Provider NewsBlast

Amerigroup
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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:

Population Health can help you care for patients with chronic health care needs

Population Health programs are designed to assist PCPs and specialists in caring for patients with chronic health care needs. Amerigroup Community Care provides members enrolled in the program with continuous education on self-management, assistance in connecting to community resources and coordination of care by a team of highly qualified professionals whose goal is to create a system of seamless health care interventions and communications.

Who is eligible?
Population Health case managers provide support to members with:

- Behavioral health conditions such as depression, schizophrenia, bipolar disorder and substance use disorder.
- Diabetes.
- Heart conditions such as congestive heart failure, coronary artery disease and hypertension.
- HIV/AIDS.
- Pulmonary conditions such as asthma and chronic obstructive pulmonary disease.

Our case managers use member-centric motivational interviewing to identify and address health risks such as tobacco use and obesity to improve condition-specific outcomes. Interventions are rooted in evidence-based clinical practice guidelines from recognized sources. We implement continuous improvement strategies to increase evaluation, management and health outcomes.

We welcome your referrals. To refer a member to Population Health:

- Call 1-888-830-4300 to speak directly to one of our team members.
- Fill out the *Population Health Referral Form* located on the provider website and fax it to 1-888-762-3199 or submit electronically via the Availity Portal.

Your input and partnership is valued. Once your patient is enrolled, you will be notified by the Population Health case manager assigned. You can also access your patient's Population Health care plan, goals and progress at any time through the Availity Portal using Patient360. We are happy to answer any questions you might have. Our registered nurse case managers are available Monday-Friday from 8:30 a.m.-5:30 p.m. local time, and our confidential voicemail is available 24 hours a day, 7 days a week.

TN-NB-0270-20

Antibiotic dispensing guidelines

Overuse of antibiotics is directly linked to the prevalence of antibiotic resistance. Promoting judicious use of antibiotics is important for reducing the emergence of harmful bacteria that is unresponsive to treatment. The following HEDIS® measures assess appropriate antibiotic dispensing for pharyngitis, upper respiratory infection and bronchitis/bronchiolitis. Changes for HEDIS 2020 include expanded age range and additional stratifications.

Appropriate Testing for Pharyngitis (CWP)
Pediatric Clinical Practice Guidelines recommend only children with lab-confirmed group A strep or other bacteria-related ailments be treated with appropriate antibiotics. This measure reports the percentage of episodes for members 3 years of age and older where the member was diagnosed with pharyngitis, prescribed an antibiotic at an outpatient visit and received a group A strep test. A higher rate indicates better performance (i.e., appropriate testing).

Appropriate Treatment for Upper Respiratory Infection (URI)
This measure calculates the percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection that did not result in an antibiotic dispensing event. Reducing unnecessary use of antibiotics is the goal of this measure. It is reported as an inverted rate. A higher rate indicates appropriate upper respiratory infection treatment (i.e., the proportion of episodes that did not result in an antibiotic dispensing event).

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)
There is considerable evidence that prescribing antibiotics for uncomplicated acute bronchitis is not indicated unless it is associated with a comorbid diagnosis. This measure assesses the percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event. It is reported as an inverted rate. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (i.e., the proportion of episodes that did not result in an antibiotic dispensing event).

Helpful tips:

- When patients present with symptoms of pharyngitis, ensure proper testing (for strep) is performed to avoid the unnecessary prescribing of antibiotics. Record the results of the strep test.
- If prescribing an antibiotic to members with acute bronchitis, be sure to use the diagnosis code for the bacterial infection and/or comorbid condition.
- Educate members on the difference between bacterial and viral infections. Refer to the illness as a common cold, sore throat or chest cold. Parents and caregivers tend to associate these labels with a less frequent need for antibiotics.
- Write a prescription for symptom relief, such as rest, fluids, cool mist vaporizers and over-the-counter medicine.
- If a patient insists on an antibiotic, consider using delayed prescribing. Refer to the CDC handout for patients titled *What is Delayed Prescribing?* available at the link below.

