Provider NewsBlast

Amerigroup
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Table of Contents

If you have questions about any of the articles contained in this NewsBlast or need assistance, contact your local Provider Relations representative or call Provider Services at the toll-free phone numbers listed below:

- Medicaid providers call 1-800-454-3730.
- Medicare providers call 1-866-805-4589.

Medicaid:

New clinical guideline: pneumatic compression devices, effective December 1, 2019

Summary of change: Amerigroup Community Care will implement the following clinical guideline effective December 1, 2019, to support the review of outpatient pneumatic compression devices (PCDs) after outpatient orthopedic procedures.

Federal and state law, as well as state contract language and CMS guidelines, including definitions and specific contract provisions/exclusions, take precedence over these prior authorization rules and must be considered first when determining coverage. **Noncompliance with new requirements may result in denied claims.**

CG-DME-46 Pneumatic Compression Devices for Prevention of Deep Vein Thrombosis of the Lower Limbs

This document addresses the use of PCDs for the prevention of deep vein thrombosis (DVT) of the lower limbs. This therapy involves the use of an inflatable garment and an electrical pneumatic pump. The garment is intermittently inflated and deflated with cycle times and pressures that vary between devices. PCDs are used in clinics, or can be purchased or rented for home use for prevention and treatment of a number of conditions. This document only addresses the home use of PCDs for post-outpatient orthopedic procedures.

Note: This document addresses devices for the prevention of DVT only. Pneumatic devices used in the treatment or prevention of lymphedema, venous insufficiency or therapy for musculoskeletal injuries are **not** addressed in this document, nor are devices for prevention of DVT post-major surgical procedures.

Not medically necessary

The use of PCDs for prevention of thromboembolism of the lower-limbs following outpatient orthopedic surgery is considered **not medically necessary** for all indications.

TN-NB-0213-19

Medical drug *Clinical Criteria* updates

Summary: On June 20, 2019, the Pharmacy and Therapeutic (P&T) Committee approved *Clinical Criteria* applicable to the **medical drug benefit** for Amerigroup Community Care. These policies were developed, revised or reviewed to support clinical coding edits.

The *Clinical Criteria* is publicly available on the provider website, and the effective dates will be reflected in the link to web posting. Visit *Clinical Criteria* to search for specific policies.

For questions or additional information, use this email.

TN-NB-0219-19

Precertification Lookup Tool — easy access to prior authorization guidelines on the Availity Portal

Amerigroup Community Care has an online tool that displays prior authorization guidelines to help you quickly determine whether certain services for Amerigroup members require a prior authorization.

You can access the **Precertification Lookup Tool** through the Availity Portal. The Precertification Lookup Tool will let you know if clinical edits apply, information such as the medical necessity criteria used in making the authorization decision and if a vendor is used — without the need to make a phone call.

Where is the Precertification Lookup Tool located on Availity?
Navigate to the Precertification Lookup Tool on the Availity Portal by selecting either 1) **Payer Spaces** or 2) **Patient Registration** from Availity's homepage. You can also reach Availity via phone at 1-800-AVAILITY (1-800-282-4548). Access to the information does not require an Availity role assignment, tax ID or NPI.

Through Availity **Payer Spaces**:

- Select Amerigroup from the *Payer Spaces* menu.
- Select the **Applications** tab.
- Select the **Precertification Lookup Tool**.

From the **Patient Registration** menu:

- Select **Authorizations and Referrals**.
- Select the **Precertification Lookup Tool** link located under *Additional Authorizations & Referrals.*

Once you have accessed the Precertification Lookup Tool, choose a line of business from the menu selection offered, then type the CPT®/HCPCS code or a code description to determine if a prior authorization is required.

Other ways to access: If you are currently accessing the Precertification Lookup Tool either through your health plan's public or secure provider website, those options are still available for you.

TN-NB-0230-19

Global 3M19 Medical Policy and Technology Assessment Committee prior authorization requirement updates

Background: Effective **February 1**, **2020**, prior authorization (PA) requirements will change for the following services. These services will require PA by Amerigroup Community Care for our members. Federal and state law, as well as state contract language and CMS 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 codes:

- **43238:** esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus
- **43242:** esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound)
- **43253:** esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s)
- **78459:** myocardial imaging, positron emission tomography (PET), metabolic evaluation
- **78491:** myocardial PET; single study, rest/stress
- **78492:** myocardial PET; multiple studies, rest and/or stress
- **78608:** brain imaging, PET; metabolic evaluation
- **78609:** brain imaging, PET; perfusion evaluation
- **78811:** PET imaging; limited area (e.g., chest, head/neck)
- **78812:** PET imaging; skull base to mid-thigh
- **78813:** PET imaging; skull base to mid-thigh
- **78814:** PET with concurrently acquired computed tomography (CT) for attenuation correction
- **78815:** PET with concurrently acquired CT for attenuation correction
- **78816:** PET with concurrently acquired CT for attenuation correction
- **81227:** Cyp2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (e.g., drug metabolism), gene analysis, common variants (i.e., *2, *3, *5, *6)
- **81231:** CYP3A5 (cytochrome P450, family 3, subfamily A, member 5) (e.g., drug metabolism), gene analysis, common variants (i.e., *2, *3, *4, *5, *6, *7)
- **81232:** DPYD (dihydropyrimidine dehydrogenase) (e.g., 5-fluorouracil/5-FU and capecitabine drug metabolism), gene analysis, common variant(s) (i.e., *2A, *4, *5, *6)
- **81346:** TYMS (thymidylate synthetase) (e.g., 5-fluorouracil/5-FU drug metabolism), gene analysis, common variant(s) (e.g., tandem repeat variant)
- **0031U:** CYP1A2 (cytochrome P450 family 1, subfamily A, member 2) (e.g., drug metabolism) gene analysis, common variants (i.e., *1F, *1K, *6, *7)

