Provider Newsletter

https://providers.amerigroup.com/MD

Amerigroup RealSolutions® in healthcare

2017
Quarter 1

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Reimbursement Policies:

Additional information on ClaimCheck® upgrade to ClaimsXten™

Amerigroup Community Care previously announced plans to upgrade from ClaimCheck to the ClaimsXten auditing system in the second quarter of 2017.

This upgrade will continue to ensure claims auditing remains consistent with accepted industry coding standards. However, claim results may present differently than those processed in the earlier software even though the end result is the same.

The new software uses a set of explanation codes that differ from those currently in use. Along with the new explanation codes, any updated associated descriptive text will display on the provider *Explanation of Payment (EOP)* or *Clear Claim Connection* explaining the edits applied to the submitted claim, just like today.

You may notice another difference on the *EOP* when ClaimsXten applies an edit based on the number of units billed. Currently, claims receiving an audit due to units that exceed the maximum allowed are displayed on two separate lines. The new software will still show separate lines for claims with less than 100 units, but claims with units billed greater than 100 will be displayed on a single line showing the reimbursement amount and the number of allowed units.

If you have questions regarding ClaimsXten edits you receive on your *EOP*, please call Provider Services at 1-800-454-3730.

ClaimCheck and ClaimsXten are registered trademarks of McKesson Technologies Inc. and McKesson Health Solutions LLC, respectively.

MD-NL-0036-17

Genetic testing services to require prior authorization

Effective May 1, 2017, genetic testing services for epidermal growth factor receptor (EGFR) testing, prothrombin G20210A (factor II) mutation testing, methylenetetrahydrofolate reductase mutation testing and cell-free fetal DNA-based prenatal testing require prior authorization (PA).

What is the impact of this change?

For dates of service on or after May 1, 2017, PA is required for EGFR testing, prothrombin G20210A (factor II) mutation testing, methylenetetrahydrofolate reductase mutation testing and cell-free fetal DNA-based prenatal testing covered 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 codes:

- 81235
- 81291
- 81420
- 81507
- 0009M

To request PA, contact us by phone at 1-800-454-3730 or by fax at 1-800-964-3627.

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers on the provider self-service website (https://providers.amerigroup.com/MD > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool).

MD-NL-0032-16

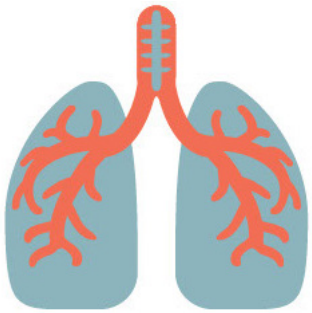
Asthma controller medication

Effective October 1, 2016, Amerigroup Community Care updated the formulary for asthma controller medications. The table below provides details regarding the new requirements for your HealthChoice members:

Medication	New status	Old status	Minimum age approved by the FDA	Less than 6 years of age[1]	6 years of age and older	12 years of age and older
Inhaled corticosteroid (ICS) products:				**Prior authorization (PA) not required**		
Aerospan[2]	Preferred	Preferred	6 years of age		✓	✓
Arnuity Ellipta	Preferred	Nonpreferred	12 years of age			✓
Budesonide Respules	Preferred	Preferred	1 year of age (up to 8 years of age)	✓		
Alvesco	Nonpreferred	Nonpreferred	12 years of age			
Asmanex HFA	Nonpreferred	Preferred	12 years of age			
Asmanex Twisthaler	Nonpreferred — 6 years of age and older	Preferred	4 years of age	✓		
Flovent Diskus	Nonpreferred — 6 years of age and older	Preferred	4 years of age	✓		
Flovent HFA	Nonpreferred — 6 years of age and older	Preferred	4 years of age	✓		
Pulmicort Flexhaler	Nonpreferred	Preferred	6 years of age			
Pulmicort Respules	Nonpreferred	Preferred	6 years of age			
Qvar[3]	Nonpreferred — 12 years of age and older	Preferred	5 years of age	✓	✓	
ICS/long-acting beta agonists products:				**PA not required**		
Breo Ellipta	Preferred	Nonpreferred	18 years of age			
Dulera	Preferred	Preferred	12 years of age			✓
Advair Diskus	Nonpreferred	Nonpreferred	4 years of age	✓[4]	✓[4]	
Advair HFA	Nonpreferred	Nonpreferred	12 years of age			
Symbicort	Nonpreferred	Preferred	12 years of age			

1 FDA minimum age restriction still applies.
2 Has integrated spacer.
3 Can be utilized with external valve holding chamber.
4 If claims history shows the member has tried one ICS agent within 180 days, the member doesn't need PA.