Resources:

- CDC's Be Antibiotics Aware campaign
- CDC handouts for patients

TN-NB-0260-19

Medical drug benefit *Clinical Criteria* updates

On September 19, 2019, the Pharmacy and Therapeutics (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* for medical drug benefits is publicly available on the provider website under *News & Announcements*, and the effective dates will be reflected in the *Clinical Criteria Web Posting September 2019*. Visit *Clinical Criteria* to search for specific policies.

For questions or additional information, use this email.

TN-NB-0251-19

Reminder: Mid-level practitioners are required to file using their NPI

Amerigroup Community Care provides benefits for covered services rendered by nurse practitioners (NPs) and physician assistants (PAs) when operating within the scope of their license. Our policy states that these mid-level practitioners are required to file claims using their specific NPI number — not that of the medical doctor.

We will continue to monitor this area of concern through medical chart review and data analysis. Billing noncompliance can be considered a contract breach.

Amerigroup recognizes the quality of care delivered to our members can be improved by the proper use of NPs and PAs. This notice is in no way intended to discourage their proper use, but rather to clearly define how services should be appropriately billed.

Thank you for your continued participation.

TN-NB-0269-19

Coding tip for psychological and neuropsychological testing

A change to CPT® codes for psychological and neuropsychological test administration and evaluation services was effective January 1, 2019.* The new codes do not crosswalk on a one-to-one basis with the deleted codes.

These coding changes separate test administration from test evaluation, psychological testing evaluation from neuropsychological testing evaluation and define the testing performed by a professional or technician. The information below clarifies coding for these services.

Please note: Prior authorization (PA) requirements have not changed. Please check Precertification Look Up Tool for PA requirements for each code.

Neurobehavioral status exams
Neurobehavioral status exams are clinical interview examinations performed by a psychologist or neuropsychologist to assess thinking, reasoning and judgment.

Providers should continue to use CPT code 96116 when billing for the first hour.

Test administration and scoring by a psychologist or neuropsychologist
Two or more tests using any method should now be billed using CPT code 96136 for the first 30 minutes and 96137 for each additional 30 minutes.

Test administration and scoring by a technician
Two or more tests using any method should now be billed using CPT code 96138 for the first 30 minutes and 96139 for each additional 30 minutes.

Testing evaluation services
Testing evaluation services include the selection of the appropriate tests to be administered; integration of patient data; interpretation of standardized test results and clinical data; clinical decision-making; treatment planning; and reporting and interactive feedback to the patient, family members, or caregivers (when performed). There are distinct testing evaluation service codes for psychological testing and for neuropsychological testing.

Providers should now use CPT code 96130 to bill for the first hour of psychological testing evaluation services and 96131 for each additional hour.

Neuropsychological evaluation services should now be billed using CPT code 96132 for the first hour and 96133 for each additional hour.

Single automated test administration
Single automated test administration should be reported with newly created code 96146 for a single automated psychological or neuropsychological instrument that is administered via electronic platform and formulates an automated result. Psychologists should not use this code if two or more electronic tests are administered and/or if administration is performed by the professional or technician. Instead, the psychologist should use the appropriate codes listed above for test administration and scoring. A single automated test as the only service is not considered appropriate for the many elements seen with test evaluation.

Screening and risk assessment (repetitive assessment after screening)
Screening and risk assessment (repetitive assessment after screening) includes brief emotional/behavioral assessment (e.g., a depression inventory or ADHD scale) with scoring and documentation, per standardized instrument. This should be billed using CPT code 96127 separately from testing. Brief emotional/behavioral assessments should not be billed as psychological or neuropsychological testing.

* American Psychological Association website: *2019 Psychological and Neuropsychological Testing Billing and Coding Guide*

TN-NB-0254-19

Coding spotlight: HIV and AIDS

Code only confirmed cases
According to ICD-10-CM coding guidelines for *Chapter One*, code only confirmed cases of HIV infection/illness. This is an exception to the hospital inpatient guideline *Section II*, *H*. In this context, *confirmation* does not require documentation of positive serology or culture for HIV. The provider's diagnostic statement that the patient is HIV positive or has an HIV-related illness is sufficient.