- **0032U:** COMT (catechol-O-methyltransferase) (drug metabolism) gene analysis, c.472G>A (rs4680) variant
- **0070U:** CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, common and select rare variants (i.e., *2, *3, *4, *4N, *5, *6, *7, *8, *9)
- **0072U:** CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis (i.e., CYP2D6-2D7 hybrid gene)
- **0073U:** CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis (i.e., CYP2D7-2D6 hybrid gene)
- **0074U:** CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis (i.e., nonduplicated gene)
- **0075U:** CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis (i.e., 5 gene duplication/ multiplication)
- **0076U:** CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis
- **0091U:** oncology (colorectal) screening, cell enumeration of circulating tumor cells, utilizing whole blood, algorithm, for the presence of adenoma or cancer, reported as a positive or negative result
- **0092U:** oncology (lung), three protein biomarkers, immunoassay using magnetic nanosensor technology, plasma, algorithm reported as risk score for likelihood of malignancy
- **0093U:** prescription drug monitoring, evaluation of 65 common drugs by LC-MS/MS, urine, each drug reported detected or not detected
- **0098U:** respiratory pathogen, multiplex reverse transcription and multiplex amplified probe technique, multiple types or subtypes, 14 targets
- **0099U:** respiratory pathogen, multiplex reverse transcription and multiplex amplified probe technique, multiple types or subtypes, 20 targets (adenovirus, coronavirus 229E, coronavirus)
- **0100U:** respiratory pathogen, multiplex reverse transcription and multiplex amplified probe technique, multiple types or subtypes, 21 targets (adenovirus, coronavirus 229E, coronavirus)
- **0104U:** hereditary pan cancer (e.g., hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer)
- **J9036:** injection, bendamustine hydrochloride (Belrapzo®), 1 mg
- **81479:** unlisted molecular pathology procedure
- **81599:** unlisted multianalyte assay with algorithmic analysis
- **0094U:** genome (e.g., unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis
- **0101U:** hereditary colon cancer disorders (e.g., Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis)
- **0102U:** hereditary breast cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer)
- **0103U:** hereditary ovarian cancer (e.g., hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of next-generation sequencing, Sanger sequencing, multiplex ligation-dependent probe amplification

- **0408T:** insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed and programming of sensing and therapeutic parameters
- **0409T:** insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed and programming of sensing and therapeutic parameters
- **0410T:** insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed and programming of sensing and therapeutic parameters
- **0411T:** insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed and programming of sensing and therapeutic parameters
- **0412T:** removal of permanent cardiac contractility modulation system; pulse generator only
- **0413T:** removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)
- **0414T:** removal and replacement of permanent cardiac contractility modulation system pulse generator only
- **0415T:** repositioning of previously implanted cardiac contractility modulation transvenous electrode (atrial or ventricular lead)
- **0416T:** relocation of skin pocket for implanted cardiac contractility modulation pulse generator
- **0417T:** programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values
- **0418T:** interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiac
- **0512T:** extracorporeal shock wave for integumentary wound healing, high energy, including topical application and dressing care; initial wound
- **0513T:** extracorporeal shock wave for integumentary wound healing, high energy, including topical application and dressing care; each additional wound
- **0544T:** transcatheter mitral valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach, including transseptal puncture
- **0545T:** transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach
- **0548T**: transperineal periurethral balloon continence device; bilateral placement, including cystoscopy and fluoroscopy
- **0549T:** transperineal periurethral balloon continence device; unilateral placement, including cystoscopy and fluoroscopy
- **0550T:** transperineal periurethral balloon continence device; removal, each balloon
- **0551T:** transperineal periurethral balloon continence device; adjustment of balloon(s) fluid volume
- **E2599:** accessory for speech generating device, not otherwise classified
- **G9143:** warfarin responsiveness testing by genetic technique using any method, any number of specimen(s)

- **J3490:** unclassified drugs (Avastin®, Mvasi™)
- **S3870:** comparative genomic hybridization microarray testing for developmental delay, autism spectrum disorder and/or intellectual disability

Request PA via:

- Availity Portal
- **Fax**: 1-800-964-3627
- **Phone**: 1-800-454-3730

Not all PA requirements are listed here. Detailed PA requirements are available to providers on our provider website > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool) and via the Availity Portal. Providers may also call Provider Services at 1-800-454-3730 for PA requirements.

TN-NB-0235-19

Coding spotlight: provider's guide to coding behavioral and emotional disorders

ICD-10-CM coding

Codes within categories F90-F98 represent behavioral and emotional disorders with onset usually occurring in childhood and adolescence and may be used regardless of the age of the patient.

Attention deficit hyperactivity disorder (ADHD) is among these common childhood disorders. While ADHD is not a learning disability, it can impact the ability to learn. This disorder is characterized by classic symptoms of inattention, hyperactivity and impulsivity.

Three subtypes of ADHD have been identified:

- Hyperactive/impulsive type — The patient does not show significant inattention.
- Inattentive type – The patient does not show significant hyperactive-impulsive behavior.
- Combined type – Patient displays both inattentive and hyperactive-impulsive symptoms.
- Hyperactive/impulsive type — The patient does not show significant inattention.
- Inattentive type – The patient does not show significant hyperactive-impulsive behavior.
- Combined type – Patient displays both inattentive and hyperactive-impulsive symptoms.

Other disorders that sometimes accompany ADHD include Tourette's syndrome, oppositional defiant disorder, conduct disorder, anxiety, depression and bipolar disorder. ADHD continues into adulthood in about 50 percent of people with childhood ADHD.

Attention deficit hyperactivity disorders are coded based on a behavior type:

- F90.0 — Attention deficit hyperactivity disorder, *predominantly inattentive type*
- F90.1 — Attention deficit hyperactivity disorder, *predominantly hyperactive type*
- F90.2 — Attention deficit hyperactivity disorder, *combined type*
- F90.8 — Attention deficit hyperactivity disorder, *other type*
- F90.9 — Attention deficit hyperactivity disorder, *unspecified type*

F90 category includes:

- Attention deficit disorder with hyperactivity
- Attention deficit syndrome with hyperactivity

ICD-10-CM lists the following conditions as special exclusions (Excludes2) to ADHD:

- Anxiety disorders (F40.-, F41.-)
- Mood (affective disorders) (F30-F39)
- Pervasive developmental disorders (F84.-)
- Schizophrenia (F20.-)

Note: *Excludes2* means *not included here*.

This type of exclusion in ICD-10-CM is indicative of conditions that are not included in the F90 category. However, the patient may have both conditions at the same time. For example, if a patient presents with ADHD and anxiety, then both conditions should be coded according to the *Excludes2* list. ICD-10-CM often lists conditions in either an *Excludes1* or *Excludes2* note. It is important that all exclusion notes be followed carefully for coding accuracy. Keep in mind that documentation drives code selection, and that the medical record must support all codes submitted on claims.

HEDIS® quality measures for attention deficit hyperactivity disorder (ADHD)
Quality measures are in place to help ensure that patients with specific conditions are receiving the appropriate care and follow-up to successfully manage their conditions. The measure listed below is applicable to those with attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD).

Follow-Up Care for Children Prescribed ADHD Medication (ADD)
This HEDIS measure looks at the percentage of children ages 6-12 years who have newly prescribed ADHD medication and have had at least three follow-up care visits within a 10-month period; the first visit should be within 30 days of the first ADHD medication dispensed.

Two rates are reported:

- Initiation phase — Follow-up visit with prescriber occurred within 30 days of prescription.
- Continuation and maintenance phase — Patient remained on ADHD medication and had two more visits within nine months.

When prescribing a new ADHD medication:

- Be sure to schedule a follow-up right away — The visit must occur within 30 days of ADHD medication initially prescribed or restarted after a 120-day break.
- Schedule follow-up visits while patients are still in the office.
- Have your office staff call patients at least three days before appointments.
- After the initial follow-up visits, schedule at least two more office visits in the next nine months to monitor the patient's progress.
- Be sure that follow-up visits include the diagnosis of ADHD.

