Provider Newsblast

https://providers.amerigroup.com/TN

December 2017

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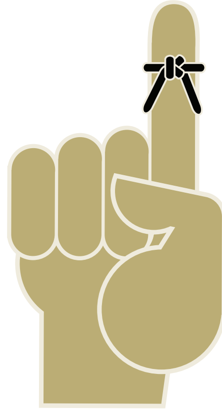
Amerigroup Community Care complies with all applicable federal and state civil rights laws, rules and regulations and does not discriminate against members/participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability. To report a discrimination complaint or to request language, communication or disability assistance for a member/participant, call 1-800-600-4441. Information about civil rights laws can be found on our website and is available from the U.S. Department of Health and Human Services.

December 2017
Revised: December 21, 2017

TN-NL-0136-17

Provider subcontractor requirement



Contracted providers with Amerigroup Community Care may not subcontract any portion or part of covered services to other vendors, providers or nonemployed personnel without the prior written consent of Amerigroup. Failure to request and obtain prior written approval from Amerigroup for a subcontract that is for the purposes of providing TennCare covered services may lead to the subcontract contract being declared null and void, and all claims related to such services being denied for payment at the option of Amerigroup or the Division of TennCare. In addition, claims submitted by the subcontractor or the provider for services furnished by the subcontractor may be considered improper payments and/or false claims. Any such improper payments may be subject to action under federal and state false claims statutes or be subject to recoupment by Amerigroup and/or the Division of TennCare as overpayment.

TN-NL-0129-17

Amerigroup Community Care to conduct postservice reviews of certain modifiers and services

Effective January 1, 2018, Amerigroup will conduct postservice reviews of professional claims billed with the following modifiers: 25, 62, 80, 81, 82, AS and 91. Additionally, Amerigroup will conduct postservice reviews of Evaluation and Management services billed during a global surgery period.

What is the impact of this change?

As part of the review, Amerigroup may contact providers to request additional documentation related to the services. If billing discrepancies are identified, Amerigroup will provide a written report of the findings to providers and initiate recoupments as appropriate. Findings may assist your office with quality improvement efforts.

What if I need assistance?

For more information about postservice reviews, contact Provider Services at 1-800-454-3730.

TN-NL-0125-17

Medical Policies and *Clinical Utilization Management Guidelines* update

Medical Policies update

On August 3, 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.

CG-DRUG-29 Hyaluronan Injections in the Knee will be implemented as investigational and not medically necessary on December 1, 2017. RAD.00035 will be archived effective September 15, 2017. CG-MED-58 will be effective September 15, 2017.

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
8/17/2017	DRUG.00111	Guselkumab (Tremfya™)	New
9/27/2017	LAB.00035	Multi-biomarker Disease Activity Blood Tests for Rheumatoid Arthritis	New
8/17/2017	DRUG.00040	Abatacept (Orencia®)	Revised
8/17/2017	DRUG.00058	Pharmacotherapy for Hereditary Angioedema	Revised
8/17/2017	DRUG.00071	Pembrolizumab (Keytruda®)	Revised
8/17/2017	DRUG.00082	Daratumumab (DARZALEX™)	Revised
8/17/2017	DRUG.00099	Cerliponase Alfa (Brineura™)	Revised
8/17/2017	DRUG.00107	Avelumab (Bavencio®)	Revised
8/17/2017	GENE.00011	Gene Expression Profiling for Managing Breast Cancer Treatment	Revised
8/17/2017	MED.00051	Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry	Revised
8/17/2017	MED.00081	Cognitive Rehabilitation	Revised
8/17/2017	RAD.00035	Coronary Artery Imaging: Contrast-Enhanced Coronary Computed Tomography Angiography (CCTA), Fractional Flow Reserve derived from Computed Tomography (FFRCT), Coronary Magnetic Resonance Angiography (MRA), and Cardiac Magnetic Resonance Imaging (MRI)	Revised
8/17/2017	RAD.00066	Multiparametric Magnetic Resonance Fusion Imaging Targeted Prostate Biopsy	Revised
8/17/2017	SURG.00055	Cervical Total Disc Arthroplasty	Revised
8/17/2017	SURG.00121	Transcatheter Heart Valve Procedures	Revised

Clinical Utilization Management Guidelines update

On August 3, 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 August 24, 2017.