Status	ICD-10-CM code
Asymptomatic HIV	• Assign code Z21 — Asymptomatic human immunodeficiency virus HIV infection status when the patient without any documentation of symptoms is listed as being *HIV positive*, *known HIV*, *HIV test positive* or similar terminology. • Assign code B20 — Human immunodeficiency virus HIV disease on the claim when the term *AIDS* is used, when the patient is being treated for HIV-related illness or when the patient is described as having any active HIV-related condition.
Patients with inconclusive HIV serology	• Assign code R75 — Inconclusive laboratory evidence of human immunodeficiency virus (HIV) when the patient's record is documented with inconclusive HIV serology but there is no definitive diagnosis or manifestations of the illness.
Previously diagnosed HIV-related illness	• Code B20 if you document a patient as having had any known prior diagnosis of an HIV-related illness — Z21 is no longer reported. If the patient develops an HIV-related illness, they should be assigned code B20 on every subsequent admission/encounter.
HIV infection in pregnancy, childbirth and the puerperium	• Assign code O98.7 — Human immunodeficiency virus (HIV) disease complicating pregnancy, childbirth and the puerperium first when a patient presents for treatment of an HIV-related illness during pregnancy, childbirth or the puerperium followed by code B20.

Status	ICD-10-CM code
	• Also assign additional code(s) for HIV-related illness(es). Keep in mind that codes from *Chapter 16* take priority when sequencing codes on the claim. • If a patient with asymptomatic HIV infection status presents for a routine visit during pregnancy, childbirth or the puerperium, the correct code assignment would be O98.7 followed by code Z21.

Assign code B20 for all types of HIV infections, which may be described by a variety of terms including:

- AIDS.
- Acquired immune deficiency syndrome.
- Acquired immunodeficiency syndrome.
- AIDS-related complex (ARC).
- AIDS-related conditions.
- HIV infection, symptomatic.

Testing for HIV:

- Assign code Z11.4 — Encounter for screening for human immunodeficiency virus (HIV) when seeing a patient with no prior diagnosis of HIV infection or positive HIV status to determine their HIV status.
- Code the signs and symptoms when seeing a patient with signs or symptoms for HIV testing. If you provide counseling during the encounter, assign additional code Z71.7 — Human immunodeficiency virus (HIV) counseling.
- Assign code Z71.7 if a patient's test results are negative for HIV.
- Assign code Z72.8 if a patient is known to be in a high-risk group for HIV infection. Other problems related to lifestyle can be assigned as an additional code.

Major HIV-related conditions	
HIV-related condition	**ICD-10-CM code**
Pneumonia, unspecified organism	J18.9
Tuberculosis of other sites	A18.89
Sepsis, unspecified organism	A41.9
Candida stomatitis (thrush)	B37.0
Herpes zoster (any site)	B02.9
Encephalopathy, unspecified	G93.40
Other HIV-related conditions	
Tinea cruris	B35.6
Anemia, unspecified	D64.9
Underweight	R63.6
Acute lymphadenitis	L04.9
Arthropathy, unspecified	M12.9
Splenomegaly, not elsewhere classified	R16.1
Weakness	R53.1

HIV/AIDS prevention
The CDC works with other federal agencies, state and local health departments, national organizations, and other entities to reduce the spread of HIV in the United States. This work covers several components:

- Behavioral interventions — These interventions ensure people have the information, motivation and skills necessary to reduce the risk of infection.
- HIV testing — Testing is critical to prevent the spread of HIV.
- Treatment and care — Treatment and care enable individuals with HIV to live longer, healthier lives.

The CDC remains on the forefront of pursuing high-impact prevention. This approach is designed to maximize the impact of prevention efforts for all Americans at risk for HIV infections and the CDC is aligning its efforts with the first National HIV/AIDS Strategy for the United States (NHAS). The Division of HIV/AIDS Prevention has developed a strategic three-year plan for 2017-2020 with the goal of one day achieving a future free of HIV.

Resources:

1. *ICD-10-CM Expert for Physicians.* The complete official code set. Optum360, LLC. 2019.
2. CDC website: HIV/AIDS.

TN-NB-0261-19

Medicare Advantage:

Coverage provided by Amerigroup Inc.

Reminder: Mid-level practitioners are required to file using their NPI

View the full article in the Medicaid section.

TN-NB-0269-19

Coding tip for psychological and neuropsychological testing

View the full article in the Medicaid section.

