Provider NewsBlast

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

October 2018

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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.

Medicaid:

Implementation of the *New Amerigroup Facility Proprietary Reimbursement Methodology*

Effective November 1, 2018 and January 1, 2019, Amerigroup Community Care will fully implement a new Facility Proprietary Reimbursement Methodology. The new Facility Proprietary Reimbursement Methodology will include:

Effective November 1, 2018:

- **IPPS** Fixed Weight File based on CMS FY18 MS-DRG Relative Weights
- **IPPS** Base Rate will remain at CMS FY18

Effective January 1, 2019:

- **OPPS** Fixed Wage Index based on CMS Calendar Year 2018
- **OPPS** Custom-Fixed APC Rate based on CMS Calendar Year 2018 Relative Weights and Conversion Factor. The contract rate is determined by applying Calendar Year 2018 APC CMS Relative Weight to the Calendar Year 2018 Conversion Factor

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 Facility Proprietary Reimbursement Methodology is compliant with the Division of TennCare (TennCare) Contractor Risk Agreement**.**

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 facility providers will receive an *Amendment by Notification* (*ABN*) as applicable along with a cover letter setting out additional information regarding the new Facility Proprietary Reimbursement Methodology within the next 60 days. Section 8.1 of the Amerigroup *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 provider's reimbursement.

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

If you have additional questions, please contact your local Provider Relations Representative or call Provider Services at 1-800-454-3730.

TNPEC-2468-18-B

EDI Gateway migration

Amerigroup Community Care has partnered with Availity to become our designated EDI Gateway effective January 1, 2019.

What does this mean to you as a provider?
All EDI submissions currently received are now available on Availity. Please note, there is no impact to provider participation statuses and no impact on how claims adjudicate.

Next steps
Contact your clearinghouse to validate their transition dates to Availity. If your clearinghouse notifies you of changes regarding connectivity, workflow or the financial cost of EDI transactions, there is a no-cost option available to you — You can submit claims directly through Availity!

Register with Availity
If you wish to submit directly through Availity for your 837 (claim), 835 (electronic remittance advice) and 27X (claim status and eligibility) transactions, please visit https://www.availity.com to register.

We look forward to delivering a smooth transition to the Availity EDI Gateway.

If you have any questions please contact Availity Client Services at 1-800-282-4548, Monday-Friday, 8 a.m.-7:30 p.m. Eastern time.

TN-NB-0075-18

Ambulance claims reimbursement reminder

Amerigroup Community Care follows CMS guidelines for ambulance claims reimbursement. All transportation claims must include the complete pickup and drop-off location addresses, including ZIP codes and drop-off location name (usually the hospital) for reimbursement. If all the pertinent information is not on the claim form, the claim will be rejected on the front end.

If you need additional information, visit the CMS website.

TN-NB-0067-18

Caremark Medical Specialty

Certain medical injectables may be filled through Caremark Medical Specialty (Caremark). Orders should only be submitted to the Caremark in Monroeville, Pennsylvania.

Special instructions:

- To help prevent delays in shipment, remind members that Caremark will contact them prior to dispensing medication.
- Medical injectables requiring a prior authorization (PA) must be approved in order for Caremark to dispense the medication. Once approval is received, fax the approval letter and order form to Caremark.

Contact information:

Specialty pharmacy:	Caremark Medical Specialty
Location:	Monroeville, PA
NPI #:	1043382302
Phone:	1-877-254-0015
Fax:	1-866-336-8479

TN-NB-0070-18

Vaginal birth after cesarean shared decision-making aid available

As part of our commitment to provide you with the latest clinical information, we have posted a vaginal birth after cesarean (VBAC) shared decision making aid to our provider site. This tool has been reviewed and certified by the Washington Health Care Authority* and is available to aid in discussions with your patients regarding their treatment options.

* The Washington Health Care Authority is recognized as a certifying body by NCQA.

TN-NB-0059-18

Cervical length measurement by transvaginal ultrasound

Summary of change: In our efforts to improve pregnancy outcomes, including the prevention of preterm birth, Amerigroup Community Care previously communicated our endorsement of the American College of Obstetricians and Gynecologists (ACOG) and Society for Maternal Fetal Medicine (SMFM) guidelines on cervical length (CL) screening and progesterone treatment.

