November 2021

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Amerigroup

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Table of Contents

MD-NL-0479-21

COVID-19 information from Amerigroup Community Care

Amerigroup is closely monitoring COVID-19 developments and how the novel coronavirus will impact our customers and provider partners. Our clinical team is actively monitoring external queries and reports from the Centers for Disease Control and Prevention (CDC) and Maryland Department of Health (MDH) to help us determine what action is necessary on our part. Amerigroup will continue to follow MDH guidance policies.

For additional information, reference the *COVID-19 Updates* section of our **website**.

MDPEC-2081-20

Administration

Unspecified diagnosis reminder

This is a reminder to all providers that we require laterality-specific coding when applicable. Therefore, claims processed on or after October 1, 2021, will be denied when ICD-10-CM laterality coding guidelines are not followed.

In accordance with the International Classification of Disease, 10th Revision, clinical modification (ICD-10-CM) correct coding guidelines, in which state Medicaid programs follow, we will begin to edit diagnosis in *Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue* for appropriate laterality billing.

ICD-10-CM diagnosis coding falls under *Health Insurance Portability and Accountability Act (HIPAA)* correct code sets and they are designed to specifically define laterality (e.g., left, right, unspecified, or exists bilaterally, etc.). Providers are required to submit the defined code in accordance with the condition. The ICD-10-CM guidelines for Coding and Reporting state (for Laterality coding), "Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. If the side is not identified in the medical record, assign the code for the unspecified side."

The ICD-10-CM diagnosis code should correspond to the medical record, CPT® and HCPCS code(s), and/or modifiers billed.

MD-NL-0463-21

Electronic data interchange process

Availity* serves as our electronic data interchange (EDI) partner for all electronic data and transactions. The Availity EDI processing generates response files for each submitted electronic file and delivers them to the submitter's Availity mailbox. It is important to review these responses to understand where your claims are in the process.

Electronic file submitter:

- If your organization uses a clearinghouse or vendor, they have an Availity mailbox to submit clients' files. Availity delivers the responses for claims to the same mailbox, and the clearinghouse or vendor is responsible for returning the results to their clients and resubmitting any files rejected for formatting, interchange, or transaction set errors. The submitter in this scenario is the clearinghouse or vendor.
- If your organization uses a practice management software, an Availity mailbox is set up during initial registration for your electronic file submissions. The submitter is your organization and is responsible for analyzing the responses to verify there are not any file errors or claim rejections that require correction and resubmission within timely filing guidelines.

Availity electronic file process:

1. **Submit electronic file to Availity** — Availity validates for file format and returns file acknowledgments to the submitter's Availity mailbox. If there are any edits at this point, the entire electronic file will not advance and will require resubmission within timely filing guidelines.
2. ***HIPAA* and payer specific edits** — The electronic file moves to the next phase, which is *HIPAA* and business editing. Examples include:
   - Valid subscriber ID for the date of service
   - Billing and coding validation

   If an error occurs at this point, the individual claims with the errors must be corrected, resubmitted as an original claim and do not advance. The claims that do not have an edit will then route to the adjudication systems for second-level edit validation.
3. **Amerigroup Community Care payer receives electronic file from Availity** — For the Medicaid line of business, there is a second level of editing.

   Edits for this second level return the *Delayed Payer Report (DPR)*. Only claims that pass will advance for adjudication and will be displayed using Availity claim status, electronic claim status transactions, Availity remittance inquiry, 835 electronic remittance advice, and paper Explanation of Payment. If there are edits, the claim requires resubmission within timely filing guidelines.

Read more online.

** Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup Community Care.*

MD-NL-0442-21

Policy Updates

Medical drug benefit *Clinical Criteria* updates

On August 21, 2020, November 20, 2020, and June 24, 2021, the Pharmacy and Therapeutics (P&T) Committee approved several *Clinical Criteria* applicable to the medical drug benefit for Amerigroup Community Care. These policies were developed, revised, or reviewed to support clinical coding edits.

Read more online.

MD-NL-0461-21

Visit the ***Clinical Criteria* website** to search for specific policies. If you have questions or would like additional information, reach out via **email**.

Claims editing update for ICD-10-CM Excludes1 notes

Beginning with dates of service on or after December 1, 2021, Amerigroup Community Care will implement revised claims editing logic tied to Excludes1 notes from ICD-10-CM 2020 coding guidelines. To ensure the accurate processing of claims, use ICD-10-CM coding guidelines when selecting the most appropriate diagnosis for member encounters. Please remember to code to the highest level of specificity. For example, if there is an indication at the category level that a code can be billed with another range of codes, it is imperative to look for Excludes1 notes that may prohibit billing a specific code combination.