Asthma controller medication continued



Prescribing preferred products helps avoid the need for PA as well as avoid the inconvenience for your patients due to denial of medications.

If you determine preferred products are not clinically appropriate for a specific patient, you can do one of the following to obtain PA:

- Call our Pharmacy department at 1-800-454-3730 and follow the voice prompts for pharmacy PA.
- Fax a *Maryland Pharmacy PA Form* (https://providers.amerigroup.com/MD > Pharmacy > Prior Authorization Form) and all required information to 1-855-363-0728.

MD-NL-0043-17

Continuous interstitial glucose monitoring to require prior authorization

Effective March 1, 2017, continuous interstitial glucose monitoring will require prior authorization (PA).

What is the impact of this change?

For dates of service on or after March 1, 2017, PA will be required for continuous interstitial glucose monitoring covered 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 codes:

- A9276: sensor — invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system (one unit = one-day supply)
- A9277: transmitter — external, for use with interstitial continuous glucose monitoring system
- A9278: receiver (monitor) — external, for use with interstitial continuous glucose monitoring system
- 95250: ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours — sensor placement, hook-up, calibration of monitor, patient training, removal of sensor and printout of recording
- 95251: ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours — interpretation and report

To request PA, contact us by phone at 1-800-454-3730 or by fax at 1-800-964-3627.

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers on the provider self-service website (https://providers.amerigroup.com/MD > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool).

MD-NL-0024-16

Over-the-counter heartburn medication

Amerigroup Community Care covers up to $15 worth of certain generic over-the-counter (OTC) medications every three months (quantity limits and safety restrictions apply). When prescribing medication to treat symptoms of gastroesophageal reflux disease and other conditions caused by excess stomach acid, Amerigroup prefers OTC formulations instead of legend medications.

The preferred medications you can prescribe for your HealthChoice patients include the following OTC products:

- Omeprazole OTC 20 mg tablet or omeprazole magnesium OTC 20.6 mg capsule
- Lansoprazole OTC 15 mg capsule
- Prevacid 24-hour OTC 15 mg capsule
- Nexium OTC 22.3 mg capsule

For higher dosing, the preferred OTC products listed above may be prescribed up to two per day (for a total of 60 per month) without the need for prior authorization (PA).

When prescribing one of these agents, please notate OTC on the prescription to direct the pharmacist to select one of the preferred OTC products.

These OTC formulations are as clinically effective as their legend counterparts and are more cost effective — upwards of $100-$200 less. Additionally, prescribing preferred OTC products helps avoid the need for PA as well as avoid inconvenience to your patients due to denial of legend medications.

Thank you for your cooperation in prescribing the preferred products. If you have any questions, contact your Provider Relations representative, Provider Services (1-800-454-3730) or our Pharmacy team (1-800-454-3730).

Additional information:

Note, in order for Amerigroup to cover an OTC medication, providers must write a prescription for the patient to submit to their network pharmacy. A list of common OTC medications on the formulary for HealthChoice members is available on the provider website (https://providers.amerigroup.com/MD > Pharmacy > *Common OTC Medications List* or *Medicaid Preferred Drug List*).

MD-NL-0042-17

New Policy

Modifier 26 and TC: Professional and Technical Component

(Policy 15-004, effective 07/01/17)

Amerigroup Community Care allows reimbursement of the professional component and technical component of a global procedure or service when appended with Modifier 26 and Modifier TC when appropriate.

Professional Component (Modifier 26)

The professional component:

- Is used to indicate when a physician or other qualified health care professional renders only the professional component of a global procedure or service
- Includes the supervision and interpretation portion of a procedure and the preparation of a written report

Technical Component (Modifier TC)

The technical component includes the technician, equipment, supplies and institutional charges associated with the performance of the service or procedure.

Unless otherwise indicated in the policy, when a physician or other qualified health care professional performs a service in a facility, only the facility may be reimbursed for technical component of the service; facility is defined in exhibit A. To view Exhibit A, refer to the Modifier 26 and TC: Professional and Technical Component reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare. The physician or other qualified health care professional should make an arrangement with the facility for reimbursement to perform any technical components of a service.

Please note that portable X-ray suppliers should bill only for the technical component by appending Modifier TC.

Global Procedure

In the absence of Modifier TC and Modifier 26, the physician or other qualified health care professional will be reimbursed for the global procedure if they performed both the professional component and technical component of that service.

