Provider NewsBlast

Amerigroup
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https://providers.amerigroup.com/TN

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Medicaid:

Amerigroup Community Care expands work with AIM Specialty Health for outpatient genetic testing services authorizations

Effective February 1, 2019 AIM Specialty Health® (AIM) will provide health services review for prior authorization of genetic testing services.

If precertification is required, services will be provided through AIM Specialty Health. The clinical criteria used to review these service requests will not change with the transition of processing of prior authorizations for genetic testing to AIM. Clinical criteria used to determine medical necessity of these services can be found on our provider website.

You can also visit our provider website to determine if a specific code requires prior authorization: https://providers.amerigroup.com/TN > Quick Tools > Precertification Lookup Tool. The Precertification Lookup Tool allows you to search by CPT code, HCPCS code or code description.

For information on how to request prior authorization for genetic testing services, please read the following:

- The ordering provider is responsible for obtaining a health services review authorization. To obtain this authorization, you can access AIM at https://providerportal.com or https://www.availity.com. You can also can contact AIM toll free at 1-800-714-0040, Monday-Friday, 7 a.m. to 7 p.m. Central time.
    - The AIM ***Provider****Portal*℠ is the fastest, easiest way to contact AIM. An online application, ***Provider****Portal* offers a convenient way to enter your order requests or check on the status of your previous orders. Go to https://providerportal.com to begin; registration is required.
- Fax requests will not be accepted for the services reviewed by AIM.
- Providers should verify that the necessary prior authorization has been obtained in advance of rendering the service. Failure to do so may result in nonpayment of your claim.
- Services performed as part of urgent/emergent care do not require prior authorization. Services provided as part of a planned inpatient admission may require prior authorization; however, they are not handled by AIM.

While prior authorization procedures for genetic testing services have changed as noted above, certain core services and capabilities, while subject to change independent of AIM's role in genetic testing prior authorization, remain unchanged at this time. These include:

- Claims processing.
- Clinical and coverage guidelines.
- The network of providers offering these services to our members.

Please note that adhering to these new policies and procedures is required to ensure appropriate payment of claims. Should you have questions, please contact your local Provider Relations representative or Provider Services at 1-800-454-3730.

TN-NB-0066-18-A

Electronic data interchange gateway update

Amerigroup Community Care has designated Availity as a **no-cost option** to operate and service your electronic data interchange (EDI) entry point (or EDI gateway). This designation will ensure greater consistency and efficiency in EDI submission.

Who is Availity?
Availity is well known as a web portal and claims clearinghouse, but they are much more. Availity also functions as an EDI gateway for multiple payers and serves as the single EDI connection.

Your organization can submit and receive the following transactions through Availity's EDI gateway:

- 837 — institutional claims
- 837 — professional claims
- 837 — dental claims
- 835 — electronic remittance advice (ERA)
- 276/277 — claim status
- 270/271 — eligibility request

Get started with Availity:

- If you wish to submit directly to Availity, setup is easy. Go to the Availity Welcome Application and begin the process of connecting to the Availity EDI Gateway for your EDI transmissions.
- If you wish to use another clearinghouse or billing company, please work with them to ensure connectivity.

Need assistance?
The *Availity Quick Start Guide* will assist you with any EDI connection questions.
Availity payer IDs
You can access the *Availity Payer List* here.

Electronic funds transfer (EFT) registration
To register or manage account changes for EFT only, use the EnrollHub™, a CAQH Solutions™ enrollment tool, a secure electronic EFT registration platform. This tool eliminates the need for paper registration, reduces administrative time and costs, and allows you to register with multiple payers at one time.

If you were previously registered to receive EFT only, you must register using EnrollHub to manage account changes. No other action is needed.

ERA registration
Use Availity to register and manage account changes for ERA. If you were previously registered to receive ERA, you must register using Availity to manage account changes.

Manage your paper remittance vouchers suppression (turn off) here.

Contacting Availity
If you have any questions, call Availity Client Services at 1-800-AVAILITY (1-800-282-4548) Monday-Friday from 8 a.m.-7:30 p.m. Eastern time.

TN-NB-0093-18

Pharmacy management information

Need up-to-date pharmacy information?
Log in to our provider website to access our *Formulary Prior Authorization* forms, *Preferred Drug List* and process information.

Have questions about the *Formulary* or need a paper copy?
Call our Provider Services department at 1-800-454-3730.

Our Member Services representatives serve as advocates for our members. To reach Member Services, please call 1-800-600-4411 (TTY).

