December 2021
https://provider.amerigroup.com/WA
Provider Services:
Medicaid: **800-454-3730** • Medicare: **866-805-4589**

Amerigroup

Provider Newsletter

Want to receive our *Provider Newsletter* and other communications via email?

Submit your information to us using the QR code to the left or click **here**.

Coverage provided by Amerigroup Inc.

WA-NL-0609-21

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COVID-19 information from Amerigroup Washington, Inc.

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 the Washington State Department of Health to help us determine what action is necessary on our part. Amerigroup will continue to follow Washington State Department of Health guidance policies.

For additional information, reference our **website**.

WAPEC-2237-20

Administration

Medicare Advantage

Adjudicating claims for COVID-19 vaccines, their administration and COVID-19 monoclonal antibodies

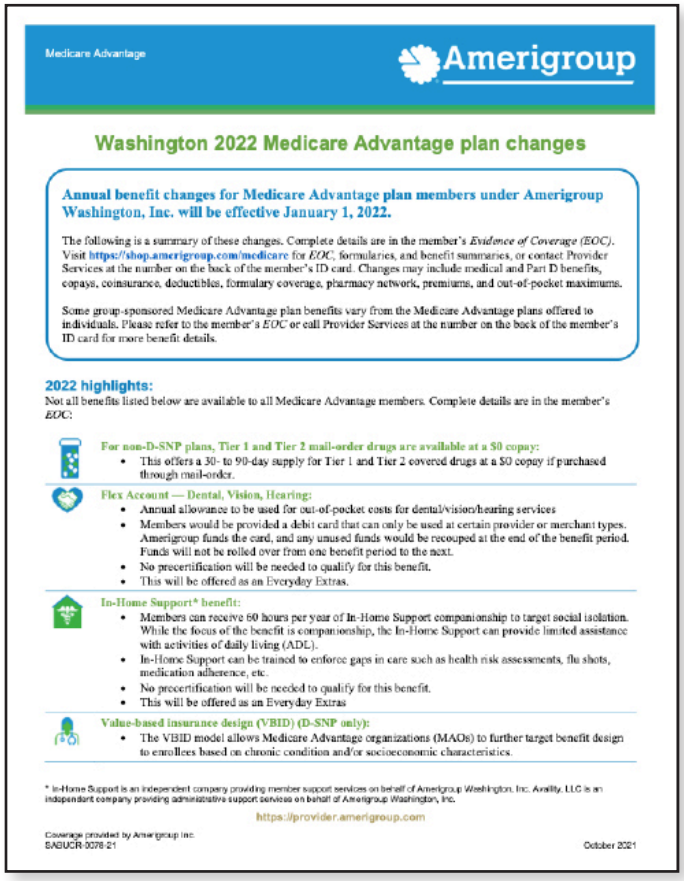
Beginning January 1, 2022, Medicare Advantage Organizations (MAOs) and Medicare-Medicaid Plans (MMPs) are responsible for adjudicating claims for COVID-19 vaccines and their administration and for COVID-19 monoclonal antibodies and their administration.

AGPCRNL-0378-21

Medicare Advantage

2022 Medicare Advantage service area and benefit updates

An overview of **notable 2022 benefit changes and service area updates** are now available. Continue to check **https://provider.amerigroup.com/WA** for the latest Medicare Advantage information.



Medicare Advantage

Amerigroup

Washington 2022 Medicare Advantage plan changes

Annual benefit changes for Medicare Advantage plan members under Amerigroup Washington, Inc. will be effective January 1, 2022.

The following is a summary of these changes. Complete details are in the member's *Evidence of Coverage (EOC)*. Visit **https://shop.amerigroup.com/medicare** for *EOC*, formularies, and benefit summaries, or contact Provider Services at the number on the back of the member's ID card. Changes may include medical and Part D benefits, copays, coinsurance, deductibles, formulary coverage, pharmacy network, premiums, and out-of-pocket maximums.

Some group-sponsored Medicare Advantage plan benefits vary from the Medicare Advantage plans offered to individuals. Please refer to the member's *EOC* or call Provider Services at the number on the back of the member's ID card for more benefit details.

2022 highlights:

Not all benefits listed below are available to all Medicare Advantage members. Complete details are in the member's *EOC*:

For non-D-SNP plans, Tier 1 and Tier 2 mail-order drugs are available at a $0 copay:

- This offers a 30- to 90-day supply for Tier 1 and Tier 2 covered drugs at a $0 copay if purchased through mail-order.