Helpful tips:

- Educate your members and their parents, guardians, or caregivers about the use of and compliance with long-term ADHD medications and the condition.
- Collaborate with other organizations to share information, research best practices about ADHD interventions, appropriate standards of practice and their effectiveness and safety.
- Contact your Provider Relations representative for copies of ADHD-related patient materials.

Resources:

1. *ICD-10-CM Expert for Physicians. The complete official code set*. Optum360, LLC. 2019.
2. *ICD-10-CM/PCS Coding. Theory and practice. 2019/2020 Edition*. Elsevier
3. *NCQA: HEDIS & Performance Management*

TN-NB-0226-19

Coding spotlight — provider's guide to coding respiratory diseases

ICD-10-CM coding

Respiratory diseases are classified in categories J00 through J99 in Chapter 10, "Diseases of the Respiratory System" of the *ICD-10-CM Official Guidelines for Coding and Reporting*.

Pneumonia

Pneumonia is coded in several ways in ICD-10-CM. Combination codes that account for both pneumonia and the responsible organism are included in Chapter 1, "Certain Infectious and Parasitic Diseases" and Chapter 10, "Diseases of the Respiratory System." Examples of appropriate codes for pneumonia include:

- J15.0 — pneumonia due to Klebsiella
- J15.211 — pneumonia due to Staphylococcus aureus
- J11.08 + J12.9 — viral pneumonia with influenza.

Other types of pneumonia are coded as manifestations of underlying infections classified in chapter 1; two codes are required in such cases. Examples of this dual classification coding include I00 + J17 — pneumonia in rheumatic fever.

When the diagnostic statement is pneumonia without any further specification and the organism is not identified, the assigned code is J18.9 — pneumonia, unspecified organism.

Influenza
ICD-10-CM classifies influenza as the following categories:

- J09 — due to certain identified influenza viruses
- J10 — due to other identified influenza virus
- J11 — due to unidentified influenza virus.

Codes from categories J09 and J10 should be assigned only for confirmed cases of avian flu and other novel influenza A, or for other identified influenza virus.

Chronic obstructive pulmonary disease (COPD) and asthma
COPD is a general term used to describe a variety of conditions that result in obstruction of the airway. ICD-10-CM classifies these conditions to category J44, other chronic obstructive pulmonary disease. Category J44 includes the following conditions:

- Asthma with chronic obstructive pulmonary disease
- Chronic asthmatic (obstructive) bronchitis
- Chronic bronchitis with airways obstruction
- Chronic bronchitis with emphysema
- Chronic emphysematous bronchitis
- Chronic obstructive asthma
- Chronic obstructive bronchitis
- Chronic obstructive tracheobronchitis

Category J44 is further subdivided to specify whether there is an acute lower respiratory infection (J44.0) and whether there is an exacerbation of the condition (J44.1). If applicable, a code from category J45 is assigned to specify the type of asthma. It is appropriate to code both the COPD with acute exacerbation and COPD with a lower respiratory infection. Be specific in the documentation, including the type of infection and the infective agent. For COPD, document severity as either mild, moderate or severe. COPD can occur with or without acute or chronic respiratory failure, so any respiratory failure should be separately noted.

Asthma is classified into category J45; a fourth character indicates the severity as either mild intermittent, mild persistent, moderate persistent, severe persistent, other and unspecified; also, a final character indicates whether the condition is uncomplicated, or whether status asthmaticus or exacerbation is present.

Asthma characterized as obstructive or diagnosed in conjunction with COPD is classified to category
J44 — other chronic obstructive pulmonary disease. If the specific type of asthma is documented, also use code J45.

Signs and symptoms of COPD or asthma that are separately reported when they occur include hypercapnia, hypoxemia, polycythemia, and acute or chronic respiratory failure. Document any dependence on a ventilator or supplemental oxygen.

A diagnosis of asthmatic bronchitis without further specification is coded as J45.9-. If the diagnosis is stated as exacerbated or acute chronic asthmatic bronchitis, code J44.1 is assigned. A diagnosis of asthmatic bronchitis with COPD or chronic asthmatic bronchitis is coded to J44.9. Examples of coding for asthma include the following:

- J45.902 — asthmatic bronchitis with status asthmaticus
- J44.9 + J45.40 — moderate persistent asthma with COPD.

In addition to codes in categories J44 and J45, codes may also be assigned to identify exposure to environmental tobacco smoke (Z77.22), history of tobacco dependence (Z87.891), occupational exposure to environmental tobacco smoke (Z57.31), tobacco dependence (F17.-) or tobacco use (Z72.0)

HEDIS® quality measures for respiratory conditions

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Medication Management for People with Asthma (MMA)
This HEDIS measure looks at patients aged 5-64 who have been identified as having persistent asthma and have been dispensed appropriate medication on which they remained during the treatment period.

Two rates are reported:

- The percentage of patients who remained on an asthma controller medication for at least 50 percent of their treatment period
- The percentage of patients who remained on an asthma controller medication for at least 75 percent of their treatment period

For patients with asthma, you should:

- Prescribe controller medication.
- Educate them on identifying asthma triggers and taking controller medications.
- Create an asthma action plan (document in the medical record).
- Remind them to get their controller medication filled regularly.
- Remind them to continue taking the controller medications even if they are feeling better and free of symptoms.

Exclusions:

- Acute respiratory failure
- Chronic respiratory conditions due to fumes/vapors
- COPD
- Cystic fibrosis
- Emphysema
- Other emphysema

Asthma Medication Ratio (AMR)
This HEDIS measure looks at patients aged 5-64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.5 or greater during the measurement year.

Helpful tips:

- For each patient, count the units of asthma controller medications dispensed during the measurement year.
- For each patient, count the units of asthma reliever medications dispensed during the measurement year.
- For each patient, sum the units calculated in step 1 and step 2 to determine units of total asthma medications.
- For each patient, calculate the ratio of controller medications to total asthma medications (units of controller medications divided by units of total asthma).

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
This HEDIS measure looks at patients 40 years of age and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis.

Helpful tips:

- Managing chronic conditions takes planning. A pre-visit chart review is a good place to start.
- Proper diagnosis is needed to ensure patients receive appropriate short- and long-term treatment.
- Both symptomatic and asymptomatic patients suspected of COPD should have spirometry performed to establish airway limitation and severity.