TN-NB-0254-19/AGPCRNL-0082-19

Complex discharge planning

Background: As we begin 2020, we are adding utilization management complex discharge planning and case management complex discharge planning roles to our teams. We are excited to offer members, their families and caregivers someone to work with them while the member is inpatient and after discharge.

This team member will work with the facility to understand the member's needs, discharge plan and possible home needs. If your patient is sent to a post-acute setting, we will also work with that facility to understand any barriers to discharge and referrals to other Medicare programs.

If the member requires assistance after discharge, we will offer a team member to help the member receive necessary referrals to identified programs, help the member follow their discharge plan and assist in making any necessary appointments to see their doctors.

This is a collaborative program; we need your help to understand what your patients need to be successful upon discharge and to reach our common goal — avoidance of readmissions and ER utilization.

We look forward to working with you and the acute and post-acute facilities that offer this value-added program to our Medicare Advantage population.

AGPCARE-0354-20

Outpatient Rehabilitation Program transition: new prior authorization requirements

Summary of update: Effective April 1, 2020, Amerigroup Community Care will transition the utilization management of our Outpatient Rehabilitation Program to AIM Specialty Health® (AIM). AIM is a specialty health benefits company. The Outpatient Rehabilitation Program includes physical, occupational and speech therapy services. Amerigroup has an existing relationship with AIM in the administration of other programs.

This relationship with AIM will enable Amerigroup to expand and optimize this program, further ensuring that care aligns with established evidence-based medicine. AIM will follow the clinical hierarchy established by Amerigroup for medical necessity determination. Amerigroup makes coverage determinations based on guidance from CMS, including national coverage determinations, local coverage determinations, other coverage guidelines and instructions issued by CMS, and legislative changes in benefits. When existing guidance does not provide sufficient clinical detail, AIM will determine medical necessity using an objective, evidence-based process.

AIM will continue to use criteria documented in Amerigroup clinical guidelines *CG.REHAB.04*, *CG.REHAB.05* and *CG.REHAB.06* for review of these services. These clinical guidelines can be reviewed online.

Detailed prior authorization requirements are available on the Availity Portal by accessing the Precertification Lookup Tool under *Payer Spaces*. Contracted and noncontracted providers should call Provider Services at the phone number on the back of the member's ID card for prior authorization requirements.

Prior authorization review requirements
For services to be rendered for dates of service from October 1, 2019-March 31, 2020, no prior authorization is required for outpatient rehabilitation services. For these service dates, in addition to all other rights Amerigroup has under our provider contract and law, Amerigroup and AIM will continue to monitor claims history and utilization trends and will validate provider and member information. AIM will facilitate training sessions to provide an overview of the program and demonstrate the AIM ***Provider****Portal*SM. Please access the AIM Rehabilitation Provider Portal to register for an upcoming session.

For services that are scheduled on or after April 1, 2020, providers must contact AIM to obtain prior authorization. Beginning March 19, 2020, providers will be able to contact AIM for prior authorization of services to take place on or after April 1, 2020. Providers are strongly encouraged to verify that they have obtained prior authorization before scheduling and performing services.

How to place a review request
You may place a prior authorization request online via the AIM ***Provider****Portal*. This service is available 24 hours a day, 7 days a week to process requests in real time using clinical criteria. Go to the AIM ***Provider****Portal* website to register. You can also call AIM at 1-800-714-0040, Monday-Friday 7 a.m.-7 p.m. Central time.

For more information
Find resources to help your practice get started with the Outpatient Rehabilitation Program here. For website login issues, call 1-800-252-2021.

The AIM website provides access to useful information and tools, such as order entry checklists, clinical guidelines and an FAQ.

AGPCARE-0329-19

Nonpreferred products and corresponding preferred alternatives

Beginning January 1, 2020, patients using nonpreferred products with a high patient cost share are now contacted about the availability of lower patient cost share preferred alternatives. If the patient is interested in switching, we will call or fax their provider who can determine whether the preferred alternative is clinically appropriate. This is strictly informational and not a substitute for physician-directed medical evaluations or treatments.

A list of the included nonpreferred products and corresponding preferred alternatives are listed below.