TN-NB-0089-18

Practitioners' rights during credentialing process

The credentialing process must be complete before a practitioner begins seeing members and enters into a contractual relationship with a health care insurer. As part of our credentialing process, practitioners have certain rights as briefly outlined below.

Practitioners can request to:

- Review information submitted to support their credentialing application.
- Correct erroneous information regarding a credentialing application.
- Be notified of the status of credentialing or recredentialing applications.

The Council for Affordable Quality Healthcare (CAQH®) universal credentialing process is used for individual providers who contract with Amerigroup Community Care. To apply for credentialing with Amerigroup, go to the CAQH website and select **CAQH ProView™**. There is no application fee.

We encourage practitioners to begin the credentialing process as soon as possible when new physicians join a practice. Doing so will help minimize any disruptions to the practice and members' claims.

CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

TN-NB-0089-18

Implementation of the new *Amerigroup Community Care Ambulatory Surgery Center Proprietary Reimbursement Methodology*

Effective January 1, 2019, Amerigroup will fully implement a new *Amerigroup Ambulatory Surgery Center (ASC) Reimbursement Methodology*. The new *ASC Reimbursement Methodology* will include a fixed *CMS ASC* payment rate based on CMS CY18, which is equivalent to the *CMS ASC* October 2018 payment rate.

Why is this change necessary?
Currently, Amerigroup uses a floating fee schedule tied to CMS, which requires change to ensure full compliance with the *Division of TennCare (TennCare) Contractor Risk Agreement (CRA)*. *Section 2.13.2.2 of t*he *TennCare CRA* prohibits TennCare managed care organizations from reimbursing providers based on automatic escalators or linkages to other methodologies that escalate, (such as current Medicare rates or inflation indexes) unless otherwise allowed by TennCare.

The new *Amerigroup ASC Reimbursement Methodology* is compliant with the *TennCare CRA***.**

Providers can review the *CRA* in its entirety by visiting the TennCare website.

Participating facility providers will receive an *Amendment by Notification* as applicable along with a cover letter setting out additional information regarding the new *Facility Reimbursement Methodology* within the next 60 days. Section 8.1 of the provider agreement permits amendment for this purpose.

Additional information

How will this impact the way I am currently being paid?
This change will not cause any material change in your reimbursement.

How will this impact the way I submit claims?
There will be no impact or change in the way you submit claims

TN-NB-0102-18

Appointment availability and after-hours access requirements

To ensure members receive care in a timely manner, PCPs, specialty providers and behavioral health providers must maintain the following appointment availability standards:

Requirements for PCPs and specialists	
Appointment type	Appointment standard
Emergency visits — all provider types	Immediately
Urgent visits — all provider types	Within 48 hours
Routine or preventive visits — PCPs	Within three weeks
Routine visits — specialists	Within 30 days of referral
Optometry visits, regular visits	Within three weeks

Wait time	Should not exceed 45 minutes for scheduled appointment
OB/prenatal care	Within three weeks
Requirements for behavioral health providers	
Outpatient (non-MD services)	Within 10 business days; urgent within 48 hours
Intensive outpatient services	Within 10 business days; urgent within 48 hours
Substance abuse, outpatient services	Within 10 business days; for detoxification: within 24 hours
Intensive community based treatment services	Within seven calendar days
Crisis services (mobile)	Face-to-face contact within one hour for emergencies; within four hours for urgent
Crisis stabilization	Within four hours of referral

After-hours access requirements for PCPs:

To ensure continuous 24-hour coverage, PCPs must maintain one of the following arrangements for their members to make contact after normal business hours:

- Have the office telephone answered after hours by an answering service that can contact the PCP or another designated network medical practitioner. All calls answered by an answering service must be returned within 60 minutes.
- Have the office telephone answered after normal business hours by a recording in the language of each of the major population groups served by the PCP to direct the member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable.
- Have the office telephone transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or a designated Amerigroup Community Care network medical practitioner who can return the call within 60 minutes.
- Have an automated answering machine that directs the member to the practitioner or appropriate covering practitioner.

The following telephone answering procedures are **not** acceptable:

- Office telephone that is only answered during office hours.
- Office telephone that is answered after hours by a recording that directs members to go to an emergency room for any services needed.
- After-hours calls that are answered outside of 60 minutes.

TN-NB-0097-18

Medical Policies and *Clinical Utilization Management Guidelines* update

The *Medical Policies* and *Clinical Utilization Management (UM) Guidelines* below were developed 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. For markets with carved-out pharmacy services, the applicable listings below are informational only.

