Provider Newsletter

Amerigroup
An Anthem Company

https://providers.amerigroup.com/MD

2017
Quarter 3

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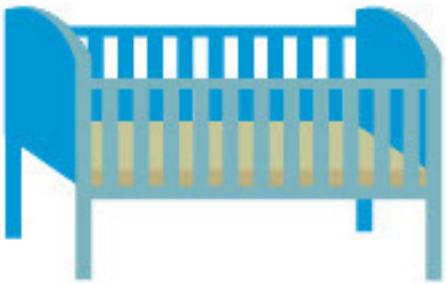
Reimbursement Policies:

Preterm birth rate on the rise

The provisional 2016 preterm birth rate was released in a report from the National Center for Health Statistics. The U.S. preterm birth rate was 9.84 percent in 2016, up 2 percent from 9.63 percent in 2015. This marks the second consecutive increase after steady declines over the previous seven years. Preterm births account for approximately 70 percent of newborn deaths and 36 percent of infant deaths. As an OB/GYN provider, you play a leading role in diagnosing and treating premature labor and birth. We encourage you to continue best practices in detection and prevention of preterm birth:

- Increase use of progesterone for women with a history of prior preterm birth
- Appropriate screening and management of short cervix
- Optimize birth spacing and reduce unintended pregnancies by discussing family planning options
- Continue to screen for tobacco, alcohol and drug use before, after and during pregnancy —offering intervention and resources



Amerigroup Community Care does approve provider requests for Makena when appropriate prior authorization has been received. Please submit your request early to avoid delays in starting the medication. Also, we encourage you to refer any high-risk pregnant members to case management for additional support, resources and education throughout their pregnancy. Please call 1-800-600-4441 and request to speak to an OB case manager. Together, we can help to fight the morbidity and mortality associated with preterm birth.

MD-NL-0069-17

March of Dimes and Anthem Foundation continue efforts to prevent premature births

Prematurity is the number one killer of babies in the U.S., and babies born even a few weeks early have higher rates of illness and hospitalization compared to full-term newborns. In addition to the toll on families, economic costs for prematurity are estimated at more than $26 billion annually by the National Academy of Medicine. The Anthem Foundation, our philanthropic affiliate, has awarded a $1.1 million grant to support programs across the country that helps prevent premature birth and improve mom and baby health. The funding provided by the Anthem Foundation will support March of Dimes community grants for CenteringPregnancy®, smoking cessation programs and programs to prevent unnecessary early elective delivery.

The grant to the March of Dimes is part of Anthem Foundation's ongoing commitment to addressing health disparities and improving public health across the country. "Although a lot of progress has been made to prevent premature birth and improve mom and baby health, it's critical that we continue to ensure programs are available and expanded to reach growing and diverse communities," said Craig Samitt, MD, chief clinical officer at Anthem, Inc. "We're proud to team with the March of Dimes in its efforts to drive cutting-edge research, treatment and outreach to give every baby a healthy start in life."

MD-NL-0069-17

Interactive Care Reviewer tool: Register and start using today!

Beginning June 17, 2017, your practice can submit online preauthorization requests from Amerigroup Community Care for HealthChoice members more efficiently and conveniently with our Interactive Care Reviewer (ICR) tool available through the Availity Portal. The ICR offers a streamlined process to request inpatient and outpatient procedures as well as locate information on previously submitted requests.

What benefits/efficiencies does the ICR tool provide?

- **You are automatically routed to our ICR tool.** Once the ICR tool is available, when you go to Authorizations in Availity, you are automatically routed to the ICR tool in order to begin your preauthorization request.
- **You can determine if preauthorization is needed.** For most requests, when you enter patient, service and provider details, you will receive a message indicating whether or not review is required.
- **You have inquiry capability.** Ordering and servicing physicians and facilities can locate information on preauthorization requests for those they are affiliated with; this includes requests previously submitted via phone, fax or the ICR tool.
- **The ICR tool reduces the need to fax.** The ICR tool allows text detail as well as images to be submitted along with the request. Therefore, you can submit requests online and reduce the need to fax medical records.
- **There is no additional cost to you.** The ICR tool is a no-cost solution that's easy to learn and even easier to use.
- **You can access the ICR tool almost anywhere.** You can submit your requests from any computer with internet access. (Note: We recommend you use Internet Explorer 11, Chrome, Firefox or Safari for optimal viewing.)
- **You receive a comprehensive view of all your preauthorization requests.** You have a complete view of all the utilization management requests you submit online, including the status of your requests and specific views that provide case updates and a copy of associated letters.

How do I gain access to the ICR tool?

You can access the ICR tool through Availity.

- **If your organization has not yet registered for Availity:**
  1. Go to https://www.availity.com.
  2. Select **Register** in the upper right-hand corner of the page.
  3. Then, select **PORTAL REGISTRATION Let's get started!** and follow the prompts of the online registration wizard.
- **If your organization already has access to Availity:**
  1. Your Availity administrator can grant you access to "authorization and referral request" for submission capability and "eligibility and benefits inquiry" for inquiry capability.
  2. You can then find our tool in Availity under *Patient Registration and Authorizations & Referrals*.

