Provider NewsBlast

Amerigroup
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Medicaid:

Prior authorization requirement update for Mylotarg (gemtuzumab ozogamicin)

Effective July 1, 2018, prior authorization (PA) is required for Mylotarg (gemtuzumab ozogamicin) to be covered by Amerigroup Community Care through the medical benefit. 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:

- Mylotarg (gemtuzumab ozogamicin) — a humanized anti-CD33 monoclonal antibody for the treatment of acute myeloid leukemia and acute promyelocytic leukemia (J9203)

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

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

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers on the provider website (https://providers.amerigroup.com/TN > Quick Tools > Precertification Lookup Tool). Providers may also call Provider Services at 1-800-454-3730 for PA requirements.

TN-NB-0006-18

Electrical stimulation device to require prior authorization

Effective August 1, 2018, prior authorization (PA) is required for the electrical stimulation device. 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:

- E0766 — Electrical stimulation device used for cancer treatment, includes all accessories, any type

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

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

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers on the provider website (https://providers.amerigroup.com/TN > Quick Tools > Precertification Lookup Tool). Providers may also call Provider Services at 1-800-454-3730 for PA requirements.

TN-NB-0011-18

Medical Policies and *Clinical Utilization Management Guidelines* update

Medical Policies update

On November 28, 2017, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Medical Policies* which are applicable to Amerigroup Community Care. These *Medical 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 provider website on the publish date listed below. To search for specific policies, visit https://medicalpolicies.amerigroup.com/search. **Existing precertification requirements have not changed.**

On January 30, 2018, the clinical guidelines were made publicly available on the Amerigroup *Medical Policies* and *Clinical UM Guidelines* subsidiary website. To search for specific guidelines policies, visit https://medicalpolicies.amerigroup.com/search. **Existing precertification requirements have not changed.**

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

Publish date	*Medical Policy* number	*Medical Policy*	New/revised
12/27/2017	DRUG.00112	Gemtuzumab Ozogamicin (Mylotarg®)	New
12/27/2017	DRUG.00118	Copanlisib (Aliqopa®)	New
11/9/2017	MED.00123	Axicabtagene ciloleucel (Yescarta™)	New
11/9/2017	DME.00040	Automated Insulin Delivery Devices	Revised
12/27/2017	DRUG.00050	Eculizumab (Soliris®)	Revised
12/27/2017	DRUG.00071	Pembrolizumab (Keytruda®)	Revised
12/27/2017	DRUG.00075	Nivolumab (Opdivo®)	Revised
11/9/2017	DRUG.00081	Eteplirsen (Exondys 51™)	Revised
12/27/2017	DRUG.00109	Durvalumab (Imfinzi™)	Revised
12/27/2017	GENE.00011	Gene Expression Profiling for Managing Breast Cancer Treatment	Revised
11/9/2017	SURG.00089	Balloon and Self-Expanding Absorptive Sinus Ostial Dilation	Revised
12/27/2017	TRANS.00023	Hematopoietic Stem Cell Transplantation for Multiple Myeloma and Other Plasma Cell Dyscrasias	Revised
12/27/2017	TRANS.00024	Hematopoietic Stem Cell Transplantation for Select Leukemias and Myelodysplastic Syndrome	Revised
12/27/2017	TRANS.00027	Hematopoietic Stem Cell Transplantation for Pediatric Solid Tumors	Revised
12/27/2017	TRANS.00028	Hematopoietic Stem Cell Transplantation for Hodgkin Disease and Non-Hodgkin Lymphoma	Revised

Publish date	*Medical Policy* number	*Medical Policy*	New/revised
12/27/2017	TRANS.00029	Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias	Revised
12/27/2017	TRANS.00030	Hematopoietic Stem Cell Transplantation for Germ Cell Tumors	Revised

***Clinical Utilization Management Guidelines* update**

On November 28, 2017, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Clinical Utilization Management (UM) Guidelines* which are 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 below listing. The *Clinical UM Guidelines* on this list represent the *Clinical UM Guidelines* adopted by the Medical Operations Committee for the Government Business Division on January 30, 2018. To see the full utilization management guidelines on the website, visit https://medicalpolicies.amerigroup.com/search.