Note:

- Effective November 1, 2018, AIM Specialty Health® (AIM) *Musculoskeletal Level of Care Guidelines*, *Sleep Study Guidelines* and *Radiology Guidelines* will be used for clinical reviews.
- When requesting services for a patient (including medical procedures and medications), the Precertification Look-Up Tool may indicate that precertification is not required, but this does not guarantee payment for services rendered; a *Medical Policy* or *Clinical UM Guideline* may deem the service investigational or not medically necessary. In order to determine if services will qualify for payment, please ensure applicable clinical criteria is reviewed prior to rendering services.

Please share this notice with other members of your practice and office staff.

To search for specific policies or guidelines, visit https://medicalpolicies.amerigroup.com/search.

Medical Policies

On July 26, 2018, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Medical Policies* applicable to Amerigroup Community Care.

Publish date	***Medical Policy* #**	***Medical Policy* title**	**New or revised**
8/29/2018	DRUG.00096	Ibalizumab-uiyk (Trogarzo™)	New
8/29/2018	GENE.00049	Circulating Tumor DNA Testing for Cancer (Liquid Biopsy)	New
8/29/2018	ADMIN.00007	Immunizations	Revised
8/29/2018	DRUG.00046	Ipilimumab (Yervoy®)	Revised
8/29/2018	DRUG.00050	Eculizumab (Soliris®)	Revised
8/2/2018	DRUG.00067	Ramucirumab (Cyramza®)	Revised
8/2/2018	DRUG.00071	Pembrolizumab (Keytruda®)	Revised
8/29/2018	DRUG.00075	Nivolumab (Opdivo®)	Revised
8/29/2018	DRUG.00088	Atezolizumab (Tecentriq®)	Revised
8/29/2018	DRUG.00098	Lutetium Lu 177 dotatate (Lutathera®)	Revised
8/29/2018	GENE.00006	Epidermal Growth Factor Receptor (EGFR) Testing	Revised
8/2/2018	GENE.00011	Gene Expression Profiling for Managing Breast Cancer Treatment	Revised
8/29/2018	GENE.00025	Molecular Profiling and Proteogenomic Testing for the Evaluation of Malignant Tumors	Revised
8/29/2018	GENE.00029	Genetic Testing for Breast and/or Ovarian Cancer Syndrome	Revised
8/2/2018	MED.00124	Tisagenlecleucel (Kymriah®)	Revised
8/2/2018	SURG.00023	Breast Procedures including Reconstructive Surgery, Implants and Other Breast Procedures	Revised
8/2/2018	SURG.00032	Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention	Revised

Clinical UM Guidelines

On July 26, 2018, the MPTAC approved the following *Clinical UM Guidelines* applicable to Amerigroup. This list represents the guidelines adopted by the medical operations committee for the Government Business Division on August 31, 2018.

Publish date	***Clinical UM Guideline* #**	***Clinical UM Guideline* title**	**New or Revised**
9/20/2018	CG-DME-45	Ultrasound Bone Growth Stimulation	New
9/20/2018	CG-DRUG-103	Botulinum Toxin	New
9/20/2018	CG-DRUG-104	Omalizumab (Xolair®)	New
9/20/2018	CG-DRUG-105	Abatacept (Orencia®)	New
9/20/2018	CG-DRUG-106	Brentuximab Vedotin (Adcetris®)	New
9/20/2018	CG-DRUG-107	Pharmacotherapy for Hereditary Angioedema	New
9/20/2018	CG-DRUG-108	Enteral Carbidopa and Levodopa Intestinal Gel Suspension	New
9/20/2018	CG-DRUG-109	Asfotase Alfa (Strensiq™)	New
9/20/2018	CG-DRUG-110	Naltrexone Implantable Pellets	New
9/20/2018	CG-DRUG-111	Sebelipase alfa (KANUMA™)	New
9/20/2018	CG-DRUG-112	Abaloparatide (Tymlos™) Injection	New
9/20/2018	CG-MED-73	Hyperbaric Oxygen Therapy (Systemic/Topical)	New
9/20/2018	CG-MED-74	Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry	New
9/20/2018	CG-MED-75	Medical and Other Non-Behavioral Health-Related Treatments for Autism Spectrum Disorders and Rett Syndrome	New
9/20/2018	CG-MED-76	Magnetic Source Imaging and Magnetoencephalography	New
9/20/2018	CG-MED-77	SPECT/CT Fusion Imaging	New
9/20/2018	CG-REHAB-11	Cognitive Rehabilitation	New
9/20/2018	CG-SURG-81	Cochlear Implants and Auditory Brainstem Implants	New
9/20/2018	CG-SURG-82	Bone-Anchored and Bone Conduction Hearing Aids	New
10/31/2018	CG-SURG-83	Bariatric Surgery and Other Treatments for Clinically Severe Obesity	New
9/20/2018	CG-SURG-84	Mandibular/Maxillary (Orthognathic) Surgery	New
10/31/2018	CG-SURG-85	Hip Resurfacing	New
10/31/2018	CG-SURG-86	Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection	New
9/20/2018	CG-SURG-87	Nasal Surgery for the Treatment of Obstructive Sleep Apnea and Snoring Previous title: Nasal Surgery for the Treatment of Obstructive Sleep Apnea and Snoring	New
9/20/2018	CG-SURG-88	Mastectomy for Gynecomastia	New
9/20/2018	CG-SURG-89	Radiofrequency Neurolysis and Pulsed Radiofrequency Therapy for Trigeminal Neuralgia	New
8/29/2018	CG-ADMIN-02	Clinically Equivalent Cost Effective Services — Targeted Immune Modulators	Revised
8/29/2018	CG-DRUG-09	Immune Globulin (Ig) Therapy	Revised
8/29/2018	CG-DRUG-65	Tumor Necrosis Factor Antagonists	Revised
8/29/2018	CG-DRUG-68	Bevacizumab (Avastin®) for Non-Ophthalmologic Indications	Revised
8/29/2018	CG-DRUG-73	Denosumab (Prolia®, Xgeva®)	Revised
8/29/2018	CG-DRUG-81	Tocilizumab (Actemra®)	Revised
8/29/2018	CG-GENE-03	BRAF Mutation Analysis	Revised
8/29/2018	CG-MED-35	Retinal Telescreening Systems	Revised