Whom can I contact with questions?

- For help using our ICR tool, please contact your local Network Relations representative.
- For help accessing our tool via Availity, call Availity Client Services at 1-800-AVAILITY (1-800-282-4548). Availity Client Services is available Monday-Friday from 8 a.m.-7 p.m. ET (excluding holidays) to answer your registration questions.

Note: ICR is not currently available for requests involving transplant services or services administered by AIM Specialty Health® or OrthoNet LLC. For these requests, follow the same preauthorization process you use today.

MDPEC-1289-17

Access to Disease Management — helping you care for patients with chronic health care needs

Amerigroup Community Care Disease Management programs are designed to assist PCPs and specialists in managing the care of members with chronic health care needs. Members are provided with care management and education by a team of highly qualified disease management professionals whose goal is to create a system of coordinated health care interventions and communications for enrolled members.

Case managers provide support to members with:

- Behavioral health conditions.
- Diabetes.
- Heart conditions.
- HIV/AIDS.
- Pulmonary conditions.
- Substance use disorder.

Additionally, in order to improve condition-specific outcomes, case managers use motivational interviewing to identify and address health risks such as tobacco use and obesity.

Licensed nurse case managers are available Monday-Friday from 8:30 a.m.-5:30 p.m. local time, and our confidential voicemail is available 24 hours a day, 7 days a week. To contact our Disease Management team, call 1-888-830-4300.

Additional information about our Disease Management programs can be found on our provider website (https://providers.amerigroup.com/MD > Provider Resources & Documents > Disease Management Centralized Care Unit). Members can obtain information about our Disease Management programs by visiting www.myamerigroup.com.

MD-NL-0060-17

Distribution of *Clinical Practice and Preventive Health Guidelines*

Evidence-based guidelines are *Clinical Practice Guidelines* known to be effective in improving health outcomes. Guideline effectiveness is determined through scientific evidence, professional standards or expert opinion. Amerigroup Community Care provides clinical and preventive health guidelines to our network physicians. These guidelines are based on current research and national standards. Members and providers may request a paper copy of a guideline by calling Provider Services at 1-800-454-3730 and are available on our website at https://providers.amerigroup.com/MD.

MD-NL-0068-17

Diabetes Prevention Program grant

Amerigroup Community Care was selected by the Department of Health and Mental Hygiene to participate in a demonstration project to pilot a Diabetes Prevention Program (DPP) with Medicaid recipients and to develop a sustainable reimbursement model. Maryland was awarded funding for this project by the National Association of Chronic Disease Directors. Amerigroup is partnering with CDC-recognized DPP providers in Maryland, which include the following community-based programs: Soul So Good Healthy, Inc. in Baltimore City, Prince Georges and Montgomery County; and the virtual vendor, Retrofit. If you have any Amerigroup members who are prediabetic, obese and/or have had a history of gestational diabetes and would like to refer them to a DPP, please contact Amerigroup at 1-800-964-2112, ext. 44120. Enrollment is open until January 31, 2018.

MD-NL-0068-17

Access to Case Management

Our Case Management (CM) program is part of a comprehensive health care management services program that offers a continuum of services including CM, disease management and care coordination. Since many members have complex needs that require services across multiple providers and systems, a potential for gaps may occur in the health care delivery system serving these members. These gaps can create barriers to members receiving optimal care. Our CM program helps reduce these barriers by identifying the unmet needs of members and assisting them in finding solutions to those needs.

Our case managers can assist in:

- Coordinating care.
- Accessing community services.
- Providing disease-specific education.
- Facilitating any number of interventions to improve the quality of life and functionality of members along with efficiently using health care resources.

If you need to refer a member to our case management program, call Provider Services at 1-800-454-3730.

If you would like to learn more about our Disease Management Centralized Care Unit, call 1-888-830-4300 and ask to speak to a care manager.

MD-NL-0068-17

Utilization management

If an Amerigroup Community Care physician reviewer denies your service request due to medical necessity, both you and the member will receive a notice of action letter that will include the reason for denial, note the criteria/guidelines used for the decision and explain the provider/member appeal process and rights. If you would like to arrange to speak with a physician reviewer about a medical necessity determination within 24 hours/one business day of the initial notice of action about the service request denial, call the MD Peer-to-Peer line at 1-866-696-2709. Administratively denied requests must follow the appeal process only.

To request a copy of the specific criteria/guideline used for the decision, please call 1-800-600-4441 or write to:
Attn: Utilization Management Medical Management
Amerigroup Community Care
7550 Teague Road, Suite 500
Hanover, MD 21076

Access to utilization staff

Providers have access to clinical professionals who coordinate member care and are available 24 hours a day, 7 days a week to accept precertification requests. You can submit a precertification request by:

- Calling 1-800-474-3730.
- Faxing 1-800-964-3627.
- Logging in to https://providers.amerigroup.com/MD and using the precertification lookup tool.

