COVID-19 update: Suspension of select prior authorization rules and announces significant policy adjustments in response to unprecedented demands on health care providers

Amerigroup Community Care recognizes the intense demands facing doctors, hospitals and all health care providers in the face of the COVID-19 pandemic. Today, unless otherwise required under state and federal mandates, as detailed below, Amerigroup health plans will suspend select prior authorization (PA) requirements, member copays, and claims review and handling protocols to allow health care providers to focus on caring for patients diagnosed with COVID-19. These adjustments apply to members of all lines of business.

Where permissible, these guidelines apply to Federal Employee Plan (FEP) members. For the most up-to-date information about the changes FEP is making, go to **https://www.fepblue.org/coronavirus**.

Inpatient and respiratory care

PA requirements are suspended for patient transfers.

- Prior authorization will be waived for inpatient nonelective admissions. Although PA is not required, Amerigroup requests voluntary notification via the usual channels to aid in our members' care coordination and management.
- Concurrent review for discharge planning will continue unless required to change by federal or state directive.
- PA requirements are suspended for COVD-19 DME, including oxygen supplies, respiratory devices, and continuous positive airway pressure (CPAP) devices, noninvasive ventilators, and multi-function ventilators for patients who need these devices for any medical reason as determined by a provider, along with the requirement for authorization to exceed quantity limits on gloves and masks.
- Respiratory services for acute treatment of COVID-19 will be covered. PA requirements are suspended where previously required.

COVID-19 testing

Laboratory tests for COVID-19 at both in-network and out-of-network laboratories will be covered with no cost sharing for members.

Claims audits, retrospective review, peer-to-peer review and policy changes

Amerigroup will adjust the way we handle and monitor claims to ease administrative demands on providers:

- Hospital claims audits requiring additional clinical documentation will be limited for the next 90 days, though Amerigroup reserves the right to conduct retrospective reviews on these findings with expanded lookback recovery periods for all lines of business except

Medicare. To assist providers, Amerigroup can offer electronic submission of clinical documents through the provider portal.

- Retrospective utilization management review will also be suspended during this 90-day period, and Amerigroup reserves the right to conduct retrospective utilization management review of these claims when this period ends and adjust claims as required.
- **Suspend peer to peer reviews** except where required pre-denial per operational workflow or where required by State during this time period for all lines of business except Medicare. Our Special Investigation programs targeting provider fraud will continue, as well as other program integrity functions that help ensure payment accuracy.
- New payment and utilization management policies and policy updates will be minimized, unless helpful in the management of the COVID-19 pandemic.

Otherwise, Amerigroup will continue to administer claims adjudication and payment in line with our benefit plans and state and federal regulations, including claims denials where applicable. Our timely filing requirements remain in place, but Amerigroup is aware of limitations and heightened demands that may hinder prompt claims submission.

Providers should watch the **Provider News** page for any future administrative changes or policy adjustments we may make in response to the COVID-19 pandemic.