



Provider Guidebook

Medicare Advantage



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1 AMERIGROUP OVERVIEW

Amerigroup corporation is a wholly owned by Amerigroup, Inc. (Amerigroup). As a leader in managed health care services for the public sector, the Amerigroup subsidiary health plans help low-income families, children, pregnant women, people with disabilities, and members of Medicare Advantage and Special Needs Plans get the health care they need.

1.1 Purpose Statement

Together, we are transforming health care with trusted and caring solutions.

1.2 Vision

To be America's valued health partner.

- Trustworthy
- Accountable
- Innovative
- Caring
- Easy to do business with

1.3 Strategy

Our strategy is to:

- Improve access to preventive primary care services by ensuring the selection of a primary care provider (PCP) who will serve as doctor, service manager and coordinator for all basic medical services.
- Improve the health statuses and outcomes of our members.
- Educate members about their benefits, responsibilities and the appropriate use of health care services.
- Encourage stable, long-term relationships between providers and members.
- Encourage medically appropriate use of specialists and emergency rooms.
- Commit to community-based enterprises and community outreach.
- Facilitate the integration of physical and behavioral health care.
- Foster quality improvement processes that actively involve providers in re-engineering health care delivery.
- Encourage a customer service orientation with regular measurement of member and provider satisfaction.
- Partner with providers to ensure members receive preventive services for improving our Healthcare Effectiveness Data and Information Set (HEDIS) data collection and star ratings.

1.4 Summary

Escalating health care costs are driven in part by a pattern of fragmented, episodic care and, quite often, unmanaged health problems of members. Amerigroup strives to educate members to encourage the appropriate use of the managed care system and to be involved in all aspects of their health care.

2 MEDICARE ADVANTAGE OVERVIEW

Amerivantage refers to the Medicare Advantage Special Needs Plans (SNPs) and integrated Medicare Advantage Prescription Drug (MA-PD) plans we offer. All network providers are contracted with Amerigroup through a *Participating Provider Agreement*. As a participating provider in the Medicare network, your contract will have a Medicare rate sheet in addition to any rate sheets for other Amerigroup products in which you participate. We strive to incorporate expertise available nationally into operating local community-based health care plans with experienced staff to complement our operations.

Amerigroup believes hospitals, physicians and other providers play a pivotal role in managed care. Amerigroup can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, high-quality provider network. We are committed to assisting you in providing quality health care and hope the information in this manual is beneficial to you and your office staff. As a participating provider, you are invited to participate in our quality improvement committees. Most committee meetings are prescheduled at times and locations intended to be convenient for you. Please call Provider Services at the Dedicated Service Unit (DSU) at 1-866-805-4589 with any suggestions, comments or questions, or if you are interested in learning more about specific policies. Together, we can arrange for and provide an integrated system of coordinated, efficient and quality care for our members.

3 MEDICARE MEMBER AND ENROLLMENT INFORMATION

Members have a choice of getting their Medicare health care services through original Medicare or through one of the Amerivantage plans we offer. The Centers for Medicare & Medicaid Services (CMS) mails a copy of the document *Medicare & You* to Medicare beneficiaries describing Medicare benefits and plan choices every fall.

Medicare beneficiaries can enroll in Medicare Advantage plans like Amerivantage during certain time periods called election periods. Five important election periods are:

- Annual Election Period (AEP): The AEP occurs from October 15-December 7 every year. Medicare beneficiaries can enroll into or disenroll from a Medicare Advantage plan during this time. The effective date of the change is January 1 of the following year.
- Medicare Advantage Disenrollment Period (MADP): During the MADP, Medicare beneficiaries have the opportunity to disenroll from a Medicare Advantage plan and return to original Medicare. If they choose to return to original Medicare, they have the option of enrolling into a stand-alone prescription drug plan, which Amerigroup does not offer. The time frame for this election period is January 1-February 14 of each year.
- Initial Coverage Election Period (ICEP): When a person first becomes eligible for Medicare Part A and enrolls in Medicare Part B, he or she has a seven-month period to enroll in a Medicare Advantage plan. This usually happens around the person's 65th birthday.
- Initial Enrollment Period for Part D (IEP): This is the period when an individual is first eligible to enroll in a Part D plan. An individual is eligible to enroll in a Part D plan when he or she is entitled to Part A or is enrolled in Part B and permanently resides in the service area of the plan. Generally, individuals will have an IEP that is the same period as the Initial Enrollment Period for Medicare Part B, a seven-month period that begins three months before the month the individual meets the eligibility requirements for Part B and ends three months after the month of eligibility.
- Special Election Period (SEP): CMS has identified several circumstances under which a person may change Medicare options outside of the annual or initial enrollment periods. For example, Medicare

beneficiaries who are also eligible for Medicaid can enroll in or disenroll from Medicare Advantage plans throughout the year.

Note: Special Needs Plan (SNP) enrollees may change Medicare Advantage plans at any time during the year with changes effective the first of the following month, subject to CMS approval.

After CMS confirms the enrollee's eligibility, we send the member a letter to confirm his or her enrollment. A new member will also receive:

- An ID card.
- A provider directory.
- A formulary (which lists the prescription drugs we cover).
- An *Evidence of Coverage (EOC)* document
- *Summary of Benefits*

Additionally, CMS can perform a retro-enrollment or retro-disenrollment in limited circumstances. Amerigroup follows CMS directives on member enrollment and disenrollment dates; they are not determined by the plan. If retro-activity occurs, this may have an impact on claims payments.

Members who choose to enroll in an Amerivantage plan will receive a member ID card containing the member's name, member number and basic information about the member's benefits. Members enrolled in an Amerivantage plan receive an *EOC* document from Amerigroup describing the Medicare benefits and services they receive. Amerivantage plan members should present their member ID cards when receiving services (sample ID cards below).



3.1 Our Amerivantage Plans

Amerigroup is a licensed health maintenance organization. We have contracted with CMS to provide Dual-Eligible Special Needs Plans (D-SNPs), as well as traditional Medicare Advantage Prescription Drug health plans in the following variations:

- Amerivantage Classic (HMO)
- Amerivantage Plus (HMO)
- Amerivantage Select (HMO)
- Amerivantage Smart Value (HMO)
- Amerivantage COPD (HMO C-SNP)
- Amerivantage Diabetes (HMO C-SNP)
- Amerivantage Heart (HMO C-SNP)

- Amerivantage Heart Care (HMO C-SNP)
- Amerivantage CareMore ESRD (HMO C-SNP)
- Amerivantage ESRD (HMO-POS C-SNP)
- Amerivantage Dual Coordination (HMO D-SNP)
- Amerivantage Dual Premier (HMO D-SNP)
- Amerivantage Dual Secure (HMO D-SNP)
- Amerivantage Balance (HMO)
- Amerivantage Care Access (HMO)
- Amerivantage CareMore Care To You (HMO I-SNP)
- Amerivantage Care To You (HMO I-SNP)

All 17 Amerivantage plans (i.e., Medicare Advantage products) include full Medicare Part D prescription drug coverage, as well as supplemental benefits covering other health care services beyond those offered by traditional fee-for-service Medicare. **Not all plans are offered in all service areas or carry the same supplemental benefits.** Please see the appropriate *Summary of Benefits* document online at <https://providers.amerigroup.com> for more information.

Amerigroup Medicare Advantage HMO members may have the option to choose a primary care physician (PCP) through a contract PMG (provider medical group) or a PCP directly contracted with Amerigroup under a fee-for-service agreement:

- Members assigned to a PCP through an Independent Practice Association (IPA) or PMG will have an ID card indicating the PCP name and IPA/Group name. Referrals are coordinated through the PMG.
- Members may select a PCP directly contracted with Amerigroup. The member ID card will indicate the assigned PCP and will **not** indicate an IPA/PMG. The PCP coordinates referrals using the Amerigroup Medicare Advantage HMO network. Authorizations are coordinated directly through Amerigroup.

Amerivantage Dual Coordination (HMO D-SNP), Amerivantage Dual Premier (HMO D-SNP), and Amerivantage Dual Secure (HMO D-SNP) are available to Medicare beneficiaries who are entitled to Medicare Part A (Part A), enrolled in Medicare Part B (Part B) and eligible for some level of Medicaid, which may include coverage of Medicare cost sharing and in some cases additional Medical Assistance from the state (either as full benefit dual-eligible, Qualified Medicare Beneficiary (QMB or QMB Plus), or Specified Low-income Medicare Beneficiary (SLMB Plus). There are some copays for prescription drugs in all markets except New Jersey (Low-income Subsidy [LIS] copays are by the state SNP Agreement). Any cost sharing applied to Medicare-covered medical services can be billed to the appropriate Medicaid carrier for process in accordance to the beneficiary's Medicaid coverage. In some cases, that will be Amerigroup. Please always refer to the *Explanation of Payment (EOP)* sent with each claim processed. Amerivantage Dual Coordination (HMO D-SNP), Amerivantage Dual Premier (HMO D-SNP), and Amerivantage Dual Secure (HMO D-SNP) plans do not have out-of-network benefits. All out-of-network services must be authorized prior to rendering services.

Amerivantage Classic (HMO), Amerivantage Select (HMO), Amerivantage Care Access (HMO), and Amerivantage Smart Value (HMO) plans are available to Medicare beneficiaries who are entitled to Part A and enrolled in Part B. These plans have copays for most services. Amerivantage Classic (HMO), Amerivantage Select (HMO), Amerivantage Care Access (HMO), and Amerivantage Smart Value (HMO)

plans do not have out-of-network benefits. All out-of-network services must be authorized prior to rendering services.

Amerivantage COPD (HMO C-SNP), Amerivantage Diabetes (HMO C-SNP), Amerivantage Heart (HMO C-SNP), Amerivantage Heart Care (HMO C-SNP), Amerivantage CareMore ESRD (HMO C-SNP) and Amerivantage ESRD (HMO-POS C-SNP) are Chronic Condition Special Needs Plans (C-SNPs). C-SNPs restrict enrollment to special needs individuals with specific severe or disabling chronic conditions. C-SNPs focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations and helping beneficiaries move from high risk to lower risk on the care continuum. Members are eligible for Amerivantage CareMore ESRD (HMO C-SNP) and Amerivantage ESRD (HMO-POS C-SNP) if they have End Stage Renal Disease requiring dialysis. Amerivantage ESRD (HMO-POS C-SNP) has a Point of Service (POS) option which allows out-of-network coverage on certain benefits. Check the member's benefits for out-of-network coverage. Amerigroup contracts with VillageHealth DM, LLC, d/b/a DaVita Integrated Kidney Care, for care management and care coordination for Amerivantage ESRD (HMO-POS C-SNP).

Our Amerivantage plans are designed to:

- Address the greater incidence of chronic disease and disability in the Medicare and Medicaid dual-eligible and Medicare-only populations.
- Enhance the coordination of a member's primary and acute care, long-term care and prescription drug benefits through a unified case management program.

Our Amerivantage plans provide members with the benefits of integrated case management through a holistic approach while promoting continuity of care and preserving provider choice.

To learn more about our Amerivantage plans and the work we are doing to help our members receive quality health care, visit <https://providers.amerigroup.com>, contact your local Provider Relations representative to schedule a visit or call the Dedicated Service Unit at 1-866-805-4589.

3.2 The Provider Self-Service Website

Amerigroup provides access to a website, <https://providers.amerigroup.com>, that contains the full complement of online provider resources. The website features an online provider inquiry tool to reduce unnecessary telephone calls by enabling easy access at your convenience to the following resources:

- Online support services, such as:
 - New user registration and activation, login help, and username and password reset
 - Forms to update provider demographics and information such as tax ID or group affiliation changes
 - Provider panel reports
 - Online daily PCP quality reports
 - Hospital/inpatient admission, transfer and discharge reports
 - HEDIS measures
- Interactive look-up tools and reference materials, such as:
 - Provider/referral directories
 - Prior Authorization lookup tool
 - Claims status/submission tool
 - Reimbursement policies

- Provider manuals and quick reference cards (provider manuals are available two ways, via the provider website or through your local Network Relations Consultant)

Amerigroup also offers a dedicated Provider Services team called the Dedicated Service Unit to assist with prior authorization and notification, health plan network information, member eligibility, claims information, and inquiries. The team can also take any recommendations you may have for improving our processes and managed care program. Below you will find additional information we hope will assist you in your day-to-day interaction with Amerigroup.

3.3 Availity Portal

The Availity Portal is a tool to help reduce costs and administrative burden. Whether you work with one managed care organization (MCO) or hundreds, Availity can help you easily submit claims, check eligibility, process payments, submit claim payment disputes and more.

To initiate the registration process, your primary controlling authority (PCA) — the individual in your organization who is legally entrusted to sign documents — must first complete registration at <https://www.availity.com>. Once your PCA completes this initial process, your primary access administrator (PAA) — the individual in your organization who is responsible for maintaining users and organization information — will receive a temporary password to gain access. Then, they can add users to specific areas for your organization.

For training, visit <https://www.availity.com> and select Availity Learning Center under Resources in the top bar. From here, you can sign up for informative webinars and even receive credit from the American Academy of Professional Coders for many sessions.

For any questions or additional registration assistance, contact Availity Client Services at 1-800-282-4548, Monday-Friday from 5 a.m.-4 p.m. Pacific time.

3.4 Quick Reference Information

Quick Reference Information	
Dedicated Service Unit (DSU)	Contact the DSU at 1-866-805-4589 for member eligibility, Nurse HelpLine and pharmacy services.
AT&T Relay Service	For English call 1-800-855-2880, for Spanish call 1-800-855-2884
Notification/ Prior Authorization	<ul style="list-style-type: none"> • May be telephoned, submitted online or faxed to Amerigroup: <ul style="list-style-type: none"> ○ Telephone: 1-866-805-4589 ○ Fax: <ul style="list-style-type: none"> ▪ Home health, durable medical equipment, therapies and discharge planning: 1-888-235-8468 ▪ Concurrent review clinical documentation: 1-888-700-2197 ▪ Behavioral health inpatient: 1-844-430-1702 ▪ Behavioral health outpatient: 1-844-430-1703

Quick Reference Information								
	<ul style="list-style-type: none"><ul style="list-style-type: none">▪ Initial admission notifications and all other services: 1-800-964-3627○ Web: https://providers.amerigroup.com• Data required for complete notification/prior authorization:<ul style="list-style-type: none">○ Member ID number○ Legible name of referring provider○ Legible name of individual referred to provider○ Number of visits/services○ Dates of service○ Diagnosis○ Current Procedural Terminology (CPT) code• Pre-Service Prior Authorization: Providers are required to provide notification in advance of services to allow Amerigroup to meet CMS processing timeframes:• Medical:<ul style="list-style-type: none">○ Standard — 14 Calendar Days○ Expedited — 72 Hours• Pharmacy (including Part B medical injectables):<ul style="list-style-type: none">○ Standard — 72 Hours○ Expedited — 24 Hours• ER admissions:<ul style="list-style-type: none">○ Within one business day for all ER admissions.• Clinical staff is available during normal business hours from 8 a.m.-5 p.m. local time.• Clinical information is required for prior authorization (the <i>Prior Authorization Request Form</i> is also available online.)							
Claims Submission: Paper (for all Medicare markets: Arizona, Iowa, New Jersey, New Mexico, Tennessee, Texas and Washington)	Submit paper claims to: Amerigroup P.O. Box 61010 Virginia Beach, VA 23466-1010 If you are a delegated provider with an organization that is not listed here, please contact your delegation organization to report change in address and/or practice status.							
Claims Submission: Electronic	Electronic claims payer ID: <table><tr><th>Clearinghouse</th><th>Payer number</th><th>Phone number</th></tr><tr><td>Availity</td><td>26375</td><td>1-877-334-8446</td></tr></table> For help, call the Amerigroup Electronic Data Interchange Hotline at 1-800-590-5745.		Clearinghouse	Payer number	Phone number	Availity	26375	1-877-334-8446
Clearinghouse	Payer number	Phone number						
Availity	26375	1-877-334-8446						

Quick Reference Information	
	<p>Timely filing is governed by the terms of the provider agreement. Timely filing for each market is the same as the Amerigroup timely filing requirement for its Medicaid product in each state and within the number of days listed in the table below from the date of service. Please see your contract for timely filing requirements.</p> <ul style="list-style-type: none"> Amerigroup provides an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status and prior authorization status at https://providers.amerigroup.com. If you are unable to access the internet, you may receive claims, eligibility and prior authorization status over the telephone at any time by calling our automated Provider Services number at the DSU toll free at 1-866-805-4589.
National Provider Identifier NPI)	<p>The <i>Health Insurance Portability and Accountability Act (HIPAA) of 1996</i> requires the adoption of a standard unique provider identifier for health care providers. All Amerigroup participating providers must have an NPI number.</p> <p>The NPI is a 10-digit intelligence-free numeric identifier. Intelligence-free means the numbers do not carry information about health care providers, such as the state in which they practice or their specialty.</p> <p>Providers can apply for an NPI by completing an application:</p> <ul style="list-style-type: none"> Online at https://nppes.cms.hhs.gov (Estimated time to complete the NPI application is 20 minutes) By downloading a paper copy at https://nppes.cms.hhs.gov By calling 1-800-465-3203 and requesting an application <p>Please send your NPI to: Provider Data Management Amerigroup P. O. Box 62509 Virginia Beach, VA 23466-2509 Email: NPI@mail@amerigroup.com</p> <p>Providers in Washington may also send provider data updates to waopsrequest@amerigroup.com.</p> <p>Fax: 757-490-7556</p>
Medicare Advantage Participating Provider Appeals	<p>Medicare appeals are determined by the liable party, not by the initiator. Please refer to the denial letter or <i>Explanation of Payment (EOP)</i> issued to determine the correct appeals process.</p> <p><u>Medicare Participating Provider Standard Appeals:</u></p> <p>A formal request for review of a previous Amerigroup decision where medical necessity was not established where provider liability was assigned (see original decision letter) for services already rendered.</p>

Quick Reference Information	
	<p>Medicare Complaints, Appeals & Grievances (MCAG) Attention: Medical Necessity Provider Appeals Mailstop: OH0205-A537 4361 Irwin Simpson Road Mason, Ohio 45040</p>
<p>Medicare Advantage Participating Provider Administrative Plea and Disputes</p>	<p>Medicare Provider Administrative Pleas: A formal request for review of a previous Amerigroup decision where a determination was made that the participating provider failed to follow administrative rules and provider liability was assigned (see original decision letter) where services have already been rendered.</p> <p>and</p> <p>Medicare Provider Payment Disputes A formal request from a provider contesting the paid amount on a claim which does not include a medical necessity or administrative denial and claims payment determinations have already been rendered. Provider Payment Disputes P.O. Box 61599 Virginia Beach, VA 23466-1599</p> <p>Readmission Disputes</p>
<p>Medicare Member Appeals</p>	<p>Medicare appeals are determined by the liable party, not by the initiator. Please refer to the denial letter or <i>EOP</i> issued to determine the correct appeals process to follow. All Medicare member liability appeals should be sent to:</p> <p>Amerigroup Medicare Complaints, Appeals & Grievances (MCAG) Attention: Member Appeals Unit Mailstop: OH0205-A537 4361 Irwin Simpson Road Mason, Ohio 45040</p> <p>Physicians can request expedited or standard pre-service appeals on behalf of members; however, if the request is not from the treating physician, an <i>Appointment of Representative</i> form (AOR) may be required. The <i>Appointment of Representative Form</i> can be found online and downloaded at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207.</p> <p>In the event that applying the standard appeal timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, an expedited or fast appeal can be initiated by contacting us in one of the following ways:</p>

Quick Reference Information	
	<p>Medicare Complaints, Appeals and Grievances Department Amerigroup – Expedited Appeals 4361 Irwin Simpson Road Mason, Ohio 05040-9598 Mail Stop: OH0205-A537 Fax: 1-888- 458-1406 (Part C) 1-888-458-1407 (Part D)</p> <p>Phone: Call the number on the back of the member’s ID card.</p> <p>Please indicate if you are requesting an expedited appeal.</p>
Provider Service Representatives	For more information, contact Provider Services at the DSU at 1-866-805-4589 or your local Network Relations Consultant.

3.5 Ongoing Provider Communications and Feedback

To ensure providers are up to date with information required to work effectively with Amerigroup and our members, we provide frequent communications to providers in the form of broadcast faxes, provider manual updates, newsletters and information posted to the website.