If you have questions about utilization decisions or the utilization management process, call the clinical team at 1-800-454-3730, Monday-Friday, 8 a.m.-5 p.m. ET.

MD-NL-0068-17

Long-acting reversible contraception

Overview

Long-acting reversible contraception (LARC) is the most effective form of reversible contraception and has the highest continuation rate among reversible methods. Use of LARC has increased in the United States but is still low at 11.6 percent. Amerigroup continues to encourage providers to offer their patients LARC as an option for effective and safe family planning. LARC devices are a medical benefit and may be offered to members via a buy-and-bill procedure. Also, the American Congress of Obstetricians and Gynecologists endorses that immediate postpartum provision of LARC is safe and effective and can be a particularly favorable time for providing LARC methods. If your affiliated hospital currently stocks these devices, we encourage you to offer our members the option of immediate postpartum placement. As always, engage in discussion with your patients early in pregnancy about options for family-planning and choosing a method that best suits their needs.

Please be aware that CMS has assigned a temporary code for reporting the new IUD, Kyleena (levonorgestrel releasing intrauterine system, 19.5 mg). Effective July 1, 2017, Kyleena can be reported using Q9984. A permanent J-code should be available for use starting January 1, 2018. We are still currently working with CMS to finalize pricing for this new device. We appreciate your patience and please know that any denied claims for Kyleena will be reviewed and corrected as appropriate.

Further information

About half of all births in Maryland are unintended. The American Congress of Obstetrics and Gynecology recommends that LARC methods, such as intrauterine devices and contraceptive implants, be offered as first-line contraceptive methods. This recommendation is based upon the fact that LARC devices are safe and highly beneficial when inserted immediately postpartum.

Amerigroup Community Care is committed to enhancing access to women's health services and improving birth outcomes by providing access to LARC in the form of intrauterine devices (IUDs) and etonogestrel implants.

How this benefit works

During an inpatient facility admission, you will have the ability to implant the device of your patient's choice and receive the same reimbursement as if the device were implanted on an outpatient basis. The inpatient facility will provide the device. Please work closely with your obstetrical unit to understand the logistics of obtaining the devices.

What to do before providing this benefit to your patients

We respectfully ask you to discuss the option for immediate postpartum placement of LARC with your patients early on during the third trimester of pregnancy. Please provide additional counseling and support to your teenage and young patients (ages 13-19) as this group is at the greatest risk for early discontinuation of these methods.[1] It appears that there is lower discontinuation at two years of IUDs as compared to the etonogestrel implant.[2] When clinically appropriate, IUDs should be considered over the implant.

Long-acting reversible contraception (cont.)

Advantages of LARC

Unintended pregnancies are associated with higher rates of maternal and neonatal complications of pregnancy and continue to be a concerning health problem in the United States.[3] Long-acting methods are more effective at preventing unintended pregnancies and have significantly greater continuation rates than oral contraceptives, the vaginal contraceptive ring or the contraceptive patch. These methods also have very low rates of serious side effects.[4]

FAQ

When should the intrauterine device (IUD) or Nexplanon be inserted postpartum?

The IUD can be inserted in the postpartum period:

- Within 10 minutes after the delivery of the placenta.
- Up to 48 hours after delivery.
- At the time of Cesarean delivery.
- At any point following delivery.

What are instances when postpartum IUD placement should be avoided?

Immediate postplacenta insertion should be avoided in patients with a fever. Patients with rupture of membranes greater than 36 hours before delivery, a postpartum hemorrhage or extensive genital lacerations should be referred for interval insertion.

Where can I find additional information regarding postpartum long-acting reversible contraception (LARC)?

Additional information can be found at www.acog.org. Information may also be found at www.arhp.org.

What are the CPT codes associated with IUD and Nexplanon insertion in the hospital setting?

The CPT and associated ICD-10 codes are unchanged for the hospital setting. Use 11981 — insertion, nonbiodegradable drug delivery implant; 58300 — insertion of IUD.

Does placement of an IUD in the postpartum period increase a woman's chance of infertility in the future?

No, there is no data to suggest that there is any adverse effect on future fertility. Baseline fecundity has been shown to return rapidly after IUD removal.[5]

Is there a greater rate of IUD expulsion with postpartum placement of an IUD?

Yes, the actual expulsion rate varies with device type. An important study of the Copper T 380A by Celen et al demonstrated expulsion rates at six weeks, six months and 12 months of 5.1 percent, 7 percent and 12.3 percent,[6] respectively. A study of expulsion rates of the levonorgestrel-containing system demonstrated an expulsion rate of 10 percent at 10 weeks.[7]

When should patients be seen in follow-up?

Patients should be seen between 21 days and six weeks. Many patients resume intercourse before the six-week checkup. To prevent unintended pregnancies, it is important to confirm that the device is still in place.

OB Corner (cont.)

Long-acting reversible contraception (cont.)