Flex Account — Dental, Vision, Hearing:

- Annual allowance to be used for out-of-pocket costs for dental/vision/hearing services
- Members would be provided a debit card that can only be used at certain provider or merchant types. Amerigroup funds the card, and any unused funds would be recouped at the end of the benefit period. Funds will not be rolled over from one benefit period to the next.
- No precertification will be needed to qualify for this benefit.
- This will be offered as an Everyday Extras.

In-Home Support* benefit:

- Members can receive 60 hours per year of In-Home Support companionship to target social isolation. While the focus of the benefit is companionship, the In-Home Support can provide limited assistance with activities of daily living (ADL).
- In-Home Support can be trained to enforce gaps in care such as health risk assessments, flu shots, medication adherence, etc.
- No precertification will be needed to qualify for this benefit.
- This will be offered as an Everyday Extras

Value-based insurance design (VBID) (D-SNP only):

- The VBID model allows Medicare Advantage organizations (MAOs) to further target benefit design to enrollees based on chronic condition and/or socioeconomic characteristics.

* In-Home Support is an independent company providing member support services on behalf of Amerigroup Washington, Inc. Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup Washington, Inc.

https://provider.amerigroup.com

Coverage provided by Amerigroup Inc.
SABUCR-0076 21

October 2021

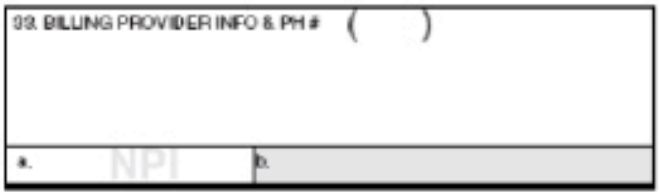
AGPCRNL-0375-21

Front-end claim rejection rule change

Effective August 12, 2021, Amerigroup Washington, Inc. implemented a front-end claim rejection rule for claims that are billed with a P.O. Box listed in the billing address field. Please ensure you are submitting claims with a street address in Box 33 on professional claims and Box 1 for facility claims.

Amerigroup follows the National Uniform Claim Committee guideline. Reference *Title 33* **online**.

ITEM NUMBER 33, 33a, AND 33b



TITLE 33: Billing Provider Info & Ph #

INSTRUCTIONS: Enter the provider's or supplier's billing name, address, ZIP code, and phone number. The phone number is to be entered in the area to the right of the field title. Enter the name and address information in the following format:

1st Line – Name
2nd Line – Address
3rd Line – City, State and ZIP code

Item 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed.

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. Report a 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen. Do not use a hyphen or space as a separator within the telephone number.

If reporting a foreign address, contact payer for specific reporting instructions.

5010A1 requires the "Billing Provider Address" be a street address or physical location. The NUCC recommends that the same requirements be applied here.

DESCRIPTION: The billing provider's or supplier's billing name, address, ZIP code, and phone number is the billing office location and telephone number of the provider or supplier.

FIELD SPECIFICATION: This field allows for the entry of the following: 3 characters for area code, 9 characters for phone number, and 3 lines of 29 characters in the Billing Provider Info area.

Medicaid

Network providers must be in active status in ProviderOne

The Health Care Authority (HCA) has announced that they will begin rejecting encounters for medical providers who are not in active status in ProviderOne. Effective January 1, 2022, Amerigroup Washington, Inc. will begin rejecting claims for providers who are not in active status with the HCA. If you are not in active status, contact the HCA at **providerenrollment@hca.wa.gov** or **800-562-3022, extension 16137**.

As a reminder, providers cannot bill the client unless the client was informed prior to receiving services that the provider is not an active Apple Health provider. The client must agree to receive and pay for the services, and this agreement must be documented in the client's record.

Visit **https://bit.ly/3CZU5BT** to read the FAQ for Medicaid requirements for ordering, prescribing, and referring providers to assist your network. If you have further questions, email the HCA at mailbox **hcamcprograms@hca.wa.gov** with *Provider not in Active Status* in the subject line.

WA-NL-0606-21

Medicaid

Urinary tract infection toolkits are on the way

To support the health of our members, Amerigroup Washington, Inc. 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.