On August 3, 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.

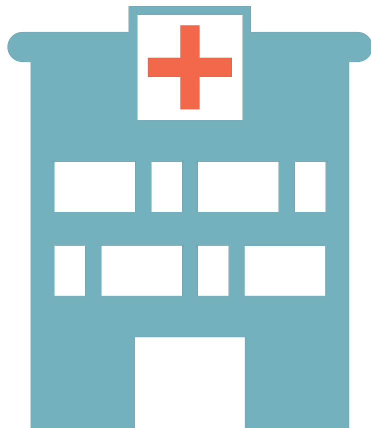
Effective date	Clinical UM Guideline number	Clinical UM Guideline title	New or revised
9/27/2017	CG-ADMIN-02	Clinically Equivalent Cost Effective Services – Targeted Immune Modulators	New
9/27/2017	CG-MED-57	Cardiac Stress Testing with Electrocardiogram (ECG)	New
8/17/2017	CG-ANC-06	Ambulance Services: Ground; Non Emergent	Revised
8/17/2017	CG-SURG-27	Sex Reassignment Surgery	Revised

TNPEC-1964-17

Include NPI on surgical procedure UB04 bills

In October 2017, Amerigroup Community Care will edit for operating provider NPI when a surgical procedure code is billed for members having an individual Medicare Advantage or MMP plan. A surgical procedure code is a code within the range of 10021-69990 but excluding 10035, 10036, 15780-15783, 15786-15789, 15792, 15793, 20527, 20550-20553, 20555, 20612, 20615, 29581-29584, 36406, 36410, 36415, 36416, 44705, 47531, 47532, 50430, 50431, 59425, 59426, 59430, 62302-62305, 62320-62327, 62367-62370, 69209, 69210. When a surgical procedure code is billed, the operating provider's NPI must be billed in box 77 on the facility *UB04 CMS 1450 Claim Form* for outpatient services. If a surgical procedure code is billed without an operating provider NPI, the claim will be denied for missing NPI.

SSO-NL-0030-17



Critical access hospitals (CAH) reimbursed at Medicare rate

Effective May 26, 2017, Amerigroup Community Care began using a rate database, sourced from CMS-published Medicare hospital cost reports, of CAH inpatient, swing bed and outpatient rates to price claims from non-contracted CAHs for individual Medicare Advantage and MMP members. Consequently, Amerigroup usually will not need a Medicare Administrative Contractor (MAC) rate letter to process claims from non-contracted CAHs for individual Medicare Advantage and MMP members. However, Amerigroup will require a MAC rate letter in the situations noted below. We look forward to handling your claims in a more timely manner with this process change.

Amerigroup still will require a MAC rate letter or additional information from CAHs in the following situations.

- Non-contracted CAHs must submit a MAC rate letter for claims for Medicare Advantage group-sponsored members.
- Contracted CAHs compensated using Medicare rates must continue to submit MAC rate letters to their Amerigroup network managers as required by contract.
- All CAHs should update Amerigroup regarding a change in status in Method (from I to II or II to I). Note that Method II reimbursement applies to contracted CAHs only if specified in contract.

SSO-NL-0032-17

Amerigroup Tennessee, Inc. is a D-SNP plan with a Medicare contract and a contract with the State Medicaid program. Enrollment in Amerigroup Tennessee, Inc. depends on contract renewal.

Complete *OptiNet*® assessments for out-of-state office locations; drop-down menu changed

Contracted providers with Amerigroup Community Care who render services to Medicare Advantage members in other state counties that are contiguous to their home state should complete the ***Opti**Net* registration. The ***Opti**Net* program has expanded to include these providers who render services in other state counties contiguous to their home state; these providers should register by January 1, 2018.

All participating providers who provide imaging services, including X-rays and ultrasounds as noted above, must complete the registration. Providers who do not register, who score less than 76 or who do not complete the survey will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only.

The provider registration is available online at www.providerportal.com. Please note that the drop-down menu selection for participating Medicare Advantage providers has changed. Select Medicare Advantage/Medicaid from the drop-down menu. This drop-down is changing from Amerigroup MA.

If you have questions or need help completing the registration, please call AIM Customer Service at 1-800-252-2021 Monday-Friday 8 a.m. to 7 p.m. ET or send an email to Assessment@AIMSpecialtyHealth.com.