1 Aoun J, Dines VA, Stovall DW, Mete M, Nelson CB, et al. *Effects of Age, Parity, and Device Type on Complications and Discontinuation of Intrauterine Devices*. Obstetrics & Gynecology 2014;123:585-92.

2 O'Neil-Callahan M, Peipert JF, Zhao Q, Madden T, Secura G. *Twenty-Four-Month Continuation of Reversible Contraception*. Obstet Gynecol 2013;122:1083-91.

3 Hellerstedt WL, Pirie PL, Lando HA, Curry SJ, McBride CM, Grothaus LC, et al. *Differences in prenconceptional and prenatal behaviors in women with intended and unintended pregnancies*. AM J Public Health 1998; 88:663-6.

4 Winner B, Peipert JF, Zhao Q, Buckel C, Madden T, Allsworth JE, et al. *Effectiveness of long-acting reversible contraception*. N Engl J Med 2012; 366 1998-2007.

5 Hov GG, Skjeldestad FE, Hilstad T. *Use of IUD and subsequent fertility — follow-up after participation in a randomized clinical trial*. Contraception 2007;75:88–92.

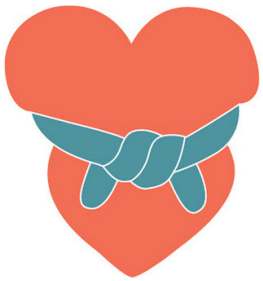
6 Celen S, Möröy P, Sucak A, Aktulay A, Danişman N. *Clinical outcomes of early postplacental insertion of intrauterine contraceptive devices*. Contraception. 2004;69:279–82.

7 Hayes JL, Cwiak C, Goedken P, Zieman M. *A pilot clinical trial of ultrasound-guided postplacental insertion of a levonorgestrel intrauterine device*. Contraception. 2007;76:292–6.

MD-NL-0069-17 MDPEC-1327-17

Did you know?

Did you know that a blood pressure of 140/90 is out of range? Consider performing a repeat blood pressure prior to the member leaving your office. This reading should be recorded and documented in the member's chart.



MD-NL-0068-17

Formulary update

Did you know that our formulary has changed? You can find our most updated list at https://providers.amerigroup.com/MD. Prior authorization can be completed for many medications that are nonformulary.

Call 1-800-359-5781 or visit our website for more details!

MD-NL-0068-17

Hepatitis C medications state policy reminders

- The most up-to-date Prior Authorization (PA) Form for Hepatitis C medications can be found on the website under the Pharmacy tab at https://providers.amerigroup.com/MD > Provider Resources & Documents > Pharmacy > Prior Authorization Form.
- All documentation should be dated within 90 days for PA approval.
- Viral load should be obtained following treatment completion. (This must be within 12 months of the initial fill date.)

MD-NL-0068-17

HEDIS Coding Tips

The following CPT Category II and ICD-10-CM codes can help reduce the number of medical records we ask for during HEDIS® medical record review season (January-May each year). Adding these codes to a claim will help us identify additional information about the visit and improve the accuracy of reporting quality measures.*

Prenatal and postpartum care	
Initial prenatal care visit	0500F or 0501F — if *Prenatal Care Flow Sheet* documented in medical record by first prenatal visit
Subsequent prenatal care visit	0502F
Postpartum care visit	0503F — Make sure it is within 21-56 days of delivery.
Body mass index (BMI) — adult	
Z68.1-Z68.45	Refer to ICD-10 description to select the appropriate code.
BMI — child	
Z68.51-Z68.54	Refer to ICD-10 description to select the appropriate code.

Diabetes care	
Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed	2022F
Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed	2024F
Eye imaging validated to match diagnosis from 7 standard field stereoscopic photos results documented and reviewed	2026F
Low risk for retinopathy (no evidence of retinopathy in the prior year)	3072F
HbA1c level less than 7	3044F
HbA1c level equal to 7-9	3045F
HbA1c level greater than 9	3046F
Most recent LDL-C greater than 100 mg/dL	3048F
Most recent LDL-C equal to 100-129 mg/dL	3049F
Most recent LDL-C less than/equal to 130 mg/dL	3050F
Positive microalbuminuria test	3060F
Negative microalbuminuria test	3061F
Positive macroalbuminuria test	3062F
Documentation of treatment for nephropathy (e.g., patient receiving dialysis; patient being treated for ESRD, CRF, ARF or renal insufficiency; any visit to a nephrologist)	3066F
Angiotensin converting enzyme inhibitor or angiotensin receptor blocker therapy prescribed or currently being taken (coronary artery disease, chronic kidney disease, heart failure)	4010F
Controlling blood pressure	
Most recent systolic blood pressure less than 130 mm Hg	3074F
Most recent systolic blood pressure 130-139 mm Hg	3075F
Most recent systolic blood pressure greater than/equal to 140 mm Hg	3077F
Most recent diastolic blood pressure less than 80	3078F
Most recent diastolic blood pressure 80-89	3079F
Most recent diastolic blood pressure greater than/equal to 90	3080F

** The codes listed are for informational purposes only and are not intended to suggest or guide reimbursement. If applicable, please refer to your provider contract or health plan contact person for reimbursement information.*

MDPEC-1320-17

New case management program for PTSD in the neonatal intensive care unit

On October 1, 2017, Amerigroup Community Care is launching a new case management (CM) program in Maryland for screening of PTSD in parents of infants hospitalized in the neonatal intensive care unit (NICU). This CM program supports mothers and families at risk for PTSD due to the stressful experience of having a baby in the NICU.