WA-NL-0599-21

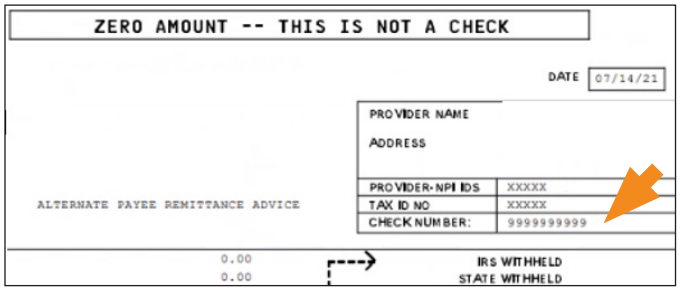
Medicaid | Medicare Advantage

Good news: Non-payment remittance advice enhancements are here

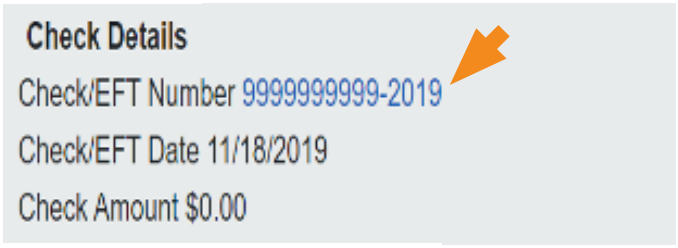
We have enhanced your ability to search, review, and download a copy of the remittance advice on Availity* when there is not an associated payment. For remit advice with payment, you can continue to search with the Check/EFT number.

Below are images reflecting the scenarios that have been enhanced:

Paper remittance



Electronic remittance advice (ERA/835)



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 Washington, Inc.*

WA-NL-0581-21\AGPCRNL-0211-21

Policy Updates

Medicaid

Medical drug benefit *Clinical Criteria* updates

August 2021 update

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

View more online.

WA-NL-0604-21

Medicare Advantage

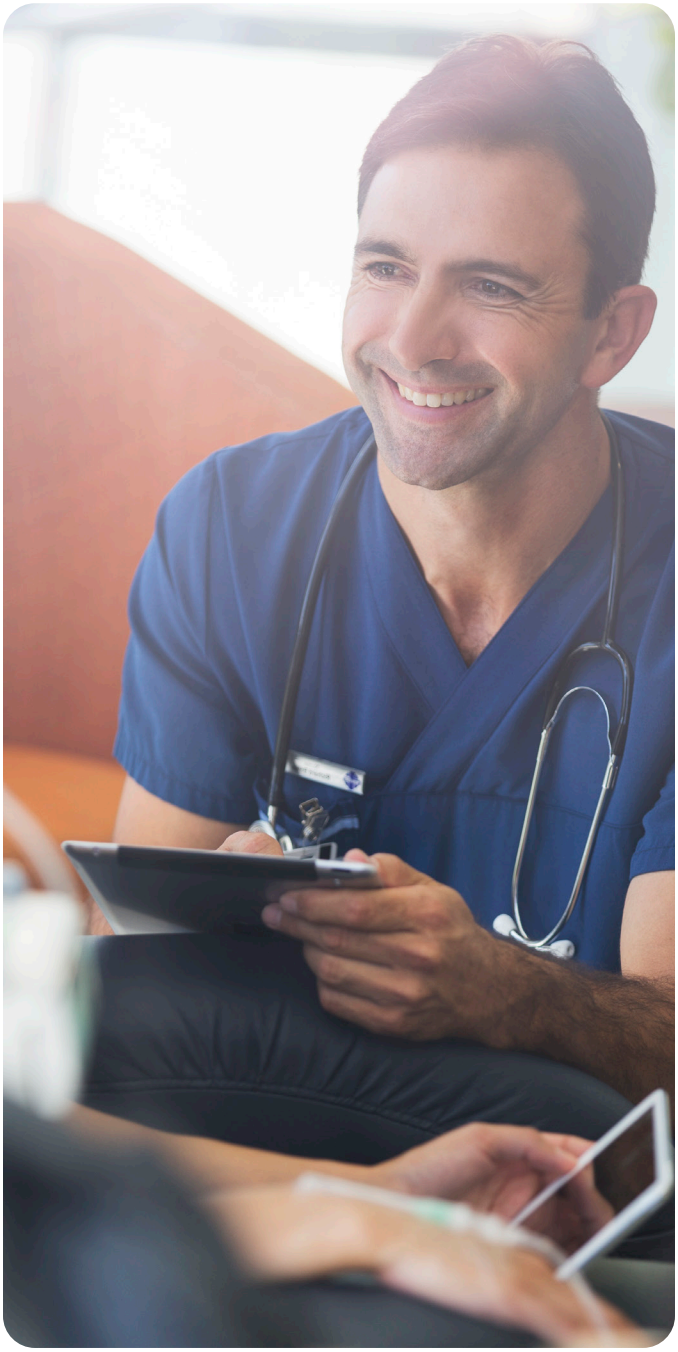
Medical drug benefit *Clinical Criteria* updates

August 2021 update

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

View more online.

