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COVID-19 information from Amerigroup Community Care of New Mexico, 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) to help us determine what action is necessary on our part.

For additional information, reference the COVID-19 News and Resources section on the homepage of our website.

AGPCARE-0423-20

MCG Care Guidelines — 24th edition

Effective August 1, 2020, Amerigroup Community Care of New Mexico, Inc. will upgrade to the 24th edition of MCG Care Guidelines for the following modules: Inpatient & Surgical Care (ISC), General Recovery Care (GRC), Chronic Care (CC), Recovery Facility Care (RFC), and Behavioral Health Care (BHC). The tables highlight new guidelines and changes that may be considered more restrictive.

AGPCRNL-0102-20

Medical drug Clinical Criteria updates

February 2020 update

On November 15, 2019, and February 21, 2020, the Pharmacy and Therapeutics (P&T) Committee approved Clinical Criteria applicable to the medical drug benefit for Amerigroup Community Care of New Mexico, Inc. These policies were developed, revised or reviewed to support clinical coding edits.

Effective dates are reflected in the Clinical Criteria web posting.

AGPCRNL-0109-20

The Clinical Criteria is publicly available on our provider website. Visit Clinical Criteria to search for specific policies.

Please submit your questions to email.
2020 Medicare risk adjustment provider trainings

The Medicare Risk Adjustment Regulatory Compliance team at Amerigroup Community Care of New Mexico, Inc. offers two provider training programs regarding Medicare risk adjustment and documentation guidelines. Information for each training is outlined below.

**Medicare Risk Adjustment and Documentation Guidance (General)**
- **When:** Offered the first Wednesday of each month from 1 p.m. to 2 p.m. ET
- **Learning objective:** This onboarding training will provide an overview of Medicare Risk Adjustment, including the Risk Adjustment Factor and the Hierarchical Condition Category (HCC) Model, with guidance on medical record documentation and coding.
- **Credits:** This live activity, Medicare Risk Adjustment and Documentation Guidance, from January 8, 2020, to December 2, 2020, has been reviewed and is acceptable for up to one prescribed credit(s) by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

For those interested in joining us to learn how providers play a critical role in facilitating the risk adjustment process, register for one of the monthly training sessions at https://bit.ly/2z4A81e.

*Note: Dates may be modified due to holiday scheduling.*

**Medicare Risk Adjustment, Documentation and Coding Guidance (Condition Specific)**
- **When:** Offered on the third Wednesday of every other month at noon to 1 p.m. ET
- **Learning objective:** This is a collaborative learning event with Enhanced Personal Health Care (EPHC) to provide in-depth disease information pertaining to specific conditions, including an overview of their corresponding hierarchical condition categories (HCC), with guidance on documentation and coding.
- **Credits:** This live series activity, Medicare Risk Adjustment Documentation and Coding Guidance, from January 15, 2020, to November 18, 2020, has been reviewed and is acceptable for credit by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

For those interested in joining us for this six-part training series, please see the list of topics and scheduled training dates below:
- **Red Flag HCCs, part one:** Training will cover HCCs most commonly reported in error as identified by CMS (chronic kidney disease stage 5, ischemic or unspecified stroke, cerebral hemorrhage, aspiration and specified bacterial pneumonias, unstable angina and other acute ischemic heart disease, end-stage liver disease) *(Recording will play upon registration.)*
- **Red Flag HCCs, part two:** Training will cover HCCs most commonly reported in error as identified by CMS (atherosclerosis of the extremities with ulceration or gangrene, myasthenia gravis/myoneural disorders and Guillain-Barre syndrome, drug/alcohol psychosis, lung and other severe cancers, diabetes with ophthalmologic or unspecified manifestation) *(Recording will play upon registration.)*
  https://bit.ly/3abKg52
- **Neoplasms** *(Recording link will be available later 2020.)*
- **Acute, Chronic and Status Conditions** *(July 15, 2020)*
- **Diabetes Mellitus and Other Metabolic Disorders** *(September 16, 2020)*
- **TBD — This Medicare Risk Adjustment webinar will cover the critical topics and updates that surface during the year** *(November 18, 2020)*

AGPCRNL-0106-20
Modifier use reminders

Billing for patient treatment can be complex, particularly when determining whether modifiers are required for proper payment. Amerigroup Community Care of New Mexico, Inc. reimbursement policies and correct coding guidelines explain the appropriate use of coding modifiers. We would like to highlight the appropriate use of some commonly used modifiers.