What is the purpose of this program?

The NICU PTSD program seeks to improve outcomes for families of babies who are in the NICU by screening and facilitating referrals to treatment for PTSD in parents.

How does it work?

Case managers will reach out by phone to screen parents of babies who have been in the NICU for 30 days or more. Parents who are determined to suffer from PTSD are referred for treatment.

What is PTSD?

PTSD is an anxiety disorder that may develop after exposure to a terrifying event or ordeal. Additionally, those who have witnessed another person experience a life-threatening event can suffer from PTSD.

Facts about PTSD:

- PTSD is diagnosed when stress symptoms persist for more than a month.
- Symptoms of PTSD include intrusive memories (i.e., flashbacks and upsetting dreams), attempts to avoid thinking or talking about the event, and hyperarousal (e.g., irritability or anger).
- The onset of PTSD symptoms may be delayed for as much as a year after the initiating event.

Why screen for PTSD in parents of long-term NICU patients?

- One in 10 infants in the United States are admitted to a NICU.
- Incidence of parental NICU-related PTSD varies from 20-41 percent.
- PTSD is treatable if identified.
- Lack of treatment can affect the health of the parent and the child.
- Children cared for by mothers with PTSD are at significantly higher risk for psychological aggression, child abuse and neglect.
- PTSD in parents can have long-term, adverse impacts on children, such as lower cognitive performance and conduct disorders.

What if I need assistance?

If you have questions about the new CM program for PTSD in the NICU or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

MDPEC-1347-17

Medical Policies and Clinical Utilization Management Guidelines update

Medical Policies update

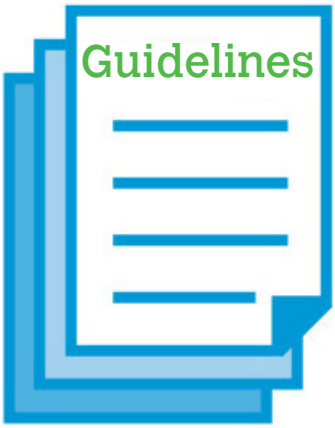
On May 4, 2017, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Medical Policies* applicable to Amerigroup Community Care. These policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the below listing.

The *Medical Policies* were made publicly available on the Amerigroup provider website on the effective date listed below. Visit https://medicalpolicies.amerigroup.com/search to search for specific policies.

Existing precertification requirements have not changed. Please share this notice with other members of your practice and office staff.

Please note: For markets with pharmacy services carved out, the applicable listings below would be informational only.

Effective date	*Medical Policy* number	*Medical Policy* title	New or revised
5/18/2017	DRUG.00099	Cerliponase Alfa (Brineura™)	New
5/18/2017	DRUG.00107	Avelumab (Bavencio®)	New
5/18/2017	DRUG.00109	Durvalumab (IMFINZI™)	New
6/28/2017	MED.00121	Implantable Interstitial Glucose Sensors	New
6/28/2017	MED.00122	Wilderness Programs	New
6/28/2017	SURG.00148	Spectral Analysis of Prostate Tissue by Fluorescence Spectroscopy	New
6/28/2017	SURG.00149	Percutaneous Ultrasonic Ablation of Soft Tissue	New
6/28/2017	SURG.00150	Leadless Pacemakers	New
5/18/2017	DME.00040	Automated Insulin Delivery Devices	Revised
5/18/2017	DRUG.00002	Tumor Necrosis Factor Antagonists	Revised
5/18/2017	DRUG.00038	Bevacizumab (Avastin®) for Non Ophthalmologic Indications	Revised
5/18/2017	DRUG.00041	Rituximab (Rituxan®) for Non Oncologic Indications	Revised
5/18/2017	DRUG.00047	Brentuximab Vedotin (Adcetris®)	Revised
6/28/2017	DRUG.00062	Obinutuzumab (Gazyva®)	Revised
5/18/2017	DRUG.00066	Antihemophilic Factors and Clotting Factors	Revised
5/18/2017	DRUG.00071	Pembrolizumab (Keytruda®)	Revised
5/18/2017	DRUG.00075	Nivolumab (Opdivo®)	Revised
5/18/2017	DRUG.00083	Elotuzumab (Empliciti™)	Revised
5/18/2017	DRUG.00088	Atezolizumab (Tecentriq®)	Revised
5/18/2017	DRUG.00104	Nusinersen (SPINRAZA™)	Revised
5/18/2017	GENE.00032	Molecular Marker Evaluation of Thyroid Nodules	Revised
5/18/2017	GENE.00035	Genetic Testing for TP53 Mutations	Revised
6/28/2017	SURG.00121	Transcatheter Heart Valves	Revised
5/18/2017	THER-RAD.00004	External Beam Intraoperative Radiation Therapy	Revised
5/18/2017	TRANS.00024	Hematopoietic Stem Cell Transplantation for Select Leukemias and Myelodysplastic Syndrome	Revised