Nonpreferred products	Preferred alternative(s)
Aciphex DR	omeprazole pantoprazole
Actos	pioglitazone HCL
Advair Diskus	fluticasone-salmeterol Wixela Inhub

Nonpreferred products	Preferred alternative(s)
Aggrenox	aspirin-dipyridamole ER
Ampyra ER	dalfampridine ER
Breo Ellipta	fluticasone-salmeterol Wixela Inhub
Cambia	diclofenac sumatriptan
chlorzoxazone	cyclobenzaprine
Coumadin	warfarin
Crestor	rosuvastatin
Dexilant	omeprazole pantoprazole
Dilantin	phenytoin
Diovan HCT	valsartan/hydrochlorothiazide
Duexis	ibuprofen & famotidine
Dymista	fluticasone & azelastine
Epzicom	abacavir-lamivudine
Evzio	naloxone HCL
Farxiga	Jardiance
Gleevec	imatinib
Glumetza	metformin ER (generic Glucophage XR)
Incruse Ellipta	Spiriva
Invega	paliperidone ER
Invokana	Jardiance
Jublia	ciclopirox
Kerydin	ciclopirox
Kombiglyze	Janumet XR
Lamictal	lamotrigine
Lanoxin	digoxin
Lipitor	atorvastatin
Livalo	atorvastatin lovastatin pravastatin simvastatin
Lovaza	omega-3 acid ethyl esters
Mestinon	pyridostigmine
metformin ER (generic Glumetza)	metformin ER (generic Glucophage XR)
metformin ER OSM (generic Fortamet)	metformin ER (generic Glucophage XR)
Mirapex	pramipexole
Myrbetriq ER	oxybutynin
Nexium	omeprazole pantoprazole
Nilandron	nilutamide
Novolin N	Humulin N
Novolog	Humalog

Nonpreferred products	Preferred alternative(s)
omeprazole-bicarbonate	omeprazole pantoprazole
Onfi	clobazam
Onglyza	Januvia
Pennsaid	meloxicam
Protonix	omeprazole pantoprazole
Renvela	sevelamer
Requip	ropinirole
Restasis	Xiidra
Soolantra	metronidazole azelaic acid
Symbicort	fluticasone-salmeterol Wixela Inhub
Synthroid	levothyroxine
Tresiba	Basaglar Lantus Toujeo
Trokendi XR	topiramate
Tudorza Pressair	Spiriva
Vasotec	enalapril
Vimovo	naproxen & omeprazole
Wellbutrin XL	bupropion XL
Xalatan	latanoprost
Xenazine	tetrabenazine
Zestoretic	lisinopril/hydrochlorothiazide
Zestril	lisinopril
Zileuton ER	montelukast

AGPCRNL-0091-20

Personal Home Helper benefit

Your patient's current supplemental benefit for Personal Home Helper has been reauthorized for 2020. For billing in 2020, use the new authorization number. For more information or to view the new authorization number, sign into the Availity Portal or call Provider Services at 1-800-499-9554.

Submit claims electronically through Availity

Availity is well known as a web portal and claims clearinghouse, but they are much more. Availity also functions as an electronic data interchange (EDI) gateway for multiple payers and is the single EDI connection for all of Anthem, Inc. It will allow you to submit claims electronically, verify preauthorization and member information, check claims status, and much more.
To get started, visit this page and select your state.

Benefits update for Special Supplemental Benefits for the Chronically Ill

Amerigroup Community Care filed a number of supplemental benefits under new guidelines released by CMS. The guidelines, known as Special Supplemental Benefits for the Chronically Ill (SSBCI), allow Medicare Advantage (MA) plans to offer expanded benefits/services, provided they have a reasonable expectation of improving or maintaining the health or overall function of the enrollee as it relates to the chronic condition or illness.

New benefits filed under the new SSBCI guideline include nutrition benefits (Healthy Nutrition, Prescribed Nutrition), a pest control benefit and a benefit providing support to our members with service dogs through the *Americans with Disabilities Act*. Not all benefits are available on every MA plan.

To comply with CMS guidance, Amerigroup **must** ascertain that the member meets the criteria defined by CMS for being chronically ill. In some cases, information will be available in patient records. In other cases, Amerigroup will need to contact providers to ensure that member has a qualifying condition and that, as the member's physician, they concur this benefit meets the standards of helping improve or maintain the member's condition.