4 PARTICIPATING PROVIDER INFORMATION

4.1 The Medicare Advantage Provider Network

Medicare members obtain covered services by choosing a PCP who is part of the network to assist and coordinate their care. Members are encouraged to coordinate with their PCP before seeking care from a specialist, except in the case of specified services (such as women’s routine and preventive care and behavioral health care).

Note: Some services provided by a specialist may require prior authorization or a referral. All referrals to a provider that are not within the Amerigroup network require prior authorization. Please refer to [Provider Obligations — Prior Authorization](#).

When referring a member to a specialist, it’s critical to select a participating provider within our Medicare network to maximize the member’s benefit and minimize their out-of-pocket expenses. If you need help finding a participating provider, please call Provider Services at the Dedicated Service Unit (DSU) at 1-866-805-4589. If you believe you must refer to a provider outside of our network, you must notify Amerigroup in advance of that request in order for an organization determination to be made. Failure to initiate this request may result in claims denials and member liability. This includes such services as laboratories however does not include urgent or emergent services. Please refer to [Provider Obligations — Prior Authorization](#).

4.2 The PCP Role

Members are asked to select a PCP when enrolling in an Amerivantage plan and may request a change to their selected PCP at any time. Member-requested PCP changes will become effective the first day of the following month except in extenuating circumstances. Amerigroup contracts with certain physicians

that members may choose as their PCPs and may be individual practitioners associated with a contracted medical group or an independent practice association. The PCP is responsible for referring or obtaining prior authorization for covered services for members. Medicare-participating PCPs are generally physicians of internal medicine, family practitioners, general practitioners, pediatricians, obstetricians/gynecologists or geriatricians. Federally qualified health centers (FQHCs) and rural health clinics (RHCs) may be included as PCPs.

The PCP is a network physician who has responsibility for the complete care of his or her members, whether providing it himself or herself or by referral to the appropriate provider of care within the network. Any referral to a provider outside of the network will require prior authorization from HealthPlus Amerigroup. Please refer to [Provider Obligations — Prior Authorization](#).

When coordinating member care, the PCP should refer the member to a participating provider within the Amerigroup network. To assist the specialty care provider, the PCP should provide the specialist with the following clinical information:

- Member name
- Referring PCP
- Reason for the consultation
- History of the present illness
- Diagnostic procedures and results
- Pertinent past medical history
- Current medications and treatments
- Problem list and diagnosis
- Specific request of the specialist

Any referral to a nonparticipating provider will require prior authorization from Amerigroup or the services may not be covered. Contact Provider Services at the DSU at 1-866-805-4589 for questions or more information.

4.3 The Specialist Role

A specialist is any licensed provider (as defined by Medicare) providing specialty medical services to members. A PCP may refer a member to a specialist when medically necessary. Specialists must obtain authorization from Amerigroup before performing certain procedures or when referring members to noncontracted providers. Please refer to the *Summary of Benefits* or *EOC* documents for those procedures requiring prior authorization. You can review prior authorization requirements online at <https://providers.amerigroup.com> or call Provider Services at the DSU at 1-866-805-4589.

After performing the initial consultation with a member, a specialist should:

- Communicate the member's condition and recommendations for treatment or follow-up care with the PCP.
- Send the PCP the consultation report, including medical findings, test results, assessment, treatment plan and any other pertinent information.

If the specialist needs to refer a member to another provider, the referral should be to another Amerigroup provider. Any referral to a nonparticipating provider will require prior authorization from Amerigroup. Please refer to [Provider Obligations — Prior Authorization](#).

4.4 Specialist as a PCP

In some cases, a specialist, physician assistant, nurse practitioner or certified nurse midwife under physician supervision may be a PCP. This must be authorized by the health plan's Case Management department. Requirements and exceptions vary by market. If you have any questions, contact the DSU. To download a copy of the *Specialist as a PCP Form*, go to <https://providers.amerigroup.com> and select *Forms* under *Provider Resources & Documents*.

4.5 Participating Provider Responsibilities

- Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers, providing coordination necessary for services provided by specialists and ancillary providers (both in and out-of-network), and maintaining a medical record meeting Amerigroup standards
- Provide coverage 24 hours a day, 7 days a week; regular hours of operation should be clearly defined and communicated to members
- Provide all services ethically, legally and in a culturally competent manner, and meet the unique needs of members with special health care needs
- Participate in systems established by Amerigroup to facilitate the sharing of records, subject to applicable confidentiality and *HIPAA* requirements
- Make provisions to communicate in the language or fashion primarily used by his or her assigned members
- Provide hearing interpreter services on request to members who are deaf or hard of hearing
- Participate in and cooperate with Amerigroup in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by Amerigroup
- Comply with Medicare laws, regulations and CMS instructions, agree to audits and inspections by CMS and/or its designees, cooperate, assist and provide information as requested, and maintain records for a minimum of 10 years
- Participate in and cooperate with the Amerigroup appeal and grievance procedures
- **Agree to not balance bill** members for monies that are not their responsibility or that should be paid for by another carrier (in the case of a dually-eligible member covered both by Medicare and Medicaid with full coverage of Medicare cost sharing under a Medicare Savings Program or a dually eligible member enrolled in the Qualified Medicare Beneficiary (QMB) program, federal law requires providers may bill only the member's health plan or the state Medicaid agency for copays or other cost-sharing amounts. **Providers may not bill such members for cost sharing.**)
- Continue care in progress during and after termination of a member's contract for up to 60 days, or such longer period of time required by state laws and regulations, until a continuity of service plan is in place to transition the member to another network provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations (**for New Jersey providers**, continuity of care requirements are in accordance with *Attachment B – Medicare to Amerigroup New Jersey, Inc. Participating Provider Agreement*)
- Comply with all applicable federal and state laws regarding the confidentiality of patient records
- Develop and have an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens
- Establish an appropriate mechanism to fulfill obligations under the *Americans with Disabilities Act of 1990 (ADA)*

- Support, cooperate and comply with Amerigroup Quality Improvement program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner
- Inform Amerigroup if a member objects to the provisions of any counseling, treatments or referral services for religious reasons
- Treat all members with respect and dignity, provide appropriate privacy, and treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release
- Provide members complete information concerning their diagnosis, evaluation, treatment and prognosis and give them the opportunity to participate in decisions involving their health care, except when contraindicated for medical reasons
- Advise members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program and advise them on treatments that may be self-administered
- When clinically indicated, contact members as quickly as possible for follow up regarding significant problems and/or abnormal laboratory or radiological findings
- Have a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection
- Agree to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide high-quality patient care
- Agree any notation in a member's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research will be clearly contrasted with entries regarding the provision of nonresearch-related care
- Participate in the interdisciplinary care team meetings when necessary
- If a member self-refers or a provider is referring to another provider, that provider is responsible for checking the Amerigroup provider directory to ensure the specialist is in the network. Referrals to Amerigroup-contracted specialists do not require prior authorization, all referrals to providers outside Amerigroup require prior authorization unless urgent or emergent services are needed. Some procedures performed by specialist physicians may require prior authorization. Please refer to the *Summary of Benefits* document for procedures that require prior authorization or call Provider Services at the DSU at 1-866-805-4589. If you cannot locate a provider in the Amerigroup network, you should contact Provider Services at the DSU at 1-866-805-4589. You must obtain authorization from Amerigroup before referring members to noncontracted providers. Additionally, certain services/procedures require prior authorization from Amerigroup.
- Provide **advanced** notification to members of services that are not covered by the plan or Medicare in accordance with Medicare requirements and must explicitly state that such increased benefits are applicable to Medicare only and do not indicate increased Medicaid benefits to avoid potential member confusion. Additionally, each marketing item must include the following disclaimer:
 - Notice: The state plan is not responsible for payment for these benefits, except for appropriate cost-sharing amounts. The State Plan is not responsible for guaranteeing the availability or quality of these benefits.
- Please refer to [Provider Obligations — Prior Authorization](#).

Note: Amerigroup does **not** cover the use of any experimental procedures or experimental medications, except under certain circumstances.

4.6 Enrollment and Eligibility Verification

All health care providers are responsible for verifying enrollment and eligibility before services are rendered, except in the case of an emergency. In general, eligibility should be verified at the time of service and at least once monthly for ongoing services. In an emergency, eligibility should be determined as soon as possible after the member's condition is stabilized. When a patient presents as a member, providers must verify eligibility, enrollment and coverage by performing the following steps:

- Request the member's Amerigroup ID card; if there are questions regarding the information, call Provider Services at the DSU at 1-866-805-4589 to verify eligibility, deductibles, coinsurance amounts, copays and other benefit information or use the online provider inquiry tool at <https://providers.amerigroup.com>
- Copy both sides of the member's Amerigroup ID card and place the copies in the member's medical record
- Determine if the member is covered by another health plan to record information for coordination of benefits purposes
- If you are a PCP, check your Amerigroup Member Panel Listing via <https://providers.amerigroup.com> to ensure you are the member's doctor
- If the patient does not have an ID card, use the online provider inquiry tool at <https://providers.amerigroup.com> or call Provider Services at the DSU at 1-866-805-4589

4.7 Member Missed Appointments

Members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. Amerigroup requires providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling. The contact must be by telephone and should be designed to educate the member about the importance of keeping appointments and to encourage the member to reschedule the appointment.

Members who frequently cancel or fail to show up for appointments without rescheduling may need additional education in appropriate methods of accessing care. In these cases, please call Provider Services at the DSU at 1-866-805-4589 to address the situation. Amerigroup staff will contact the member and provide more extensive education and/or case management as appropriate. It is the Amerigroup goal for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCP.

4.8 Noncompliant Amerigroup Members

Amerigroup recognizes providers may need help in managing nonadherent members. If you have an issue with a member regarding behavior, treatment cooperation, completion of treatment and/or making or appearing for appointments, call Provider Services at the DSU at 1-866-805-4589.

A Member or Provider Services representative will contact the member by telephone, or a member advocate will visit the member to provide education and counseling to address the situation and will report the outcome of any counseling efforts to you.

4.9 Second Medical or Surgical Opinion

Members may request a second opinion if they:

- Dispute the reasonableness of a decision.
- Dispute the necessity of a procedure decision.

- Do not respond to medical treatment after a reasonable amount of time.

To receive a second opinion, members must:

- Obtain a second opinion from a provider within the Amerigroup network.
- Be responsible for the applicable copay.

Our DSU staff at can assist members and providers with identifying a participating provider for obtaining a second opinion.

4.10 Access and Availability

Participating Amerigroup providers must:

- Provide coverage for members 24 hours a day, 7 days a week.
- Ensure another on-call Amerigroup provider is available to administer care when the PCP is not available.
- Not substitute hospital emergency rooms or urgent care centers for covering providers.
- See members within 30 minutes of a scheduled appointment or inform them of the reason for delay (e.g., emergency cases) and offer an alternative appointment.
- Provide an after-hours telephone service to ensure a response to emergency phone calls within 30 minutes and a response to urgent phone calls within one hour; individuals who believe they have an emergency medical condition should be directed to immediately seek emergency services from the nearest emergency facility.

4.11 Access and Availability Standards

Type of appointment (medical or behavioral)	Availability standard
Patient visit with new PCP	Within 30 calendar days
Routine follow-up or preventive care	As soon as possible but within 30 calendar days
Routine/symptomatic	Within 7 days
Nonurgent care	Within 7 days
Urgently needed services	Within 24 hours
Emergency	Immediately

Amerigroup monitors adherence to appointment availability standards through office visits, long-term care visits, and tracking of complaints and grievances related to access and/or discrimination. Deviations from the policy are reviewed by the medical director for educational and/or counseling opportunities and tracked for provider recredentialing.

All providers and hospitals are expected to treat Amerivantage plan members with the same dignity and consideration as afforded to their non-Medicare patients.

4.12 Covering Physicians

During a provider's absence or unavailability, the provider must arrange for coverage for his or her members. The provider will either: 1) make arrangements with one or more Amerigroup network

providers to provide care for his or her members or 2) make arrangements with another similarly licensed and qualified provider who has appropriate medical staff privileges at the same network hospital or medical group, as applicable, to provide care to the members in question. In addition, the covering provider will agree to the terms and conditions of the network provider agreement, including any applicable limitations on compensation, billing and participation. Providers will be solely responsible for a non-network provider's adherence to such provisions. Providers will be solely responsible for any fees or monies due and owed to any non-network provider providing substitute coverage to a Medicare member on the provider's behalf.

4.13 Reporting Changes in Address and/or Practice Status

Any changes in a provider's address and/or practice status can be updated online by logging in to <https://providers.amerigroup.com> or reported to your local Amerigroup office.

Market	Provider relations address
Arizona providers	<p>Amerigroup PO Box 61010 Virginia Beach, VA 23466-1010</p> <p>CareMore providers: CareMore Health Attn: Network Operations/Demographic Updates 12900 Park Plaza Drive, Suite 150 Cerritos, CA 90703 providerrelationssupport@caremore.com</p> <p>If you are a delegated provider with an organization that is not listed here, please contact your delegation organization to report change in address and/or practice status.</p>
Iowa providers	<p>4800 Westown Pkwy Suite 200 West Des Moines, IA 50266</p>
New Jersey providers	<p>Amerigroup 101 Wood Ave. South, Eighth Floor Iselin, NJ 08830</p>
New Mexico providers	<p>Amerigroup Two Park Square 6565 Americas Parkway NE, Suite 200 Albuquerque, NM 87110</p>
Tennessee providers	<p>Amerigroup 22 Century Blvd., Suite 310 Nashville, TN 37214</p>
Dallas/Fort Worth	<p>Amerigroup 2505 N. Highway 360, Suite 300 Grand Prairie, TX 75050</p>
El Paso	<p>Amerigroup</p>

Market	Provider relations address
	7430 Remcon Circle, Building C, Suite 120 El Paso, TX 79912
Houston	Amerigroup 3800 Buffalo Speedway, Suite 400 Houston, TX 77098
Lubbock	Amerigroup 3232 S. Loop 289, Suite 110 Lubbock, TX 79423
San Antonio	Amerigroup 4400 Piedras Drive South, Suite 100 San Antonio, TX 78228
Washington	Amerigroup 705 5th Avenue South, Suite 300 Seattle, WA 98104

4.14 Amerigroup Plan-specific Termination Criteria

The occurrence of any of the following is grounds for termination of the Amerigroup provider's participation:

- Loss of reputation among peers due to unethical clinical practice or attitude
- The practice of fraud, waste and/or abuse
- Adverse publicity involving the provider due to acts of omission or commission
- Substance abuse
- Loss of professional office
- Inadequate record keeping
- Unsafe environment in the provider's office relative to inadequate access or other related issues that might cause a member injury
- An office that is improperly kept, unclean or does not present a proper appearance
- Failure to meet OSHA guidelines
- Failure to meet ADA guidelines
- Failure to meet *Clinical Laboratory Improvement Amendments (CLIA)* guidelines
- Customer satisfaction ratings that drop below pre-established standards as determined by the Medical Advisory Committee (MAC) (this would include complaints relative to appearance, behavior, medical care, etc.)
- Repetitive complaints about office staff demeanor, presentation and appearance
- Inclusion on the Debarred Providers Listing of the Office of the Inspector General of the Department of Health and Human Services (see Sanctioned Providers)
- Unfavorable inpatient- or outpatient-related indicators:
 - Severity-adjusted morbidity and mortality rates above established norms
 - Severity-adjusted length-of-stay above established norms
 - Unfavorable outpatient utilization results
 - Consistent inappropriate referrals to specialists
 - Improper maintenance of high-risk patients, such as those members with diabetes and hypertension

- Underutilization relative to minimum standards of care established per medical management guidelines and/or accepted clinical practice in the community
- Unfavorable malpractice-related issues
- Frequent litigious activity above and beyond what would be expected for a provider in that particular specialty

Amerigroup providers have 30 calendar days to appeal a termination. The Amerigroup process is designed to comply with all state and federal regulations regarding the termination appeal process.

4.15 Incentives and Payment Arrangements

Financial arrangements concerning payment to providers for services to Medicare members are set forth in each provider's agreement with Amerigroup. Amerigroup may also use financial incentives to reward providers for achieving certain quality indicator levels.

Amerigroup does not use or employ financial incentives that would directly or indirectly induce providers to limit or reduce medically necessary services furnished to individual enrollees. In cases where Amerigroup approves provider subcontracting arrangements, those subcontractors cannot employ any financial incentives inconsistent with this policy or with Medicare Advantage regulations.

4.16 Laws Regarding Federal Funds

Payments providers receive for furnishing services to members are derived in whole or part from federal funds. Therefore, providers and any approved subcontractors must comply with certain laws applicable to individuals and entities receiving federal funds, including but not limited to *Title VI of the Civil Rights Act of 1964* as implemented by 45 CFR Part 84; the *Age Discrimination Act of 1975* as implemented by 45 CFR Part 91; the *Rehabilitation Act of 1973*; and the *Americans with Disabilities Act*.

4.17 Prohibition Against Discrimination

Neither Amerigroup nor its contracted providers may deny, limit or condition the coverage or furnishing of services to members on the basis of any factor related to health status, including but not limited to the following:

- Medical condition, including mental as well as physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability

4.18 Provider Panel — Closing a Panel

When closing a provider panel to new Amerigroup members or other new patients, providers must:

- Give Amerigroup prior written notice to Provider Relations in their health plan or submission using the online portal/provider website the provider panel is closing to new members as of a specific closing date, and accept new members until that closing date. (written notice only required in Tennessee)
- Keep the provider panel open to members who were patients of that practice before the panel closed or before they were enrolled with Amerigroup

- Close the provider panel uniformly to all new Medicare patients, including all private payers and commercial or governmental insurers the practice participates with
- Give Amerigroup prior written notice when reopening the provider panel, including a specific reopening date

4.19 Provider Panel — Transferring and Terminating Members

Amerigroup will determine reasonable cause for transferring a member based on written request and documentation submitted by the provider. Providers may not transfer a member to another provider due to the costs associated with the member's covered services.

A provider may request termination of a member due to fraud, disruption of medical services or the member's repeated failure to make the required reimbursements for services. In such cases, the provider should contact the DSU at 1-866-805-4589.

In the event a practitioner makes the decision to terminate their relationship with a delegated risk entity and decides to join a different delegated risk entity, Amerigroup will allow the practitioner to keep all of their paneled Amerigroup membership and move membership to the different risk entity if the following conditions are met:

- Delegated risk entity must be participating for all products that the practitioner's member panel is comprised of.
- Practitioner must have an attestation stating that the practitioner is leaving their current delegated risk entity and joining a different entity. This attestation must contain effective date of termination from former entity. Amerigroup will transfer membership within 2-weeks of request.
- The new risk entity must include on the roster that is sent to Amerigroup to add the practitioner a column noting that an attestation was received from the practitioner. Said attestation will be available for Amerigroup to review upon request.

The delegated risk entity that the practitioner is terminating from will make no effort to contact membership assigned to the practitioner nor will the delegated risk entity take action against Amerigroup as Amerigroup is to remain unbiased and neutral throughout all practitioner movement.

Delegated Risk Entities whom have language in their contract preventing practitioners whom leave the entity from transferring membership from 1 entity to another. Documentation of signed contract will need to be presented to health plan shall the IPA want to dispute. The information will need to be provided to Amerigroup within 30 days of request.

4.20 Reporting Obligations — Cooperation in Meeting CMS Requirements

Amerigroup is required to provide information to CMS necessary to administer and evaluate the Medicare Advantage program and to establish and facilitate a process for current and prospective members to exercise their choice in obtaining Medicare services.

Amerigroup provides the following information:

- Plan quality and performance indicators such as disenrollment rates (for beneficiaries enrolled in the plan the previous two years)
- Information on member satisfaction
- Information on health outcomes

Providers must cooperate with Amerigroup in its data reporting obligations by providing Amerigroup with any information required to meet these obligations in a timely fashion.

4.21 Reporting Obligations — Certification of Diagnostic Data

Amerigroup is required to submit information to CMS necessary to characterize the context and purposes of each encounter between a member and provider, supplier, physician or other practitioner (encounter data). Providers that furnish diagnostic data must certify (to the best of their knowledge, information and belief) the accuracy, completeness and truthfulness of the data.