We continue to encourage you to obtain a CL measurement with your patient's routine prenatal anatomic evaluation ultrasound. For claims submitted on or after January 1, 2019, if a vaginal approach is necessary in addition to an abdominal scan to obtain this measurement, the transvaginal ultrasound will be considered for a multiple procedure reduction.

What is the impact of this change?
When a routine anatomic evaluation ultrasound (76801, 76802, 76805, 76810) and a transvaginal ultrasound (76817) are billed on the same day by the same provider, the transvaginal ultrasound is considered a part of the multiple procedure payment reduction policy and will be paid at 50 percent of the applicable fee schedule, and the complete procedure will be paid at the full applicable fee schedule.

TNPEC-2295-18

Prior authorization requirements for Interferon beta-1a

Effective January 1, 2019, prior authorization (PA) requirements will change for injectable/infusible drug Interferon beta-1a to be covered by Amerigroup Community Care for Medicaid members. 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.**

PA requirements will be added to the following:

- Interferon beta-1a — injection, 30 mcg (J1826)

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

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

TN-NB-0062-18

Prior authorization requirements for Somatrem

Effective January 1, 2019, prior authorization (PA) requirements will change for injectable/infusible drug Somatrem to be covered by Amerigroup Community Care for Medicaid members. 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.**

PA requirements will be added to the following:

- Somatrem — injection, 1 mg (J2940)

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

Not all PA requirements are listed here. PA requirements are available to contracted and noncontracted providers on our provider website (https://providers.amerigroup.com/TN >

Quick Tools > Precertification Lookup Tool). Providers may also call us at 1-800-454-3730 for PA requirements.

TN-NB-0063-18

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 July 30, 2018, InterQual® 2018 and 2018.1 releases will be used. InterQual will continue to be used for home care criteria, long-term care criteria, rehabilitation criteria, and subacute and skilled nursing facilities.
- Effective November 1, 2018, MCG Heath Care Guidelines will be used for reviews, to include the use of customizations to certain guidelines and:
    - Inpatient and Surgical Care Guidelines
    - General Recovery Care Guidelines excluding Long-Term Acute Care Guidelines
    - Chronic Care Guidelines
- Additionally, effective November 1, 2018, AIM Specialty Health® Proton Beam Therapy will be used for clinical reviews.

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 May 3, 2018, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Medical Policies* applicable to Amerigroup Community Care.

Publish date	***Medical Policy* number**	***Medical Policy* title**	**New or revised**
6/6/2018	DRUG.00098	Lutetium Lu 177 dotatate (Lutathera®)	New
6/6/2018	DRUG.00046	Ipilimumab (Yervoy®)	Revised
5/10/2018	DRUG.00047	Brentuximab Vedotin (Adcetris®)	Revised
5/10/2018	DRUG.00053	Carfilzomib (Kyprolis®)	Revised
6/6/2018	DRUG.00071	Pembrolizumab (Keytruda®)	Revised
6/6/2018	DRUG.00075	Nivolumab (Opdivo®)	Revised
5/10/2018	DRUG.00076	Blinatumomab (Blincyto®)	Revised
6/6/2018	DRUG.00111	Monoclonal Antibodies to Interleukin-23	Revised

Publish date	*Medical Policy* number	*Medical Policy* title	New or revised
5/10/2018	SURG.00026	Deep Brain, Cortical and Cerebellar Stimulation	Revised

Clinical UM Guidelines

On May 3, 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 April 19, 2018.