Resources:

- *ICD-10-CM Expert for Physicians*: *the complete official code set*. Optum360, LLC. 2019.
- *ICD-10-CM/PCS Coding: theory and practice*. 2019/2020 Edition. Elsevier
- NCQA: HEDIS & performance management

TN-NB-0247-19

Reimbursement for early elective deliveries

The collaborative efforts of Amerigroup Community Care and the state Medicaid agencies, the March of Dimes, CMS, The Joint Commission, the American Congress of Obstetricians and Gynecologists, and many others have contributed to improvements in early elective delivery (EED) rates across the country. They have encouraged discussion among Amerigroup patients, care providers and hospitals. Hospital hard-stop policies describing the review of clinical indication and scheduling approval for EEDs also increased awareness of the harm caused by non-medically necessary EEDs. Additionally, voluntary efforts combined with payment reform have been found to further decrease EED rates while increasing gestational age and birth weight for the covered population.*

To improve birth outcomes for our members and further reduce EEDs, effective December 1, 2019, we'll require a Z3A diagnosis code indicating the gestational age on all professional delivery claims with supporting medical necessity diagnosis codes for EEDs. We'll apply MCG Care Guidelines, which define medically necessary criteria for EEDs.

All professional delivery claims (59400, 59409, 59410, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620 and 59622) with dates of service December 1, 2019, or after will require a Z3A code indicating the gestational age at the time of delivery. If the code is not on the claim, we will deny the claim with the explanation code e02 — *Delivery diagnoses incomplete without report of pregnancy weeks of gestation*. You may resubmit the claim with the appropriate Z3A code.

Professional delivery claims with dates of service December 1, 2019, or after with gestational ages of 37 and 38 weeks will require a supporting medically necessary diagnosis code for the early elective delivery. If a professional delivery claim is submitted without evidence of medical necessity, we will deny the claim with the explanation code k34 — *Delivery is not medically indicated.* You may resubmit the claim with the appropriate supporting diagnosis code or submit an appeal with the relevant medical records. For more information on the appeal process, refer to the *Provider Manual*.

* Dahlen, H. M., et al. (2017). Texas Medicaid Payment Reform: Fewer Early Elective Deliveries and Increased Gestational Age and Birthweight. Health Affairs, 36 (3), 460-467.

TN-NB-0229-19

CMS implementation of patient driven payment model for skilled nursing facility

Effective October 1, 2019, CMS has implemented the skilled nursing facility (SNF) patient driven payment model (PDPM). This pricing applies to SNF billing on type of bill (TOB) code 021X and hospital swing bed providers billing on TOB 018X. These changes will not affect contracted providers paid at the contracted per diem rates.

Under PDPM, the Health Insurance Prospective Payment System (HIPPS) code will be structured differently:

- The first position represents the physical and occupational therapy case mix group.
- The second position represents the speech/language pathology case mix group.
- The third position represents the nursing case mix group.
- The fourth position represents the nontherapy ancillary case mix group.
- The fifth position represents the assessment indicator code.

Additional notes:

- Inpatient SNF claims are paid using the resource utilization group-III (RUG-III) codes.
- Revenue code 0022 must be reported on the claim along with the RUG-III code claims for outpatient SNF.
- If the SNF is contracted and paid a per diem rate:
    - Amerigroup Community Care will not use the PDPM classification system to derive the payment.
    - Amerigroup will continue to pay based on the revenue codes billed.

- For **all** Amerigroup Amerivantage (Medicare Advantage) SNF claims (except critical access hospital skilled nursing swing bed claims), Amerigroup will continue to require SNFs to bill at least one revenue code 22 line with a HIPPS code.
- While SNFs will continue to bill using revenue code 22 and a HIPPS code, the HIPPS codes have changed to accommodate the PDPM.

TN-NB-0248-19

Behavioral health school-based services

Amerigroup Community Care received a memo from the Division of TennCare to clarify Individual Education Plan (IEP) requirements. Behavioral health services delivered in a school-setting are covered by TennCare and must meet TennCare's definition of medical necessity.

When the billing entity is a behavioral health provider:

- Behavioral health providers, such as community mental health centers, may render behavioral health services in a school-setting.
- Managed Care Organizations (MCOs) shall reimburse for such services, provided the related claims are billed appropriately, and shall not require such services to be included in the IEP.

When the billing entity is a school district:

- For school districts to be reimbursed by an MCO as a provider for TennCare members, the service must be included in the IEP.
- At MCO's discretion, school districts may contract with MCOs to provide services not contained in the IEP. This would be treated the same as services provided by any other MCO contracted provider.

Additionally, all TennCare medically necessary covered services provided on school grounds must be billed with the place of service code 03.

TNPEC-3011-19

Hospice tips

Summary: Amerigroup Community Care is pleased to provide our hospice provider community with a hospice tip sheet. This document is designed to give a high-level overview and includes CMS, the Division of TennCare and Amerigroup guidelines for credentialing, authorizations, claims submissions, routine care changes and service intensity add-on (SIA) payments.

Credentialing requirements:

- A full and complete credentialing application must be included with all required forms for each unique NPI and tax ID combination.

- For palliative or physician care providers, please attach a completed provider roster that includes all required demographic elements for loading into our claims adjudication system.
- Recredentialing is required at least every three years for each unique NPI and tax ID combination.
- Every hospice provider should be fully registered with the Division of TennCare, have a valid Medicaid ID and have an active Disclosure of Ownership on file to adhere to the TennCare policy.
    - Division of TennCare website
    - Provider manual: Provider website > Manuals & QRCs > Medicaid Provider Manual

Authorization requirements:

- Hospice (Q codes) authorizations are not required for members enrolled in both Medicare and Medicaid as of July 1, 2017.
- Although authorization is not a requirement at this time, Amerigroup medical directors may reach out to discuss members who are receiving benefits beyond 3-6 months.
- **Authorization is required for SIA procedure codes G0299, G0300 and G0155:**
    - **SIAs are postauthorization requests and can be requested up to two weeks after a member's death.**
    - When completing the *Precertification Request* form, please include all member and provider information as well as the member's date of death, dates of service for SIA, number of visits/hours and procedure code(s).
    - Fax the request to 1-866-495-5789.

Billing room and board claims:

- Effective July 1, 2018, there are no longer distinct level one and level two nursing facility rates in the state of Tennessee.
- Nursing facility reimbursement rate changes were implemented August 1, 2018, but were in effect as of July 1, 2018.
- The new blended rate will be loaded to the nursing facility level one Medicaid ID.
- Revenue code 0658 and procedure codes Q5003 (level one) or Q5004 (level two) should be used.
- The use of T codes will cause the claim to deny as a billing error.
- Hospices must report the NPI of any nursing facility where the patient is receiving hospice services, regardless of the level of care provided when the site of service is not the billing hospice.
- Per CMS guidelines, for dates of service on or after July 1, 2018, the billing hospice provider must now obtain the NPI for the facility where the patient is receiving care and report the facility's name, address and NPI in box 80 of the *UB-04* claim form. If any of the three items are missing in box 80, the claim will deny as a billing error.
    - Box 80 contains four lines with a 19-character limit on line one and a 24-character limit for each lines 2-4.
- For dates of service prior to July 1, 2018, the nursing facility name and Medicaid level ID must be included in box 80 of the *UB-04* claim form. If any of the two items are missing in box 80, the claim will deny as a billing error.