4.22 Cultural Competency

Cultural competency is the integration of congruent behaviors, attitudes, structures, policies and procedures that come together in a system or agency or among professionals. Cultural competency assists providers and members to:

- Acknowledge the importance of culture and language.
- Assess cross-cultural relations.
- Embrace cultural strengths with people and communities.
- Strive to expand cultural knowledge.
- Understand cultural and linguistic differences.

The quality of the patient-provider interaction has a profound impact on the ability of a patient to communicate symptoms to his or her provider and to adhere to recommended treatment. Some of the reasons that justify a provider's need for cultural competency include but are not limited to:

- The perception that illness and disease and their causes vary by culture
- The diversity of belief systems related to health, healing and wellness are very diverse
- The fact that culture influences help-seeking behaviors and attitudes toward health care providers
- The fact that individual preferences affect traditional and nontraditional approaches to health care
- The fact that patients must overcome their personal biases within health care systems
- The fact that health care providers from culturally and linguistically diverse groups are under-represented in the current service delivery system

Cultural barriers between the provider and member can impact the patient-provider relationship in many ways, including but not limited to:

- The member's level of comfort with the practitioner and the member's fear of what might be found upon examination
- The differences in understanding on the part of diverse consumers in the United States health care system
- A fear of rejection of personal health beliefs
- The member's expectation of the health care provider and of the treatment

To be culturally competent, Amerigroup expects providers serving members within their geographic locations to demonstrate the following:

Cultural Awareness

- The ability to recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior
- The ability to modify one's own behavioral style to respond to the needs of others, while at the same time maintaining one's objectivity and identity

Cultural Knowledge

- Culture plays a crucial role in the formation of health or illness beliefs
- Culture is generally behind a person's rejection or acceptance of medical advice and treatment
- Different cultures have different attitudes about seeking help
- Feelings about disclosure are culturally unique
- There are differences in the acceptability and effectiveness of treatment modalities in various cultural and ethnic groups
- Verbal and nonverbal language, speech patterns and communication styles vary by culture and ethnic groups
- Resources such as formally trained interpreters should be offered to and used by members with various cultural and ethnic differences

Cultural Skills

- The ability to understand the basic similarities and differences between and among the cultures of the persons served
- The ability to recognize the values and strengths of different cultures
- The ability to interpret diverse cultural and nonverbal behavior
- The ability to develop perceptions and understanding of other's needs, values and preferred means of having those needs met
- The ability to identify and integrate the critical cultural elements of a situation to make culturally consistent inferences and to demonstrate consistency in actions
- The ability to recognize the importance of time and the use of group processes to develop and enhance cross-cultural knowledge and understanding
- The ability to withhold judgment, action or speech in the absence of information about a person's culture
- The ability to listen with respect
- The ability to formulate culturally competent treatment plans
- The ability to use culturally appropriate community resources
- The ability to know when and how to use interpreters and to understand the limitations of using interpreters
- The ability to treat each person uniquely
- The ability to recognize racial and ethnic differences and know when to respond to culturally based cues
- The ability to seek out information
- The ability to use agency resources
- The capacity to respond flexibly to a range of possible solutions
- The acceptance of ethnic differences among people and the understanding of how these differences affect the treatment process
- The willingness to work with clients of various ethnic minority groups

4.23 Marketing

Providers may not develop or use any materials that market Amerigroup or the Amerivantage plans without Amerigroup prior written approval. Under Medicare Advantage program rules, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage plan unless the materials meet the CMS marketing guidelines and are first submitted to CMS for review and approval. Additionally, providers can have plan marketing materials in their office as long as marketing materials for all plans the providers participate in are represented. Providers are allowed to have posters or notifications that show they participate in the Amerivantage plans as long as the provider displays posters or notifications from all Medicare plans in which they participate.

4.24 Americans With Disabilities Act Requirements

The Amerigroup policies and procedures are designed to promote compliance with the *ADA*. Providers are required to take actions to remove an existing barrier and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes the following:

- Access to an examination room that accommodates a wheelchair
- Access to a lavatory that accommodates a wheelchair
- Elevator or accessible ramp into facilities
- Handicap parking clearly marked unless there is street side parking
- Street-level access

5 FIRST LINE OF DEFENSE AGAINST FRAUD AND ABUSE

5.1 General Obligation to Prevent, Detect and Deter Fraud, Waste and Abuse

As a recipient of funds from state and federally sponsored health care programs, Amerigroup has a duty to help prevent, detect and deter fraud, waste and abuse. Amerigroup is committed to detecting, mitigating and preventing fraud, waste and abuse as outlined in its Corporate Compliance Program. As part of the requirements of the federal *Deficit Reduction Act*, each provider is required to adopt Amerigroup policies on detecting, preventing and mitigating fraud, waste and abuse in all the federally and state funded health care programs in which Amerigroup participates.

The Amerigroup policy on fraud, waste and abuse prevention and detection is part of the Amerigroup Corporate Compliance Program.

Amerigroup maintains several ways to report suspected fraud, waste and abuse. As a Medicare Advantage provider and a participant in government-sponsored health care, you and your staff are obligated to report suspected fraud, waste and abuse. These reports can be made anonymously at <https://www.fighthealthcarefraud.com/report-fraud-form> or by calling 1-866-847-8247. In addition to anonymous reporting, suspected fraud, waste and abuse may also be reported via email to medicaresiu@anthem.com.

In order to meet the requirements under the *Deficit Reduction Act*, you must adopt the Amerigroup fraud, waste and abuse policies and distribute them to any staff members or contractors who work with Amerigroup. If you have questions or would like more details concerning the Amerigroup fraud, waste and abuse detection, prevention and mitigation program, please contact the Amerigroup Chief Compliance Officer.

5.2 Importance of Detecting, Deterring and Preventing Fraud, Waste and Abuse

Health care fraud costs taxpayers increasingly more money every year. State and federal laws are designed to crack down on these crimes and impose strict penalties. Fraud, waste and abuse in the health care industry may be perpetuated by every party involved in the health care process. There are several stages to inhibiting fraudulent acts, including detection, prevention, investigation and reporting. In this section, Amerigroup educates providers on how to help prevent member and provider fraud by identifying the different types as the first line of defense.

Many types of fraud, waste and abuse have been identified, including the following:

Provider fraud, waste and abuse

- Billing for services not rendered
- Billing for services that were not medically necessary
- Double billing
- Unbundling
- Upcoding

Providers can prevent fraud, waste and abuse by ensuring the services rendered are medically necessary, accurately documented in the medical records and billed according to American Medical Association guidelines.

Member fraud, waste and abuse

- Benefit sharing
- Collusion
- Drug trafficking
- Forgery
- Illicit drug seeking
- Impersonation fraud
- Misinformation/misrepresentation
- Subrogation/third-party liability fraud
- Transportation fraud

To help prevent fraud, waste and abuse, providers can educate members about these types of fraud and the penalties levied. Also, spending time with patients and reviewing their records for prescription administration will help minimize drug fraud and abuse. One of the most important steps to help prevent member fraud is as simple as reviewing the Medicare member ID card. It is the first line of defense against fraud. Amerigroup may not accept responsibility for the costs incurred by providers rendering services to a patient who is **not** an Amerigroup member, even if that patient presents a Medicare member ID card. Providers should take measures to ensure the cardholder is the person named on the card.

Additionally, encourage members to protect their cards as they would a credit card or cash, carry their Amerigroup member ID card at all times, and report any lost or stolen cards to Amerigroup as soon as possible.

Amerigroup believes awareness and action are vital to keeping the state and federal programs safe and effective. Understanding the various opportunities for fraud, waste and abuse and working with members to protect their Amerigroup ID card can help prevent fraud, waste and abuse. Amerigroup encourages its members and providers to report any suspected instance of fraud, waste and abuse using the contact methods referenced earlier. No individual who reports violations or suspected fraud, waste or abuse will be retaliated against, and Amerigroup will make every effort to maintain anonymity and confidentiality.

5.3 Health Insurance Portability and Accountability Act

The *Health Insurance Portability and Accountability Act (HIPAA)*, also known as the *Kennedy-Kassebaum Bill*) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud and simplifies the administration of health insurance.

Amerigroup strives to ensure both Amerigroup and contracted participating providers conduct business in a manner that safeguards patient/member information in accordance with the privacy regulations enacted pursuant to *HIPAA*. Providers must have the following procedures in effect since April 14, 2003, to demonstrate compliance with the *HIPAA* privacy regulations.

Amerigroup recognizes its responsibility under the *HIPAA* privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting Amerigroup. However, please note the privacy regulations allow the transfer or sharing of member information, which may be requested by Amerigroup to conduct business and make decisions about care such as a member's medical record to make an authorization determination or resolve a payment appeal. Such requests are considered part of the *HIPAA* definition of treatment, payment or health care operations.

Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to Amerigroup, verify the receiving fax number is correct, notify the appropriate staff at Amerigroup and verify the fax was appropriately received.

Email (unless encrypted) should not be used to transfer files containing member information to Amerigroup (e.g., Excel spreadsheets with claim information). Such information should be mailed or faxed.

Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific individual, P.O. Box or department at Amerigroup.

The Amerigroup voicemail system is secure and password-protected. When leaving messages for Amerigroup associates, providers should only leave the minimum amount of member information required to accomplish the intended purpose.

When contacting Amerigroup, providers should be prepared to verify their name, address and tax identification number or national provider identifier number.

6 MEDICAL RECORDS

6.1 Requirements Overview

Amerigroup providers must maintain permanent medical records that are:

- Current, detailed and organized; permit effective, confidential patient care; and allow quality reviews
- In conformity with good professional medical practice and appropriate health management
- Located at the primary care site for every Amerigroup member
- Kept in accordance with Amerigroup and state standards as described in this manual
- Retained for 10 years from the final date of the contract or from the date of completion of any audit
- Accessible upon request to Amerigroup and/or downstream entities, any state agency and the federal government

Amerigroup will:

- Systematically review medical records to ensure compliance with standards. The health plan's MAC oversees and directs Amerigroup in formalizing, adopting and monitoring guidelines
- Institute actions for improvement when standards are not met
- Maintain a record keeping system that is designed to collect all pertinent medical management information for each member
- Make information readily available to appropriate health professionals and appropriate state agencies
- Use nationally recognized standards of care and work with providers to develop clinical policies and guidelines of care for members

6.2 Member Medical Records Standards

We require medical records to be current, detailed and organized for effective, confidential patient care and quarterly review. Your medical records must conform to good professional medical practice and be permanently maintained at the primary care site.

Members are entitled to one copy of their medical record each year provided at no cost. Members or their representatives should have access to these records.

Our medical records standards include:

1. Patient identification information — patient name or ID number must be shown on each page or electronic file
2. Personal/biographical data — age, sex, address, employer, home and work telephone numbers, and marital status
3. Date and corroboration — dated and identified by the author
4. Legibility — if someone other than the author judges it illegible, a second reviewer must evaluate it
5. Allergies — must note prominently:
 - Medication allergies
 - Adverse reactions
 - No known allergies (NKA)
6. Past medical history — for patients seen three or more times. Include serious accidents, operations, illnesses and prenatal care of mother and birth for children
7. Immunizations — a complete immunization record for pediatric members age 20 and younger with vaccines and dates of administration

8. Diagnostic information
9. Significant illnesses and chronic and recurrent medical conditions are indicated in the problem list on all member medical records
10. Report contributory and/or chronic conditions if they are monitored, evaluated, addressed or treated at the visit and impact the care.
11. All diagnoses reported on the claim should be fully documented in the medical record, and each diagnosis noted in the medical record should be reported in the claim corresponding to that encounter.
12. Medical information including medication and instruction to patient
13. Identification of current problems
 - Serious illnesses
 - Medical and behavioral conditions
 - Health maintenance concerns
14. Instructions including evidence the patient was provided basic teaching and instruction for physical or behavioral health condition
15. Smoking/alcohol/substance abuse — notation required for patients age 12 and older and seen three or more times
16. Consultations, referrals and specialist reports — consultation, lab and X-ray reports must have the ordering physician's initials or other documentation signifying review; any consultation or abnormal lab and imaging study results must have an explicit notation
17. Emergencies — all emergency care and hospital discharge summaries for all admissions must be noted
18. Hospital discharge summaries — must be included for all admissions while enrolled and prior admissions when appropriate
19. *Advance Directive* — must document whether the patient has executed an *Advance Directive* such as a *Living Will* or *Durable Power Of Attorney*

6.3 Documentation Standards for an Episode of Care

When we request clinical documentation from you to support claims payments for services, you must ensure the information provided to us:

- Identifies the member
- Is legible
- Reflects all aspects of care

To be considered complete, documentation for episodes of care will include at a minimum the following elements:

- Patient identifying information
- Consent forms
- Health history, including applicable drug allergies
- Types and dates of physical examinations
- Diagnoses and treatment plans for individual episodes of care
- Physician orders
- Face-to-face evaluations
- Progress notes
- Referrals
- Consultation reports
- Laboratory reports

- Imaging reports (including X-ray)
- Surgical reports
- Admission and discharge dates and instructions
- Preventive services provided or offered appropriate to the member's age and health status
- Evidence of coordination of care between primary and specialty physicians

Refer to the standard data elements to be included for specific episodes of care as established by The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A single episode of care refers to continuous care or a series of intervals of brief separations from care to a member by a provider or facility for the same specific medical problem or condition. Documentation for all episodes of care must meet the following criteria:

- Is legible to someone other than the writer
- Contains information that identifies the member on each page in the medical record
- Contains entries in the medical record that are dated and include author identification (e.g., handwritten signatures, unique electronic identifiers or initials)

Other documentation not directly related to the member

Records should contain information relevant to support clinical practice and used to support documentation regarding episodes of care, including:

- Policies, procedures and protocols
- Critical incident/occupational health and safety reports
- Statistical and research data
- Clinical assessments
- Published reports/data

Amerigroup may request that you submit additional documentation, including medical records or other documentation not directly related to the member, to support claims you submit. If documentation is not provided following the request or notification or if documentation does not support the services billed for the episode of care, we may:

- Deny the claim.
- Recover and/or recoup monies previously paid on the claim.

Section 1833(e) of the Social Security Act, states that Medicare payment can be made only when the documentation supports the service/item. Amerigroup is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

6.4 Patient Visit Data Records Standards

You must provide:

1. A history and physical exam with both subjective and objective data for presenting complaints.
2. Behavioral health treatment, including at-risk factors:
 - Danger to self/others
 - Ability to care for self
 - Affect
 - Perpetual disorders
 - Cognitive functioning
 - Significant social health

3. Admission or initial assessment must include:
 - Current support systems.
 - Lack of support systems.
4. Behavioral health treatment — documented assessment at each visit for client status and symptoms, indicating:
 - Decreased
 - Increased
 - Unchanged
 - A plan of treatment, including:
 - Activities.
 - Therapies.
 - Goals to be carried out.
 - Diagnostic tests.
 - Evidence of family involvement in therapy sessions and/or treatment.
5. Follow-up care encounter forms or notes indicating follow-up care, call or visit in weeks, months or PRN.
6. Referrals and results of all other aspects of patient care and ancillary services.

We systematically review medical records to ensure compliance and institute actions for improvement when our standards are not met.

We maintain a professional recordkeeping system for services to our members. We make all medical management information available to health professionals and state agencies and retain these records for 10 years from the date of service.

6.5 Medical Record Review

Federal regulations require Medicare MCOs and their agents review medical records to avoid over or under payment and verify documentation to support of diagnostic conditions. Additionally, the vice president or local health plan leadership for quality management and the Quality Management Committee conduct medical record audits periodically and use the results in the provider recredentialing process.

6.6 Risk Adjustment Data Validation

As part of the risk adjustment process, CMS will perform risk adjustment data validation (RADV) audits to ensure the accuracy and integrity of risk adjustment data submitted by a Medicare Advantage organization for risk adjustment payments. These audits are typically performed annually. If a Medicare Advantage organization is selected by CMS to participate in a RADV audit, the Medicare Advantage organization and its providers will be required to participate in the audit; please be aware that medical records may be requested from your office.

Amerigroup may contract with a third-party vendor to acquire medical records or conduct onsite reviews. Under CFR 164.502 (*HIPAA* implementation), providers are permitted to disclose requested data for the purpose of health care operations after they have obtained the *general consent* of the member. A general consent form should be an integral part of your medical record file.

More information related to risk adjustment can be found at www.cms.gov.

6.7 Clinical Practice Guidelines

Using nationally recognized standards of care, Amerigroup works with providers to develop clinical policies and guidelines for the care of its membership. The Medical Advisory Committee (MAC) oversees and directs Amerigroup in formulating, adopting and monitoring guidelines.

Amerigroup selects at least four evidence-based *Clinical Practice Guidelines* (CPGs) relevant to the Medicare member population. The guidelines are reviewed and revised by the Amerigroup Quality Improvement Council at least every two years or whenever the guidelines change.

The Amerigroup CPGs are located online at <https://providers.amerigroup.com>. To access the CPGs, log in to the secure site with your user name and password and select the **Clinical Practice Guidelines** link from the *Clinical Policy and Guidelines* section on the top navigation menu. A copy of the guidelines can be printed from the website.

6.8 Advance directives

Advance directives are written instructions that:

- Give direction to health care providers as to the provision of health care.
- Provide for treatment choices when a person is incapacitated.
- Are recognized under state law when signed by a competent person.

There are three types of *Advance Directives*:

- A *Durable Power Of Attorney* for health care (durable power) allows the member to name a patient advocate to act on behalf of the member
- A *Living Will* allows the member to state his or her wishes in writing but does not name a patient advocate
- A declaration for mental health treatment gives instructions about a member's future mental health treatment if the member becomes unable to make those decisions. The instructions state whether the member agrees or refuses to have the treatments described in the declaration with or without conditions and limitations

Amerigroup advance directive policies include:

- Respecting the rights of the member to control decisions relating to his or her own medical care, including the decision to have provided, withheld or withdrawn the medical or surgical means or procedures calculated to prolong his or her life; this right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession
- Adhering to the *Patient Self-Determination Act* and maintaining written policies and procedures regarding advance directives; providers must adhere to this act and to all state and federal standards as specified in SSA 1902(a)(57), 1903(m)(1)(A), 42 CFR §422.128, and 42 CFR 489 subpart I
- Advising members of their right to self-determination regarding advance directives
- Encouraging members to request an advance directive form and education from their PCP at their first appointment
- Assisting members with questions about an advance directive; no Amerigroup employee may serve as witness to an advance directive or as a member's authorized agent or representative
- While members have the right to formulate an advance directive, an Amerigroup associate, a facility or a provider may conscientiously object to an advance directive within certain limited circumstances if allowed by state law

- Having Member Services, Health Promotion, Provider Relations and/or Health Care Management Services staff review and update advance directive notices and education materials for members on a regular basis
- Member materials will contain information, as applicable, regarding provisions for conscience objection. Materials explain the differences between institution-wide objections based on conscience and those that may be raised by individual physicians
- Amerigroup or the practitioner must issue a clear and precise written statement of this limitation to CMS and request a conscience protection waiver. The conscientious objection will be stated clearly and describes the following:
 - Describes the range of medical conditions or procedures affected by the conscience objection
 - Identifies the state legal authority permitting such objection
- Noting the presence of advance directives in the medical records when conducting medical chart audits

Providers must:

- Comply with the *Patient Self-Determination Act* requirements.
- Make sure the first point of contact in the PCP's office asks the member if he or she has executed an advance directive.
- Document in the member's medical record his or her response to an offer to execute any advance directive in a prominent place, including a do-not-resuscitate directive or the provider and member's discussion and action regarding the execution or nonexecution of an advance directive.
- Ask members who have executed an advance directive to bring a copy of the advance directive(s) to the PCP/provider at the first point of contact.
- Make an advance directive part of the member's medical record and put in a prominent place.
 - The physician discusses potential medical emergencies with the member and/or family/significant other and with the referring physician, if applicable.
 - If an advance directive has not been executed, the first point of contact at the PCP/provider's office will ask the member if he or she would like advance directive information. If the member desires further information, member advance directive education will be provided
- Not discriminate or retaliate against a member based on whether he or she has executed an advance directive.

The requirements for advance directives, to include psychiatric advance directives, vary from state to state. Specific forms that meet compliance with each state can be found on the state's official website. Psychiatric advance directive information may be found at <http://www.nrc-pad.org>.