Publish date	*Clinical UM Guideline* number	*Clinical UM Guideline* title	New or revised
6/6/2018	CG-LAB-12	Testing for Oral and Esophageal Cancer	New
6/6/2018	CG-MED-71	Wound Care in the Home Setting	New
6/28/2018	CG-DME-44	Electric Tumor Treatment Field (TTF)	New
6/28/2018	CG-DRUG-67	Cetuximab (Erbitux®)	New
6/28/2018	CG-DRUG-94	Rituximab (Rituxan®) for Nononcologic Indications	New
6/28/2018	CG-DRUG-95	Belatacept (Nulojix®)	New
6/28/2018	CG-DRUG-96	Ado-trastuzumab emtansine (Kadcyla®)	New
6/28/2018	CG-DRUG-97	Rilonacept (Arcalyst®)	New
6/28/2018	CG-DRUG-98	Bendamustine Hydrochloride	New
6/28/2018	CG-DRUG-99	Elotuzumab (Empliciti™)	New
6/28/2018	CG-DRUG-100	Interferon gamma-1b (Actimmune®)	New
6/28/2018	CG-DRUG-101	Ixabepilone (Ixempra®)	New
6/28/2018	CG-DRUG-102	Olaratumab (Lartruvo™)	New
6/28/2018	CG-MED-72	Hyperthermia for Cancer Therapy	New
6/28/2018	CG-SURG-76	Carotid, Vertebral and Intracranial Artery Stent Placement with or without Angioplasty	New
6/28/2018	CG-SURG-77	Refractive Surgery	New
6/28/2018	CG-SURG-78	Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies	New
6/28/2018	CG-SURG-79	Implantable Infusion Pumps	New
6/28/2018	CG-SURG-80	Transcatheter Arterial Chemoembolization and Transcatheter Arterial Embolization for Treating Primary or Metastatic Liver Tumors	New
5/10/2018	CG-DRUG-50	Paclitaxel, protein bound (Abraxane®)	Revised
6/6/2018	CG-DRUG-60	Gonadotropin Releasing Hormone Analogs for the Treatment of Oncologic Indications	Revised
6/6/2018	CG-DRUG-62	Fulvestrant (FASLODEX®)	Revised
6/6/2018	CG-DRUG-78	Antihemophilic Factors and Clotting Factors	Revised

Amerivantage:

EDI Gateway migration

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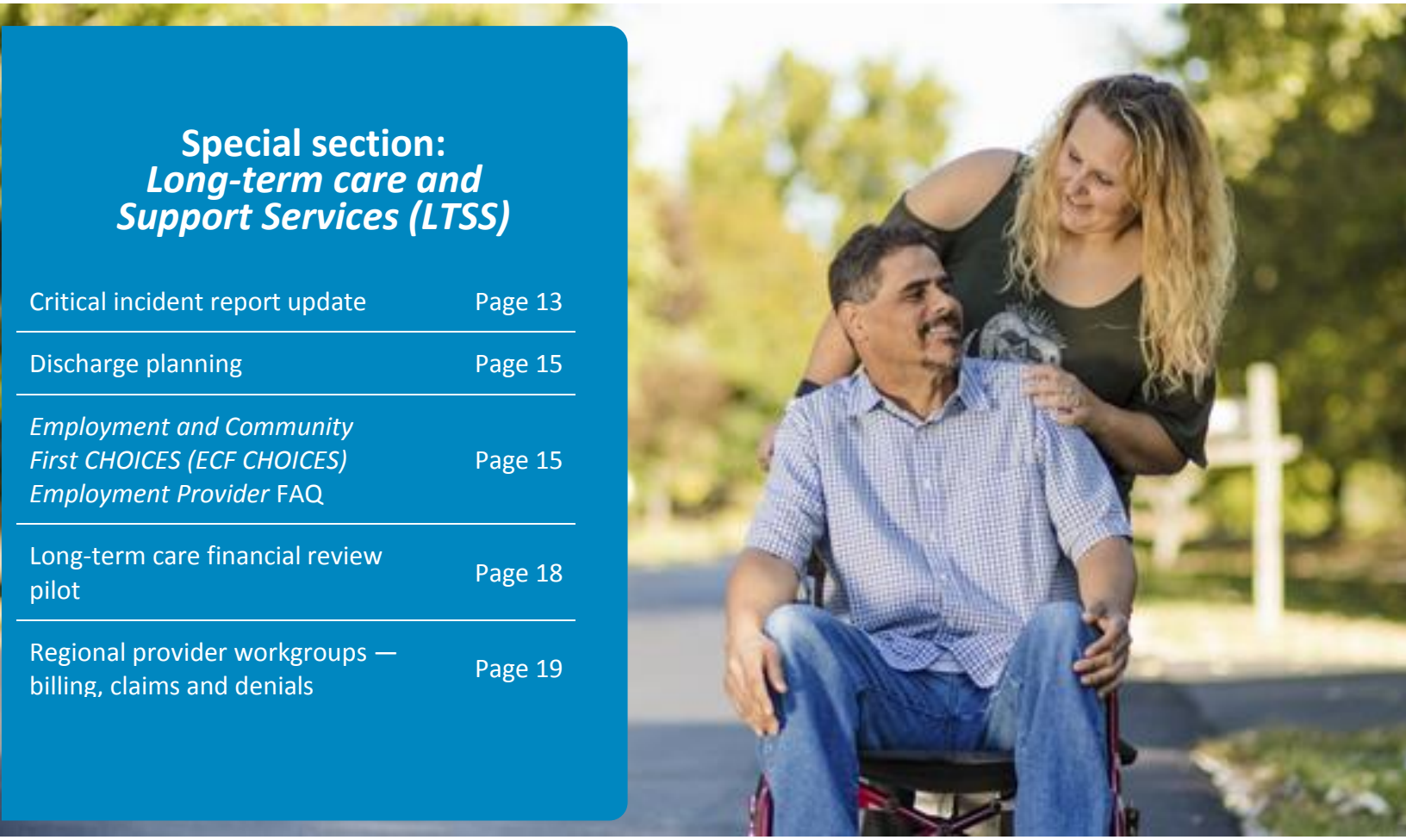
Please view the full article included in the Medicaid section.