On January 30, 2018, the clinical guidelines were made publicly available on the Amerigroup *Medical Policies* and *Clinical UM Guidelines* subsidiary website. To search for specific guidelines policies, visit https://medicalpolicies.amerigroup.com/search. **Existing precertification requirements have not changed.**

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

Update to clinical guideline, CG-MED-39, Central (Hip or Spine) Bone Density Measurement and Screening for Vertebral Fractures Using Dual Energy X-Ray Absorptiometry (CG-MED 39), was published January 30, 2018.

Effective January 30, 2018, this clinical guideline will apply to Medicaid lines of business.

The clinical indication section specific to female screening of osteoporosis was revised to reflect that an initial (baseline) central (hip or spine) bone density measurement is considered medically necessary when conducted in postmenopausal individuals 65 years of age or older.

The guideline also identifies other clinical indications when initial and repeat central bone mineral density measurements are medically necessary.

For Tennessee, non-injectable drugs pharmacy is carved out.

Publish date	*Clinical UM Guideline* number	*Clinical UM Guideline* title	New/revised
12/27/2017	CG-DME-40	Electrical Bone Growth Stimulation	New
12/27/2017	CG-DME-41	Ultraviolet Light Therapy Delivery Devices for Home Use	New
12/27/2017	CG-DRUG-65	Tumor Necrosis Factor Antagonists	New
12/27/2017	CG-DRUG-66	Panitumumab (Vectibix®)	New
12/27/2017	CG-DRUG-68	Bevacizumab (Avastin®) for Non-Ophthalmologic Indications	New
12/27/2017	CG-DRUG-69	Ustekinumab (Stelara®)	New

Publish date	*Clinical UM Guideline* number	*Clinical UM Guideline* title	New/revised
12/27/2017	CG-DRUG-70	Eribulin mesylate (Halaven®)	New
12/27/2017	CG-DRUG-71	Ziv-aflibercept (Zaltrap®)	New
12/27/2017	CG-DRUG-72	Pertuzumab (Perjeta®)	New
12/27/2017	CG-DRUG-73	Denosumab (Prolia®, Xgeva®)	New
12/27/2017	CG-DRUG-74	Canakinumab (Ilaris®)	New
12/27/2017	CG-DRUG-75	Romiplostim (Nplate®)	New
12/27/2017	CG-DRUG-76	Plerixafor Injection (Mozobil™)	New
12/27/2017	CG-DRUG-77	Radium Ra 223 Dichloride (Xofigo®)	New
12/27/2017	CG-DRUG-78	Antihemophilic Factors and Clotting Factors	New
12/27/2017	CG-DRUG-79	Siltuximab (Sylvant®)	New
12/27/2017	CG-DRUG-80	Cabazitaxel (Jevtana®)	New
12/27/2017	CG-DRUG-81	Tocilizumab (Actemra®)	New
12/27/2017	CG-GENE-01	Janus Kinase 2 (JAK2) V617F Gene Mutation Assay	New
12/27/2017	CG-GENE-02	Analysis of KRAS Status	New
12/27/2017	CG-GENE-03	BRAF Mutation Analysis	New
12/27/2017	CG-GENE-04	Molecular Marker Evaluation of Thyroid Nodules	New
12/27/2017	CG-MED-61	Preoperative Testing for Low Risk Invasive Procedures and Surgeries	New
12/27/2017	CG-MED-62	Resting Electrocardiogram Screening in Adults	New
12/27/2017	CG-MED-63	Treatment of Hyperhidrosis	New
12/27/2017	CG-MED-64	Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)	New
12/27/2017	CG-MED-65	Manipulation Under Anesthesia of the Spine and Joints other than the Knee	New
12/27/2017	CG-MED-66	Cryopreservation of Oocytes or Ovarian Tissue	New
12/27/2017	CG-MED-67	Melanoma Vaccines	New
12/27/2017	CG-MED-68	Therapeutic Apheresis	New
12/27/2017	CG-SURG-61	Cryosurgical Ablation of Solid Tumors Outside the Liver	New
12/27/2017	CG-SURG-62	Radiofrequency Ablation to Treat Tumors Outside the Liver	New
12/27/2017	CG-SURG-63	Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure	New
12/27/2017	CG-SURG-65	Recombinant Human Bone Morphogenetic Protein	New
12/27/2017	CG-SURG-66	Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)	New
12/27/2017	CG-SURG-67	Treatment of Osteochondral Defects	New
12/27/2017	CG-SURG-68	Surgical Treatment of Femoracetabular Impingement Syndrome	New
12/27/2017	CG-SURG-69	Meniscal Allograft Transplantation of the Knee	New
12/27/2017	CG-DRUG-38	Pemetrexed Disodium (Alimta®)	Revised
12/27/2017	CG-DRUG-50	Paclitaxel, protein-bound (Abraxane®)	Revised
12/27/2017	CG-DRUG-61	Gonadotropin Releasing Hormone Analogs for the Treatment of Non-Oncologic Indications	Revised
12/27/2017	CG-MED-21	Anesthesia Services and Moderate (“Conscious”) Sedation	Revised

