Amerigroup Community Care
Medicaid | Medicare Advantage

Amerigroup

Provider News | August 2022

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Coverage provided by Amerigroup Inc.

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Contact Us

If you have questions or need assistance, visit the *Contact Us* section at the bottom of our provider website for up-to-date contact information and self-service tools or call Provider Services.

Provider website:

- **https://provider.amerigroup.com/NJ**

Provider Services:

- Medicaid: **800-454-3730**
- Medicare Advantage: **866-805-4589**

Administrative

Medicaid

Provider demographic changes

Reminder

Notify Provider Data Management immediately of any changes in licensure, demographics, or participation status (for example, practice locations, physician additions, and deletions). You can report demographic changes by sending an email to: NJProviderData@anthem.com

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

NJAGP-CAID-001348-22

Medicaid

Prior authorization requirement changes — updated effective date

Effective November 1, 2022, prior authorization (PA) requirements will change for multiple codes. The medical codes listed below will require PA by Amerigroup Community Care.

PA requirements will be added to the following:

- L6026: Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device, excludes terminal device

NJ-NL-0778-22

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 a PA, you may use one of the following methods:

- Availity:* Once logged in to **Availity**, select Patient Registration > Authorizations & Referrals, then select **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**. Contracted and noncontracted providers who are unable to access Availity may call Provider Services at **800-454-3730** for assistance with PA requirements.

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Prior authorizations for post-acute care

For services beginning on November 1, 2022, prior authorization requests for admission to or concurrent stay in a skilled nursing facility (SNF), an inpatient acute rehab facility (IRF), or a long-term acute care hospital (LTACH) will be reviewed by myNEXUS* services for Medicare Advantage individual, group retiree solutions (GRS), and dual-eligible plan members. Through this program, myNEXUS clinicians will collaborate with members, caregivers, and facility care managers/discharge planners to provide transition planning as well as the pre-service and concurrent review authorizations of post-acute care services. The goal of this program is to support members through their recovery process in the most appropriate, least restrictive environment.

How to submit or check a prior authorization request

For SNF, IRF, or LTACH admissions, myNEXUS will begin receiving requests through the NexLync website on Sunday, October 30, 2022, and by telephone or fax on Monday, October 31, 2022, for members whose anticipated discharge date is November 1, 2022, or after. Concurrent stay review requests for members admitted to SNF, IRF, or LTACH facilities prior to November 1, 2022, should be directed to Amerigroup Community Care.

Providers are encouraged to request authorization using NexLync. Visit **https://portal.mynexuscare.com/home** to get started. You can upload clinical information and check the status of your requests through this online tool seven days a week, 24 hours a day. If you are unable to use the link or website, you can call the myNEXUS Provider Call Center at **844-411-9622** during normal operating hours from 7 a.m. to 7 p.m. CT, Monday through Friday, or send a fax to myNEXUS at **833-311-2986**.

Please note: myNEXUS will not review authorization requests for durable medical equipment (DME), ambulance, and other related services that do not fall under Medicare-covered home healthcare services, such as home infusion, hospice, outpatient therapy, or supplemental benefits that help with everyday health and living such as personal home helper services offered under essential/everyday extras.

To learn more about myNEXUS and upcoming training webinars, visit **www.myNEXUScare.com/Anthem** or email Provider_Network@myNEXUScare.com.

What if I need assistance?

If you have additional questions, please call the myNEXUS Provider Call Center at **844-411-9622**. If you have questions about this communication or need assistance with any other item, contact your assigned Provider Experience associate or call Provider Services via the number on the back of the member's ID card.

** myNEXUS is an independent company providing health management services on behalf of Amerigroup Community Care.*

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Medicaid

Using SBIRT to address opioid and substance use disorders

COVID-19 impact on opioid and substance use disorders

As a result of the COVID-19 pandemic, there has been a 20% increase in substance use nationwide, and nearly 100,000 opioid overdose related deaths between 2020 and 2021.[1] Black Americans have been disproportionately affected by this increase in overdoses.[2] Increasing screening, brief intervention, and referral to treatment (SBIRT) may help provide an opportunity to engage those with emerging and existing substance use disorders through proactive identification and connection to professional services when indicated.

SBIRT Resources for providers

A provider toolkit for SBIRT is available on the Amerigroup Community Care provider website. This toolkit includes SBIRT collateral materials for your use, which outline recommended screening tools, a guided SBIRT process, and resources to help identify appropriate referrals.

More about the SBIRT approach

SBIRT is a "comprehensive, integrated public health approach to the delivery of early intervention and treatment services for persons with substance use disorders (SUD), as well as those who are at risk of developing these disorders," according to the Substance Abuse and Mental Health Service Administration (SAMHSA). The goal of SBIRT is to reduce the potential consequences of SUDs.[3]

SBIRT encounters include a brief screening and intervention that identifies:

- One or more behaviors related to risky alcohol or drug use.
- Right type and amount of treatment.