Amerigroup does not allow reimbursement for use of Modifier 26 or Modifier TC when:

- It is reported with an Evaluation and Management (E&M) code
- There is a separate standalone code that describes the professional component only, technical component only, or global test only of a selected diagnostic test

Amerigroup reserves the right to perform post-payment review of claims submitted with Modifier 26 or Modifier TC.

For additional information and to view Exhibit A, refer to the Modifier 26 and TC: Professional and Technical Component Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

MD-NL-0017-16

Policy Update
Modifier Usage
(Policy 06-006, effective 08/01/16)

Reimbursement for covered services provided to eligible members when billed with appropriate procedure codes and appropriate modifiers is based on the code-set combinations submitted with the correct modifiers. The use of correct modifiers does not guarantee reimbursement. The use of certain modifiers requires the provider to submit supporting documentation along with the claim. In the absence of state-specific modifier guidance, we will default to CMS guidelines.

Refer to the Exhibit A: Reimbursement Modifiers Listing for descriptions and guidance on documentation submission. For additional information, refer to the Modifier Usage reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

MD-NL-0013-16

Policy Update
Modifier 91: Repeat Clinical Diagnostic Laboratory Test
(Policy 06-020, effective 07/01/17)

Amerigroup Community Care allows reimbursement of claims for repeat clinical diagnostic laboratory tests appended with Modifier 91 and is based on 100 percent of the applicable fee schedule or contracted/negotiated rate.

Medical documentation may be requested to support the use of Modifier 91, and failure to use the modifier appropriately may result in denial of the repeated laboratory test as a duplicate service. It is inappropriate to use Modifier 91 when only a single test result is required.

Refer to the Modifier 91: Repeat Clinical Diagnostic Laboratory Test reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

MD-NL-0014-16

Policy Update

Reimbursement for Reduced and Discontinued Services

(Policy 10-003, effective 04/27/2015)

Amerigroup Community Care allows reimbursement to professional providers and facilities for reduced or discontinued services when appended with the appropriate modifier. Modifiers 52, 53, 73 and 74 can be appended for reduced and discontinued services, if applicable.

Modifier 52 indicates procedures for which services performed are significantly less than usually required. Reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate. Do not report Modifier 52 on Evaluation & Management (E&M) and consultation codes.

Modifier 53 indicates the physician elected to terminate a surgical or diagnostic procedure due to extenuating circumstances that threatened the well-being of the patient. Reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate. Modifier 53 is not applicable for facility billing and is not valid when billed with E&M or time-based codes.

Modifier 73 indicates the physician canceled the surgical or diagnostic procedure prior to administration of anesthesia and/or surgical preparation of the patient. Reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate. Modifier 73 is not applicable for professional provider billing.

Modifier 74 indicates a procedure was stopped after the administration of anesthesia or after the procedure was started. Reimbursement is 100 percent of the applicable fee schedule or contracted/negotiated rate. Modifier 74 is not applicable for professional provider billing.

For additional information and/or applicable modifier rules, refer to the Reimbursement for Reduced and Discontinued Services reimbursement policy https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

MD-NL-0010-16

Policy Reminder

Claims Timely Filing

(Policy 06-050, originally effective 07/01/2013)

To be considered for reimbursement, the initial claim must be received and accepted by the following standard:

- 180 days for participating providers and facilities
- 6 months for undisputed claims where the member has self-referred or [180 days] for nonparticipating providers and facilities

If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last day of service. Limits are based on calendar days unless otherwise specified. Services denied for failure to meet timely filing requirements are not subject to reimbursement unless the provider presents documentation proving a clean claim was filed within the applicable filing limit.

For additional information, refer to the Claims Timely Filing reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

MD-NL-0012-16

Policy Reminder

Split-Care Surgical Modifiers

(Policy 11-005, effective 08/01/16)

Reimbursement of **surgical codes** appended with "split-care modifiers" is allowed and based on a percentage of the fee schedule or contracted/ negotiated rate for the surgical procedure. The percentage is determined by which modifier is appended to the procedure code:

- Modifier 54 (surgical care only): 80 percent
- Modifier 55 (postoperative management only): 20 percent

Included in the global surgical package are preoperative services, surgical procedures and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member's care.

Claims received with split-care modifiers after a global surgical claim is paid will be denied. Assistant surgeon and/or multiple procedure rules and fee reductions apply when an assistant surgeon is used and/or multiple procedures are performed.

For more information, refer to the Split-Care Surgical Modifiers reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

MD-NL-0018-16