**Things to remember**

- Review the CPT® Surgical Package Definition found in the current year’s CPT Professional Edition. Use modifiers such as 25 and 59 only when the services are not included in the surgical package.
- Review the current CPT Professional Edition Appendix A — Modifiers for the appropriate use of modifiers 25, 57 and 59.
- When an evaluation and management (E&M) code is reported on the same date of service as a procedure, the use of the modifier 25 should be limited to situations where the E&M service is “above and beyond” or “separate and significant” from any procedures performed the same day.
- When appropriate, assign anatomical modifiers (Level II HCPCS modifiers) to identify different areas of the body that were treated. Proper application of the anatomical modifiers helps ensure the highest level of specificity on the claim and show that different anatomic sites received treatment.
- Use modifier 59 to indicate that a procedure or service was distinct or independent of other non-E&M services performed on the same date of service. The modifier 59 represents services not normally performed together, but which may be reported together under the circumstances.

If you feel that you have received a denial after appropriately applying a modifier under correct coding guidelines, please follow the normal claims dispute process and include medical records that support the use of the modifier(s) when submitting claims for consideration.

Amerigroup will publish additional articles on correct coding in provider communications.

AGPCRNL-0097-20
Amerigroup Community Care of New Mexico, Inc. working with Optum to collect medical records for risk adjustment

Risk adjustment is the process by which the Centers for Medicare & Medicaid Services (CMS) reimburses Medicare Advantage plans, based on the health status of their members. Risk adjustment was implemented to pay Medicare Advantage plans more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (age and gender) as well as health status.

In 2020, Amerigroup will work with Optum,* who is working with Ciox Health,* to request medical records with dates of service for the target year 2019 through present day.

Jaime Marcotte, Medicare Retrospective Risk Program Lead, is managing this project. If you have any questions regarding this program, please contact Jaime at jaime.marcotte@anthem.com or 1-843-666-1970.

Additional information, including an FAQ, will be available by visiting the provider website, selecting your state and going to the News & Announcements section.

* Optum and Ciox Health are independent companies providing medical record review services on behalf of Amerigroup Community Care of New Mexico, Inc.

Updates to AIM Sleep Disorder Management Clinical Appropriateness Guideline

Effective for dates of service on and after August 16, 2020, the following updates will apply to the AIM Specialty Health®* (AIM) Sleep Disorder Management Clinical Appropriateness Guideline.

Sleep Disorder Management Clinical Appropriateness Guideline updates by section:

- Bi-Level Positive Airway Pressure (BPAP) Devices:
  - Change in BPAP FiO2 from 45 to 52 mmHg based on strong evidence and alignment with Medicare requirements for use of BPAP
- Multiple Sleep Latency Testing and/or Maintenance of Wakefulness Testing:
  - Style change for clarity
  - Code changes: none

As a reminder, ordering and servicing providers may submit prior authorization (PA) requests to AIM by:

- Accessing AIM’s ProviderPortal™ directly at providerportal.com. Online access is available 24/7 to process orders in real time, and is the fastest and most convenient way to request PA.
- Accessing AIM via the Availity Portal.*
- Calling the AIM Contact Center at 1-800-714-0040 from 7 a.m. to 7 p.m. ET.

What if I need assistance?

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

* AIM Specialty Health is an independent company providing some utilization review services on behalf of Amerigroup Community Care of New Mexico, Inc. Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup Community Care of New Mexico, Inc.
Medical Policies and Clinical Utilization Management Guidelines update

The Medical Policies, Clinical Utilization Management (UM) Guidelines and Third-Party Criteria below were developed and/or revised to support clinical coding edits. Note, several policies and guidelines were revised to provide clarification only and are not included. Existing precertification requirements have not changed.

To view a guideline, visit https://medicalpolicies.amerigroup.com/am_search.html.

Medical Policies

On February 20, 2020, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following Medical Policies applicable to Amerigroup Community Care of New Mexico, Inc.

<table>
<thead>
<tr>
<th>Publish Date</th>
<th>Medical Policy #</th>
<th>Medical Policy Title</th>
<th>New or Revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/27/2020</td>
<td>GENE.00011</td>
<td>Gene Expression Profiling for Managing Breast Cancer Treatment</td>
<td>Revised</td>
</tr>
<tr>
<td>2/27/2020</td>
<td>SURG.00103</td>
<td>Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)</td>
<td>Revised</td>
</tr>
</tbody>
</table>

AGPCRNL-0108-20

Prior authorization requirements

Effective June 1, 2020, prior authorization (PA) requirements will change for several services to be covered for Amerigroup Community Care of New Mexico, Inc. members.

Read more online.

AGPCRNL-0100-20

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. Noncompliance with new requirements may result in denied claims.

To request PA:

Web: https://www.availity.com

Not all PA requirements are listed here. PA requirements are available to contracted providers by accessing the Provider Self-Service Tool at Availity* at https://providers.amerigroup.com > Login. Call the Provider Services number on the back of the member’s ID card for PA requirements.

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