AGPCRNL-0371-21



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

Updates to AIM Specialty Health *Clinical Appropriateness Guidelines*

As part of the AIM Specialty Health® (AIM)* guideline annual review process, the following updates are focused on advancing efforts to drive clinically appropriate, safe, and affordable healthcare services.

As a reminder, ordering and servicing providers may submit prior authorization requests to AIM in one of several ways:

- Access AIM's ***ProviderPortal***℠ direcly. Online access is available 24/7 to process orders in real-time and is the fastest and most convenient way to request authorization
- Access AIM via the **Availity Web Portal**.*
- Call the AIM Contact Center toll-free number: **800-714-0040** Monday through Friday from 7 a.m. to 7 p.m. CT

If you have questions related to guidelines, please contact AIM via email 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 Washington, Inc. Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup Washington, Inc.*

Medicare Advantage

Musculoskeletal Interventional Pain Management Clinical Appropriateness Guidelines

Effective for dates of service on and after March 13, 2022, the following updates will apply to the *Clinical Appropriateness Guideline* for musculoskeletal (MSK) interventional pain management from AIM.

Updates by section:

- Epidural injection procedures (ESI) and diagnostic selective nerve root blocks (SNRB):
  - Allow more frequent ESI in newly diagnosed patients
  - Remove imaging requirement in certain circumstances
  - Require similar criteria as ESI for diagnostic SNRB
  - Add epidural abscess as a contraindication
  - Limit multilevel and combination diagnostic SNRB
- Paravertebral facet injection/medial branch block (MBB)/neurolysis:
  - Limit indefinite use of diagnostic MBB
  - Add indication for diagnostic pars defect MBB
  - Expand exceptions allowed for intraarticular facet injections
  - Define MBB timing with respect to radiofrequency neurotomy, MBB limited to RFA candidacy
  - Limit open surgical neurolysis and limited multiple spinal injections
- Sacroiliac joint injections:
  - Limit indefinite use of diagnostic intraarticular injections
  - Disallow sacral lateral branch blocks
  - Disallow sacroiliac joint therapeutic injections in a previously fused joint
- Spinal cord and nerve root stimulators:
  - Allow minimally invasive pain procedures to satisfy conservative management definition
  - Specify timing of mental health evaluation
  - Define indications for repeat stimulator trial

AGPCRNL-0221-21

Medicaid | Medicare Advantage

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 *Advanced Imaging Clinical Appropriateness Guidelines*.

Updates by guideline:

- 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

WA-NL-0611-21/AGPCRNL-0373-21

Medicaid

Prior authorization requirement changes

Effective January 1, 2022, prior authorization (PA) requirements will change for 0018U and 0245U. The medical codes listed below will require PA by Amerigroup Washington, Inc. for Apple Health members. Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, including definitions and specific contract provisions/exclusions, take precedence over these PA rules and must be considered first when determining coverage. Please note: Noncompliance with new requirements may result in denied claims.

PA requirements will be added to the following:

- 0018U — Oncology (thyroid), microRNA profiling by RT-PCR of 10 microRNA sequences, utilizing fine needle aspirate, algorithm reported as a positive or negative result for moderate to high risk of malignancy
- 0245U — Oncology (thyroid), mutation analysis of 10 genes and 37 RNA fusions and expression of four mRNA markers using next-generation sequencing, fine needle aspirate, report includes associated risk of malignancy expressed as a percentage