Special section: *Long-term care and Support Services (LTSS)*

Critical incident report update

Effective September 4, 2018, the *Home- and Community-Based Services (HCBS) CHOICES Critical Incident Report* now includes the new verbal line number.

You have 24 hours to complete a verbal critical incident (CI) notification; if you leave a verbal notification, you have 48 hours from the time of being made aware to submit the written CI notification.

For example:

- If a CI happened on July 25, you have until July 26 to complete a verbal notification (this is the 24-hour verbal notification window).
- You have to complete the written notification within 48 hours, which would be by July 27.
- Additionally, you must check the 48-hour written notification report box on the report form.

When completing the CI report, please ensure you complete the following sections:

Section C — HCBS servicing provider information
• The information requested in this section is needed in order to load the case in the quality tracking database. • Provider information is needed regardless of whether the provider was involved.
Section D — CI timelines
• This section helps us determine if providers are compliant in reporting to us as well as if we are compliant with reporting to the Division of TennCare. • You must include the date and time in this section; the time can be approximate.
Section E — CI type
• You must select a type; if appropriate, you can select more than one. • Note, you can no longer use "other." The incident must fall within one of the categories. If you are unsure of the correct selection, contact Quality Management as the incident may not be considered critical (for instance, Medicaid fraud is not a critical incident). • Financial exploitation pertains to unauthorized debit card usages, checks, money taken from the bank account, food stamps, etc.
Section G — Notifications
• Adult Protective Services (APS) must be notified within 24 hours for financial exploitation, abuse and neglect. There are no exceptions! • The clock starts ticking as soon as you are made aware of a situation. Therefore, please send in your 24-hour report as soon as possible. The Audit team only has one business day to report the incident to the Division of TennCare.
Section I — Details of the CI
• Please provide details. For instance: Where was the member? Who was with the member (provide names and the relationship)?
Investigative findings
• Please complete this section with as much detail as possible. • Be sure to provide APS/police follow-up.

If a section does not apply, write N/A in all parts of that section.

If you have any questions or concerns, please contact Theresa A. Miller by phone (office: 615-316-2400, ext. 106-126-0163; mobile: 629-215-0141) or email (theresa.miller@amerigroup.com).

Discharge planning

When a TennCare CHOICES member is hospitalized, care coordinators are actively involved in discharge planning. Members receive face-to-face visits to complete a needs reassessment as well as updates to their *Plan of Care*.

As a reminder, when outreach is made in regard to sharing and submitting clinical information, hospitals should work with the discharge planners so that discharge planning is efficient and effective.

TN-NB-0069-18

Employment and Community First CHOICES (ECF CHOICES) Employment Provider FAQ

Authorization and reporting

Are preauthorizations and authorizations sent electronically? Authorizations are sent by email or fax — depending on the provider's preference.

How are outcome-based reports submitted to Amerigroup Community Care? All outcome-based reports required for authorization of payment must be submitted to AGP_ECF_progressreports@amerigroup.com for approval. Approvals are sent via reply all to this email submission, so be sure to include all individuals in your organization who need to be notified of the approval.