Clinical Utilization Management Guidelines update

On May 4, 2017, the MPTAC approved the following *Clinical Utilization Management (UM) Guidelines* applicable to Amerigroup. These clinical guidelines were developed or revised to support clinical coding edits. Several guidelines were revised to provide clarification only and are not included in the following listing. This list represents the *Clinical UM Guidelines* adopted by the Medical Operations Committee for the Government Business Division on June 5, 2017.

On May 4, 2017, the clinical guidelines were made publicly available on the Amerigroup *Medical Policies* and *Clinical UM Guidelines* subsidiary website. Visit https://medicalpolicies.amerigroup.com/search to search for specific guidelines.

Existing precertification requirements have not changed. Please share this notice with other members of your practice and office staff.

Please note: For markets with pharmacy services carved out, the applicable listings below would be informational only.

Effective date	*Clinical UM Guideline* number	*Clinical UM Guideline* title	New or revised
6/28/2017	CG-REHAB-10	Level of Care: Outpatient Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services	New
5/18/2017	CG-DRUG-34	Docetaxel (Docefrez™, Taxotere®)	Revised
5/18/2017	CG-DRUG-50	Paclitaxel, protein-bound (Abraxane®)	Revised
6/28/2017	CG-DRUG-60	Gonadotropin Releasing Hormone Analogs for the Treatment of Oncologic Indications	Revised
6/28/2017	CG-SURG-09	Temporomandibular Disorders	Revised
5/18/2017	CG-SURG-55	Intracardiac Electrophysiological Studies (EPS) and Catheter Ablation	Revised
5/18/2017	CG-THER-RAD-01	Fractionation and Radiation Therapy in the Treatment of Specified Cancers	Revised

MDPEC-1333-17

Member rights and responsibilities

Our members have defined rights and responsibilities. These can be found in your provider manual and on our website, https://providers.amerigroup.com/MD. If you would like a paper copy mailed to you, call Provider Services at 1-800-454-3730.

MD-NL-0068-17

Substance use disorders in pregnancy and neonatal abstinence syndrome

Substance use disorders (SUDs) are on the rise and are of particular concern in women of childbearing age who are or may become pregnant. Women who use opioids in the following situations are at risk for delivering babies who are born preterm, have a low birth weight, and/or have neonatal abstinence syndrome (NAS)/neonatal opioid withdrawal syndrome (NOWS):

- Taking prescribed opioids for pain or addiction treatment
- Misusing prescribed opioid medications
- Using opioids illicitly
- Using opioids in combination with benzodiazepines, selective serotonin reuptake inhibitors (SSRIs) or tobacco

Caring for babies born with NAS

While traditional care for infants in withdrawal has included tapering doses of opioids, this should not be the first choice. Preliminary studies on preterm infants treated with morphine for pain and studies exposing laboratory animals to morphine, heroin, methadone and buprenorphine reveal some concerning structural brain changes and changes in neurotransmitters. While few follow-up studies exist, those that are available are worrisome for long-term deficits in cognitive function, memory and behavior. Reduction in any exposure to opioids should be the goal for the fetus and newborn.

Approaches to reducing the incidence and severity of NAS include:

- The use of nonpharmacologic techniques to calm and ameliorate symptoms.
- Adoption of, and strict adherence to, protocols to assess and treat with pharmacologic medications if nonpharmacologic care is not sufficient.
- Inter-rater reliability testing when using standard assessment tools (such as modified Finnegan).

Strict rooming in protocols, rather than placement in neonatal intensive care units, combined with extensive parent education programs improve family involvement and have been shown to reduce lengths of stay and the need for treatment of infants with NAS. When mothers are in stable treatment programs or are stable on safely prescribed medications, breastfeeding has also been shown to reduce the symptoms of NAS.

Caring for women with SUD

Pregnancy offers women an opportunity to break patterns of unhealthy behaviors. Providers have a unique opportunity to help break the pattern of opioid misuse and, thus, reduce health consequences for both mother and child.

Collaboration with community resources, behavioral health providers, addiction treatment centers and OB providers is imperative to designing programs that engage families at risk for SUDs. Women of childbearing age who are not pregnant and who do not wish to become pregnant should receive family planning counseling. Women who are already pregnant benefit from parenting education as early as possible in their pregnancies so they can be prepared to understand and care for their babies who might experience symptoms of NAS and who often require prolonged hospitalizations after birth. As these infants may remain symptomatic for several months after hospital discharge, they are at higher risk for abuse and maltreatment; therefore, close follow up with ongoing support is imperative.