- Patient liability information should be in box 39, 40 or 41 with value code 23 and the patient liability amount. If there is no patient liability, please enter $0.
- If patient liability is left blank, the claim will deny as a billing error.
- Providers should bill for date of death.
- Provider should bill in box one the primary address that has been credentialed.

Example of room and board calculation:	
Blended nursing facility rate	$175
Hospice reimbursement 95% of above rate	$166.25
Q5003 room and board units	x 31
Total	$5,153.75
Member liability amount	- $1,000
Total claim pay amount	**$4,153.75**

2016 routine care and SIA payments:

- Routine care (revenue code 0651 with applicable HCPCS Q codes) will be reimbursed depending on the number of days the member is in hospice. The payment will be reduced beginning with day 61. These calculations are subject to the normal wage index.
- SIA payment for hospice services will include revenue code 055 with HCPCS code G0299 (RN) or revenue code 0561 with HCPCS code G0155. Reimbursement will have a maximum of four hours (in 15-minute intervals) or 16 units per day combined for both disciplines. These services will occur during the last seven days of life. Per CMS, the state period cannot span accounting years.
- Claims that are received for a member who has been disenrolled from hospice and elects to re-enroll within 60 days will continue with the current date/payment calculations.
- Claims that are received for a member who has been disenrolled from hospice and elects to re-enroll outside of 60 days will restart routine care eligibility at day one for pricing.
- Provider should bill in box one the primary address that has been credentialed.

2019 rate changes:

- Per CMS guidelines, for dates of service on or after December 1, 2019, Amerigroup will reimburse revenue codes 0551, 0561, 0651, 0652, 0655, 0656 and 0663 based on the beneficiary's locality. CMS publishes general hospice payment rates annually.

Quality and nonquality data criteria:

- Amerigroup reimbursement mirrors the federal Medicare policy.
- Annual reimbursement rates for CMS Medicaid hospice are effective October 1 of each fiscal year.
- Reimbursement is based on the location of the hospice provider.
- CMS provides a listing of facilities that meet the quality data criteria for each fiscal year as of October 1, 2016.
- Amerigroup will validate each fiscal year provider report and update rates accordingly.

Palliative care and physician charges:

- Services should be billed on a *CMS-1500* (professional) claim form.
- For palliative care, the claim should include the appropriate required data including CPT® codes, practitioner in box 24j and the hospice billing facility in box 33.
- There are no benefit or lifetime maximum restrictions for palliative care.

TNPEC-2944-19

Medicare Advantage:

Coverage provided by Amerigroup Inc.

Medical drug *Clinical Criteria* updates

View the full article in the Medicaid section.

TN-NB-0219-19/AGPCRNL-0058-19

Precertification Lookup Tool — easy access to prior authorization guidelines on the Availity Portal

View the full article in the Medicaid section.

TN-NB-0230-19

CMS implementation of patient driven payment model for skilled nursing facility

View the full article in the Medicaid section.

TN-NB-0248-19

CMS reminder: expedited/urgent requests

CMS defines an expedited/urgent request as “an expedited/urgent request for a determination is a request in which waiting for a decision under the standard time frame could place the member's life, health or ability to regain maximum function in seriously jeopardy.” Contracted providers should submit requests in accordance with CMS guidelines to allow for organization determinations within the standard turnaround time, unless the member urgently needs care based on the CMS definition of an expedited/urgent request.

AGPCRNL-0062-19

2020 Medicare Advantage benefit updates

An overview of notable 2020 benefit changes is available. Visit the provider website and select your state.

AGPCRNL-0052-19

Tennessee 2020 Medicare Advantage plan changes

Annual benefit changes for Amerigroup Amerivantage (Medicare Advantage) plan members under Amerigroup Community Care will be effective January 1, 2020. The following is a summary of these changes. Complete details can be found in the member's Evidence of Coverage. Please visit the provider website for 2020 Evidence of Coverage, formularies and benefit summaries, or contact Provider Services at the number on the back of the member's ID card. Changes may include medical and Part D benefits, copays, coinsurance, deductibles, formulary coverage, pharmacy network, premiums and out-of-pocket maximums.

Some group-sponsored Medicare Advantage plan benefits vary from the Medicare Advantage plans offered to individuals. Please refer to the member's Evidence of Coverage or call Provider Services at the number on the member ID card for more benefit detail.

2020 highlights

- **IngenioRx** — Effective January 1, 2020, IngenioRx will become our new Pharmacy Benefit Manager (PBM) and will start managing prescription coverage for your Medicare Advantage patients. IngenioRx PBM services will include handling your patients' prescriptions for mail order and specialty pharmacy medications. We will automatically transfer prescriptions to IngenioRx Home Delivery Pharmacy for patients currently using Express Scripts Mail Order Pharmacy. Members will receive instructions for initializing IngenioRx Home Delivery Pharmacy. Patients currently receiving specialty drugs from Accredo can continue to use Accredo in 2020. Most patients will be able to fill their prescriptions at their same retail pharmacy outlet. If your patient's pharmacy will not be available, we will notify your patient by letter and include a list of three alternative pharmacies near his or her home.
- **Medicare Part B step therapy —** Drug step therapy is a type of prior authorization that requires one drug (or drugs) to be tried for a medical condition prior to utilizing other drugs; the steps typically require lower cost drugs or drugs with better clinical outcomes to be tried first. In 2020, Part B step therapy may apply to some categories that include: Short Acting Colony Stimulating Factor (CSF): Preferred Drug-Zarxio, and Immune Globulins (IG): Preferred Drugs-Gamunex-C and Octagma. Other categories may be added later in 2020. If step therapy applies, the review will apply upon precertification initiation, in addition to the current medical necessity review. Step therapy will not apply for members who are actively receiving medications.
- **Medicare Community Resource Support** — This benefit supports members over-the-phone by providing information and education about navigating available benefits, community-based services and support programs.