The screening is a brief set of questions that identify the patient's risk of SUD-related problems. The brief intervention is a short (15 to 30 minutes) counseling session to raise awareness of the risks. By leveraging motivation enhancement techniques, this seeks to work with the patient where they are at and with what they are ready and willing to do to address identified substance misuse. Referral to treatment helps the patient access specialized treatment when indicated.

The purpose of the encounter is to facilitate change with the patient's immediate behavior or thoughts about a risky behavior. In addition, SBIRT results help those with higher levels of need to obtain long-term care, including referrals to specialty providers. This evidence-based program (EBP) has been shown to result in a $2 to 4 healthcare savings for every $1 spent.[4]

Healthcare providers who encounter an at-risk member have an opportunity for early intervention and referral to appropriate treatment. The core goal is to reduce and prevent problematic use, abuse, and dependence on alcohol, opioids, and other substances. SBIRT has been proven effective regardless of age, gender, race, and culture in children, adolescents, and adults.

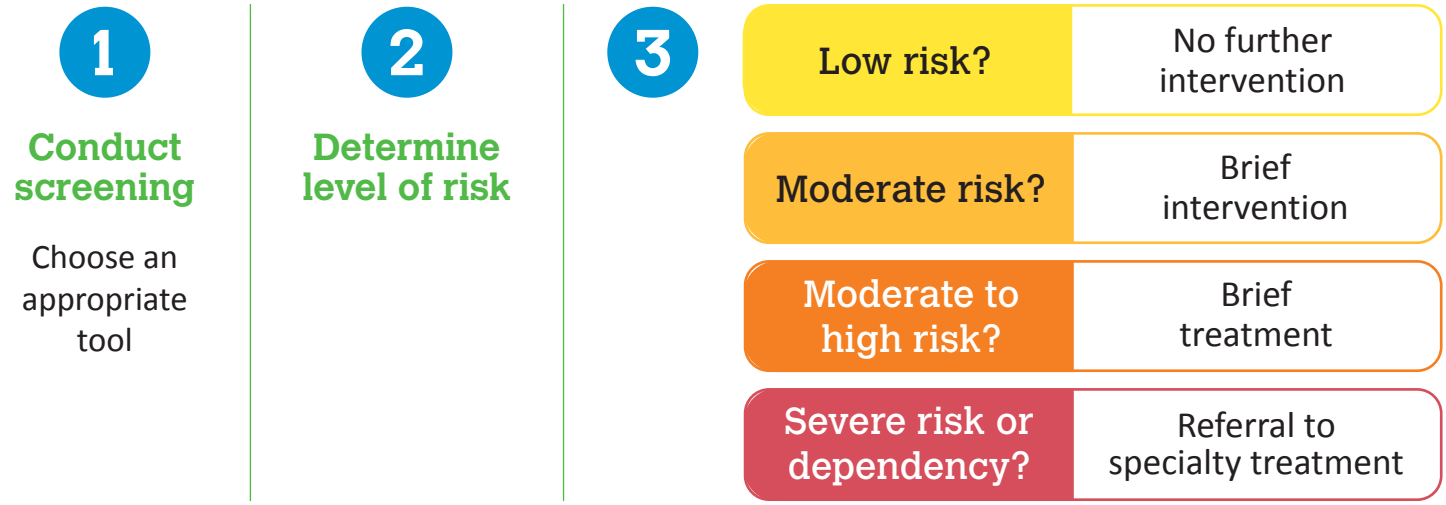
Using SBIRT to address opioid and substance use disorders (cont.)

Encounters with patients in need of SBIRT may occur in public health, non-substance use treatment settings including primary care centers, hospital emergency rooms, trauma centers, and community health settings. Primary care providers (MD/DOs, PAs, ARNPs), behavioral health providers (therapists, counselors, psychiatrists, clinical social workers), and nurses may provide SBIRT.

Recommended screening tools include:

- Alcohol use disorder identification test (AUDIT)[5] for adults with alcohol risk.
- Drug abuse screening test (DAST-10)[6] for adults with drug risk.
- Car, relax, alone, forget, family or friends, trouble (CRAFFT)[7] for children and adolescents.
- Tolerance, worried, eye opener, amnesia, k/cut down (TWEAK)[8] for pregnant people.

Below is the SBIRT process flow.



If you need assistance connecting patients to SUD treatment, or have questions about implementing SBIRT in your practice, call Provider Services at **800-454-3730**.