If a report is completed but is missing a component after the service deadline, is there an opportunity to make corrections? Yes, once a report is submitted, Amerigroup reviews it and replies within two business days. We either send an approval email or request that you correct and resubmit the report within a specific time frame.

Are electronic signatures acceptable on the *ECF CHOICES Employment Outcome-Based Report* forms? Yes.

If I receive a preauthorization for an outcome-based ECF CHOICES employment service, when can services begin? The service can start on the date listed on the preauthorization. Once the outcome is met and the report has been submitted and approved by Amerigroup, authorization to bill is sent, which allows you to bill for the service. A service cannot be billed off of a preauthorization.

Staff qualification

Have the Association of Community Rehabilitation Educators (ACRE) training rates been reduced? Yes, the University of Georgia (UGA) has agreed to provide a scholarship for providers who identify themselves as ECF CHOICES employment providers in Tennessee. UGA offers half

off the Work Works ACRE Professional Employment Certificate. For additional details, reference the memo from the Division of TennCare. Note, there are multiple options for job developers that are less expensive than Work Works, which is only required for supervisors/managers of supported employment (SE) staff if they do not currently hold the CRC.

Do job coaches and job developers have to complete the trainings for direct support professionals (DSPs) required by the Division of TennCare? Yes, completion of the DSP training is a core requirement for all ECF CHOICES employment staff. Refer to the *Core Requirements and Required Training for Direct Support Professionals Providing ECF CHOICES Services*.

Have the Training Resource Network, Inc. (TRN) rates been reduced? You can receive a 10-percent discount on the TRN Online Job Coach Training. The cost is $146 per person, $145 per person when registering a group of 3-5 people, or $135 per person for a group of 6 or more. An agency can register a group of staff to receive the group discount even if some of the staff members do not work for that agency.

Other than TRN, are there other approved courses for job coach training? The TRN Job Coach Training is the only approved training for ECF CHOICES job coaches. It is 16 hours of training and must be completed within a two-week time frame. The training is offered on demand, so you may purchase it as needed to train your staff. For more information, visit http://trn-store.com. **(Note: The TRN training is not required for ECF CHOICES job coaches who also meet the ECF CHOICES job developer qualifications.)**

Does every employment provider have to have an SE program manager? Yes, every employment provider must have a person on staff identified as an SE program manager/supervisor. Note, this person may also fill other roles within the agency. The SE must meet the qualifications stated in the *ECF CHOICES Employment Services Staff Qualifications for an SE Program Manager/Supervisor*. If the person is in place at the start of ECF CHOICES, they have one year to meet the qualifications. New hires have six months to complete the course or gain the certification.

At what point is a staff member considered a new staff? Any staff hired on by your agency after the date your agency was credentialed with an MCO for ECF CHOICES is considered a new staff, and they are required to complete the training requirements prior to working with an ECF CHOICES member.

Do providers need to submit proof of training and/or shadowing requirements to Amerigroup? No, these records should be kept in personnel files and are reviewed during an audit and/or recredentialing.

If a staff member qualifies as a job developer or SE manager through ECF CHOICES, do they also have to complete the TRN Job Coach training to conduct ECF CHOICES services that require a job coach? No, if a staff person qualifies as a job developer, they also qualify as a job coach-level staff member and are not required to complete the TRN Job Coach training requirement.

Are there any continuing education requirements for ECF CHOICES employment staff? No, there are not any continuing education requirements at this time for SE program managers, job coaches or job developers. Vocational rehabilitation (VR) requires 12 hours of continuing education credits per year for all staff working with VR clients. Certified work incentives counselors are required to maintain 18 hours of continuing certification courses per year. Staff members that acquire the certified employment support specialist certification must obtain 12 hours of continuing education credit per year to maintain the certification.

Vocational rehabilitation

Should VR reports for ECF CHOICES members be sent to support coordinators (SC)? Providers should complete and submit all required documents for the service to the funding source for that specific service, so all VR reports should be sent to the VR counselor and all ECF CHOICES reports should be submitted to the MCO. The support coordinator will obtain releases of information from the member in order to obtain the reports from the VR.