If you need assistance in determining proper coding guidance, the following site should be helpful: **https://www.cdc.gov/nchs/icd/icd10cm.htm**.

What are Excludes1 notes?

One of the unique attributes of the ICD-10-CM code set and coding conventions is the concept of Excludes1 notes. An Excludes1 note indicates that the excluded code identified in the note should not be billed with the code or code range listed above the Excludes1 note. These notes appear below the affected codes; if the note appears under the Category (first three characters of a code), it applies to the entire series of codes within that category. If the Excludes1 note appears beneath a specific code (3, 4, 5, 6, or 7 characters in length), then it applies only to that specific code.

Read more online.

MD-NL-0455-21

Multiple obstetrical ultrasounds

Effective January 1, 2022, Amerigroup Community Care will cover obstetrical examination (code 76816) and transvaginal ultrasound (code 76817) performed during the same obstetrical patient encounter when medically necessary.

When both procedures are reported for the same patient on the same day, the obstetrical examination (code 76816) will be considered the primary procedure and will be reimbursed at 100% of the fee schedule allowed amount. The transvaginal ultrasound will be considered the secondary procedure, and a 50% multiple procedure payment reduction will be applied.

Definitions:

- **Obstetrical examination** — Code 76816 describes an examination designed to reassess fetal size and interval growth or re-evaluate one or more anatomic abnormalities of a fetus previously demonstrated on ultrasound.
- T**ransvaginal obstetric ultrasound** — Code 76817 describes a transvaginal obstetric ultrasound performed separately or in addition to one of the transabdominal examinations.

MDPEC-2713-21

Medical nutrition therapy

Effective January 1, 2022, Amerigroup Community Care will require nutritional services to be delivered by a licensed nutritionist or dietician. Nutritional services include nutrition assessments and evaluations, the development and monitoring of appropriate plans to address the nutritional needs of the participant, and referrals to the appropriate community resources to achieve any nutrition goal identified in an *Individualized Education Plan (IEP)/Individualized Family Service Plan (IFSP)*.

Why is this change necessary?

On January 1, 2021, the *Maryland Medical Assistance Early & Periodic Screening, Diagnosis & Treatment Policy & Procedure Manual & Billing Instructions* stated that nutrition services must be delivered by a licensed nutritionist or dietician in order to develop and implement an IEP/IFSP.

Which medical nutrition therapy codes are impacted?

The medical nutrition therapy codes impacted are:

- **97802** — Initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- **97803** — Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- **97804** — Medical nutrition therapy, group (2 or more individuals), each 30 minutes

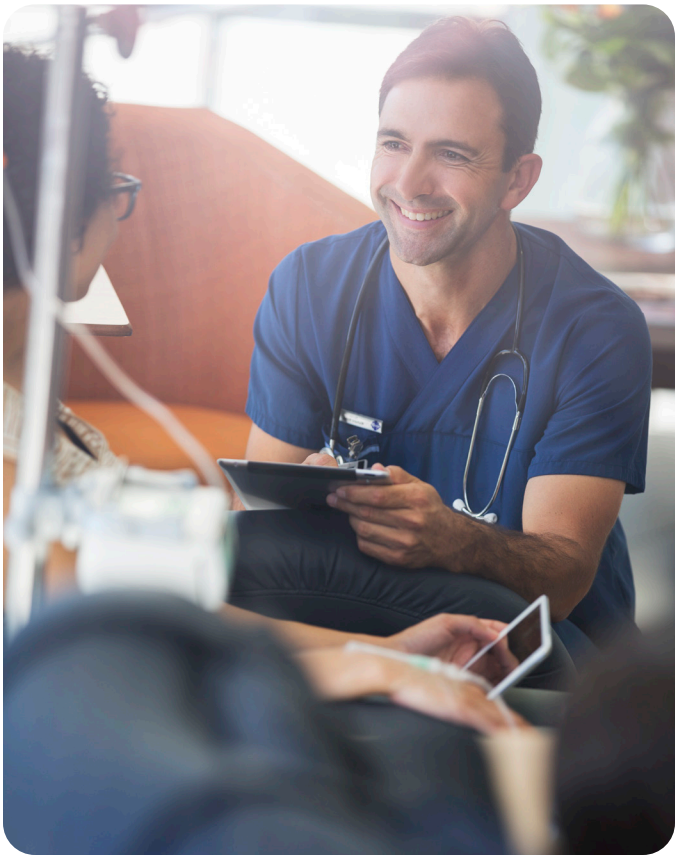
MDPEC-2712-21

J-code redirection

Effective January 1, 2022, Amerigroup Community Care will require that additional specific J code services for infusion or injectable therapy services be rendered in the patient's home or freestanding infusion center for members 8 years and older.