Publish date	*Clinical UM Guideline* number	*Clinical UM Guideline* title	New/revised
11/9/2017	CG-MED-55	Level of Care: Advanced Radiologic Imaging	Revised

TNPEC-2093-17

Chimeric antigen receptor T-cell therapy requires prior authorization for all places of service

Chimeric antigen receptor T-cell (CAR T) therapy, including immunotherapy and all inpatient stays, will continue to require a prior authorization (PA) regardless of the place of service in which it is given.

CAR T codes require PA, and all requests must be reviewed by Amerigroup Community Care for PA regardless of place of service or if billed with an unlisted code.

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.**

CAR T therapy is currently represented by the following codes:

- **Q2040** — Tisagenlecleucel (brand name: Kymriah™), up to 250 million CAR-positive viable T-cells, including leukapheresis and dose-preparation procedures, per infusion
- **Q2041** — Axicabtagene Ciloleucel, up to 200 million autologous anti-CD19 CAR T-cells, including leukapheresis and dose-preparation procedures, per infusion **(new code effective April 1, 2018)**

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

- **Web:** https://www.availity.com
- **Fax:** 1-800-964-3627
- **Phone:** 1-800-454-3730

Please refer to the Precertification Lookup Tool for detailed PA requirements by visiting https://providers.amerigroup.com/TN, choosing **Quick Tools** from the *Provider Resources & Documents* menu, and then selecting **Precertification Lookup Tool**.

TN-NL-0139-18

Reimbursement Policies:

Policy Update

Unlisted, Unspecified or Miscellaneous Codes

(Policy 06-004, effective 07/01/2018)

As of July 1, 2018, Amerigroup Community Care requires unspecified diagnosis codes be used only when an established diagnosis code does not exist to describe the diagnosis. Reimbursement is based on review of the unspecified diagnosis code on an individual claim basis. If the claim must have an unspecified diagnosis code, and there is a corresponding left, right or bilateral diagnosis, then a description supporting the use of the unspecified diagnosis code must be provided.

For additional information, please review the Unlisted, Unspecified or Miscellaneous Codes reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

TN-NL-0132-17

Policy Update

Preventive Medicine and Sick Visits on the Same Day

(Policy 05-016, effective 09/01/2018)

The following article was previously included in the February 2018 *Provider NewsBlast* with the effective date of February 1, 2018. However, the changes made to our Preventive Medicine and Sick Visits on the Same Day reimbursement policy will not be effective until September 1, 2018.

Amerigroup Community Care allows reimbursement for preventive medicine (i.e., well-child visits) and sick visits on the same day under the following conditions:

- Modifier 25 must be billed with the applicable evaluation and management code for the allowed sick visit — If Modifier 25 is not billed appropriately, the sick visit will be denied.
- Appropriate diagnosis codes must be billed for respective visits.

Reimbursement is based on the fee schedule or contracted/negotiated rate for the preventive medicine and 50% of the fee schedule or contracted/negotiated rate for the allowed sick visit.

The Preventive Medicine and Sick Visits on the Same Day reimbursement policy can be located at https://providers.amerigroup.com.

TN-NL-0116-17