7 CREDENTIALING

Amerigroup discretion

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit Amerigroup's discretion in any way to amend, change or suspend any aspect of Amerigroup's credentialing program ("Credentialing Program") nor is it intended to create rights on the part of practitioners who seek to provide healthcare services to our Members. Amerigroup further retains the right to approve, suspend, or terminate individual physicians

and health care professionals, and sites in those instances where it has delegated credentialing decision making.

7.1 Credentialing Scope

Amerigroup credentials the following licensed/state certified independent health care practitioners:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry
- Chiropractors
- Optometrists providing Health Services covered under the Health Benefit Plan
- Doctors of dentistry providing Health Services covered under the Health Benefit Plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral health care specialists who provide treatment services under the Health Benefit Plan
- Telemedicine practitioners who provide treatment services under the Health Benefit Plan
- Medical therapists (e.g., physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (non-MD/DO) (nonmedical doctors or doctors of osteopathic medicine)
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
- Registered Dietitians

The following behavioral health practitioners are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Abuse Practitioners

Amerigroup credentials the following Health Delivery Organizations ("HDOs"):

- Hospitals
- Home Health agencies
- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health Facilities providing mental health and/or substance abuse treatment in inpatient, residential or ambulatory settings, including:
 - Adult Family Care/Foster Care Homes
 - Ambulatory Detox

- Community Mental Health Centers (“CMHC”)
- Crisis Stabilization Units
- Intensive Family Intervention Services
- Intensive Outpatient – Mental Health and/or Substance Abuse
- Methadone Maintenance Clinics
- Outpatient Mental Health Clinics
- Outpatient Substance Abuse Clinics
- Partial Hospitalization – Mental Health and/or Substance Abuse
- Residential Treatment Centers (“RTC”) – Psychiatric and/or Substance Abuse
- Birthing Centers
- Home Infusion Therapy when not associated with another currently credentialed HDO

The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
- End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification)
- Portable x-ray Suppliers (FDA Certification)
- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)

7.2 Credentials Committee

The decision to accept, retain, deny or terminate a practitioner’s participation in a Network or Plan program is conducted by a peer review body, known as Amerigroup’s Credentials Committee (“CC”).

The CC will meet at least once every forty-five (45) calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the Vice President of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage (“MA”) is represented, a second vice-chair representing MA may be designated. The chair must be a state or regional lead medical director, or an Amerigroup medical director designee and the vice-chair must be a lead medical officer or an Amerigroup medical director designee, for that line of business not represented by the chair. In states or regions where only one (1) line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five (5), but no more than ten (10) external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one (1) to two (2) other types of credentialed health providers (e.g. nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair’s discretion. At least two (2) of the physician committee members must be credentialed for each line of business (e.g. Commercial, Medicare, and

Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation, or terminate a practitioner from participation in one (1) or more Networks or Plan Programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are Network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the Credentialing Program. In particular, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulating agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified that they have the right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, Amerigroup's credentialing staff ("Credentialing Department") will contact the practitioner or HDO within thirty (30) calendar days of the identification of the issue. This communication will notify the practitioner or HDO of the right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue(s) in question, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner's credentials file. The practitioner or HDO will be given no less than fourteen (14) calendar days in which to provide additional information. On request, the practitioner will be provided with the status of their credentialing or re-credentialing application.

Amerigroup may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

7.3 Nondiscrimination Policy

Amerigroup will not discriminate against any applicant for participation in its programs or provider Network(s) on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Amerigroup will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than

gender and language capabilities which are provided to the members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence. The CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Amerigroup will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. In the event discriminatory practices are identified through an audit or through other means, Amerigroup will take appropriate action(s) to track and eliminate those practices.

7.4 Initial Credentialing

INITIAL CREDENTIALING

Each practitioner or HDO must complete a standard application form deemed acceptable by Amerigroup when applying for initial participation in one (1) or more of Amerigroup's Networks or Plan Programs. For practitioners, the Council for Affordable Quality Healthcare ("CAQH") ProView system is utilized. To learn more about CAQH, visit their web site at <https://proview.caqh.org/pr>

Amerigroup will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the one hundred eighty (180) calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Amerigroup will review, among other things, verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Members.
Hospital admitting privileges at a TJC, NIAHO or AOA accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state controlled substance registrations <ul style="list-style-type: none"> a. The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating Members. Practitioners who see Members in more than one (1) state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical

Verification Element
training or education
Work history
State or federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

Verification Element
Accreditation, if applicable
License to practice, if applicable
Malpractice insurance
Medicare certification, if applicable
Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions

7.5 Recredentialing

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Amerigroup credentialing standards ("Credentialing Standards").

All applicable practitioners and HDOs in the Network within the scope of the Credentialing Program are required to be re-credentialed every three (3) years unless otherwise required by applicable state contract or state regulations.

Health Delivery Organizations

New HDO applicants will submit a standardized application to Amerigroup for review. If the candidate meets Amerigroup screening criteria, the credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail below, in the "Amerigroup Credentialing Program Standards" section, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Amerigroup may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past thirty-six (36) months for that HDO.

Re-credentialing of HDOs occurs every three (3) years unless otherwise required by regulatory or

accrediting bodies. Each HDO applying for continuing participation in Networks or Plan Programs must submit all required supporting documentation.

Upon request, HDOs will be provided with the status of their credentialing application. Amerigroup may request, and will accept, additional information from the HDO to correct incomplete, inaccurate, or conflicting credentialing information. The CC will review this information and the rationale behind it, as presented by the HDO, and determine if a material omission has occurred or if other credentialing criteria are met.

7.6 Ongoing Sanction Monitoring

To support certain Credentialing Standards between the re-credentialing cycles, Amerigroup has established an ongoing monitoring program. The Credentialing Department performs ongoing monitoring to help ensure continued compliance with Credentialing Standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the Credentialing Department will review periodic listings/reports within thirty (30) calendar days of the time they are made available from the various sources including, but not limited to, the following:

1. Office of the Inspector General (“OIG”)
2. Federal Medicare/Medicaid Reports
3. Office of Personnel Management (“OPM”)
4. State licensing Boards/Agencies
5. Member/customer services departments
6. Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
7. Other internal Amerigroup departments
8. Any other information received from sources deemed reliable by Amerigroup.

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

Denying claims by excluded and precluded providers

Amerigroup monitors appropriate sanction resource lists to identify providers for whom claims should be denied for its Medicare businesses. For pharmacy providers, the PBM shall be primarily responsible for reviewing the OIG and General Services Administration (GSA) sanction lists in their entirety to ensure no excluded providers are in the pharmacy network. Monthly updates to the sanctions lists are monitored to ensure pharmacies new to the list are not included in the network. For medical providers, Amerigroup Medicare Claims monitors the OIG website on a monthly basis to identify sanctioned providers both to prevent payment for medical claims to ineligible providers, and to support correct claim determination complying with Medicare regulations. Further, Amerigroup Provider Data Management monitors the CMS website on a monthly basis to identify precluded providers and prescribers who are prohibited from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries both to prevent payment and to support correct claims determination complying with Medicare regulations.

7.7 Appeals Process

Amerigroup has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one (1) or more of Amerigroup's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Amerigroup may wish to terminate practitioners or HDOs. Amerigroup also seeks to treat Network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Amerigroup's Networks for professional competence and conduct reasons, or which would otherwise result in a report to the National Practitioner Data Bank ("NPDB"). Additionally, Amerigroup will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is Amerigroup's intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one (1) or more of Amerigroup's Networks or Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional competence and conduct considerations. Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, has a criminal conviction, or Amerigroup's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

7.8 Reporting Requirements

When Amerigroup takes a professional review action with respect to a practitioner's or HDO's participation in one (1) or more of its Networks or Plan Programs, Amerigroup may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

7.9 Amerigroup Credentialing Program Standards

I. Eligibility Criteria

Health care practitioners:

Initial applicants must meet all of the following criteria in order to be considered for participation:

- A. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;
- B. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he or she provides services to Members; and
- C. Possess a current, valid, and unrestricted Drug Enforcement Agency ("DEA") and/or Controlled Dangerous Substances ("CDS") registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members; the DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who see Members in more than one (1) state must have a DEA/CDS registration for each state.
- D. Meet the education and training criteria as required by the Company.

In addition, Initial applicants must meet one of the following board certification criteria, as applicable, in order to be considered for participation. The Company reserves the right, in its reasonable discretion, to waive the board certification or alternative requirement when the Company determines that there are extenuating or special circumstances that warrant the waiver of such requirement.

- A. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (“ABMS”), American Osteopathic Association (“AOA”), Royal College of Physicians and Surgeons of Canada (“RCPSC”), College of Family Physicians of Canada (“CFPC”), American Board of Foot and Ankle Surgery (“ABFAS”), American Board of Podiatric Medicine (“ABPM”), or American Board of Oral and Maxillofacial Surgery (“ABOMS”) in the clinical discipline for which they are applying.
- B. If not board certified, MDs and DOs will be granted five (5) years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
- C. If not board certified, DPMs will be granted five (5) years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven (7) years after completion of their residency to meet this requirement for ABFAS.
- D. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.
 1. As alternatives to board certification, MDs and DOs meeting any one (1) of the following criteria will be viewed as meeting the education, training and certification requirement:
 - a. Previous board certification (as defined by one (1) of the following: ABMS, AOA, RCPSC, CFPC) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of ten (10) consecutive years of clinical practice;
 - b. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or
 - c. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching Facility in Amerigroup’s Network and the applicant’s professional activities are spent at that institution at least fifty percent (50%) of the time.
 2. Practitioners meeting one (1) of these three (3) alternative criteria (a, b, c) will be viewed as meeting all Amerigroup education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. The above alternatives are subject to Amerigroup review and approval.

For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (“TJC”), National Integrated Accreditation for Healthcare Organizations (“NIAHO”), Center for Improvement in Healthcare Quality (“CIHQ”), a Healthcare Facilities Accreditation Program (“HFAP”) accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such

practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.

II. Criteria for Selecting Practitioners

A. New Applicants (Credentialing)

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions;
2. Application attestation signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;
4. No evidence of potential material omission(s) on application;
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members;
6. No current license action;
7. No history of licensing board action in any state;
8. No current federal sanction and no history of federal sanctions (per System for Award Management ("SAM"), OIG and OPM report nor on NPDB report);
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who treat Members in more than one (1) state must have a valid DEA/CDS registration for each applicable state.

Initial applicants who have no DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:

- a. It can be verified that this application is pending.
- b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained.
- c. The applicant agrees to notify Amerigroup upon receipt of the required DEA/CDS registration.
- d. Amerigroup will verify the appropriate DEA/CDS registration via standard sources.
 - i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a ninety (90) calendar day timeframe will result in termination from the Network.
 - ii. Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Amerigroup's Members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA

registration the credentialing process may proceed if all the following criteria are met:

- (a) It can be verified that the applicant's application is pending; and
 - (b) The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
 - (c) The applicant agrees to notify Amerigroup upon receipt of the required DEA registration; and
 - (d) Amerigroup will verify the appropriate DEA/CDS registration via standard sources; and
 - (e) The applicant agrees that failure to provide the appropriate DEA registration within a ninety (90) day timeframe will result in termination from the network.
 - iii. Office-based practitioners who voluntarily choose to have a DEA/CDS registration that does not include all Controlled Substance Schedules (for example, Schedule, II, III or IV), if that practitioner certifies the following:
 - (a) controlled substances from these Schedules are not prescribed within his/her scope of practice; and
 - (b) he or she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances from these Schedules should it be clinically appropriate; and
 - (c) DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.
10. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions;
 11. No history of or current use of illegal drugs or history of or current alcoholism;
 12. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
 13. No gap in work history greater than six (6) months in the past five (5) years with the exception of those gaps related to parental leave or immigration where twelve (12) month gaps will be acceptable.
 14. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence. A minimum of the past ten (10) years of malpractice case history is reviewed.
 15. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Amerigroup's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
 16. No involuntary terminations from an HMO or PPO;
 17. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
 - a. Investment or business interest in ancillary services, equipment or supplies;

- b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
- c. Voluntary surrender of state license related to relocation or nonuse of said license;
- d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
- e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
- f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window;
- g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
- h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

Note: the CC will individually review any practitioner that does not meet one (1) or more of the criteria required for initial applicants.

B. Additional Participation Criteria and Exceptions for Behavioral Health practitioners (Non Physician) Credentialing. These Practitioners who fall within the scope of the credentialing program are required to meet all previous requirements. This section specifically addresses only the education and training requirements of non-physician behavioral health Practitioners.

1. Licensed Clinical Social Workers ("LCSW") or other master level social work license type:
 - a. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education ("CSWE") or the Canadian Association on Social Work Education ("CASWE");
 - b. Program must have been accredited within three (3) years of the time the practitioner graduated;
 - c. Full accreditation is required, candidacy programs will not be considered; and
 - d. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet the criteria, the doctoral program must be accredited by the American Psychological Association ("APA") or be regionally accredited by the Council for Higher Education Accreditation ("CHEA"). In addition, a doctor of social work from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.
2. Licensed professional counselor ("LPC") and marriage and family therapist ("MFT") or other master level license type:
 - a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one (1) of the fields of study above;
 - b. Master or doctoral degrees in divinity do not meet criteria as a related field of study;
 - c. Graduate school must be accredited by one (1) of the Regional Institutional

- Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, Council for Accreditation of Counseling and Related Educational Programs (“CACREP”), or Commission on Accreditation for Marriage and Family Therapy Education (“COAMFTE”) listings. The institution must have been accredited within three (3) years of the time the practitioner graduated;
- d. Practitioners with PhD training as a clinical psychologist can be reviewed. To meet criteria this doctoral program must either be accredited by the APA or be regionally accredited by the CHEA. A Practitioner with a doctoral degree in one (1) of the fields of study noted will be viewed as acceptable if the institution granting the degree has regional accreditation from the CHEA and;
 - e. Licensure to practice independently.
3. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
- a. Master’s degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing. Graduate school must be accredited from an institution accredited by one (1) of the Regional Institutional Accrediting Bodies within three (3) years of the time of the practitioner’s graduation;
 - b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable;
 - c. Certification by the American Nurses Association (“ANA”) in psychiatric nursing. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner; and
 - d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.
4. Clinical Psychologists:
- a. Valid state clinical psychologist license;
 - b. Doctoral degree in clinical or counseling, psychology or other applicable field of study from an institution accredited by the APA within three (3) years of the time of the practitioner’s graduation;
 - c. Education/Training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA accredited institution, but who is listed in the National Register of Health Service Providers in Psychology or is a diplomat of the American Board of Professional Psychology; and
 - d. Master’s level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.
5. Clinical Neuropsychologist:
- a. Must meet all the criteria for a clinical psychologist listed in B.4 above and be Board certified by either the American Board of Professional Neuropsychology

- (“ABPN”) or American Board of Clinical Neuropsychology (“ABCN”);
 - b. A practitioner credentialed by the National Register of Health Service Providers (“National Register”) in psychology with an area of expertise in neuropsychology may be considered; and
 - c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one (1) or more of the following:
 - i. Transcript of applicable pre-doctoral training;
 - ii. Documentation of applicable formal one (1) year post-doctoral training (participation in CEU training alone would not be considered adequate);
 - iii. Letters from supervisors in clinical neuropsychology (including number of hours per week); or
 - iv. Minimum of five (5) years’ experience practicing neuropsychology at least ten (10) hours per week.
6. Licensed Psychoanalysts:
- a. Applies only to practitioners in states that license psychoanalysts.
 - b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Credentialing Policy (e.g. psychiatrist, clinical psychologist, licensed clinical social worker).
 - c. Practitioner must possess a valid psychoanalysis state license.
 - i. Practitioner shall possess a master’s or higher degree from a program accredited by one (1) of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, CACREP, or the COAMFTE listings. The institution must have been accredited within three (3) years of the time the practitioner graduates.
 - ii. Completion of a program in psychoanalysis that is registered by the licensing state as licensure qualifying; or accredited by the American Board for Accreditation in Psychoanalysis (ABAP) or another acceptable accrediting agency; or determined by the licensing state to be the substantial equivalent of such a registered or accredited program.
 - (a) A program located outside the United States and its territories may be used to satisfy the psychoanalytic study requirement if the licensing state determines the following: it prepares individuals for the professional practice of psychoanalysis; and is recognized by the appropriate civil authorities of that jurisdiction; and can be appropriately verified; and is determined by the licensing state to be the substantial equivalent of an acceptable registered licensure qualifying or accredited program.
 - (b) Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
 - (c) Meet examination requirements for licensure as determined by the licensing state.

6. Licensed Psychoanalysts:

- a. Applies only to practitioners in states that license psychoanalysts.
- b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Credentialing Policy (e.g. psychiatrist, clinical psychologist, licensed clinical social worker).
- c. Practitioner must possess a valid psychoanalysis state license.
 - i. Practitioner shall possess a master's or higher degree from a program accredited by one (1) of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, CACREP, or the COAMFTE listings. The institution must have been accredited within three (3) years of the time the practitioner graduates.
 - ii. Completion of a program in psychoanalysis that is registered by the licensing state as licensure qualifying; or accredited by the American Board for Accreditation in Psychoanalysis (ABAP) or another acceptable accrediting agency; or determined by the licensing state to be the substantial equivalent of such a registered or accredited program.
 - (a) A program located outside the United States and its territories may be used to satisfy the psychoanalytic study requirement if the licensing state determines the following: it prepares individuals for the professional practice of psychoanalysis; and is recognized by the appropriate civil authorities of that jurisdiction; and can be appropriately verified; and is determined by the licensing state to be the substantial equivalent of an acceptable registered licensure qualifying or accredited program.
 - (b) Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
 - (c) Meet examination requirements for licensure as determined by the licensing state.

C.. Additional Participation Criteria and Exceptions for Nurse Practitioners, Certified Nurse Midwives, Physicians Assistants (Non Physician). Acupuncturists Credentialing. These Practitioners who fall within the scope of the credentialing program are required to meet all previous requirements. This section specifically addresses only the education and training requirements of non-physician Practitioners.

1. Process, requirements and Verification – Nurse Practitioners:

- a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
- b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
- c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
- d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Amerigroup procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
- e. All NP applicants will be certified in the area which reflects their scope of practice by any one (1) of the following:
 1. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
 2. American Academy of Nurse Practitioners – Certification Program;
 3. National Certification Corporation;
 4. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner);
 5. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY; or
 6. American Association of Critical Care Nurses ACNPC – Adult Care Nurse Practitioner; ACNPC-AG – Adult Gerontology Acute Care. This certification must be active and primary source verified.

This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Amerigroup is not required. If the applicant

- is not certified or if his/her certification has expired, the application will be submitted for individual review.
- f. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.
 - g. The NP applicant will undergo the standard credentialing processes outlined in Amerigroup's Credentialing Policies ("Credentialing Policies" or Credentialing Policy). NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three (3) years, and continuous sanction and performance monitoring upon participation in the network.
 - h. Upon completion of the credentialing process, the NP may be listed in Amerigroup's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
 - i. NPs will be clearly identified:
 - 1. On the credentialing file;
 - 2. At presentation to the CC; and
 - 3. Upon notification to Network Services and to the provider database.
2. Process, Requirements and Verifications – Certified Nurse Midwives:
- a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.
 - b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
 - c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
 - d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Amerigroup procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
 - e. All CNM applicants will be certified by either:

1. The National Certification Corporation for Ob/Gyn and neonatal nursing;
or
2. The American Midwifery Certification Board, previously known as the American College of Nurse Midwives.

This certification must be active and primary source verified. If the state licensing board primary source verifies one (1) of these certifications as a requirement for licensure, additional verification by Amerigroup is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.

- f. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.
- g. The CNM applicant will undergo the standard credentialing process outlined in Amerigroup's Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three (3) years, and continuous sanction and performance monitoring upon participation in the network.
- h. Upon completion of the credentialing process, the CNM may be listed in Amerigroup's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
- i. CNMs will be clearly identified:
 1. On the credentialing file;
 2. At presentation to the CC; and
 3. Upon notification to network services and to the provider database.
3. Process, Requirements and Verifications – Physician's Assistants (PA):
 - a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
 - b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
 - c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have

- in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
- d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Amerigroup procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
 - e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Amerigroup is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or amended by each Amerigroup Health Plan and submitted for individual review by the CC.
 - f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
 - g. The PA applicant will undergo the standard credentialing process outlined in Amerigroup's Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three (3) years, and continuous sanction and performance monitoring upon participation in the network.
 - h. Upon completion of the credentialing process, the PA may be listed in Amerigroup provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
 - i. PA's will be clearly identified:
 - 1. On the credentialing file;
 - 2. At presentation to the CC; and
 - 3. Upon notification to Network Services and to the provider database.