Substance use disorders in pregnancy and neonatal abstinence syndrome (cont.)

Guidelines and programs which have been shown to improve the care of women at risk of SUDs in pregnancy and their infants include the following:

- **Center for Addiction in Pregnancy:** www.hopkinsmedicine.org/psychiatry/bayview > Clinical Services > Addiction and Substance Abuse > Center for Addiction and Pregnancy (CAP)
- **Fir Square Combined Care Unit:** www.bcwomens.ca > Our Services > Pregnancy & Prenatal Care > Pregnancy, Drugs & Alcohol
- **Improving Outcomes for Infants and Families Affected by NAS — A Universal Training Program:** https://public.vtoxford.org > Quality & Education > NAS Universal Training Program
- **Protecting Our Infants Act: Final Strategy:** https://www.samhsa.gov > Topics > Specific Populations > Age- and Gender-Based Populations > Pregnant Women and Infants > Protecting Our Infants Act: Final Strategy
- **Public Health Strategies to prevent Neonatal Abstinence Syndrome:** Ko JY, Wolicki S, Barfield WD, et al. "CDC Grand Rounds: Public Health Strategies to Prevent Neonatal Abstinence Syndrome," *MMWR Morb Mortal Wkly Rep 2017* 66: 242-245. doi: http://dx.doi.org/10.15585/mmwr.mm6609a2.
- **Rooming In to Treat Neonatal Abstinence Syndrome: Improved Family Centered Care at Lower Cost:** Volpe Holmes, A, et al. "Rooming-In to Treat Neonatal Abstinence Syndrome: Improved Family-Centered Care at Lower Cost," *Pediatrics* 137 (2016): 6. doi: 10.1542/peds.2015-2929
- **Sheway:** A Community Program for Women and Children: http://sheway.vcn.bc.ca
- **Snuggle ME webinar series:** www.mainequalitycounts.org > Programs > Snuggle ME Webinar Series

Support

We are here to support you, our pregnant members and their little ones on the way. If you would like more information about our OB Case Management Program or if you have a member who needs behavioral health case management, contact Provider Services at 1-800-454-3730.

MD-NL-0001-17

Hemophilia factor injections to require prior authorization

Effective September 1, 2017, Amerigroup Community Care requires prior authorization (PA) for hemophilia factor injections. Federal and state law as well as state contract language 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:

- **J7175** — injection of factor x (human), 1 international unit (IU)
- **J7179** — injection of von willebrand factor (recombinant), vonvendi, 1 IU
- **J7202** — injection of factor ix (albumin fusion protein, recombinant), idelvion, 1 IU
- **J7207** — injection of factor viii, (antihemophilic factor, recombinant), pegylated, 1 IU
- **J7209** — injection of factor viii, (antihemophilic factor, recombinant), nuwiq, 1 IU

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

- Phone: 1-800-454-3730
- Fax: 1-800-964-3627
- Web: Interactive Care Reviewer tool via https://www.availity.com

For more PA requirements, please see the provider website (https://providers.amerigroup.com/MD > Quick Tools > Precertification Lookup Tool) or call Provider Services at 1-800-454-3730.

MD-NL-0059-17

Wheelchair component or accessory, not otherwise specified to require prior authorization

Effective October 1, 2017, Amerigroup Community Care requires prior authorization (PA) for wheelchair components or accessories, not otherwise specified (NOS) — K0108. Federal and state law as well as state contract language 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 code:

- **K0108** — wheelchair component or accessory, NOS

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

- Phone: 1-800-454-3730
- Fax: 1-800-964-3627
- Web: Interactive Care Reviewer tool via https://www.availity.com

For more PA requirements, please see the provider website (https://providers.amerigroup.com/MD > Quick Tools > Precertification Lookup Tool) or call Provider Services at 1-800-454-3730.

MD-NL-0047-17

Reduction in prescribed opioids filled at pharmacies

We're committed to supporting policy changes that help reduce, prevent and deter opioid use disorder as well as those that help our members better access treatment. As an organization, we've reached our collective goal of reducing prescribed opioids filled at pharmacies by 30 percent during the past five years. We originally expected to achieve this goal by 2019. One important step was to limit coverage for short-acting opioid coverage to seven days for all individual, employer-sponsored and Medicaid members beginning new opioid prescriptions. We implemented these quantity limits to prevent accidental addiction and opioid use disorder and ensure clinically appropriate use consistent with Centers for Disease Control and Prevention (CDC) guidelines.

Our organization also had large decreases in member opioid use. For example, in the past year alone, Medicaid plans showed a 29-percent reduction in Virginia, **22-percent reduction in Maryland** and a 9-percent reduction in Georgia. For employer sponsored and individual plans, there was a decrease of 23 percent in Nevada, 17 percent in Connecticut and 17 percent in Wisconsin.