1 Centers for Disease Control and Prevention (2022) **https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm**
2 Larochelle et al. (2021) **https://doi.org/10.2105/AJPH.2021.306431**
3 Substance Abuse and Mental Health Services Administration (2021) **https://www.samhsa.gov/sbirt**
4 Gentilello et al. (2005) **https://doi.org/10.1097/01.sla.0000157133.80396.1c**
5 World Health Organization (1987) **https://apps.who.int/iris/handle/10665/62031**
6 Addiction Research Foundation (1983) **https://www.drugabuse.gov/sites/default/files/audit.pdf**
7 Knight et al. (1999) **https://doi.org/10.1001/archpedi.153.6.591**
8 Russell (1994) **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6876474/**

WA-NL-0663-22

The cost of alcohol use disorder

The total economic cost of alcohol use disorder (AUD) was estimated to be $249 billion per year as of 2019, according to the CDC[1] with $27 billion coming from healthcare costs.[2] The CDC projected the total AUD economic impact on society to be $807 per person, per year.[3]

AUD and healthcare spending

Alcohol contributes to the highest amount of health plan spending related to substance use. 36% of Medicaid substance use claims were related to alcohol in 2020, accounting for over $129 million — an increase of 16% from 2019. Additionally, people with AUD are more likely to be high-cost claimants. In government and commercially insured patients across the country, the top 5% of high-cost claimants have either an existing AUD or health conditions resulting from alcohol use.[4]

AUD and the workforce

AUD also has a significant economic effect on the workforce by way of tardiness, absenteeism, employee turnover, and conflict. It causes a reduction in potential employees, customer base, and the taxpayer base.[5]

AUD and mortality

Alcohol use was directly tied to 95,000 deaths annually between 2011 and 2015, according to the CDC. This was more than all other substances combined including opioids, heroin, fentanyl, and methamphetamines. The CDC estimates that alcohol-attributed disease resulted in almost 685,000 years of potential life lost (YPLL) for the same period. YPLL is the estimation of the average time a person would have lived had they not died prematurely.[6]

Below is the YPLL related directly or indirectly to AUD.

Cause	YPLL
Total YPLL	> 2.7 million
100% alcohol attributed disease	684,750
Suicide	334,058
Motor vehicle crashes	323,610
Liver disease	202,391
Heart disease	118,021
Cancer	88,729

1 Center for Disease Control and Prevention, 2019 **https://www.cdc.gov/alcohol/features/excessive-drinking.html**
2 National Institute on Drug Use, 2018 **https://archives.drugabuse.gov/trends-statistics/costs-substance-abuse**
3 Center for Disease Control and Prevention, 2019
4 Internal Claims Data, 2022
5 National Institute on Drug Use, 2018
6 Center for Disease Control, 2020 **https://www.cdc.gov/mmwr/volumes/69/wr/mm6939a6.htm**

NJ-NL-0753-22

Autism spectrum disorder treatment provided by therapy and behavioral health providers

In accordance with the requirements of the federally mandated comprehensive and preventive child health program, Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT), Amerigroup Community Care is required to furnish all medically necessary services needed to correct and ameliorate health conditions for Medicaid members from birth through age 20.

NJ FamilyCare has expanded its existing autism spectrum disorder (ASD) services to include a combination of therapies, each targeting a different set of skills that will support a child's development, and will reimburse for The Developmental, Individual Difference, Relationship-Based Model (DIR®) therapies.

What is DIR?

The DIR provides the foundational framework for understanding human development and the critical role of social-emotional development. This development begins at birth and continues throughout the remainder of the lifespan. It allows providers to understand how each person individually perceives and interacts with the environment that surrounds them. The key components are how emotional connections and established relationships contribute to the individual's unique development; additionally, understanding how an individual interacts and develops their relationships can be used to promote healthy development and increased fulfillment of the child's potential.

Amerigroup is requesting that licensed therapy and behavioral health providers participating with Amerigroup or the Therapy Network of New Jersey (TNNJ) consider offering DIR therapies to members diagnosed with ASD by obtaining the necessary specialized training and endorsement.

Read more online.

NJAGP-CD-002935-22

Medicare Advantage

New specialty pharmacy medical step therapy requirements

Effective July 1, 2022, the following Part B medications from the current *Clinical Utilization Management (UM) Guidelines* will be included in our medical step therapy precertification review process. Step therapy review will apply upon precertification initiation, in addition to the current medical necessity review (as is current procedure). Step therapy will not apply for members who are actively receiving medications listed below.

Clinical UM Guidelines	Preferred drug(s)	Nonpreferred drug(s)
ING-CC-0166	Herceptin, Kanjinti	Herzuma, Ogivri, Ontruzant, Trazimera

Clinical UM Guidelines are publicly available on the provider website. Visit the ***Clinical Criteria* page** to search for specific criteria.