Process, Requirements and Verifications – Acupuncturists (non MD/DO):

- a. The provider applicant will submit the appropriate application and supporting documents as required of any other Practitioners with the exception of differing information regarding education/training and board certification.
- b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as an Acupuncturist and all Acupuncturists applicants must have a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM).
- c. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.

- d. The license status must be that of an Acupuncturist as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
- e. The provider applicant will undergo the standard credentialing process outlined in Amerigroup Credentialing Policies. Acupuncturists are subject to all the requirements described in these Credentialing Policies including (but not limited to): Committee review of Level II files failing to meet predetermined criteria, recredentialing every three (3) years, and continuous sanction and performance monitoring upon participation in the network.
- f. Upon completion of the credentialing process, the Acupuncturist may be listed in Amerigroup provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
- g. Acupuncturists will be clearly identified such:
 - a. On the credentialing file;
 - b. At presentation to the Credentialing Committee; and
 - c. On notification to Network Services and to the provider database.

D. Currently Participating Applicants (Re-credentialing)

- 1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
- 2. Re-credentialing application signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;
- 3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in Amerigroup's programs or provider Network(s), federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider Network(s) as well as Amerigroup's other credentialed provider Network(s).
- 4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
- 5. No new history of licensing board reprimand since prior credentialing review;
- 6. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
- 7. Current DEA/CDS registration and/or state controlled substance certification without new (since prior credentialing review) history of or current restrictions;
- 8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Members needing hospitalization;

9. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism;
10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five (5) years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
 - a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
 - b. Voluntary surrender of state license related to relocation or nonuse of said license;
 - c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
 - d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
 - e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window;
 - f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
 - g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
15. No quality improvement data or other performance data including complaints above the set threshold.
16. Re-credentialed at least every three (3) years to assess the practitioner's continued compliance with Amerigroup standards.

*It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Network practitioners and HDOs that do not meet one (1) or more of the criteria for re-credentialing.

III. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Amerigroup may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past thirty-six (36) months. If a HDO has satellite facilities that follow the same

policy and procedures, Amerigroup may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for Member access need only when the CC review indicates compliance with Amerigroup standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are re-credentialed at least every three (3) years to assess the HDO's continued compliance with Amerigroup standards.

A. General Criteria for HDOs:

1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Members. The license must be in good standing with no sanctions.
2. Valid and current Medicare certification.
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in Amerigroup's programs or provider Network(s), exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Network(s) as well as Amerigroup's other credentialed provider Network(s).
4. Liability insurance acceptable to Amerigroup.
5. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Amerigroup's quality and certification criteria standards have been met.

B. Additional Participation Criteria for HDO by Provider Type:

HDO Type and Amerigroup Approved Accrediting Agent(s)

Medical Facilities

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, CTEAM, DNV/NIAHO, HFAP, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, CTEAM, DNV/NIAHO, TJC
Home Infusion Therapy (HIT)	ACHC, CHAP, CTEAM, HQAA, TJC
Portable Xray Services	FDA Certification
Skilled Nursing Facilities/Nursing Homes	BOC INT'L, CARF, TJC

Behavioral Health

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	CTEAM, DNV/NIAHO, TJC, HFAP
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC, HFAP
Crisis Stabilization Unit	TJC

Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Abuse	ACHC, CARF, COA, DNV/NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, HFAP, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Abuse	CARF, DNV/NIAHO, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Abuse	CARF, COA, DNV/NIAHO, HFAP, TJC

Rehabilitation

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	DNV/NIAHO, HFAP, TJC, CTEAM
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Abuse Clinics	CARF, TJC, COA

Additional Medicare Advantage Product Specific Requirements:

The Medicare Advantage (MA) organization must determine that each institutional provider or supplier that has signed a contract or participation agreement with the MA organization has met the following three requirements. Current documentation should be obtained at least every 3 years, and contracts should provide for notice from the provider of any change in its Medicare approval, state licensure, or accreditation status.

1. The following types of providers and suppliers must have met requirements for participation in Medicare:
 - Hospitals (either JCAHO accreditation or Medicare certification). Note that Medicare also certifies organ procurement organizations (OPOs) and that organ transplants must generally be performed in certified organ transplants centers;
 - Home Health Agencies (HHAs);
 - Hospices;
 - Clinical laboratories (a CMS-issued CLIA certificate or a hospital-based exemption from CLIA);
 - Skilled Nursing Facilities (SNFs);
 - Comprehensive Outpatient Rehabilitation Facilities (CORFs);
 - Outpatient Physical Therapy and Speech Pathology providers;
 - Ambulatory Surgery Centers (ASCs);
 - Providers of end-stage renal disease services;
 - Providers of outpatient diabetes self-management training;
 - Portable X-ray Suppliers; and
 - Rural health clinic (RHCs) and federally qualified health center (FQHCs).
2. Is licensed to operate in the state, and is in compliance with any other applicable state or federal requirements.
3. Is reviewed and approved by an appropriate accrediting body, or meets the standards established by the MA organization itself.

- Accrediting bodies include the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation, the Community Health Accreditation Program (CHAP), and the Continuing Care Accreditation Commission.
- This standard does not require that an MA organization accept the findings of an accrediting body in determining whether to contract with a provider, or that it reject providers that are not accredited. However, an MA organization that does not rely on independent accreditation must develop its own standards for approval of institutional providers and determine that such providers meet those standards before including them in its network.
- Primary source verification of accreditation and licensure is not required, unless otherwise provided in the MA organization's Medicare contract. Accordingly, an MA organization may rely on documentation supplied by the institutional provider.

8 PERFORMANCE AND TERMINATION

8.1 Performance Standards and Compliance

All providers must meet specific performance standards and compliance obligations. When evaluating a provider's performance and compliance, Amerigroup reviews a number of clinical and administrative practice dimensions, including:

- Quality of care — measured by clinical data related to the appropriateness of care and outcomes
- Efficiency of care — measured by clinical and financial data related to health care costs
- Member satisfaction — measured by the members' reports regarding accessibility, quality of health care, member/provider relations and the comfort of the office setting
- Administrative requirements — measured by the provider's methods and systems for keeping records and transmitting information
- Participation in clinical standards — measured by the provider's involvement with panels used to monitor quality of care standards

Providers must:

- Comply with all applicable laws and licensing requirements.
- Furnish covered services in a manner consistent with professionally recognized standards of medical and surgical practice generally accepted in the professional community at the time of treatment
- Comply with Amerigroup standards, including:
 - Guidelines established by the Centers for Disease Control and Prevention (or any successor entity).
 - Federal, state and local laws regarding professional conduct.
- Comply with Amerigroup policies and procedures regarding the following:
 - Participating on committees and clinical task forces to improve the quality and cost of care
 - Prenotification and/or prior authorization requirements and time frames
 - Provider credentialing requirements
 - Referral policies
 - Case Management Program referrals
 - Appropriately releasing inpatient and outpatient utilization and outcomes information

- Providing accessibility of member medical record information to fulfill Amerigroup business and clinical needs
- Cooperating with efforts to assure appropriate levels of care
- Maintaining a collegial and professional relationship with Amerigroup personnel and fellow providers
- Providing equal access and treatment to all Medicare members

The following types of noncompliance issues are key areas of concern:

- Unnecessary out-of-network referrals and utilization (which require prior authorization)
- Failure to provide advance notice of admissions or prior authorization of discharges from inpatient facilities, comprehensive outpatient rehabilitation facilities or home health care services
- Member complaints and grievances filed against the provider
- Underutilization, overutilization or inappropriate referrals
- Inappropriate billing practices, such as balance billing of Medicare members for monies that are not their responsibility
- Nonsupportive actions and/or attitude

Provider noncompliance is tracked on a calendar year basis. Corrective actions are taken as appropriate.

8.2 Physician – Patient Communications

Providers acting within the lawful scope of practice are encouraged to advise Amerigroup members of the following:

- Health status, medical care or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options
- Risks, benefits and consequences of treatment or nontreatment
- Opportunity for the individual to refuse treatment and to express preferences about future treatment decisions

Physician and patient communications are a necessary component of standard medical practice. Although coverage under this program is determined by Amerigroup, the provider remains responsible for all treatment decisions related to the Amerivantage plan member.

8.3 Provider Participation Decisions: Appeal Process

Upon a denial, suspension, termination or nonrenewal of a physician's participation in the provider network, Amerigroup acts as follows:

- The affected physician is given a written notice of the reasons for the action, including if relevant the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by Amerigroup
- The physician is allowed to appeal the action to a hearing panel
- The physician is provided written notice of the right to a hearing and the process and timing for requesting a hearing
- Amerigroup ensures the majority of the hearing panel members are peers of the affected physician
- Amerigroup notifies the NPDB, the appropriate state licensing agency and any other applicable licensing or disciplinary body to the extent required by law, if a suspension or termination is the result of quality of care deficiencies

Subcontracted physician groups must ensure these procedures apply equally to physicians within those subcontracted groups.

Amerigroup decisions subject to an appeal include decisions regarding reduction, suspension or termination of a provider's participation resulting from quality deficiencies. Amerigroup notifies the NPDB, the appropriate state licensing agency and any other applicable licensing or disciplinary body to the extent required by law. Written communication to the provider details the deficiencies and informs him or her of the right to appeal.

8.4 Notification to Members of Provider Termination

Amerigroup makes a good faith effort to provide at least 30 calendar days written notice of a provider's termination to all members who are seen on a regular basis by that provider before the termination effective date, regardless of the reason for the termination. Amerigroup may provide member notification in less than 30 days' notice as a result of a provider's death or exclusion from the federal health programs.

When a termination involves a PCP, all members who are patients of that PCP are notified of the termination.

9 QUALITY MANAGEMENT

Amerigroup maintains a comprehensive Quality Management (QM) program to objectively and systematically monitor and evaluate care and service provided to members. The scope and content of the program reflects the demographic, epidemiologic, medical and behavioral health needs of the population served. Key components of the program include but are not limited to:

- Quality of member care and service
- Accessibility and availability of services
- Member safety and prevention
- Continuity and coordination of care
- Appropriateness of service utilization
- Cultural competency
- Member outcomes
- Member and provider satisfaction
- Regulatory and accreditation standards

Members and providers have opportunities to participate in quality management and make recommendations for areas of improvement through complaints, grievances, appeals, satisfaction or other surveys, committee participation where applicable, quality initiatives/projects, and calls to the health plans. QM program goals and outcomes are available to providers and members upon request.

Quality activities are planned across the continuum of care and service with ongoing proactive evaluation and refinement of the program.

The Amerigroup QM program tracks and trends quality of care issues and service concerns identified for all care settings. QM staff review member complaints/grievances, reported adverse events and other information to evaluate the quality of service and care provided to our members. Practitioners and providers must allow Amerigroup to use performance data in cooperation with our quality improvement program and activities.

9.1 CMS Star Ratings

The Centers for Medicare & Medicaid Services (CMS) evaluates all Medicare Advantage (MA) and Prescription Drug (MA-PD) plans using a star rating system. The CMS Five-Star Quality Rating System provides helpful information to consumers, families and caregivers for comparing MA-PD plans based on a one to five rating:

- * * * * * equals excellent
- * * * * equals very good
- * * * equals good
- * * equals fair
- * equals poor

Many of the measures included in the CMS rating system are measures of preventive care and routine disease management. Some of these are listed below and are subject to change:

1. Staying healthy — screening, tests and vaccines:
 - Colorectal cancer screening
 - Annual flu vaccine
 - Improving and maintaining physical and mental health
 - Monitoring physical activity
 - Adult body mass index assessment
2. Managing chronic conditions:
 - SNP Care Management
 - Care for the older adult: medication review, functional status assessment and pain screening
 - Managing osteoporosis in women who had a fracture
 - Obtaining diabetes care for eye exams, kidney disease monitoring, and blood sugar and cholesterol control
 - Controlling blood pressure
 - Managing rheumatoid arthritis
 - Improving bladder control
 - Reducing the risk of falling
 - Plan all-cause readmissions
 - Medication adherence and management (oral diabetics, hypertension and cholesterol medications)

With the growing focus on quality health care and plan member satisfaction, CMS assesses MA plan performance. The CMS assessment results in a star rating assigned to each plan. One of the assessment tools used is the Consumer Assessment of Healthcare Providers and Systems® (CAHPS) survey. Medicare beneficiaries who receive health care services through a MA-PD plan receive CAHPS surveys through the mail in late February.

The survey asks the Medicare beneficiary to assess his or her health and the care received from his or her primary care providers and specialists over the past six months. The survey includes questions regarding providers' communication skills and the member's perception about his or her access to needed health care services. Several questions directly correlate to a plan's CMS star rating. The survey questions ask the member to report his or her opinion about access to care and the health plan's customer service. It also asks the member to rate the communication received from his or her providers.

A second assessment tool used by CMS is the Health Outcomes Survey (HOS) to evaluate all managed care organizations with a MA contract. CMS randomly samples Medicare beneficiaries from each participating MA plan. Two years after the initial HOS survey, the same Medicare beneficiaries are surveyed again. The results are part of the effectiveness of care component of the HEDIS rates for the MA plan.

The rating system empowers consumers, families and caregivers with information to compare MA-PD plans. The measures of the rating system include preventive care and routine disease management. This information gives consumers, families and caregivers results to make an educated decision about their health care needs. The ratings are posted online and may be accessed at <https://www.medicare.gov>. Please note there are separate ratings for Part C (medical) and Part D (prescription drug) services.

Amerigroup encourages participating providers to help improve member satisfaction by:

- Ensuring members receive appointments within acceptable time frames as outlined in the Access and Availability Standards Table in this manual.
- Educating members and talking to them during each visit about their preventive health care needs and disease management goals.
- Ensuring providers answer any questions members have regarding newly prescribed medications.
- Ensuring members know to bring all medications and medical histories to their specialists and knows the purpose of a specialist referral.
- Allowing time during the appointment to validate members' understanding of their health conditions and the services required for maintaining a healthy lifestyle.
- Referring members to the Member Services department at the DSU and speaking to a case manager.

9.2 Committee Structure

Amerigroup maintains a comprehensive quality management committee structure as noted below with program oversight by the board of directors.

9.3 Quality Improvement Council

The purpose of the Corporate Quality Improvement Council is to provide leadership and oversight of the corporate and health plan quality management programs, improve safety, quality of care and services, improve customer service, and improve operating efficiencies.

Responsibilities include:

- Review and approval of the program descriptions
- Work plans and annual evaluations for quality management, utilization management, health promotion, credentialing, case management, pharmacy and disease management
- Review and approval reporting of complaints, appeals and *Service Level Agreements (SLAs)*
- Review of regular standardized reports (at least semi-annually) delineating progress towards goals of the program, actions taken, improvements made, focused study results and follow-up actions on identified opportunities
- Evaluation of resource adequacy to ensure effective implementation of the programs and ongoing effectiveness
- Recommending policy decisions
- Instituting needed actions and ensure completion
- Ensuring practitioner participation

9.4 Quality Management Committee

The purpose of the health plan Quality Management Committee (QMC) is to maintain quality as a cornerstone of Amerigroup culture and to be an instrument of change through demonstrable improvement in care and service.

The QMC's responsibilities are to:

- Establish strategic direction and monitor and support implementation of the Quality Management Program.
- Establish processes and structure that ensure National Committee for Quality Assurance (NCQA) compliance.
- Review planning, implementation, measurement and outcomes of clinical/service quality improvement initiatives/projects.
- Coordinate communication of quality management activities throughout the health plans.
- Review HEDIS data and action plans for improvement.
- Review and approve the annual Quality Management Program description.
- Review and approve the annual work plans for each service delivery area.
- Provide oversight and review of delegated services.
- Provide oversight and review of subordinate committees.
- Receive and review reports of utilization review decisions and take action when appropriate.
- Analyze member and provider satisfaction survey responses.
- Monitor the plan's operational indicators through the plan's senior staff.

9.5 Medical Advisory Committee

The health plan Medical Advisory Committee (MAC) has multiple purposes. The MAC assesses levels and quality of care provided to members and recommends, evaluates and monitors standards of care. The MAC identifies opportunities to improve services and clinical performance by establishing, reviewing and updating *Clinical Practice Guidelines* based on review of demographic and epidemiologic information to target high-volume, high-risk and problem-prone conditions. The MAC oversees the peer review process that provides a systematic approach for the monitoring of quality and the appropriateness of care. The MAC advises the health plan administration in any aspect of the health plan policy or operation affecting network providers or members. The MAC approves and provides oversight of the peer review process, the QM Program and the Utilization Review Program. It oversees and makes recommendations regarding health promotion activities.

The MAC's responsibilities are to:

- Utilize an ongoing peer review system to monitor practice patterns to identify appropriateness of care and to improve risk prevention activities.
- Approve clinical protocols/guidelines that help ensure the delivery of quality care and appropriate resource utilization.
- Review clinical study design and results.
- Develop action plans/recommendations regarding clinical quality improvement studies.
- Oversee member access to care.
- Review and provide feedback regarding new technologies.
- Approve recommendations from subordinate committees.

9.6 Credentialing Committee

The health plan Credentialing Committee (CC) has been delegated authority of the credentialing program by the health plan Quality Management Committee and the National Credentials Committee. It is responsible for the oversight of the credentialing program, decisions regarding the credentialing and recredentialing of the practitioners and providers contracted with the health plan, and oversight of organizations for which credentialing has been delegated

The CC's responsibilities are to:

- Consider/act in response to provider sanctions.
- Approve credentialing/recredentialing policies and procedures.
- Review practitioner and provider credentialing and recredentialing applicants for participation in Amerigroup provider networks.
- Provide pre-delegation, ongoing oversight and annual review of delegated entities.
- Approve/deny participation at initial credentialing based on credentials meeting or not meeting standards for participation.
- Approve/term continuing participation at recredentialing based on credentials meeting/not meeting standards for participation.

10 HEALTH CARE MANAGEMENT SERVICES

Amerigroup continuously seeks to improve the quality of care provided to its members. We encourage and expect our providers to participate in health promotion and disease prevention programs. Providers are encouraged to collaborate with Amerigroup in efforts to promote healthy lifestyles through member education and information sharing.

Providers must fully comply with:

- Health care management services policies and procedures.
- Quality improvement and other performance improvement programs.
- All regulatory requirements.

The health care delivery system is a gatekeeper model that supports the role and relationship of the PCP. The model includes direct contracts with PCPs, hospitals, specialty physicians and other providers as required to deliver Medicare benefits, additional benefits and Amerigroup programs for members with complex medical needs. All contracted providers are available to Medicare members by PCP or self-referral for the services identified below. There are no sub networks that limit the choice of specialist referrals based on selection of PCP.

The gatekeeper model requires all members to select a PCP upon joining the plan. Members who do not choose a PCP are assigned one. Amerigroup works with the member, the physician and the member's representative, as appropriate, to ensure the PCP is suitable to meet the member's special needs. Members must have access to their PCP or a covering physician 24 hours a day, 7 days a week.

10.1 Self-Referral Guidelines

Medicare members may self-refer for the following services:

- Screening mammograms
- Behavioral health
- Influenza and pneumococcal vaccinations

- All preventive services (e.g., routine physical examinations, prostate screening and preventive women's health services, such as Pap tests)

Except for emergent or out-of-area urgent care and dialysis services, in general, Medicare members must obtain services within the Amerigroup network or obtain a prior authorization for covered services outside the network. As a contracted provider with the plan you are responsible for either referring within the network or obtaining prior authorization from the plan.

10.2 Referral Guidelines

PCPs may only refer members to Amerigroup contracted network specialists to ensure the specialist receives appropriate clinical background data and is aware of the member's ongoing primary care relationship. If a member does not have out-of-network benefits, such as an HMO member and has expressed a desire to receive care from a different specialist or you believe the required specialty is not available within the contracted network, contact Provider Services at the DSU at 1-866-805-4589. Provider must obtain prior authorization from Amerigroup before referring members to nonplan providers. Referring a Medicare member out-of-network will result in the claim denying with member liability unless urgent, emergent, out of area renal dialysis or if prior authorization was obtained from the plan.