Amerigroup encourages our members to consult with their physician when selecting a benefit. As some of these benefits are elective and include other options, providers may be able to help their patients make the most appropriate benefit choice for their needs.

For more information on SSBCI, visit the CMS website.

AGPCRNL-0083-19

Special section:
Long-Term Services and Supports (LTSS)

New timelines and standards for outcome-based employment services

The Employment team at Amerigroup Community Care conducted training for our employment providers on new timelines and standards for all outcome-based employment services via webinar during the month of February 2020. The overall goal for the new guidelines is to ensure members receive services in a timely manner. We believe implementing these new guidelines will result in improved outcomes and communication between providers and Amerigroup.

New standards include:

- Providers are to notify an employment specialist as soon as a delay in service is identified.
- If there are more than two provider-driven extensions needed, we may approach other providers to complete the service or terminate the preauthorization.
- If there are more than two member-driven extensions, the support coordinator will address the issues with the member and their supports.

Information on provider changes:

- When staff turnover results in delays, immediate notification is required.
- If there are unforeseen staffing issues that the provider cannot immediately address, the provider should let us know this and send a realistic timeline of when they anticipate having staff to serve the member.

Increased focus on authorizations in an individual's PCSP

As we move into 2020, Amerigroup Community Care wants to thank those providers who deliver valuable services to the Employment and Community First CHOICES (ECF CHOICES) members we support. Our goal is to have services authorized by Amerigroup in a timely manner so that each provider agency has seamless billing throughout the year. As we strive to reach our goal, we ask that ECF CHOICES providers have an increased focus on reviewing our members' person-centered support plans (PCSPs), and ensure that authorizations for services listed on the PCSP are correct and have the needed time frames. We also ask that ECF CHOICES providers are aware of the end dates of current authorizations and notify the support coordinator of any authorizations ending to ensure re-authorizations are completed prior to the service ending.

On our end, we are adding an increased focus on support coordinators, ensuring re-authorizations are completed prior to the service ending on the PCSP. Through a joint effort on consistent reviews of the PCSPs, we will reduce any gaps in services for those we support. You may contact the provider request inbox at ltcprovreq@amerigroup.com with any questions regarding the re-authorization of services or to notify them that a service on the PCSP will be ending soon and needs to be re-authorized by the support coordinator.

EVV reminder

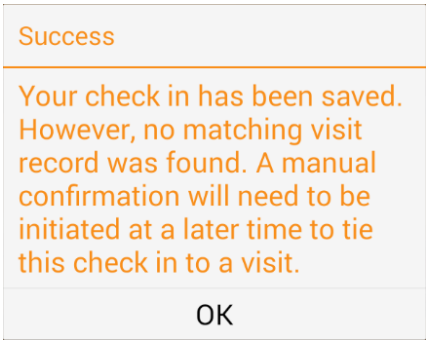
If staff does not clock in within the start window for services, an electronic visit verification (EVV) representative will reach out to the individual scheduled to receive services and the provider authorized to provide services. The EVV representative will need to know the following information from the provider when verifying staffing:

- Caregiver name
- Caregiver arrival time
- Why one of the preferred methods was not used (e.g., device, bring your own device or interactive voice response)
- Any issue as to why the caregiver is not using the preferred methods

Providing the scheduled start window does **not** suffice as the actual time the caregiver arrived.

- Example 1: start window of 8 a.m.-9 a.m.
    - The appointment will roll to late at 9:15 a.m.
    - The appointment will roll to missed at 10 a.m., which will prompt a missed visit alert and the EVV team will call to verify staffing information.
- Example 2: hard start window of 8 a.m.
    - Appointment will roll to late at 8:15 a.m.
    - Appointment will roll to missed at 9 a.m., which will prompt a missed visit alert and the EVV team will call to verify staffing information.

The caregiver can clock in up to 15 minutes prior to the start of the window. For anything greater than the 15 minutes, the caregiver will receive the following message:



It is the expectation of Amerigroup Community Care that providers should have **at least one** full-time staff person devoted to EVV system monitoring, including after hours and weekends if an individual is scheduled to receive care, and **two** staff persons fully trained and knowledgeable of the EVV system and its functionality. Use of this system is compulsory by providers administering home- and community-based services to individuals receiving services through Amerigroup.

TN-NB-0272-20