- **Continuous glucose monitor** — This plan only covers FreeStyle Libre Continuous Glucose Monitors (CGMs). We will not cover other brands unless you tells us it is medically necessary. CGMs **must** be purchased at a network retail or our mail-order pharmacy to be covered. If a member purchases these supplies through a Durable Medical Equipment (DME) provider, these items will not be covered. Coverage limitations:
    - Two sensors per month
    - One receiver every two years
- **Medicare opioid benefit** — Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan: FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, substance use counseling, individual and group therapy, and/or toxicology testing.
- **No cost for certain labs** — $0 labs for A1C, urine protein, fecal occult blood test and diabetic eye exam
- **Emergency room copays** — Emergency room copay will be waived if a member receives care at a PCP, Urgent Care center or through LiveHealth Online within 24 hours prior to an emergency room visit.
- **Everyday Extras —** The Essential Extras package, available to HMO and HMO D-SNP members, allows members to select one of the following benefits to help them achieve their health goals. These benefits may help patients with meals, mobility and more. Prior authorization and/or recommendation from a licensed clinician may be required for some of these benefits. Members may choose one of the following benefits at enrollment or throughout the plan year. Members can request their selection through customer service. Because some benefits have an eligibility requirement, members are encouraged to consult their physician prior to their selection. Members may choose one of the following benefits:
    - **Transportation**: Provides up to 60 trips to get members to and from medical visits, SilverSneakers® locations and visits to a pharmacy to pick up prescriptions. Trips must be scheduled 48 hours in advance.
    - **Personal Home Helper:** Assistance services to provide in-home support for home-based chores and activities of daily living (ADL) to address needs while recovering from injury or illness. **This is nonskilled support for eligible members.** This benefit covers up to 124 hours of care (four hours per day for 31 days) in a calendar year. To qualify, members must need help with at least two activities of daily living (ADLs). Amerigroup will contact the member's physician to confirm the member's eligibility for this benefit based on the criteria above.
    - **Assistive Devices:** A $500 allowance toward the purchase of assistive or safety devices, such as ADA toilet seats, shower stools, hand-held showerheads, and reaching devices to help members live safely and comfortably in their own homes.
    - **Alternative Medicine:** Covers up to a combined total of 24 medically necessary acupuncture and/or therapeutic massage visits each calendar year.

- **Healthy Food Deliveries:** Meals to prevent or treat a health-related issue and to avoid health-related complications. Covers up to 16 delivered meals four times each calendar year (64 total) to support members who are either discharged from an overnight stay at a hospital, have a Body Mass Index (BMI) more than 25 or less than 18, or has an A1C level more than 9.0. The member must get prior approval from the health plan and a nutritional assessment or support by a health care provider may be required. Provider attestation will be required. Amerigroup will contact the provider on the member's behalf to secure the attestation. Providers are encouraged to request meals on the member's behalf to help ensure timely delivery following the qualifying event.
- **Healthy Nutrition:** This benefit provides members with certain chronic conditions access to nutritional counseling as well as monthly pantry staples (nonperishable items) that support a member's transition to more healthy eating habits. Provider attestation will be required. Amerigroup will contact the provider on the member's behalf to confirm the member's eligibility for this benefit based on qualifying chronic condition criteria.
- **Day Center Visits:** This benefit includes one visit per week, less than or equal to eight hours, and includes transportation to and from the adult day care location. To qualify, members must get prior approval from the health plan, need help with at least two (2) activities of daily living (ADLs) and must be recommended by a clinician. Provider attestation is required. The member must request reimbursement for a plan-approved, licensed facility (maximum reimbursement of $80 per day). Amerigroup will contact the member's physician to confirm the member's eligibility for this benefit based on the criteria above.
- **Service Dog Support:** An allowance to help pay for items, such as leashes and vests, used to care for a member's ADA-approved service dog. Provider attestation required. Amerigroup will contact the provider on the member's behalf to secure the attestation.
- **Health and Fitness Tracker:** Includes a fitness tracking device and access to an on-line memory fitness program with exercises for attention, brain speed, memory, people skills, navigation and intelligence.
- **Pest Control**: A pest control allowance for eligible members with asthma, other conditions to help ensure their residence is free of insects and other pests that may be detrimental to their health. Members who qualify for this benefit based upon their medical condition will have the option of a quarterly pest control service for common pests or, if required based on their condition, a one-time treatment of one to two rooms of specific pests, such as bed bugs. Provider attestation required. Provider attestation will be required. Amerigroup will contact the provider on the member's behalf to confirm the member's eligibility for this benefit based on qualifying chronic condition criteria.

Medicare Advantage HMO

Name change
Amerigroup Dual Coordination (HMO SNP) will be called Amerigroup Dual Coordination (HMO D-SNP) in 2020.

Three HMOs are expanding into McMinn County in 2020. They are:

1. Amerivantage Dual Coordination (HMO D-SNP)
2. Amerivantage Classic (HMO)
3. Amerivantage Balance (HMO)

Frequently offered supplemental benefits — Complete details can be found in the member's Evidence of Coverage.

- Annual exam — $0
- Preventive dental care
- Vision exam
- SilverSneakers® fitness program
- Hearing aid allowance
- Over-the-counter (OTC) allowances for medications and health-related items at more than 4,600 Walmart and Neighborhood Market stores and other participating retailers
- LiveHealth Online — Convenient access to a doctor via live, two-way video on a computer or mobile device; members logon to the LiveHealth Online website
- Nursing hotline
- Chiropractic care
- Post-discharge meals
- Worldwide coverage
- Personal Emergency Response System (PERS) — The Emergency Response System is intended to help people maintain independence in their own homes who might otherwise need to live in an assisted living facility. Monthly monitoring and testing is included.

Formulary and pharmacy

Formulary and pharmacy benefits for 2020 are as listed below:

- 100-day prescription refills – Members are eligible to receive a 100-day supply for the same price as a 90-day supply fill for drugs placed on tier 1 for the plans using a 5 tier formulary or on tier 6 for plans using a 6 tier formulary.
- Hyaluronic acid — Our plan covers Durolane, Euflexxa, Supartz and Gel-SYN-3 hyaluronic acids. We will not cover other brands unless you tell us it is medically necessary.

Your patients will have formulary changes and will need your help to ensure they get their prescriptions at the most affordable cost.

Please encourage your patients to review the 2020 formulary information within their Annual Notice of Change (ANOC) mailing or their new member kit, or online. Ask them if the coverage for any of their prescriptions has been changed, and consider alternative medications in a lower cost-sharing tier that may meet their needs.

Most individual MAPD plans have a pharmacy network that includes preferred and standard network retail pharmacies. Members may save more by paying a lower cost-sharing amount at preferred cost-sharing pharmacies. Our preferred cost-sharing pharmacies include **CVS/pharmacy, Giant Eagle, Kroger, Target, Sam's Club and Walmart. Additional independent pharmacies have been added to the cost-sharing network for 2020.**

Members can fill a prescription at a network retail pharmacy, but their cost-sharing amount may be higher.

Balance billing reminder
CMS and Amerigroup do not allow you to balance bill Medicare Advantage HMO and PPO members for Medicare-covered services. CMS provides an important protection for Medicare beneficiaries and our members such that, after our members have met any plan deductibles, they only have to pay the plan's cost-sharing amount for services covered by our plan. As a Medicare provider and/or a plan provider, you are not allowed to balance bill members for an amount greater than their cost share amount. This includes situations where we pay you less than the charges you bill for a service. This also includes charges that are in dispute.

Prior authorizations for Medicare Advantage plans
Prior authorization requirements are available by accessing the provider self-service tool via the Availity Portal. Contracted and non-contracted providers who are unable to access Availity may call our Provider Services at the phone number on the back of the member's ID card for prior authorization requirements.