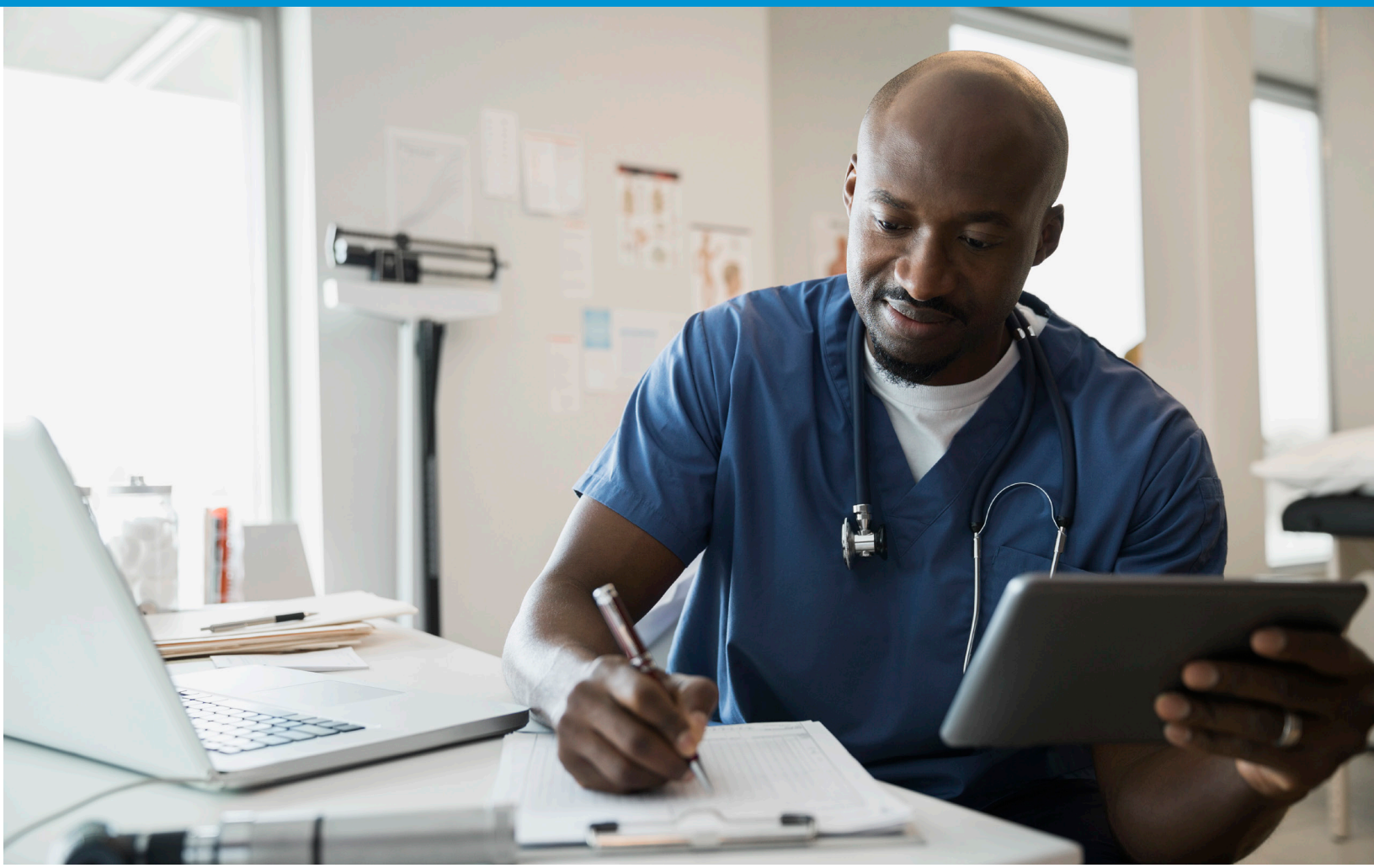
WA-NL-0594-21

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

- Through the Availity Portal:* Once logged in to **Availity**, select Patient Registration > Authorizations & Referrals > Choose either **Authorizations** or **Auth/Referral Inquiry**, as appropriate.
- By fax: **844-493-9209**
- By phone: **800-454-3730**

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers on the **provider website**. You must log in to see detailed PA requirements. Contracted and noncontracted providers who are unable to access Availity may call 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 Washington, Inc.*



Medicaid | Medicare Advantage

Policy Update
Drug Screen Testing
(Effective March 1, 2022)

Effective March 1, 2022, separate reimbursement is not allowed for specimen validity testing when utilized for drug screening. Reimbursement is included in the CPT® and HCPCS code descriptions for presumptive and definitive drug testing. Modifier 59, XE, XP, XS, and XU will not be allowed to override.