Providing Noncovered Services Advanced Notification

For services that require prior authorization or are non-covered by the plan (i.e., statutory exclusion), it becomes extremely important that Amerigroup authorization procedures are followed. If a member elects to receive such care the member cannot be held financially responsible unless notified in advance of the noncovered services. In such cases when the network physician fails to follow Amerigroup authorization protocols, Amerigroup may decline to pay the claim in which case the physicians will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

CMS-issued guidance concerning Advance Notices of Noncoverage. The ABN is a FFS document and cannot be used for Medicare Advantage denials or notifications. Per the [Medicare Claims Processing Manual](#) from CMS (page 4), the ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). CMS advised Medicare Advantage plans that contracted providers are required to provide a coverage determination for services that are not covered by the member's Medicare Advantage plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. If there is any doubt about whether a service is not covered, please seek a coverage determination from the plan.

10.3 Prior Authorization

Certain services/procedures require prior authorization from Amerigroup for participating and nonparticipating PCPs and specialists. Please refer to the list below or the Precertification Lookup tool online, or call Provider Services at the DSU at 1-866-805-4589 for more information. You can also access information concerning prior authorization requirements on our website at <https://providers.amerigroup.com>.

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.

The following are examples of services requiring prior authorization before providing the following nonemergent or urgent care services:

- Inpatient mental health services
- Behavioral health partial hospitalization
- Skilled Nursing Facility (SNF)
- Home health care
- Diagnostic tests, including but not limited to MRI, MRA, PET scans, etc.
- Hospital or ambulatory care center-based outpatient surgeries for certain procedures
- Elective inpatient admissions
- Transplant evaluation and services
- Referrals and services from noncontracted providers
- Durable Medical Equipment (DME)*
- Outpatient IV infusion or injectable medications
- Prosthetics
- Certain reconstructive procedures
- Occupational, speech and physical therapy services
- Referrals outside of the Amerigroup network
- Requests for noncovered services under the Medicare program

For services that require prior authorization or are noncovered by the plan (i.e., statutory exclusion), it becomes extremely important that all authorization procedures are followed. If a member elects to receive such care the member cannot be held financially responsible unless notified in advance of the noncovered services. In such cases when the network physician fails to follow authorization protocols, Amerigroup may decline to pay the claim in which case the physicians will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

A written coverage determination will help ensure that a claim for noncovered care from a contracted provider is paid accurately. According to CMS, if the appropriate written notice of denial of payment is not given to the Medicare Advantage member regarding a noncovered service, the claim may be denied and the member cannot be held financially responsible. Therefore, your failure to obtain an appropriate coverage determination could result in a denial of payment for the noncovered service.

Contact us prior to services being rendered to comply with this requirement and ensure appropriate claims payment and allow you to bill the Medicare member in the event of noncoverage. As a contracted provider with us, you are prevented from billing the Medicare member for any service that is deemed noncovered if you have not ensured this advanced notification has been issued.

10.4 Medically Necessary Services and Medical Criteria

Multiple clinical and coverage determination guidelines are used to review the appropriateness of a service that has been rendered or requested to determine the care is reasonable and necessary for the diagnosis or treatment of illness or injury, provided in the most appropriate level of care, and is not

furnished for the convenience of the member or provider. The clinical guidelines used may include any of the following based on the type of request: CMS, National and Local Coverage and Benefit Guidelines, current editions of InterQual® Level of Care, MCG Guidelines (formerly Milliman Care Guidelines®), Amerigroup *Medical Policies* and *Clinical Utilization Management Guidelines* to review the medical necessity and appropriateness of physical health services, unless superseded by state requirements or regulatory guidance. Amerigroup *Behavioral Health Medical Necessity Criteria* are used for all behavioral health services, unless superseded by state or federal requirements or regulatory guidance. The *Medical Policies* and *Clinical Utilization Management Guidelines* are developed by the Amerigroup Medical Policy and Technology Assessment Committee (MPTAC). Criteria for review of behavioral health issues are reviewed by the National Behavioral Health Clinical Advisory Committee, a subcommittee of MPTAC. In addition to policies developed and or approved through MPTAC, the health plan's medical reviewers use criteria developed by AIM Specialty Health® for review of selected requests in some markets.

Amerigroup may collaborate with vendors to conduct medical necessity reviews for physical therapy, occupational therapy and spine and back pain management and/or other services for our Medicare Advantage members.

These criteria and guidelines are objective and provide a rules-based system for screening proposed medical and behavioral health care based on patient-specific, best medical care processes and consistently match medical services to patient needs, based upon clinical appropriateness.

The criteria's comprehensive range of level-of-care alternatives is sensitive to the differing needs of adults, adolescents, and children. When using the criteria to match a level of care to the member's current condition, all reviewers consider the severity of illness and comorbidities, as well as episode-specific variables. Their goal is to view members in a holistic manner to ensure they receive necessary support services within a safe environment optimal for recovery.

Criteria and guidelines are reviewed and approved annually by members of the Medical Policy and Technology Assessment Committee, and updated when appropriate. Input from the medical community is solicited and used in developing and updating policies. Policies and procedures for application of medical necessity criteria are reviewed and approved annually by the Medical Operations Committee.

Getting the best care in the most appropriate setting is key to achieving the best outcomes for our Amerigroup members. These members rely on their health care professionals and their health plan to help coordinate this important aspect of their care. To do this, timely communication is essential.

Ensuring that you provide the correct and complete clinical information at the correct time when requesting a medical necessity review when clinical information is needed.

If the information provided does not support medical necessity, the service cannot be approved under Medicare law. Please provide the necessary information to justify the services you are requesting at the time of the request to allow for an appropriate decision to be made. Any service determined to require a clinical review will be processed in accordance with:

- Section 1861(a)(1)(A) of the *Social Security Act*, which states that Medicare payment can only be made for services/items that are medically necessary and reasonable.
- Section 1833(e) of the *Social Security Act*, which states that Medicare payment can be made only when the documentation supports the service/item.

UM criteria are made available to practitioners upon request. If a medical necessity decision results in an adverse determination, practitioners are welcome to discuss the denial decision with a Medical Director. For additional information, to speak to a Medical Director, obtain UM criteria or for any inquiries, contact may be made via the Customer Services Department by calling the number on the members' identification card.

11 HOSPITAL AND ELECTIVE ADMISSION MANAGEMENT

Amerigroup requires prior authorization of all inpatient elective admissions. The referring PCP or specialist physician is responsible for prior authorization.

The referring physician identifies the need to schedule a hospital admission and must submit the request to the Amerigroup Health Care Management Services department.

Requests for prior authorization with all supporting documentation should be submitted immediately upon identifying the inpatient request or at least 72 hours prior to the scheduled admission. This will allow Amerigroup to verify benefits and process the prior authorization request. For services that require prior authorization, Amerigroup makes case-by-case determinations that consider an individual's health care needs and medical history, in conjunction with nationally recognized standards of care.

Interactive Care Reviewer (ICR)

The ICR is the preferred method for the submission of preauthorization requests offering a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for members. Additionally, providers can use this tool to make inquiries on previously submitted requests regardless of how they were sent (phone, fax, ICR or other online tool).

- Initiate preauthorization requests online, eliminating the need to fax. ICR allows detailed text, photo images and attachments to be submitted along with your request.
- Make inquiries on previously submitted requests via phone, fax, ICR or other online tool.
- Instant accessibility from almost anywhere including after business hours.
- Use the dashboard to provide a complete view of all UM requests with real-time status updates including email notifications if requested using a valid email address.
- Real-time results for some common procedures with immediate decisions.
- Access ICR under *Authorizations and Referrals* via the Availity Portal.

To register for an ICR webinar, visit [ICR Webinar](#).

For an optimal experience with the ICR, use a browser that supports 128-bit encryption. This includes Internet Explorer, Chrome, Firefox or Safari.

ICR is not currently available for the following:

- Transplant services
- Services administered by vendors such as AIM Specialty Health. (*For these requests, follow the same preauthorization process that you use today.*)

Our website will be updated as additional functionality and lines of business are added throughout the year.

The hospital can confirm a prior authorization is on file using the ICR or by calling Provider Services at the DSU at 1-866-805-4589 (see the Amerigroup website and the [Provider Inquiry Line section](#) of this

manual for instructions on use of the Provider Inquiry Line). If coverage of an admission has not been approved, the facility should call Provider Services at the DSU at 1-866-805-4589. Amerigroup will contact the referring physician directly to resolve the issue.

Amerigroup is available 24 hours a day, 7 days a week to accept prior authorization requests. When a request is received from the physician via telephone or fax for medical services, the care specialist will verify eligibility and benefits. This information will be forwarded to the prior authorization nurse.

The prior authorization nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. When appropriate, the prior authorization nurse will assist the physician in identifying alternatives for health care delivery as supported by the medical director.

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with nationally recognized standards of care, an Amerigroup reference number will be issued to the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

If the prior authorization documentation is incomplete or inadequate, the prior authorization nurse will notify the referring provider to submit the additional necessary documentation.

If the Medical Director denies coverage of the request, the appropriate denial letter, including the appropriate appeal rights, will be mailed to the member and provider.

Member liability for inpatient admissions will be assigned only:

- When the denial is issued prior to the services being rendered
- When the important message from Medicare is delivered in accordance with CMS guidelines
- When inpatient services were rendered by a nonparticipating facility, were not precertified and are not considered services covered under the plan

Participating providers will be held liable for all other inpatient denials issued. Any subsequent appeals should follow the correct process as outlined in the denial letter.

11.1 Emergent Admission Notification Requirements

Amerigroup requires immediate notification by network hospitals of emergent admissions. Network hospitals must notify Amerigroup of emergent admissions within one business day. Amerigroup Health Care Management Services staff will verify eligibility and determine benefit coverage.

Coverage of emergent admissions is authorized based on review by continued stay review process by Amerigroup. When the clinical information received meets nationally recognized standards of care, an Amerigroup approval number will be issued to the hospital.

If the notification documentation provided is incomplete or inadequate, Amerigroup will not approve coverage of the request but will notify the hospital to submit the additional necessary documentation.

If the medical director denies coverage of the request, the appropriate denial letter will be mailed to the member and provider, including the appropriate appeal rights.

11.2 Nonemergent Outpatient and Ancillary Services — Prior Authorization and Notification Requirements

Amerigroup requires prior authorization for coverage of selected nonemergent outpatient and ancillary services. Requests for prior authorization with all supporting documentation should be submitted immediately upon identifying the need for the request.

To ensure timeliness of the decision, the following must be provided:

- Member name and ID number
- Name, telephone number and fax number of physician performing the elective service
- Name of the facility and telephone number where the service is to be performed
- Date of service
- Member diagnosis
- Name of elective procedure to be performed with CPT code
- Medical information to support requested services (medical information includes current signs/symptoms, past and current treatment plans, response to treatment plans and medications)

Pre-service prior authorizations

Providers are required to provide notification in advance of services to allow Amerigroup to meet CMS processing timeframes:

- Medical:
 - Standard 14 — calendar days
 - Expedited — 72 hours
- Pharmacy (Including Part B Medical Injectables):
 - Standard — 72 Hours
 - Expedited — 24 Hours
- ER admissions:
 - Amerigroup requires notification within one business day for all ER admissions.
- CMS defines an expedited/urgent request 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.

11.3 Inpatient Admission Reviews

Urgent and emergent admissions require notification within one business day by the provider. The Amerigroup utilization review clinician determines the member's medical status through communication with the hospital's Utilization Review department. Appropriateness of the stay is documented, and concurrent review is initiated. Cases may be referred to the Medical Director who renders a decision regarding the coverage of hospitalization. Diagnoses meeting specific criteria are referred to the Medical Director for possible coordination by the care management program.

11.4 Affirmative Statement About Incentives

Amerigroup, as a corporation and as individuals involved in UM decisions, is governed by the following statements: UM decision-making is based only on the appropriateness of care and service and existence of coverage.

- Amerigroup does not specifically reward practitioners or other individuals for issuing denials of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support denials of benefits.
- Financial incentives for Amerigroup UM decision-makers do not encourage decisions that result in underutilization or create barriers to care or service

11.5 Discharge Planning

Discharge planning is designed to assist the provider in the coordination of a member's discharge when acute care (hospitalization) is no longer necessary. The Amerigroup concurrent review nurse or case manager (working with the Amerigroup medical director) will assist providers and hospitals with the discharge planning process in accordance with requirements of the Medicare Advantage program. At the time of admission and during the hospitalization, the Amerigroup case manager will discuss discharge planning with the provider, member and/or member advocate.

When the provider identifies medically necessary and appropriate services for the member, Amerigroup will assist the provider and the discharge planner in providing a timely and effective transfer to the next appropriate level of care. Providers must notify Amerigroup of a member's discharge and discharge disposition within one business day of the actual discharge date.

11.6 Hospital-Acquired Conditions

A Hospital-Acquired Condition (HAC) is a medical condition or complication that a patient develops during a hospital stay, which was not present at admission. Examples of HAC include but are not limited to:

- A pattern of substandard care that is likely to result in future dangers to members
- Failure to comply with accepted ethical and professional standards of behavior
- An action that represents a clear and serious breach of accepted professional standards of care, such that the continued care of members by the provider could endanger their safety or health
- Potential quality of care issues related to underutilization or overutilization

Our Quality Management staff will review the identified or potential quality of care issue, request medical records, supporting documentation and other information as appropriate relevant to the case. The medical director will make a determination.

We review and analyze the quality of care issues quarterly for the health plan and identify opportunities for improving care and making recommendations for quality improvement actions. On an annual basis, we report quality of care issues to our corporate Quality Improvement Committee. The Credentialing department uses quality of care reports to evaluate practitioners during the recredentialing process. As appropriate and required, we will report incidents to federal, state and contractual entities as required. Please contact your local Quality Management department when you identify potential incidents.

11.7 Confidentiality Statement

Members have the right to privacy and confidentiality regarding their health care records and information in accordance with the Medicare Advantage program and provisions of *HIPAA* concerning members' rights with respect to their protected health information and obligations of covered entities.

Utilization management, case management, disease management, discharge planning, quality management and claims payment activities are designed to ensure patient-specific information, particularly protected health information obtained during review, is kept confidential in accordance with applicable laws, including *HIPAA*. Information is used for the purposes defined above and shared only with entities who have the authority to receive such information and only with those individuals who need access to such information in order to conduct utilization management and related processes.

Providers must comply with all state and federal laws concerning privacy, confidentiality, accuracy and timely maintenance of health and other member information. Providers must have policies and procedures regarding use and disclosure of health information and comply with applicable laws.

11.8 Misrouted Protected Health Information (PHI)

Providers and facilities are required to review all member information received from Amerigroup to ensure no misrouted PHI is included. Misrouted PHI includes information about members whom a provider or facility is not currently treating. PHI can be misrouted to providers and facilities by mail, fax, or email. Providers and facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, providers and facilities must contact Provider Services to report the receipt of misrouted PHI.

11.9 Emergency Services

Amerigroup provides a 24-hour-a-day, 7-day-a-week Nurse Helpline service with clinical staff to provide triage advice and referral and, if necessary, to make arrangements for treatment of the member. The staff has access to qualified behavioral health professionals to assess behavioral health emergencies.

Amerigroup does **not** discourage members from using the 911 emergency system nor deny access to emergency services. Emergency services are provided to members without requiring prior authorization. Any hospital or provider calling for prior authorization for emergency services will be granted one immediately upon request. Emergency services coverage includes services needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

An emergency medical condition is defined as a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: 1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; and/or 3) serious dysfunction of any bodily organ or part.

Emergency response is coordinated with community services, including the police, fire and Emergency Medical Services (EMS) departments, juvenile probation, the judicial system, child protective services, chemical dependency, emergency services and local mental health authorities, if applicable.

When a member seeks emergency services at a hospital, the determination as to whether the need for those services exists will be made for purposes of treatment by a physician licensed to practice medicine or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine. The physician or other appropriate personnel will indicate in the member's chart the results of the emergency medical screening examination. Amerigroup will compensate the provider for the screening, evaluations and examinations that are reasonable and calculated to assist the health care provider to determine whether or not the patient's condition is an emergency medical condition.

If there is concern surrounding the transfer of a patient (i.e., whether the patient is stable enough for discharge or transfer or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) actually caring for the member at the treating facility prevails and is binding on Amerigroup. If the emergency department is unable to stabilize and release the member, Amerigroup will assist in coordination of the inpatient admission regardless of whether the hospital is network or non-network. All transfers from non-network to network facilities are to be conducted only after the member is medically stable and the facility is capable of rendering the required level of care.

If the member is admitted, the Amerigroup concurrent review nurse will implement the concurrent review process to ensure coordination of care.

11.10 Post-stabilization Care Services

Post-stabilization care services are covered services related to an emergency condition provided after a patient is stabilized to maintain the stabilized condition or improve or resolve the patient's condition. Prior authorization is not required for emergency services in or out of the network. All emergency services are reimbursed at least at the Medicare network rate. Amerigroup will adjudicate emergency and SNF post-stabilization care services that are medically necessary until the emergency condition is stabilized and maintained.

11.11 Nonemergency Services

For routine, symptomatic, beneficiary-initiated outpatient appointments for primary preventive medical care, the request-to-appointment time must be no greater than 30 days, unless the member requests a later time. For routine, symptomatic, beneficiary-initiated outpatient appointments for nonurgent primary medical care, the request-to-appointment time must be no greater than four to six weeks, unless the member requests a later time. Primary medical, including dental care outpatient appointments for urgent conditions, must be available within 48 hours. For specialty outpatient referral and/or consultation appointments, the request-to-appointment time must be consistent with the clinical urgency but no greater than 21 days, unless the member requests a later time. For outpatient scheduled appointments, the time the member is seen must not be more than 45 minutes after the scheduled time, unless the member is late. For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time must be consistent with the clinical urgency but no greater than 14 days, unless the member requests a later time. For urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability will be consistent with the clinical urgency but no greater than 48 hours. The timing of scheduled follow-up outpatient visits with practitioners must be consistent with the clinical need.

11.12 Urgent Care

Amerigroup requests its members to contact their PCP in situations when urgent, unscheduled care is necessary. Prior authorization with Amerigroup is not required for a member to access an urgent care center.

12 MEMBER MANAGEMENT SUPPORT

12.1 Welcome Call

As part of our member management strategy, Amerigroup offers a welcome call to new members. During the welcome call, new members who have been identified through their health risk assessment as possibly needing additional services are educated regarding the health plan and available services. Additionally, Member Services representatives offer to assist members with any current needs, such as scheduling an initial checkup.

12.2 Appointment Scheduling

Amerigroup, through its participating providers, ensures members have access to primary care services for routine, urgent and emergency services and to specialty care services for chronic and complex care. Providers will respond to a member's needs and requests in a timely manner. The PCP should make every effort to schedule members for appointments using the PCP Access and Availability guidelines.

12.3 Nurse HelpLine

The Amerigroup Nurse HelpLine is a service designed to support the provider by offering information and education about medical conditions, health care and prevention to members after normal physician practice hours. The Nurse HelpLine provides triage services and helps direct members to appropriate levels of care. The Amerigroup Nurse HelpLine telephone number is 1-866-805-4589 and is listed on the member's ID card. This ensures members have an additional avenue of access to health care information when needed. Features of the Nurse HelpLine include:

- Availability 24 hours a day, 7 days a week for crisis and triage services
- Information based upon nationally recognized and accepted guidelines
- Free translation services for 150 different languages and for members with difficulty hearing
- Education for members about appropriate alternatives for handling nonemergent medical conditions
- Member assessment reports faxed to providers' offices within 24 hours of the call

12.4 Interpreter Services

Amerigroup provides our members with free interpreter services. Services are available 24 hours a day, 7 days a week and include over 150 languages, as well as services for members who are deaf or hard of hearing. To arrange interpreter services for a member in your care, call Provider Services at the DSU at 1-866-805-4589.

12.5 Health Promotion

Amerigroup strives to improve healthy behaviors, reduce illness and improve the quality of life for our members through comprehensive programs. Educational materials are developed or purchased and disseminated to our members, and health education classes are coordinated with community organizations and network providers contracted with Amerigroup.