The codes below will be added to the previous redirection code list:

Procedure description	J-code
Injection, rituximab, 10 mg	J9312
Injection, pertuzumab, 1 mg	J9306
Injection, nivolumab, 1 mg	J9299
Injection, trastuzumab, excludes biosimilar, 10 mg	J9355
Injection, rituximab-abbs, biosimilar, 10 mg	Q5115
Injection, bevacizumab-awwb, biosimilar, (Mvasi), 10 mg	Q5107
Injection, bevacizumab, 10 mg	J9035
Injection, trastuzumab-anns, biosimilar, (kanjinti), 10 mg	Q5117
Injection, trastuzumab-dkst, biosimilar, (Ogivri), 10 mg	Q5114
Injection, bortezomib (Velcade), 0.1 mg	J9041
Injection, ipilimumab, 1 mg	J9228
Injection, cetuximab, 10 mg	J9055



Unless there is a medical reason for providing the specific J-code service in an outpatient hospital setting, the services should be rendered in the patient's home by a certified home infusion vendor or in a freestanding infusion center.

In addition, where the availability and accessibility to outpatient infusion centers and home infusion providers is adequate, certain J-code services will require review and precertification of the site of service when medical necessity of the service is met, and hospital outpatient site of service is requested.

All service authorization requests will be processed according to State Medicaid requirements.

Read more online.

MDPEC-2714-21

Prior authorization updates for specialty pharmacy

Effective for dates of service on and after November 1, 2021, the following specialty drug codes from current or new *Clinical Criteria* documents will require prior authorization.

Please note, inclusion of the national drug code (NDC) on your claim will help expedite claim processing of drugs billed with a not otherwise classified (NOC) code.

Visit the ***Clinical Criteria* website** to search for the specific *Clinical Criteria* listed below.

Clinical Criteria	HCPCS or CPT® code(s)	Drug	Drug classification
ING-CC-0170	J1823	Uplizna	Immunosuppressive agents
ING-CC-0172	J3490, J3590, C9071	Viltepso	Muscular dystrophies
ING-CC-0173	J3490, J3590	Enspryng	MISC conditions
ING-CC-0174	J3490, J3590, C9399	Kesimpta	Multiple sclerosis
ING-CC-0168	J9999, C9073	Tecartus	CAR-T
ING-CC-0171	J9223	Zepzelca	Cancer
ING-CC-0169	J9316	Phesgo	Cancer
ING-CC-0175	J9015	Proleukin	Cancer
ING-CC-0176	J9032	Beleodaq	Cancer
ING-CC-0178	J9262	Synribo	Cancer
ING-CC-0177	J3304	Zilretta	Osteoarthritis
ING-CC-0002	Q5122	Nyvepria	Blood cell deficiency
ING-CC-0038	J3110	Forteo	Osteoporosis

MDPEC-2638-21/MD-NL-0472-21

Four things you can do to encourage cancer screenings for your women patients

The American Cancer Society estimates there will be approximately 1,898,160 cancer cases diagnosed in 2021. That's the equivalent of 5,200 new cases every day.[1] The good news is, patients say they are more likely to get screened when you recommend it. What else can you do to influence cancer screenings?[2]

1. **Understand the power of the physician recommendation:**
   - Your recommendation is the most influential factor in whether a person decides to get screened.
   - Patients are 90% more likely to get a screening when they reported a physician recommendation.
   - "My doctor did not recommend it," is the primary reason for screening avoidance.
2. **Measure the screening rates in your practice; it may not be as high as you think:**
   - Set goals to get screening rates up.
   - Follow the HEDIS® guidelines included in this article to help accurately track your care gap closures.
3. **More screening doesn't have to mean more work for you:**
   - Reach out to us about available member data — We may be able to help identify those members who are due for screenings.
   - Develop a reminder system, which has been demonstrated to be effective, to remind you and staff that patients have screenings due.
4. **Help members access benefit information about screenings to eliminate the cost barrier:**
   - Log on to **Availity.com*** and use the *Patient Registration* tab to run an Eligibility and Benefits Inquiry.
   - Members can access their benefit information by logging on to **myamerigroup.com/md** and selecting the Benefits tab, or by using **Amerigroup Mobile**.

Read more online.

1 CA: A Cancer Journal for Clinicians. Cancer Statistics, 2021
https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21654
2 **http://thecanceryoucanprevent.org/wp-content/uploads/14893-80_2018-PROVIDER-PHYS-4-PAGER-11-10.pdf**

MDPEC-2683-21