Publish date	*Clinical UM Guideline* #	*Clinical UM Guideline* title	New or Revised
8/29/2018	CG-MED-71	Wound Care in the Home Setting	Revised
8/2/2018	CG-SURG-24	Functional Endoscopic Sinus Surgery (FESS)	Revised
8/29/2018	CG-SURG-49	Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities	Revised
8/2/2018	CG-SURG-73	Balloon Sinus Ostial Dilation	Revised

TNPEC-2518-18

Referral Directory update

Effective January 1, 2019, Amerigroup will no longer mail referral directories. Referral directories are available online at www.myamerigroup.com/TN/Care/Find-a-doctor.html. You can call for a printed copy at 1-800-600-4441.
TN-NB-0110-18

Introducing the *New Amerigroup Professional Provider Market Master Fee Schedule*

Background: Effective January 1, 2019, Amerigroup Community Care will implement a new fee schedule. The new Amerigroup Professional Provider Market Master Fee Schedule will be frozen at current levels and will no longer be tied to CMS inflation indexes.

Why is this change necessary?
Amerigroup currently has a floating fee schedule tied to CMS that requires change to ensure full compliance with the Division of TennCare (TennCare) Contractor Risk Agreement (CRA), which prohibits the TennCare MCOs from reimbursing providers based on automatic escalators or linkages to other methodologies that escalate, such as current Medicare rates or inflation indexes, unless otherwise allowed by TennCare. The new Amerigroup Professional Provider Market Master Fee Schedule fee schedule is compliant with the (TennCare) CRA.

Providers can access and read the *CRA* in its entirety by visiting the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf.

Participating professional providers will receive an *Amendment by Notification* along with a cover letter setting out additional information about the new Amerigroup Professional Provider Market Master Fee Schedule within the next 30 days. Section 8.1 of the Amerigroup *Provider Agreement* permits *Amendment by Notification* for this purpose. In order to comply with Federal and State regulatory requirements, and in certain circumstances, those regulatory mandates may require Amerigroup to make changes to confidential portions of your *Provider Agreement*.

How does this affect Behavioral Health Providers?
Only those rates and services tied to CMS will be moved to the new Amerigroup Professional Provider Market Master Fee Schedule. All fixed pricing, case rates and per-diems will remain the same.

How will this impact the way I am currently being paid?
This change will not cause any material change in a provider's reimbursement.

How will this impact the way I submit claims?
There will be no impact or change in the way providers submit claims.

What if I need assistance?
If you have additional questions, or to obtain a copy of the *new Amerigroup Professional Provider Market Master Fee Schedule*, please contact your local Provider Relations representative at 615-232-2160 or call Provider Services at 1-800-454-3730, or to receive a copy via email, please send request toTNproviderfeeschedulerequests@amerigroup.com.
Note, due to the size of the fee schedule document, you will not receive a copy by mail with the Amendment by Notification.

TNPEC-2466-18-G

Online registration processes for electronic remittance advices and electronic funds transfers

No action is required for providers already registered for electronic funds transfers (EFTs) and electronic remittance advices (ERAs). The information in this communication is applicable to both Medicaid and Medicare programs.