Amerigroup manages projects that offer our members education and information regarding their health. Ongoing projects include:

- Creation and distribution of *Ameritips*, the Amerigroup health education tool used to inform members of health promotion issues and topics
- Health Tips on Hold (educational telephone messages while the member is on hold)
- Health education programs offered to members
- Development of health education curricula and procurement of other health education tools (e.g., breast self-exam cards)
- Relationship development with community-based organizations to enhance opportunities for members

12.6 Member Rewards for Health Program*

Amerigroup encourages our members to participate in their health care for living healthier lives. Our program rewards members for receiving preventive health care services and gives them the option of receiving up to a total of \$50 in gift cards per calendar year. When the member visits your office for one or more of the preventive services listed below, he or she will ask you to sign the Rewards for Health reply card. The member will mail the reply card and receive a gift card. The goal of the program is to increase early detection, decrease the cost of treatment and improve members' quality of life.

The preventive health services eligible for the Member Rewards for Health Program include:

- Adult immunizations (e.g., flu, hepatitis B and pneumonia vaccinations)
- Annual wellness visit
- Cardiovascular disease screening
- Colorectal cancer screening
- Diabetes screening
- Glaucoma screening (every two years)
- Bone mass measurement
- Smoking cessation
- Mammography
- Prostate cancer screening

*Does not apply to all Amerigroup Medicare Advantage plans

12.7 Case Management

The Case Management Solutions Program is a member-centric, integrated continuum of care model that strives to address the totality of each member's physical, behavioral, cognitive, functional and social needs.

The scope of the Case Management Solutions Program includes but is not limited to:

- Member identification using a prospective approach that is designed to focus case management resources for members expected to be at the highest risk for poor health outcomes
- Initial and ongoing assessment
- Problem-based, comprehensive care planning to include measurable goals and interventions tailored to the complexity level of the member as determined by initial and ongoing assessments
- Coordination of care with PCPs and specialty providers

- Member education
- Member empowerment using motivational interviewing techniques
- Facilitation of effective member and provider communications
- Program monitoring and evaluation using quantitative and qualitative analysis of data
- Satisfaction and quality of life measurement

Using a prospective systematic approach, members with a risk of poor health outcomes are identified and targeted for case management services. This continuous case finding system evaluates members of a given population based on disease factors and claims history with the goal of improving quality of life through proper utilization of necessary services and a reduction in the use of unnecessary services.

Case management member candidate lists are updated monthly and prioritized to identify members with the highest expected needs for service. Case management resources are focused on meeting listed members' needs by using a mix of standardized and individualized approaches.

A core feature of the Case Management Solutions Program is the emphasis on an integrated approach to meeting the needs of members. The program considers the whole person, including the full range of each member's physical, behavioral, cognitive, functional and social needs. The role of the case manager is to engage members of identified risk populations and to follow them across health care settings, to collaborate with other health care team members to determine goals and to provide access to resources and monitor utilization of resources. The case manager works with the member to identify specific needs and interfaces with the member's providers with the goal of facilitating access to quality, necessary, cost-effective care.

Using information gathered through the assessment process, including a review of the relevant evidence-based clinical guidelines, the case manager develops a goal-based care plan that includes identified interventions for each diagnosis, short- and long-term goals, interventions designed to assist the member in achieving these goals and identification of barriers to meeting goals or complying with the care plan.

Assessment information, including feedback from members, family/caregivers and in some cases providers, provides the basis for identification of problems. Areas identified during the assessment that may warrant intervention include but are not limited to:

- Conditions that compromise member safety
- History of high service utilization
- Use of inappropriate services
- Current treatment plan has been ineffective
- Permanent or temporary loss of function
- High-cost illnesses or injuries
- Comorbid conditions
- Medical/psychological/functional complications
- Health education deficits
- Poor or inconsistent treatment/medication adherence
- Inadequate social support
- Lack of financial resources to meet health or other basic needs
- Identification of barriers or potential barriers to meeting goals or complying with the care plan

Preparation of the care plan includes an evaluation of the member's optimal care path, as well as the member's wishes, values and degree of motivation to take responsibility for meeting each of the care plan goals. Wherever possible, the case manager encourages the member to suggest his or her own goals and interventions, as this may increase their investment in their successful completion.

Our case managers work closely with the member and providers to develop and implement the plan of care. As a provider, you may receive a call from the case manager, or a copy of the member's care plan may be sent to you.

If you have identified a patient as a possible candidate for case management and wish to have them evaluated to see if they qualify, you can call in the referral for evaluation to 1-866-805-4589 or the number on the members identification card and ask for someone in the Case Management department. The case management department is available Monday-Friday from 8 a.m. to 5 p.m. EST.

12.8 Model of Care (Special Needs Plan)

Model of Care

We have a model of care program in place for members of our Special Needs Plans (SNPs). Our model of care program is comprised of the following elements:

1. Perform an evaluation of our population and create measurable goals designed to address the needs identified the SNP model of care is designed to improve the care of our members in all of the following areas:
 - Improving access and affordability of the health care needs of the population
 - Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the health risk assessment (HRA), Individualized Care Plan (ICP) and Interdisciplinary Care Team.
 - Enhanced care transitions across all health care settings and providers
 - Ensuring appropriate utilization of services for preventive health and chronic conditions.
 - Goals specific to the population may be defined as part of our model of care.
2. Our staff structure and care management roles are designed to manage the special needs population. Each SNP member will have an assigned care coordinator, as well as an individualized interdisciplinary care team which may include any of the following members: nurses, physicians, social workers, pharmacists, our member, behavioral health specialists, or other participants as determined by the member.
3. We work to complete an HRA on each member. For new members the goal is to complete the initial HRA within 90 days of eligibility and annually before the anniversary of the last HRA. As some individuals may be difficult to reach by phone, our team may contact your office for updated contact information.
4. Based on the results of the health risk assessment, an Individual Care Plan (ICP) will be developed by the case manager working directly with the member, and the interdisciplinary care team to address identified needs. The ICP includes interventions designed to educate, inform and serve as an advocate for our members. Use of community resources is facilitated for the member, and benefits are coordinated between Medicare and Medicaid for our dual special needs members. The member's care plan will coordinate with and support your medical plan of care.
5. An interdisciplinary care team (ICT) is assigned to each member and is responsible for reviewing the care plans, collaborating with you and other network providers and providing recommendations for management of care. You and/or your patient may be asked to participate in the care planning and management of the plan of care.

6. We have a contracted provider network having special expertise to manage the special needs population and monitor the use of *Clinical Practice Guidelines* by the contracted providers. Roles of providers include advocating, informing and educating members, performing assessments, diagnosing and treating. If you believe our local network does not meet all of your members' specialized needs, and would like to recommend possible additions to our network, please contact provider relations at the number on the members' identification card or discuss with the case manager.
7. We are committed to effective, efficient communication with you. We have developed a communication system to support effective information between you, your members and our care team. Information from our internal systems are available to you through the provider portal and may assist you in managing your patient's care. You can access claim information, the care plan, medication history, the HRA results and see other providers involved in providing care to the member. Our case managers may reach out to you to discuss needs identified during our case management process. We may also reach out by phone or fax to provide important information or to assist in coordinating care. You may also receive a copy of the care plan or a phone call from the case manager asking you to review, make comments or recommendations about the care plan or the needs that have been identified during the care planning process. You may reach your members' care team by calling the number provided to you on any correspondence from us or the number on the members' identification card. General information is available online through the provider portal on our website.
8. We support transitions in care for your patients. Special needs plan members typically have many providers and may transition into and out of health care institutions. Our Care Management team may contact you and your patient related to certain types of transitions. If you are aware of an upcoming care transition for your patient and would like our team to assist in the coordination, please notify us at the number provided on the members' identification card. Care transition protocols and your role in this process are communicated in this manual.
9. Performance and health outcome measurements are collected, analyzed and reported to measure health outcomes and quality measures and also to evaluate the effectiveness of the model of care. These measurements are used by our Quality Management Program and include the following measures:
 - HEDIS — used to measure performance on dimensions of care and service
 - Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction survey
 - *Health Outcomes Survey* (HOS) member survey is multi-purpose and used to compute physician and mental component scores to measure the health status, while not limited to SNP members responses we use these results to assist us in the population assessment.
 - CMS Part C Reporting Elements, including benefit utilization, adverse events, organizational determinations and procedure frequency
 - Medication therapy measurement measures
 - Clinical and administrative/service quality improvement projects

SNP model of care training is required annually and available to providers, employees and contractors. The training may be provided to you in your provider manual, through newsletters, provider orientation, or on our provider portal.

Annual Program Evaluation

Each year an evaluation of the model of care occurs to identify any modifications that are needed and assess progress toward meeting the program goals. Throughout the year, we periodically review our

program to assist us in early identification of any potential issues that may require actions. The results of our defined goals are included as part of the program evaluation. When necessary, we develop action plans for goals that may not be trending toward our benchmarks. We do a comparison of our goals to the previous year to evaluate our progress toward our benchmarks. In most of our markets we are meeting or exceeding in many areas. We are also showing an upward trend when we compare the year over year results. We continue to work on ways to improve our outreach to our members and improving our completion rates for completion of the health risk assessments, the creation of an individualized care plan and establishing an interdisciplinary care team for each of our special needs plan members. We manage utilization of inpatient and emergency room services and have programs in place to address areas where we have opportunities for improvement. The goals related to managing transitions include access to the PCP and post discharge management continue to improve in most markets. Preventive care goals are established for our programs and managed as part of the Healthcare Effectiveness Data and Information Set (HEDIS®) program.

One of our desired outcomes as part of the model of care is to assist you in managing and coordinating care in order to improve the health status and outcomes of your patients. If you have any input regarding our model of care, we welcome your feedback.

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

12.9 Care Transition Protocols and Management

Assisting with the management of transitions is an important part of our case management and model of care. Members are at risk of fragmented and unsafe care during transitions between care settings and levels of care. To help members and caregivers navigate transitions successfully, assistance is provided through many touch points and through educational materials. Transitions in care refer to the movement between health care providers and settings and includes changes in a member's level of care. Examples of transitions include transitions to and from: acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility, home, home health care, and outpatient or ambulatory care centers. A team approach is necessary to assist the member with a successful transition.

Managing transitions includes protocols such as assisting with logistical arrangements, providing education to the member and care giver, coordination between health care professionals and a provider network with appropriate specialists who can address the complex needs of the special needs population. Transitional care includes both the receiving and sending aspects of the transfer.

Transitional care management assists in providing continuity of care by creating an environment where the member and the provider are cooperatively involved in ongoing health care management with goal of providing access to high-quality, cost-effective medical care.

Personnel Responsible for Coordinating Care Transition

Providers are essential members of the ICT and should assist members by coordinating care and communicating with members of the ICT. Members are connected to the appropriate provider to care for their individual needs including any complex medical conditions. The PCP is responsible for coordinating and arranging referrals to the appropriate care provider.

When services are not a covered benefit, coordination with community resources occurs to meet the needs of the population. For our dual population, you are required to coordinate between Medicare and Medicaid. Coordination with Medicaid services includes coordination of benefits and also working with Medicaid case managers/service coordinators and providers of long term services and supports (LTSS) to close care gaps.

Protocols outlining the expectations for managing transitions may be communicated to the provider network through newsletters, published in the provider manual or on the provider portal. Below are some additional protocols for managing transitions not previously addressed in the provider responsibilities:

- Participate in the interdisciplinary care team meetings
- Notify the member in advance of a planned transition
- Provide documentation to the provider or facility about the member to assist in providing continuity of care
- Communicate and follow up with the member about the transition process
- Communicate health status and plan of care to the member
- Provide a treatment plan/discharge instructions to the member prior to being discharged from one level of care to another
- Provide the relevant patient history to the receiving provider prior to a known transition
- Forward any pertinent diagnostic results to the treating provider
- Communicate the treatment plan and any test results to the referring provider post transition

We assist our members and providers in the management of transitions in multiple ways within our care management programs. The actions below represent some of the ways our care team works with our providers and members to coordinate care and assist in the management of transitions:

- Communicates with the provider to discuss the member's care needs as identified during case management or model of care activities.
- Assist the member in making appointments
- Coordination between Medicaid and Medicare benefits
- Perform medication reconciliation
- Arranging transportation
- Refer to external or internal programs
- Coordinate care with behavioral health
- Assist with arranging durable medical equipment (DME) and home health services
- Coordinate and facilitate transitions to the appropriate level of care
- Provide the member with disease specific education and self-management techniques
- Contact high-risk members post discharge to reduce unnecessary readmissions
- During interactions with the member, communicate support is available from member services to serve as a central point of contact and assist during any transition

12.10 Member Satisfaction

Amerigroup periodically surveys members to measure overall customer satisfaction, including satisfaction with the care received from providers. Amerigroup reviews survey information and shares the results with network providers.

Members are also surveyed by CMS twice a year through the *CAHPS* and *HOS Surveys*. The results of both CMS surveys are part of the Medicare Advantage plans' HEDIS and star ratings. Amerigroup encourages its participating providers to encourage members to actively participate in their health care, to receive preventive services timely and to improve their quality of life by following the provider's treatment plan. See the [CMS Star Ratings section](#) of this manual.

13 CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

13.1 Claims — Billing and Reimbursement

Clean claims for Medicare members are generally adjudicated within 30 calendar days from the date Amerigroup receives the claim. For nonclean claims, the provider receives written notification identifying the claim number, the reason the claim could not be processed, the date the claim was received by Amerigroup and the information required from the provider in order to adjudicate the claim. Amerigroup produces and mails an *Explanation of Payment (EOP)* on a daily basis. The *EOP* delineates for the provider the status of each claim that has been paid or denied.

Medicare members must **not** be balance billed for services rendered as outlined in the participating provider agreement and the Attachment A rate sheet. Medicare members are also not held liable for noncovered services where the provider failed to provide advanced notice of noncoverage via the organization determination process. Reimbursement by Amerigroup constitutes payment in full except for applicable copays, deductibles and coinsurance. These amounts will be indicated on the *EOP* and direction provided based on whether Amerigroup is responsible for processing both the primary and secondary claims or not. In instances where Amerigroup is only responsible for processing primary claims, the provider should bill the state Medicaid agency, as would be the standard practice in the Medicare fee-for-service program for Specialty + Rx plan members. See the [Billing Members section](#) of this manual for additional details about cost sharing.

Provider must use *HIPAA*-compliant billing codes when billing. This applies to both electronic and paper claims. When billing codes are updated, the provider is required to use appropriate replacement codes for submitting claims for covered services. An amendment to the *Participating Provider Agreement* will not be required to replace such billing codes. Amerigroup follows Strategic National Implementation Process (SNIP) level 1 through 6 editing for all claims received in accordance with *HIPAA*. Amerigroup will not reimburse any claims submitted using noncompliant billing or SNIP codes.

Providers resubmitting claims for corrections must clearly mark the claim “Corrected Claim.” Failure to mark the claim appropriately may result in denial of the claim as a duplicate. Corrected claims must be received within the applicable timely filing requirements of the originally submitted claim, due to the original claim not being considered a clean claim.

13.2 Claim Status

Providers should access the Amerigroup online claim status inquiry tool at <https://providers.amerigroup.com> or call Provider Services at the DSU at 1-866-805-4589 to check claim status.

13.3 Provider Claims

Providers should submit claims to Amerigroup as soon as possible after service is rendered. Claims should be filed using the *CMS-1500* (02-12) or *CMS-1450* (UB-04) claim form or filed electronically.

13.4 Billing Differences for Medicare Advantage

CMS-1500 (08-05)

Box 9, 9A-D	Other Insurance, including Medicaid
Box 25	Federal tax ID number
Box 33	State Medicaid number

Hospitals

Hospitals should submit claims to the Amerigroup claims address as soon as possible after service is rendered, using the standard *UB-04* form or by filing electronically.

UB-04/CMS 1450

Box 5	Federal tax ID number
Box 51a	Amerigroup unique provider ID number
Box 51b	State Medicaid number
Box 51c	Medicare ID number

13.5 Coordination of Benefits

Amerigroup and its providers agree Medicare coverage is secondary and the Medicaid program is the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicare members. When Amerigroup is aware of third-party resources prior to paying for a medical service, it will follow appropriate coordination of benefits standards by either rejecting a provider's claim and redirecting the provider to bill the appropriate insurance carrier or, if Amerigroup does not become aware of the resource until sometime after payment for the service was rendered, by pursuing post payment recovery of the expenditure. Providers must not seek recovery in excess of the applicable Medicare and/or Medicaid payable amounts.

Amerigroup will follow appropriate coordination of benefits standards for trauma-related claims where third-party resources are identified prior to payment. Otherwise, Amerigroup will follow a pay and pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched postpayment to determine likely cases based on information obtained through communications with members and providers. Amerigroup handles the filing of liens and settlement negotiations both internally and externally via its vendors.

13.6 Electronic Submission

Amerigroup encourages the submission of claims electronically through Electronic Data Interchange (EDI). Providers must submit claims within the timely filing limits noted below from the date of discharge for inpatient services or from the date of service for outpatient services.

Market	Timely filing (days)	Market	Timely filing (days)
Arizona	180	Tennessee	120
Iowa	Refer to your contract for timely filing requirements.	Texas	95
New Jersey	180	Washington	Refer to your contract for timely filing requirements.
New Mexico	90		

Electronic claims submission is available through Availity (formerly THIN) — Claim Payer ID 26375.

Providers have the option of submitting claims electronically through EDI.

The advantages of electronic claims submission are as follows:

- Facilitates timely claims adjudication
- Acknowledges receipt and rejection notification of claims electronically
- Improves claims tracking
- Improves claims status reporting
- Reduces adjudication turnaround
- Eliminates paper
- Improves cost-effectiveness
- Allows for automatic adjudication of claims

The guide for EDI claims submission is located at <https://providers.amerigroup.com>. Log in to the secure site by entering your user name and password. From the *RealTools* menu select **Claims**, then **Electronic Data Interchange**. The *EDI Claim Submission Guide* includes additional information related to the EDI claim process.

To initiate the electronic claims submission process or obtain additional information, please contact the Amerigroup EDI Hotline at 1-800-590-5745.

13.7 EDI Submission for Corrected Claims

For corrected professional (837P) claims submitted via EDI claim professional, providers should use one the following frequency codes to indicate a correction was made to a previously submitted and adjudicated claim:

7 – Replacement of Prior Claim

8 – Void/Cancel Prior Claim

Note: A full definition of each code and confirmation of the use of these codes on a professional claim can be found on the NUBC website www.NUCC.org

Indicator Placement:

Loop: 2300 (Claim Information)

Segment: CLM 05-03 (Claim Frequency Type Code)

Value: 7, 8

For corrected institutional (837I) claims submitted via EDI, providers should use one the following Bill Type Frequency Codes to indicate a correction was made to a previously submitted and adjudicated claim:

0XX5 – Late Charges Only Claim

0XX7 – Replacement of Prior Claim

0XX8 – Void/Cancel Prior Claim

Note: A full definition of each code can be referenced on Pages II-111 through II-114 of the *Ingenix UB04 Billing Manual*.

Indicator Placement:

Loop: 2300 (Claim Information)

Segment: CLM 05-03 (Claim Frequency Type Code)

Value: 5, 7, 8

13.8 Paper Claims Submission

Providers also have the option of submitting paper claims. Amerigroup uses Optical Character Recognition (OCR) technology as part of its front-end claims processing procedures. The benefits include the following:

- Faster turnaround times and adjudication
- Claims status availability within five days of receipt
- Immediate image retrieval by Amerigroup staff for claims information, allowing more timely and accurate response to provider inquiries

To use OCR technology, claims must be submitted on original red claim forms (not black and white or photocopied forms) and laser printed or typed (not handwritten) in a large, dark font. Providers must submit a properly completed *UB-04* or *CMS-1500 (08-05)* within 90 days from the date of discharge for inpatient services or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date the third-party documents resolution of the claim.

In accordance with the implementation timelines set by CMS and NUCC, Amerigroup requires the use of the *CMS-1500 (08-05)* for the purposes of accommodating the National Provider Identifier (NPI).

In accordance with the implementation timelines set by CMS and NUBC, Amerigroup requires the use of the new *UB-04 CMS-1450* for the purposes of accommodating the NPI.

