheels
- E0641 — Standing frame/table system, multi-position (for example, three-way stander), any size including pediatric, with or without wheels
- E0642 — Standing frame/table system, mobile (dynamic stander), any size including pediatric
- E2230 — Manual wheelchair accessory, manual standing system
- E2301 — Wheelchair accessory, power standing system, any type
- E2402 — Negative pressure wound therapy electrical pump, stationary, or portable

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

- Web: Once logged in to **Availity**,* select Patient Registration > Authorizations & Referrals, then choose **Authorizations** or **Auth/Referral Inquiry**, as appropriate.
- Fax: **800-964-3627**
- Phone: **800-454-3730**

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers on the **provider website** > Login. Contracted and noncontracted providers who are unable to access Availity may call our Provider Services at **800-454-3730** for assistance with PA requirements.

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

MD-NL-0470-21

August 2021 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://provider.amerigroup.com/maryland-provider/resources/manuals-and-guides/medical-policies-and-clinical-guidelines**.

Notes/updates:

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

- *CG-SURG-112 — Carpal Tunnel Decompression Surgery
  - Outlines the *Medically Necessary* and *Not Medically Necessary* criteria for carpal tunnel decompression surgery
- *CG-SURG-113 — Tonsillectomy with or without Adenoidectomy for Adults
  - Outlines the *Medically Necessary* and *Not Medically Necessary* criteria
- • *DME.00043 — Neuromuscular Electrical Training for the Treatment of Obstructive Sleep Apnea or Snoring
  - The use of a neuromuscular electrical training device is considered *Investigational & Not Medically Necessary* for the treatment of obstructive sleep apnea or snoring
- *GENE.00058 — TruGraf Blood Gene Expression Test for Transplant Monitoring
  - TruGraf blood gene expression test is considered *Investigational & Not Medically Necessary* for monitoring immunosuppression in transplant recipients and for all other indications
- *LAB.00040 — Serum Biomarker Tests for Risk of Preeclampsia
  - Serum biomarker tests to diagnosis, screen for, or assess risk of preeclampsia are considered *Investigational & Not Medically Necessary*
- *LAB.00042 — Molecular Signature Test for Predicting Response to Tumor Necrosis Factor Inhibitor Therapy
  - Molecular signature testing to predict response to Tumor Necrosis Factor inhibitor (TNFi) therapy is considered *Investigational & Not Medically Necessary* for all uses, including but not limited to guiding treatment for rheumatoid arthritis
- *OR-PR.00007 — Microprocessor Controlled Knee-Ankle-Foot Orthosis
  - Outlines the *Medically Necessary* and *Not Medically Necessary* criteria for the use of a microprocessor controlled knee-ankle-foot orthosis
- *SURG.00032 — Patent Foramen Ovale and Left Atrial Appendage Closure Devices for Stroke Prevention
  - Added *Medically Necessary* statement for transcatheter closure of left atrial appendage (LAA) for individuals with non-valvular atrial fibrillation for the prevention of stroke when criteria are met
  - Revised *Investigational & Not Medically Necessary* statement for transcatheter closure of left atrial appendage when the criteria are not met

August 2021 update (cont.)

- *SURG.00077 — Uterine Fibroid Ablation: Laparoscopic, Percutaneous, or Transcervical Image Guided Techniques
  - Added *Medically Necessary* statement on use of laparoscopic or transcervical radiofrequency ablation
  - Added *Not Medically Necessary* statement on use of laparoscopic or transcervical radiofrequency ablation when criteria in *Medically Necessary* statement are not met
  - Removed laparoscopic radiofrequency ablation from *Investigational & Not Medically Necessary* statement
  - Removed *Investigational & Not Medically Necessary* statement on radiofrequency ablation using a transcervical approach

Medical Policies

On August 12, 2021, the Medical Policy and Technology Assessment Committee (MPTAC) approved several *Medical Policies* applicable to Amerigroup Community Care. These guidelines take effect November 30, 2021.

Clinical UM Guidelines

On August 12, 2021, the MPTAC approved several *Clinical UM Guidelines* applicable to Amerigroup. These guidelines adopted by the Medical Operations Committee for our members on September 23, 2021. These guidelines take effect November 30, 2021.

MD-NL-0486-21