Effective September 1, 2018, our provider disbursement processes have changed. These changes include the following:

- New EFT enrollment: Go to EnrollHub™, a Council for Affordable Quality Healthcare (CAQH) Solutions™ enrollment tool.
- New ERA-only enrollment and change management for existing ERA-only enrollments: These will be managed through Availity. Go to https://www.availity.com and select **Enrollments Center** in the *My Account Dashboard* on the home page. Select **ERA Enrollment** in the *Multi-Payer Enrollments* section. Then, simply follow the wizard and submit. After submitting, you will be notified by email that enrollment is complete and start receiving *835s* through Availity.
- Change Healthcare and PaySpan will no longer be used for EFT/ERA enrollment.
- Providers now have access to *Explanation of Payment* letters through our secure self-service provider website.
- Medicaid and Medicare remittance advices have been consolidated.

These enhancements offer providers streamlined reimbursement registration tools.

The following chart summarizes information about the new processes to enroll in EFT or ERA or to update EFT and ERA transaction information after September 1, 2018.

Process to enroll or update electronic transactions after September 1, 2018		
Type of transaction	**How to enroll, update, change or cancel**	**Contact to resolve issues**
EFT only	Use the CAQH EFT EnrollHub tool available at http://www.caqh.org/solutions/enrollhub.	CAQH Provider Help Desk 1-844-815-9763
ERA only	Register for ERAs at https://www.availity.com.	Availity 1-800-282-4548

Is registration required?
Providers are not obligated to register for either EFT or ERA and will continue to receive a paper check and remittance advice.

Is there a cost to providers for the changes to the EFT and ERA?
There is no cost to providers from Amerigroup Community Care. Providers should inquire with trading partners and other vendors they work with to understand additional steps or any changes to services.

Information and changes to expect
Medicaid and Medicare claim payments and recoveries with claim adjudication beginning Date, will be incorporated into one remittance advice for paper or electronic payments. Checks and EFTs from Amerigroup will also be combined. Medicaid and Medicare will be grouped separately on the paper remittance in a section for each product line:

- The back of the remittance advice will contain specific instructions on how to file Medicare appeals.
- Medicaid and Medicare claims are identified in the Claim Filing Indicator Code (CLP06 segment) on the *ERA/835* for Medicaid with **MC** and Medicare with **MB**, **MA** or **16**
- Effective September 1, 2018, we will discontinue the email notification providers currently receive when an EFT and ERA is issued.
- The PDF versions of paper remittances are available on the provider self-service website. Both provider and clearinghouse *835s* continue to be received through the EDI process.
- More information about retrieving copies of remittance advices is available online. To access our tutorial, *Remittance Inquiry Process Guide*, go to our provider website and select the **Tutorials** drop-down menu under *Provider Documents & Resources*.
- Starting in 2018, more claim payments and remittance advices issued by Amerigroup will be made on a **weekly basis** to providers. Additionally, non-Federal Employee Program payments under $5 will be held for a maximum of 14 days to allow additional claims to combine to increase the overall payment amount.
- This change will ensure efficiency and consistency between professional and facility claim payments.
- If you are a provider who receives paper claim checks or EFT payments from Amerigroup on a daily basis, you will be able to schedule posting on a weekly cycle after this change.

- The Automated Clearing House batch header is changing. The payee name that appears on the EFT statement is changing and will be easily identifiable. This change does not impact payment to you in any way. You will now see **Amerigroup TN5C**.

How do I access historical ERAs from Change Healthcare and PaySpan?
We are in the process of migrating all historical remittance advices to our self-service provider website. We will notify you when the migration is complete. Please continue to use Change Healthcare and PaySpan until that time.

TN-NB-0029-18

Amerivantage:

Electronic data interchange gateway update

Please view the full article included in the Medicaid section.

Providers who have questions as they begin to use the new functionality should contact Amerigroup at 1-866-805-4589.

TN-NB-0093-18

Reimbursement Policy:

Policy Update
Claims Requiring Additional Documentation
(Policy 06-031, effective 03/01/19)

Professional providers and facilities are required to submit additional documentation for adjudication of applicable types of claims. If the required documentation is not submitted, the claim may be denied. Amerigroup Community Care may request additional documentation or notify the provider or facility of additional documentation required for claims, subject to contractual obligations.

Effective March 1, 2019, if an itemized bill is requested and/or required, then it must include the appropriate revenue code for each individual charge.

For additional information, please review the Claims Requiring Additional Documentation reimbursement policy at https://providers.amerigroup.com/TN > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

TN-NB-0014-18