If you have already completed an ***Opti**Net* assessment, please ensure that you keep your registration up to date. Expiring data could lead to a negative impact in your modality scores.

SSO-NL-0027-17

Liability assignment for eye refraction and self-administered drugs

Amerigroup Community Care would like to clarify liability assignment related to Statutorily Non-Covered Services of Eye Refraction (procedure code 92015) and Self-Administered Drug (procedure code A9270) when the service is denied on Medicare Advantage individual and group-sponsored claims.

For the liability assessment to be assigned appropriately, we require that the G modifier(s) be submitted on the claim form and the Notice of Denial of Medical Coverage letter be obtained prior to the service rendered.

When the Notice of Denial of Medical Coverage letter is obtained, please submit both the GX and GY modifier on the claim.

This billing process is different from traditional Medicare, which only requires a GY modifier be appended to the procedure code.

The Centers for Medicare & Medicaid Services considers providers contracted with Amerigroup for Medicare Advantage as plan "agents;" therefore, related CMS regulations must be followed. Due to this, a GY modifier only submitted on the claim form will not ensure the correct liability assignment for the denied service.

SSO-NL-0031-17

Help ensure Medicare Part D members receive a comprehensive medication review

The Centers for Medicare & Medicaid Services require that plans with Medicare Part D benefits offer a Comprehensive Medication Review (CMR) as part of the Medication Therapy Management (MTM) program. A CMR is offered to members who have three or more chronic diseases and who are receiving eight or more maintenance medications. Amerigroup Community Care employs SinfoniaRx to contact our qualifying individual and group-sponsored Medicare Part D members to complete the interactive consultation. The CMR consists of a consultation followed by a written medication summary to help educate and support provider recommendations for medication adherence. Please ask these members if they have received a letter or postcard inviting them to participate in a CMR.

SSO-NL-0028-17

Improve Medicare Advantage members' medication adherence with 90-day prescriptions

To help improve medication adherence among Medicare Advantage members, Amerigroup Community Care will fax providers prescribing a 30-day supply of oral diabetic medications, RAS antagonists and statins to promote the use of 90-day prescriptions. Ninety-day prescriptions help improve the adherence of our Medicare Advantage members by having them travel to their pharmacy less often. When medically appropriate, we request that you convert the member's prescription to a 90-day supply to improve patient adherence and outcomes without compromising the quality of care. Please note that we do not intend to transfer these prescriptions to a mail-order or specialty pharmacy. The member will obtain the 90-day supply medication at the same pharmacy where he or she previously obtained the 30-day supply prescription.

SSO-NL-0026-17

Amerigroup Communtiy Care to conduct postservice reviews of certain modifiers and services

Beginning in the fourth quarter of 2017, Amerigroup will conduct postservice reviews of professional claims billed with the following modifiers: 25, 62, 80, 81, 82, AS and 91. Additionally, Amerigroup will conduct postservice reviews of Evaluation and Management services billed during a global surgery period.

What is the impact of this change?

As part of the review, Amerigroup may contact providers to request additional documentation related to the services. If billing discrepancies are identified, Amerigroup will provide a written report of the findings to providers and initiate recoupments as appropriate. Findings may assist your office with quality improvement efforts.

SSO-NL-0024-17_NJ-NM-TN-TX-WA

Policy Update — Medicaid
Multiple Radiology Payment Reduction
(Policy 12-002, effective 03/15/18)

Amerigroup Community Care allows reimbursement for multiple diagnostic imaging procedures. Multiple diagnostic imaging procedures will be subject to a Multiple Procedure Payment Reduction when services are performed by the same provider with the same NPI on the same date of service during the same patient encounter.

The global, professional component and technical component of diagnostic imaging procedures will reimburse at 100 percent of the contracted/negotiated rate for each Professional Component and Technical Component service with the highest payment. Reimbursement of subsequent services is based on:

- 95 percent for the professional component of subsequent services furnished by the same provider to the same patient in the same session on the same day.
- 50 percent for the technical component of subsequent services furnished by the same provider to the same patient in the same session on the same day.

A reduced allowance for the second and subsequent procedures will not apply when multiple imaging procedures are billed appended with Modifier 59.

For additional information, please refer to the Multiple Radiology Payment Reduction reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

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