Please check the member ID card for any identification and/or group number changes that may affect claim submissions. Sample 2020 member ID cards will be available via the provider website.

New member enrollment receipt changes
The *Member Enrollment Receipt* is a document found at the end of member enrollment kits that allows the agent or broker to fill in plan and agent information for the new member's reference. The receipt includes:

- Rx BIN, Rx PCN, and Rx GRP numbers
- Names, phone numbers, and websites for ancillary benefit information like dental, vision and hearing.

The enrollment receipt does not contain a member ID, and we expect our plan members to continue to bring their plan ID cards to their provider visits. If a member arrives to an appointment without their plan ID card, please follow your standard procedure for validating enrollment in our plan.

SABUCR-0019-19

Review of prepayment diagnosis-related group inpatient claims

This communication applies to Amerigroup Amerivantage (Medicare Advantage) providers.

To help ensure compliance with coding and documentation guidelines in the submission of claims, beginning February 1, 2020, Amerigroup Community Care will initiate prepayment reviews for selected diagnosis-related group (DRG) inpatient claims.

Amerigroup will request documentation for identified DRG claims. Clinical information, including lab results, treatment and medical management, should be included in the medical records submitted.

TN-NB-0250-19

Prior authorization requirements for E0784, K0553 and K0554

Effective **February 1, 2020**, prior authorization (PA) requirements will change for the following services to be covered by health plan for program members. Federal and state law, state contract language and CMS guidelines (including definitions and specific contract provisions and 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 codes:

- **E0784** — Ext Amb Infusn Pump Insulin
- **K0553** — Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, one month supply = one unit of service
- **K0554** — Receiver (monitor), dedicated for use with therapeutic glucose continuous monitor system

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the provider self-service tool via the Availity Portal. Contracted and noncontracted providers who are unable to access Availity may call Provider Services using the number on the back of the member's ID card for information on PA requirements.

AGPCRNL-0076-19

Global 3M19 Medical Policy and Technology Assessment Committee prior authorization requirement updates

Effective **February 1, 2020**, prior authorization (PA) requirements will change for the following services covered by Amerigroup Community Care for Amerigroup Amerivantage (Medicare Advantage) members. Federal and state law, as well as state contract language and CMS 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 codes:

- **81230:** CYP3A4 (cytochrome P450, family 3, subfamily A, member 4) (e.g., drug metabolism), gene analysis, common variant(s) (e.g., *2, *22)
- **81231:** CYP3A5 (cytochrome P450, family 3, subfamily A, member 5) (e.g., drug metabolism), gene analysis, common variants (e.g., *2, *3, *4, *5, *6, *7)
- **81232:** DPYD (dihydropyrimidine dehydrogenase) (e.g., 5-fluorouracil/5-FU and capecitabine drug metabolism), gene analysis, common variant(s) (e.g., *2A, *4, *5, *6)

- **81346:** TYMS (thymidylate synthetase) (e.g., 5-fluorouracil/5-FU drug metabolism), gene analysis, common variant(s) (e.g., tandem repeat variant)
- **0031U:** CYP1A2 (cytochrome P450, family 1, subfamily A, member 2) (e.g., drug metabolism) gene analysis, common variants (e.g., *1F, *1K, *6, *7)
- **0032U:** COMT (catechol-O-methyltransferase) (drug metabolism) gene analysis, c.472G>A (rs4680) variant
- **0033U:** HTR2A (5-hydroxytryptamine receptor 2A), HTR2C (5-hydroxytryptamine receptor 2C) (e.g., citalopram metabolism) gene analysis, common variants (e.g., HTR2A rs7997012 c.614-2211T>C)
- **0070U:** CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, common and select rare variants (e.g., *2, *3, *4, *4N, *5, *6, *7, *8, *9)
- **0071U:** CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, full gene sequence
- **0072U:** CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis (e.g., CYP2D6-2D7 hybrid gene)
- **0073U:** CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis (e.g., CYP2D7-2D6 hybrid gene)
- **0074U:** CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis
- **0075U:** CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis
- **0076U:** CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis
- **0091U:** oncology (colorectal) screening, cell enumeration of circulating tumor cells, utilizing whole blood, algorithm, for the presence of adenoma or cancer, reported as a positive or negative result
- **0092U:** oncology (lung), three protein biomarkers, immunoassay using magnetic nanosensor technology, plasma, algorithm reported as risk score for likelihood of malignancy
- **0093U:** prescription drug monitoring, evaluation of 65 common drugs by LC-MS/MS, urine, each drug reported detected or not detected
- **0098U:** respiratory pathogen, multiplex reverse transcription and multiplex amplified probe technique, multiple types or subtypes, 14 targets (adenovirus, coronavirus, human metapneum
- **0099U:** respiratory pathogen, multiplex reverse transcription and multiplex amplified probe technique, multiple types or subtypes, 20 targets (adenovirus, coronavirus 229E, coronavirus)
- **0100U:** respiratory pathogen, multiplex reverse transcription and multiplex amplified probe technique, multiple types or subtypes, 21 targets (adenovirus, coronavirus 229E, coronavirus)
- **J9036:** injection, bendamustine hydrochloride (Belrapzo®) 1 mg
- **81599:** unlisted multianalyte assay with algorithmic analysis
- **0094U:** genome (e.g., unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis
- **0101U:** hereditary colon cancer disorders (e.g., Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis)

- **0102U:** hereditary breast cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer)
- **0103U:** hereditary ovarian cancer (e.g., hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of next-generation sequencing, Sanger sequencing, multiplex ligation-dependent probe amplification
- **0104U:** hereditary pan cancer (e.g., hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer)
- **0408T:** insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed
- **0409T:** insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed
- **0410T:** insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed
- **0411T:** insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed
- **0412T:** removal of permanent cardiac contractility modulation system; pulse generator only
- **0413T:** removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)
- **0414T:** removal and replacement of permanent cardiac contractility modulation system pulse generator only
- **0415T:** repositioning of previously implanted cardiac contractility modulation transvenous electrode, (atrial or ventricular lead)
- **0416T:** relocation of skin pocket for implanted cardiac contractility modulation pulse generator
- **0417T:** programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values
- **0418T:** interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiac
- **0512T:** extracorporeal shock wave for integumentary wound healing, high energy, including topical application and dressing care; initial wound
- **0513T:** extracorporeal shock wave for integumentary wound healing, high energy, including topical application and dressing care; each additional wound
- **0544T:** transcatheter mitral valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture
- **0545T:** transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach
- **0548T**: transperineal periurethral balloon continence device; bilateral placement, including cystoscopy and fluoroscopy
- **0549T:** transperineal periurethral balloon continence device; unilateral placement, including cystoscopy and fluoroscopy
- **0550T:** transperineal periurethral balloon continence device; removal, each balloon

- **0551T:** transperineal periurethral balloon continence device; adjustment of balloon(s) fluid volume
- **E2599:** accessory for speech generating device, not otherwise classified

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the provider self-service tool on the Availity Portal by going to the provider website > Login.