President Donald Trump declared the opioid crisis a national emergency earlier this month. From 2014 to 2015, drug overdose deaths increased by 11.4 percent — 5,349 deaths — a continuing trend the CDC has observed since 1999. It's the leading cause of accidental death in the United States, exceeding car crashes and guns.*

In response, we've taken these steps to help ensure clinically appropriate opioid use and proactively prevent the development of opioid use disorder:

- For short-acting opioids, initial prescriptions are limited to seven days. Members can only receive a maximum 14-day supply for short-acting opioids in a 30-day period without additional authorization, which is consistent with CDC guidelines. We began rolling out these quantity limit changes for individual short-acting opioids in October 2016. The limit on the most popular drug, hydrocodone acetaminophen, was effective in July.
- For all long-acting opioids, we began requiring prior authorization for initiation of therapy in September 2016. Quantity limits for long-acting opioids have existed for many years, with exceptions for members diagnosed with terminal or chronic illness.

- Individual, employer-sponsored, Medicare and Medicaid plans have pharmacy programs that assign members to one pharmacy and/or one provider for their opioid prescriptions. These programs help providers better monitor opioid access and ensure members are receiving counseling and mental health support.
- Providers who receive member electronic dashboards are notified when a member is at greater risk for developing opioid use disorder (e.g., when they have prescriptions from several providers or pharmacies or prescriptions for opioids, muscle relaxants and benzodiazepines at the same time).
- We send providers letters to alert them of other controlled substance use concerns and associated emergency room/urgent care use (e.g., when the member has prescriptions for both Suboxone® and opioids or is on persistent high doses of opioids).

Reduction in prescribed opioids filled at pharmacies (cont.)

Compared to 2012, the peak year for opioid prescription fills, these policy changes contributed to a 31 percent reduction in opioid use. As such, we've updated our collective goals for 2019. To set these goals, we researched morphine equivalents dispensed from 2012, considering both the number and dosing of opioids prescribed. By 2019, we aim to:

- Achieve a 35-percent reduction in opioid use.
- Double the number of members who receive behavioral health services as part of medication assisted therapy for opioid addiction. This helps ensure members have access to comprehensive, evidence-based care.

By setting these goals, we reconfirm our commitment to reducing the impact of this epidemic through prevention, treatment and deterrence.

If you have questions or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

** Rudd RA, Seth P, David F, Scholl L. Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015. MMWR Morb Mortal Wkly Rep 2016; 65:14451452.*

MD-NL-0070-17

Important notice for Amerigroup Community Care providers regarding Fresenius dialysis facilities

Fresenius dialysis facilities will no longer be participating Amerigroup providers as of September 1, 2017.

Amerigroup members receiving care at a Fresenius dialysis facility will be notified of this network change. Although Fresenius is no longer a part of the Amerigroup provider network, Amerigroup members may still choose to receive care at the Fresenius locations as a part of their Medicaid benefit package for self-referral services. Members can also choose a different dialysis provider from whom to receive services. Providers are asked to support members' choice of care to participating dialysis facilities. Continuation of care will be provided in accordance with state requirements.

All participating dialysis facility information may be found in the online directory. Visit http://amerigroup.prismisp.com or contact Provider Services at 1-800-454-3730 for more information. Amerigroup case managers are available to assist with the transition.

What if I need assistance?

If you have questions or know of members who need assistance during this transition, please call Provider Services or an Amerigroup case manager at 1-800-600-4441. We will be happy to help. Thank you for the care you provide to our members!

MDPEC-1311-17

Policy Update
Multiple Delivery Services
(Policy 06-044, effective 03/01/2018)

Amerigroup Community Care allows reimbursement for multiple births by a same-delivery or combined-delivery method. Professional reimbursement is based on multiple procedure guidelines for the following:

- Vaginal or cesarean deliveries involved in multiple births
- Multiple deliveries performed using a same-delivery or combined-delivery method

Vaginal and cesarean deliveries involved in multiple births should be billed with Modifier 51. Please see Multiple and Bilateral Surgery Reimbursement Policy for more information.

For market-specific information, refer to Multiple Delivery Services Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

MD-NL-0044-17

Policy Update
Modifier 62: Co-Surgeons
(Policy 06-027, effective 12/15/2017)

Amerigroup Community Care allows reimbursement of procedures eligible for co-surgeons when billed with Modifier 62. Each surgeon must bill the same procedure code(s) with Modifier 62. Reimbursement to each surgeon is based on 62.5 percent of the applicable fee schedule or contracted/negotiated rate. Co-surgeons must be from different specialties and performing surgical services during the same operative session.

For more information, please refer to Modifier 62: Co-Surgeons Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

MD-NL-0035-17

Policy Reminder
Global Surgical Package for Professional Providers
(Policy 06-041)

Amerigroup would like to remind providers that included in the global surgical package are visits occurring during the postoperative period that are related to recovery from the surgery regardless of the location. The Global Surgical Package for Professional Providers reimbursement policy includes additional information on what is included in the global surgical package and what is separately reimbursable. For additional information, please refer to the reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

MD-NL-0062-17