Will the support coordinator take the member to the VR application meeting? The role of the ECF CHOICES support coordinator is to coordinate services and ensure they are being delivered to the member per the *Person-Centered Support Plan* — not to deliver services. The support coordinator ensures the VR referral is made and that the application is submitted to VR in a timely manner, but the level of involvement of the support coordinator at the VR intake meeting varies depending on the member's situation and support needs. If the member needs assistance with transportation, the support coordinator can authorize the ECF CHOICES community transportation service.

If a member is working with VR, when can ECF CHOICES job coaching benefits begin? ECF CHOICES job coaching services cannot be authorized until VR job coaching is complete or determined unavailable to the ECF CHOICES member, which is typically at the point of stabilization. ECF CHOICES job coaching can begin as soon as stabilization is reached, and the VR counselor should send this via the *MOU Notification Form* to the support coordinator. ECF CHOICES support coordinators for Amerigroup are trained on this process and coordinate with VR to ensure authorizations are in place at the time of stabilization.

Do all staff members providing ECF CHOICES employment services also have to be approved through VR? VR approval is not required for staff working with ECF CHOICES members, but for the consistency of services to our members, it is best practice for job coaches and job developers to also be listed on your *VR Letter of Agreement* (*LOA*).

Do ECF CHOICES employment providers also need to have an *LOA* with VR? This is not required, but it is recommended for the consistency of services to our members. In particular, an *LOA* for supported employment is desirable.

Service definition

Is there a required number of hours you must spend with the individual during the exploration and discovery process prior to submitting the final report? No, there is no required amount of hours to complete exploration or discovery services. Exploration is

expected to involve, on average, 40 hours of service. Discovery is expected to involve, on average, 50 hours of service. We do expect that most of the time spent will be with the person, but the estimates include other time needed to implement the service and write the report. The service log in the final report should reflect the amount of time spent with the person and time spent doing other tasks related to implementing the service.

Can discovery be provided at the same time as an hourly service, like community integration support services (CISS)? Yes, outcome-based employment services may occur during the same time as an hourly service like personal assistance, CISS or independent living skills training. As these are outcome-based services, they are not billed on the hour and observing someone during these other services can be helpful to determine interests, skills and support needs.

Will providers be able to bill for transportation if they transport the person during an employment service, like exploration? Transportation of the individual to and from ECF CHOICES employment services is not included in the rates paid for employment services. Transportation during the provision of these services is included in the rates paid for these services. If a member needs assistance with transportation to and from the service, they may be able to access ECF CHOICES community transportation service. If an ECF CHOICES employment provider is also approved to provide community transportation and the member is approved for this service, then ECF CHOICES services can pay the provider to take the member to and from work if the member needs this assistance and this is the best, most cost-effective option.

What happens if the member receives a job offer during the discovery process?
We evaluate job offers to make sure they are a good match for the person, and we encourage providers to complete the discovery quickly. If a VR referral has not been made, the SC will make the referral and authorize any other needed supports (such as job coaching) until VR can pick up the required services.

Long-term care financial review pilot

Amerigroup Community Care is partnering with HMS to implement a long-term care (LTC) financial review pilot program. The goal of the pilot program is to ensure LTC nursing home claims are paid in accordance with program policies and billing requirements.

The HMS LTC Management team has over 40 years of experience implementing, performing and overseeing Medicaid fee-for-service and managed Medicaid LTC financial review programs. HMS works one-on-one with providers throughout the review process. Each facility is assigned a dedicated LTC auditor who assists the provider through the review process.

To minimize disruption of the facility's daily business office operations, LTC reviews are conducted as desk audits.

The pilot program begins October 2018 and includes five nursing facilities in each of the three Grand Regions. If your facility is selected to participate in the pilot program, you will receive

additional written instructions and communication.

TN-NB-0069-18

Regional provider workgroups — billing, claims and denials

To support our long-term services and supports (LTSS) providers with billing, claims and denial monitoring and management, Amerigroup Community Care is launching a series of collaborative regional provider workgroups in quarter three of 2018. Target representatives for the workgroup include coding, billing, and account receivable posting and reconciliation staff.

Through the workgroups, we hope to:

- Collaborate with providers who have a high volume of claim denials.
- Identify improvement opportunities.
- Simplify the billing process.
- Support the provider community in reducing the overall denial rate.

If your agency is interested in participating in these regional workgroup(s), please reach out to your assigned LTSS Provider Relations representative.

TN-NB-0069-18