Contracted and noncontracted providers unable to access Availity can call the Provider Services at 1-866-805-4589 for PA requirements.

AGPCRNL-0070-19

Provider training series

The Medicare Risk Adjustment Regulatory Compliance team at Amerigroup Community Care developed the following two provider training series titled:

Medicare risk adjustment and documentation guidance (general)
Series: Offered the first Wednesday of each month from 1-2 p.m. Eastern time
Learning objective: 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, offered from December 5, 2018-December 4, 2019, has been reviewed and is acceptable for up to 1.00 prescribed credit(s) by the American Academy of Family Physicians.

Those interested in joining us to learn how providers play a critical role in facilitating the risk adjustment process should register for one of the monthly training session.

Medicare Risk Adjustment, Documentation and Coding Guidance (condition specific)
Series: Offered bimonthly on the fourth Wednesday from noon-1 p.m. (ET)
Learning Objective: 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 23, 2019-to November 27, 2019, has been reviewed and is acceptable for credit by the American Academy of Family Physicians.

For those interested in joining us for this six-part training series, please see the list of topics and scheduled training dates below:

1. **Red flag HCCs, part one —** Register for recording of live session. 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.*
2. **Red flag HCCs, part two —** Register for recording of live session. 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.*
3. **Opioids and more: Substance Abuse and Dependence —** *Recording will play upon registration.*
4. **Acute, chronic and status conditions —** *Recording will play upon registration.*
5. **Diabetes Mellitus and Other Metabolic Disorders —** *Recording will play upon registration*.
6. **Behavioral health —** Training is scheduled for November 27, 2019. Registration

AGPCARE-0229-19

2019 Enhanced Personal Health Care Program releases myFHR

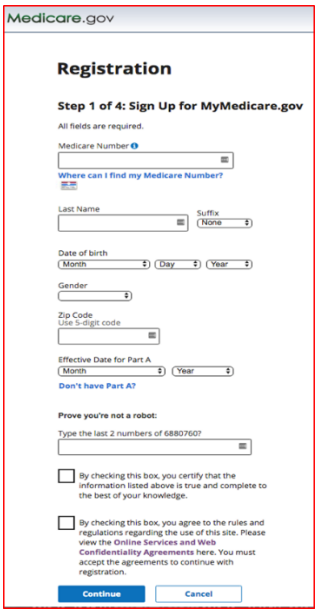
Amerigroup Community Care has released myFHR™, a new smartphone-based application that we believe will truly lead to improved care for your patients. CMS approved the inclusion of the Blue Button 2.0 standard within the myFHR application. Blue Button 2.0 is a CMS standard that enables Medicare members to download up to four year of their personal health data to the application of their choice. We are excited to offer our Medicare Advantage members this service.

There are multiple member advantages to the myFHR application:

- Provide our members with a consolidated view of their health history
- Empower members to access and control their own health data, and use it to improve their health
- Enable members to get help managing and improving their health
- Allow members to easily share health information with doctors, caregivers or anyone they choose

Amerigroup believes that empowering consumers to improve their health by giving them easy access to their own private health information is the right thing to do. Additionally, there is value to all health care stakeholders in having a longitudinal view. Providers benefit by receiving actionable access to patient data, and the myFHR application will allow your patients to share their data in your electronic medical records system. We would encourage you to discuss this option with your patients.

To connect to their Medicare claims history (Blue Button 2.0), your patient will need to register for MyMedicare and connect myFHR to their Medicare account.



If you have questions or would like more information on the myFHR application, you can reach out to your Value-Based team.

AGPCRNL-0060-19

Medicare preferred continuous glucose monitors

On January 1, 2020, Amerigroup Community Care will implement a preferred edit on Medicare-eligible continuous glucose monitors (CGMs). Currently, there are two CGM systems covered by CMS under the Medicare Advantage Part D (MAPD) benefit; these are Dexcom and Freestyle Libre. The preferred CGM for Medicare Advantage Part D individual members covered by Amerigroup will be Freestyle Libre. This edit will only affect members who are newly receiving a CGM system. Members will need to obtain their CGM system from a retail or mail order pharmacy — not a durable medical equipment (DME) facility. For Dexcom coverage requests, call 1-833-293-0661.

AGPCRNL-0057-19

Help protect your patients by providing medical ID protection — best practices

Overview

Many of our members have reported that they received unsolicited calls (or emails) from an individual or company offering to provide durable equipment devices, such as back or leg braces, or items such as topical creams at little or no cost. While it may be tempting to want to receive something for free, members should know that there is a cost.

Although our members may not receive a bill for these devices or medications, the items are billed to the insurance companies, costing hundreds or even thousands of dollars each.

How does this impact members?
Members should also know that the cost may be more than monetary. Allergic reactions may occur when using medications that are not properly prescribed. Ill-fitting leg or back braces, or equipment that is not specifically intended for the pain experienced by the member, could do more harm than good.

This problem is prevalent throughout the country, so all of our members should be aware. Billions of unsolicited telemarketing calls are made each year, many of which are promoting health care services. Calls often spoof local phone numbers or numbers that appear familiar to trick the recipient into accepting the call.

How can I help protect my patients?
While the ultimate purpose of these telemarketing calls is to sell these items, the immediate goal of the person or company placing the call is to obtain valuable personally identifiable information (PII) from the member. Without this personal information, such as a Social Security number or insurance identification number, selling these devices and medications is much more difficult. Share this information with you patients to help them learn how to protect their PII.

You can help protect your patients and their personally identifiable information from scams by reminding them of the following:

- Don't fall prey to scams!
- Take a few moments to review your *Explanation of Benefits (EOB)* and the services listed.
- When receiving robotic (robo) or telemarketing calls:
    - Simply hang up the phone.
    - Beware of threatening or urgent language used by the caller.
    - Do not provide any personally identifiable information such as your Social Security number or insurance identification number. The caller may imply that they have your information and ask you to provide it to confirm that they have the correct information. Do not provide the information or confirm it if they do happen to have any identification information.
- When receiving emails:
    - Do not open email attachments you weren't expecting.
    - Check for spelling mistakes and poor grammar.
    - Do **not** click on the links you are sent. You can type the link into a new browser.
    - Online scams can come from anywhere. Take a few moments to review your *EOB* and confirm that you received the services listed on the *EOB*.
- Additional ways to protect yourself:
    - Shred or destroy obsolete documents that contain medical claims information or *EOBs*.
    - Do not use social media to share medical treatment information.

How to report when you receive what you suspect is a scam call or email:

1. File a complaint with the Federal Trade Commission online or call 1-877-FTC-HELP.
2. Members may contact their plan's Member Services department.

AGPCRNL-0072-19