For additional information, please review the Drug Screen Testing reimbursement policy at **https://provider.amerigroup.com/WA**.

WA-NL-0596-21/AGPCRNL-0219-21

Medicaid | Medicare Advantage

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.

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
- *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

Medicaid

To view a guideline, visit **https://provider.amerigroup.com/washington-provider/medical-policies-and-clinical-guidelines**.

Medical Policies

On August 12, 2021, the Medical Policy and Technology Assessment Committee (MPTAC) approved several *Medical Policies* applicable to Amerigroup Washington, Inc. These guidelines take effect January 6, 2022.

Clinical UM Guidelines

On August 12, 2021, the MPTAC approved several *Clinical UM Guidelines* applicable to Amerigroup. These guidelines were adopted by the Medical Operations Committee for members on September 23, 2021. These guidelines take effect January 6, 2022.

View more online.

WA-NL-0612-21

Medicare Advantage

To view a guideline, visit **https://medpol.providers.amerigroup.com/green-provider/medical-policies-and-clinical-guidelines**.

Medical Policies

On August 12, 2021, the Medical Policy and Technology Assessment Committee (MPTAC) approved several *Medical Policies* applicable to Amerigroup Washington, Inc. These guidelines take effect November 29, 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 29, 2021.

Read more online.

AGPCRNL-0374-21

Products and Programs

Medicaid

New program for rehabilitative/habilitative therapy referrals

Amerigroup Washington, Inc. strives to use unique, innovative tools and a whole-person approach to simplify health care for our Medicaid members. Effective January 1, 2022, Amerigroup has a new program to help better manage rehabilitative/habilitative therapy referrals for members across the state. Too often, members are sent to outpatient hospitals for services they can receive either closer to home or in a more comfortable and convenient setting. Our goal is to find more appropriate and convenient sites of care for rehabilitative/habilitative therapy services while maintaining the highest quality of care.

To locate a therapist participating in the network, providers may access the online provider directory tool, Provider Directory Search Online. To search for therapy in a specific county, providers may enter the county name and state in the Location tab in the upper right-hand corner of the screen. Providers may then search places by type and enter the name of the therapy modality to which the member is being referred.

Beginning immediately, if you still need help referring a member for rehabilitative/habilitative therapy services that would previously be performed at a hospital, please contact Provider Services at **800-454-3730**.

Note: This does not apply to emergency room services or admissions resulting from emergency room visits.

Continuity of care guidelines apply for all members currently receiving these services at any hospital.

WA-NL-0616-21

Medicaid

HEDIS measures: Follow-Up After ED Visits for Mental Illness and Alcohol and Drug Dependency

The following HEDIS® measures assess the percentage of emergency department (ED) visits for which the member received a follow-up appointment within seven days and 30 days of being seen in the ED for mental illness or for alcohol and other drug dependence.

Follow-Up After ED Visit for Mental Illness (FUM)

Evaluates the percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit with any practitioner for mental illness. Two rates are reported. The percentage of ED visits for which the member received:

- Follow-up within seven days of the ED visit.
- Follow-up within 30 days of the ED visit.

Timely follow-up care for people with mental illness can lead to fewer repeat visits to the ED and improved physical and mental health function.

Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

Evaluates the percentage of ED visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit with any practitioner for AOD. Two rates are reported. The percentage of ED visits for which the member received:

- Follow-up within seven days of the ED visit.
- Follow-up within 30 days of the ED visit.

According to studies, follow-up care for individuals with AOD who were seen in the ED is associated with reduced substance use, repeat ED visits, and hospital admissions.

Helpful tips:

- Maintain appointment availability for patients with recent ED visits.
- Assist in scheduling in-person or telehealth follow-up appointments as soon as possible after the ED visit.
- Use appropriate documentation and correct coding. Use the same diagnosis for mental illness or substance use for follow-up visits (a non-mental health/non-substance diagnosis code will not fulfill the measure).
- Reference the plan's *Quality Measures Desktop Reference for Medicaid Providers* and the *HEDIS® Benchmarks and Coding Guidelines for Quality* that is provided for coding information.
- Educate patients on the importance of compliance with their discharge plan and their follow-up appointments.
- Reach out to patients who cancel their appointments and assist with rescheduling as soon as possible.
- Facilitate referrals to behavioral healthcare specialists when appropriate.

WA-NL-0597-21