AGPCARE-1348-22

Medicaid

HEDIS 2022: Summary of changes from NCQA

The National Committee for Quality Assurance (NCQA) has changed, revised, and retired HEDIS® measures for measurement year 2022. Below is a summary of some of the key changes.

Diabetes measures

NCQA has separated the Comprehensive Diabetes Care indicators into stand-alone measures:

- Hemoglobin A1c Control for Patients with Diabetes (Two rates reported: HbA1c Control (< 8%) and Poor Control HbA1c) (> 9%) (HBD)
- Eye Exam for Patients with Diabetes (EED)
- Blood Pressure Control for Patients with Diabetes (BPD)

The process measure Comprehensive Diabetes HbA1c testing was retired as the goal is to move toward more outcome-based measures.

Race/ethnicity stratification

An important step to address healthcare disparities is reporting and measuring performance. Given this, NCQA has added race and ethnicity stratifications to the following HEDIS measures:

- Colorectal Cancer Screening (COL)
- Controlling High Blood Pressure (CBP)
- Hemoglobin A1c Control for Patients with Diabetes (HBD)
- Prenatal and Postpartum Care (PPC)
- Child and Adolescent Well Care Visits (WCV)

NCQA plans to expand the race and ethnicity stratifications to additional HEDIS measures over several years to help identify and reduce disparities in care among patient populations. This effort builds on NCQA's existing work dedicated to advancing health equity in data and quality measurements.

Measure changes

Colorectal Cancer Screening (COL)

Measures the percentage of members 45 to 75 years of age who had appropriate screening for colorectal cancer. The Medicaid product was added to the administrative data collection method for this measure and the age range was changed to 45 to 75 years of age. Any of the following meet criteria:

- Fecal occult blood test during the measurement year
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year
- Colonoscopy during the measurement year or the nine years prior to the measurement year
- CT colonography during the measurement year or the four years prior to the measurement year
- Stool DNA (sDNA) with FIT test during the measurement year or the two years prior to the measurement year

This measure can also be reported as an Electronic Clinical Data Reporting System measure: Colorectal Cancer Screening (COL-E).

Antibiotic Utilization for Respiratory Conditions (AXR):

A newly added metric which measures the percentage of episodes for members 3 months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event. This measure was added because antibiotics prescribed for acute respiratory conditions are a large driver of antibiotic overuse.

Tracking antibiotic prescribing for all acute respiratory conditions will provide context about overall antibiotic use. Given this new measure, the broader Antibiotic Utilization measure has been retired.

Use of Imaging Studies for Low Back Pain (LBP)

This measure was expanded to the Medicare line of business, and the upper age limit for this measure was expanded to age 75. Additional exclusions to the measure were also added.

For a complete summary of 2022 HEDIS changes, visit: **https://www.ncqa.org/hedis/measures/**.

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

NJ-NL-0739-22

Chlamydia screening

Chances are one of these teenagers has chlamydia. According to the Centers for Disease Control (CDC), one of the largest growing populations for chlamydia are teens and young adults. Chlamydia infection is often asymptomatic, and screening for asymptomatic infection is a cost-effective strategy to reduce transmission and prevent pelvic inflammatory disease among females.

Talking to a teenager about sexual health issues like chlamydia can be difficult. But, left untreated, an affected individual may develop conditions such as pelvic inflammatory disease (PID), infertility, ectopic pregnancy, and chronic pelvic pain. Provider resources can help get the conversation started. To help get the conversation started, visit the **National Chlamydia Coalition website** for a free *Chlamydia How-To Implementation Guide for Healthcare Providers*.

Facts about chlamydia:

- The United States Preventive Services Task Force (USPSTF) recommends screening for chlamydia in all sexually active women 24 years or younger and in women 25 years or older who are at risk for infection.
- Chlamydia is the most commonly reported sexually transmitted disease (STD) with over 1.8 million cases reported in 2019.
- Young women account for 43% of reported cases and face the most severe consequences of an undiagnosed infection.
- It is estimated that undiagnosed STDs cause infertility in more the 20,000 women each year.

Chlamydia Screening in Women (CHL) HEDIS® measure

This HEDIS measure looks at the percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year, including teens and women who:

- Made comments or talked to you about sexual relations.
- Had a pregnancy test.
- Were prescribed birth control (even if used for acne treatment).
- Received gynecological services.
- Have a history of sexually transmitted diseases.
- Have a history of sexual assault or abuse.

Description	CPT® codes
Chlamydia tests	87110, 87270, 87320, 87490, 87492, 87810
Pregnancy test exclusion	81025, 84702, 84703

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