CMS-1500 (02-12) and *UB-04 CMS-1450* must include the following information (*HIPAA*-compliant where applicable):

- Patient's ID number
- Patient's name
- Patient's date of birth
- ICD-9 diagnosis codes/revenue codes
- Date of service
- Place of service
- Description of services rendered CPT-4 codes/HCPC codes/DRGs
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- Amerigroup provider number
- NPI of billing provider when applicable
- Name of ordering physician
- NPI of ordering physician when applicable

- Name of performing physician
- NPI of performing provider when applicable
- State Medicaid ID number
- Coordination of Benefits/other insurance information
- Authorization/prior authorization number or copy of authorization/prior authorization
- Name of referring physician
- NPI of referring physician when applicable
- CLIA Identification number when applicable (*CMS-1500* only)
- Any other state-required data

Amerigroup cannot accept claims with alterations to billing information. Claims that have been altered will be returned to the provider with an explanation of the reason for the return. Amerigroup will not accept claims from those providers who submit entirely handwritten claims, except in New Jersey where providers are permitted to submit handwritten claims.

Paper claims must be submitted within the timely filing limits noted below from the date of service:

Market	Timely filing (days)	Market	Timely filing (days)
Arizona	180	Tennessee	120
Iowa	Refer to your contract for timely filing requirements.	Texas	95
New Jersey	180	Washington	180
New Mexico	90		

Submit paper claims to the following address:

Market	Submit paper claims to:
Paper claims for all Medicare markets (Arizona, Iowa, New Jersey, New Mexico, Tennessee, Texas and Washington)	Amerigroup P.O. Box 61010 Virginia Beach, VA 23466-1010

13.9 Encounter Data

Amerigroup has established and maintains a system to collect member encounter data. Due to reporting needs and requirements, network providers who are reimbursed by capitation must send encounter data to Amerigroup for each member encounter. Encounter data can be submitted through EDI submission methods or on a *CMS-1500 (08-05)* or a *UB-04* claim form, unless other arrangements are approved by Amerigroup. Data will be submitted in a timely manner but no later than 90 days from the date of service.

The encounter data will include the following:

- Medicare member ID number
- Medicare member name (first and last name)
- Medicare member date of birth
- Provider name according to contract

- Amerigroup provider number
- Coordination of benefit information
- Date of encounter
- Diagnosis code
- Types of services provided (utilizing current procedure codes and modifiers if applicable)
- Provider tax ID number and state Medicaid ID number

Encounter data should be submitted to the address provided on the previous page.

Through claims and encounter data submissions, HEDIS information is collected. This includes but is not limited to the following:

- Preventive services (e.g., childhood immunization, mammography, Pap tests)
- Prenatal care (e.g., low birth weight, general first trimester care)
- Acute and chronic illness (e.g., ambulatory follow-up and hospitalization for major disorders)

Compliance is monitored by the Amerigroup utilization and quality improvement staff, coordinated with the medical director and reported to the Quality Management Committee on a quarterly basis. The PCP is monitored for compliance with reporting of utilization. Lack of compliance will result in training and follow-up audits and could result in termination.

13.10 Claims Adjudication

Amerigroup is dedicated to providing timely adjudication of provider claims for services rendered to members. All network and non-network provider claims submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by the CPT and ICD manuals. Institutional claims should be submitted using EDI submission methods or an *UB-04* or *CMS-1450* and provider claims using the *CMS-1500*.

Providers must use *HIPAA*-compliant billing codes when billing Amerigroup. This applies to both electronic and paper claims. When billing codes are updated, the provider is required to use appropriate replacement codes for submitted claims. Amerigroup will not pay any claims submitted using noncompliant billing codes.

Amerigroup reserves the right to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure. The automated claims auditing system verifies the coding accuracy of claims for CPT and Healthcare Common Procedure Coding System (HCPCS) procedures. This system ensures the same auditing criteria is applied across all claims. Editing decisions are supported by online medical coding policy statements published by CMS as a part of the National Correct Coding Initiative (NCCI, also known as CCI).

For claims payment to be considered, providers must adhere to the following time limits:

- Submit claims within the number of days specified for each market from the date the service is rendered, or for inpatient claims filed by a hospital, within the number of days specified for each market from the date of discharge.
- In the case of other insurance, submit the claim within the number of days specified for each market after receiving a response from the third-party payer.

- Claims for members whose eligibility has not been added to the state's eligibility system must be received within 90 days from the date the eligibility is added and Amerigroup is notified of the eligibility/enrollment.
- Claims submitted after the market specific timely filing deadline will be denied.

After filing a claim with Amerigroup, review the daily *EOP*. If the claim does not appear on an *EOP* within 30 business days as adjudicated or you have no other written indication the claim has been received, check the status of your claim by using the Amerigroup website at <https://providers.amerigroup.com> or by calling Provider Services at the DSU at 1-866-805-4589. If the claim is not on file with Amerigroup, resubmit your claim within 90 days from the date of service, or by the timely filing requirement for your market. If filing electronically, check the confirmation reports for acceptance of the claim you receive from your EDI or practice management vendor.

13.11 Clean Claims Payment

A clean claim is a request for payment for a service rendered by a provider that:

- Is submitted in a timely manner.
- Is accurate.
- Is submitted on a *HIPAA*-compliant standard claim form, including a *CMS-1500* or *CMS-1450* or successor forms thereto or the electronic equivalent of such claim form.
- Requires no further information, adjustment or alteration by the provider or by a third party in order to be processed and paid by Amerigroup.

Clean claims are typically adjudicated within 30 calendar days of receipt. If Amerigroup does not adjudicate the clean claim within the time frames specified above, Amerigroup will pay all applicable interest as required by law.

Amerigroup produces and mails an *EOP* on a daily basis, which delineates for the provider the status of each claim that has been adjudicated during the previous payment cycle. Upon receipt of the requested information from the provider, Amerigroup should complete processing of the clean claim within 30 calendar days.

Paper claims determined to be unclean will be returned to the billing provider along with a letter stating the reason for the rejection. Electronic claims determined to be unclean will be returned to the Amerigroup contracted clearinghouse that submitted the claim.

In accordance with CMS requirements, Amerigroup will pay at least 95 percent of all clean claims from practitioners either in individual or group practice or who practice in shared health facilities within 30 calendar days of the date of receipt. Amerigroup will pay or deny all other claims within 60 calendar days of the receipt of the request. The date of receipt is the date Amerigroup receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

13.12 Provider Reimbursement

Electronic Funds Transfer and Electronic Remittance Advice

Amerigroup offers Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) with online viewing capability. Providers can elect to receive Amerigroup payments electronically through Direct deposit to their bank account. In addition, providers can select from a variety of remittance information options, including:

- HIPAA-compliant data file for download directly to your practice management or patient accounting system
- Paper remittance printed and mailed by Amerigroup

Some of the benefits providers may experience include:

- Faster receipt of payments from Amerigroup
- The ability to generate custom reports on both payment and claim information based on the criteria specified
- Online capability to search claims and remittance details across multiple remittances
- Elimination of the need for manual entry of remittance information and user errors
- Ability to perform faster secondary billing

To register for ERA/EFT, please visit our website at <https://providers.amerigroup.com>.

Primary Care Provider Reimbursement

Amerigroup reimburses PCPs according to their contractual arrangement.

Specialist Reimbursement

Reimbursement to network specialty care providers and network providers not serving as PCPs is based on their contractual arrangement with Amerigroup.

Specialty care providers must obtain Amerigroup approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized or beyond the scope permitted under this program.

Specialty care provider services will be covered only when there is documentation of appropriate notification or prior authorization, as appropriate, and receipt of the required claims and encounter information to Amerigroup.

13.13 Reimbursement Policies

Reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup benefit plan. These policies can be accessed at:

<https://providers.amerigroup.com/QuickTools/Pages/ReimbursementPolicies.aspx>.

Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines. You are required to use industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully

supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities; a non-contracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however Amerigroup strives to minimize these variations.

Reimbursement Hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursements. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity, authorization requirements or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

Review Schedules and Updates

Reimbursement policies undergo reviews for updates to state contracts, federal or CMS requirements, and/or Amerigroup business decisions. We reserve the right to review and revise our policies when necessary. Reimbursement policies go through a review every two years for updates to state, federal or CMS contracts and/or requirements. When there is an update we will publish the most current policy at; <https://providers.amerigroup.com/QuickTools/Pages/ReimbursementPolicies.aspx>

Medical Coding

The Medical Coding department ensures that correct coding guidelines have been applied consistently throughout Amerigroup. Those guidelines include, but are not limited to:

- Correct modifier use
- Effective date of transaction code sets (CPT, HCPCS, ICD diagnosis/procedures, revenue codes, etc.)
- Code editing rules are appropriately applied and within regulatory requirements
- Analysis of codes, code definition and appropriate use

Reimbursement by Code Definition

Amerigroup allows reimbursement for covered services based on their procedure code definitions or descriptors, as opposed to their appearance under particular CPT categories or sections, unless otherwise noted by state, federal or CMS contracts and/or requirements. There are eight CPT sections:

1. Evaluations and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Category II codes: supplemental tracking codes that can be used for performance measurement

8. Category III codes: temporary codes for emerging technology, services or procedures

13.14 Overpayment Process

Refund notifications may be identified by two entities, Amerigroup Cost Containment Unit (CCU) or the provider. The CCU researches and notifies the provider of an overpayment by requesting a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified by Amerigroup, the CCU will notify the provider of the overpayment. The provider will submit a *Refund Notification Form* along with the refund check. If a provider identified the overpayment and returns the Amerigroup check, please include a completed *Refund Notification Form* specifying the reason for the return. This form can be found on the provider website at <https://providers.amerigroup.com>. Submission of the *Refund Notification Form* will allow the CCU to process and reconcile the overpayment in a timely manner. Once the CCU has reviewed the overpayment, you will receive a confirmation letter explaining the details of the reconciliation. For questions regarding the refund notification procedure, please call Provider Services at the DSU at **1-866-805-4589**.

Amerigroup uses an automated claims auditing system to ensure claims are adjudicated in accordance with industry billing and reimbursement standards. Claims auditing software ensures compliance with an ever-widening array of edits and rules as well as consistency of payment for providers by ensuring correct coding and billing practices are being followed. Using a sophisticated auditing logic, our code editing system determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes and processes those services according to the NCCI. NCCI was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. NCCI code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services.

In addition to code pair edits, the NCCI includes a set of edits known as Medically Unlikely Edits (MUEs). An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a single HCPCS/CPT code billed by a provider on a date of service for a single beneficiary.

13.15 Determining Dispute/Appeal Process

Please reference the notification letter received for the proper dispute/appeal process to submit your request. Note the process for appeals is different depending on whether or not the member can be held liable for any payments (member liability).

13.16 Member Liability Appeals

If a provider appeals a decision rendered with member liability, then the appeal follows the CMS Member Liability Appeals process and is processed by the Medicare Complaints, Appeals and Grievances (MCAG) department. See [Medicare Member Liability Appeals](#) process.

13.17 Participating Provider Standard Appeals

A participating provider standard appeal is a request for Amerigroup to review a decision by Amerigroup Health Care Management Services that medical necessity was not established where provider liability was assigned (see original decision letter) for services already rendered. Participating provider standard appeals and participating provider administrative pleas follow different processes, which are described in this Provider Manual. The provider is responsible for sending in all necessary information to adjudicate the standard appeal or administrative plea, and a determination will be rendered based on the information provided.

13.18 Provider Payment Disputes and Administrative Plea Processes

Provider Claim Payment Dispute process

If you disagree with the outcome of a claim, you may begin the Amerigroup provider payment dispute process. Claim Payment Disputes and Provider Administrative Pleas are different processes:

- **Provider Payment Dispute:** The claim has been finalized but you disagree with the amount that you were paid;
- **Provider Administrative Plea:** The claim has been finalized, but you disagree with the administrative denial that has been applied. An administrative denial is applied within the claims process when it is determined that the provider failed to follow the terms and conditions of their contract. Examples of administrative denials are as follows: denials such as no prior authorization or late notification.

Please be aware, there are two common claim-related issues that are **not** considered claim payment disputes. To avoid confusion with claim payment disputes, these are briefly defined below. They are:

- **Claim Inquiry:** A question about a claim, but not a request to change a claim payment.
- **Claims Correspondence:** When Amerigroup requests further information to finalize a claim. Typically, these requests include medical records, itemized bills, or information about other insurance a member may have. A full list of correspondence related materials are in the correspondence section of this provider manual.

Claims that were denied for lack of medical necessity should follow the participating provider standard appeal process. A Medicare participating provider standard appeal is a formal request for review of a previous Amerigroup decision where medical necessity was not established where provider liability was assigned (see original decision letter) for services already rendered. An example of this appeal scenario would be as follows:

- On clinical review, the services related to the prior authorization request were deemed not medically necessary but services were rendered and claim payment was denied.

For more information on each of these claim-related processes, please refer to the appropriate section in this provider manual.

The Amerigroup provider payment dispute process consists of two internal steps. You will **not** be penalized for filing a claim payment dispute and no action is required by the member.

1. **Claim Payment Reconsideration:** This is the first step in the Amerigroup provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.
2. **Claim Payment Appeal:** The second step in the Amerigroup provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.

A claim payment dispute may be submitted for multiple reason(s) including:

- Contractual payment issues.
- Disagreements over reduced claims or zero-paid claims not related to medical necessity.
- Post-service authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues.*

*Timely filing issues.

Amerigroup will consider reimbursement of a claim which has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

13.20 Claim Payment Reconsideration

The first step in the Amerigroup claim payment dispute process is called the reconsideration. It is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally and through our provider web portal within 120 calendar days from the date on the *Explanation of Payment (EOP)* (see below for further details on how to submit). Reconsiderations filed more than 120 days from the *EOP* will be considered to be untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect.

The plan encourages providers to use our claims payment reconsideration process if you feel a claim was not processed correctly, however, this optional step is not required prior to filing a claim payment appeal.

If a reconsideration requires clinical expertise, it will be reviewed by appropriate clinical Amerigroup professionals.

The plan will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days.

If the decision results in a claim adjustment, the payment and *Explanation of Payment (EOP)* will be sent separately. Overturned decisions will result in an adjustment and EPOs.

13.21 Claim Payment Appeal

If you are dissatisfied with the outcome of a Reconsideration determination you may submit a claim payment appeal. When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. Please note, we cannot process a claim payment appeal without a reconsideration on file.

If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical professionals.

The plan will make every effort to resolve the claim payment appeal within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

13.22 How to submit a Claim Payment Dispute

We have several options when filing a claim payment dispute. They are described below.

- **Verbal (Reconsideration only):** Verbal submissions may be submitted by calling Provider Services at 1-800-454-3730.
- **Web Portal (Reconsideration and Claim Payment Appeal):** The plan can receive reconsiderations and claim payment appeals via the secure Availity Payment Appeal Tool at <https://www.availity.com>. Supporting documentation can be uploaded on the Portal. You will receive immediate acknowledgement of your web submission.
- **Written (Reconsideration and Claim Payment Appeal):** Written reconsiderations and claim payment appeals should be mailed, along with the *Claim Payment Appeal Form* or the *Reconsideration Form* to:
 - Provider Payment Disputes
P.O. Box 61599
Virginia Beach, VA 23466-1599

Required Documentation for Claims Payment Disputes

Amerigroup requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

- Your name, address, phone number, email, and either your NPI or TIN.
- The member's name and their Amerigroup or Medicare ID number.
- A listing of disputed claims, which should include the Amerigroup claim number and the date(s) of service(s).
- All supporting statements and documentation.

Claim Inquiry

A question about a claim or claim payment is called an Inquiry. Inquiries do not result in changes to claim payments, but outcome of the claim inquiry may result in the initiation of the claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Our Provider Experience program helps you with claim inquiries. Just call 1-800-454-3730 and select the Claims prompt within our voice portal. We connect you with a dedicated resource team, called the Provider Service Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact, issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

Claim Correspondence

Claim correspondence is different from a payment dispute. Correspondence is when the plan requires more information in order to finalize a claim. Typically, Amerigroup makes the request for this information through the *EOP*. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, Amerigroup will use it to finalize the claim.

The following table provides examples the most common correspondence issues along with guidance on the most efficient ways to resolve them.

Type of Issue	What Do I Need to Do?
Rejected Claim(s)	Use the EDI Hotline at 1-800-590-5745 when your claim was submitted electronically but was never paid or was rejected. We're available to assist you with setup questions and help resolve submission issues or electronic claims rejections.
<i>EOP</i> Requests for Supporting Documentation (<i>Sterilization/Hysterectomy/Abortion Consent Forms</i> , itemized bills and invoices)	Submit a <i>Claim Correspondence Form</i> , a copy of your <i>EOP</i> and the supporting documentation to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
<i>EOP</i> Requests for Medical Records	Submit a <i>Claim Correspondence Form</i> , a copy of your <i>EOP</i> and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Need to submit a Corrected Claim due to errors or changes on original submission	Submit a <i>Claim Correspondence Form</i> and your corrected claim to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 365 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Amerigroup to adjust the other health

	insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI <i>EOB</i> .
Submission of coordination of benefits (COB)/third-party liability (TPL) information	Submit a <i>Claim Correspondence Form</i> , a copy of your <i>EOP</i> and the COB/TPL information to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599

13.23 Provider Payment Disputes and Administrative Plea Processes

If you believe Amerigroup has not paid for your services according to the terms of your provider agreement, submit a request using the *Appeals Form* located online under *Forms* at <https://providers.amerigroup.com>.

Providers will not be penalized for filing a provider payment dispute. Submit provider payment disputes to:

Provider Payment Disputes
P.O. Box 61599
Virginia Beach, VA 23466-1599

The Provider Disputes Unit will receive, distribute and coordinate all payment disputes.

1. Submit a written request with supporting documentation, such as an *EOP* and a copy of the claims or denial letter received along with other written documentation; a full explanation of the dispute is required and must be submitted within 120 days of when Amerigroup notice of initial determination was generated or we will not accept the request; the provider is responsible to submit all necessary documentation at the time of the request.
2. The Amerigroup Claims department conducts the review, and/or the health plan medical director reviews the second level dispute if medical information is involved; if additional information is submitted that would support payment, the denial is overturned.
3. An internal review is conducted and results communicated in a written decision to the provider within 60 calendar days if the decision is upheld; the written decision includes:
 - A statement of the provider's dispute.
 - The reviewer's decision along with a detailed explanation of the contractual and/or medical basis for such decision.
 - A description of the evidence or document that supports the decision.

14 PROVIDER COMPLAINT AND GRIEVANCE PROCEDURE

Amerigroup has a formal process for the handling of disputes pertaining to administrative issues and nonpayment-related matters. For payment disputes, see [Provider Payment Disputes](#). For Medicare member liability appeals, see [Medicare Member Appeals](#).

Provider complaints are managed separately from the Medicare member appeals process. Providers are not penalized for filing complaints. Supporting documentation should accompany the complaint and be forwarded to the nearest Amerigroup office location.

MARKET	PROVIDER RELATIONS ADDRESS
Arizona providers	CareMore Providers:

MARKET	PROVIDER RELATIONS ADDRESS
	Caremore Health Attn: Provider Dispute P.O. Box 366, Artesia, CA 90702 All Other Providers: PO Box 61010 Virginia Beach, VA 23466-1010
Iowa providers	Amerigroup 4800 Westown Pkwy Suite 200 West Des Moines, IA 50266
New Jersey Providers	Amerigroup 101 Wood Ave. South, Eighth Floor Iselin, NJ 08830
New Mexico Providers	Amerigroup Two Park Square 6565 Americas Parkway NE, Suite 200 Albuquerque, NM 87110
Tennessee Providers	Amerigroup 22 Century Blvd., Suite 310 Nashville, TN 37214
Texas: Dallas/Fort Worth	Amerigroup 2505 N. Highway 360, Suite 300 Grand Prairie, TX 75050
El Paso	Amerigroup 7430 Remcon Circle, Building C, Suite 120 El Paso, TX 79912
Houston	Amerigroup 3800 Buffalo Speedway, Suite 400 Houston, TX 77098
Lubbock	Amerigroup 3232 S. Loop 289, Suite 110 Lubbock, TX 79423
San Antonio	Amerigroup 4400 Piedras Drive South, Suite 100 San Antonio, TX 78228
Washington	Amerigroup 705 5th Avenue South, Suite 300 Seattle, WA 98104

15 COORDINATION OF BENEFITS

Amerigroup and its providers agree Medicare coverage is secondary and the Medicaid program is the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicare members. When Amerigroup is aware of third-party resources prior to paying for a medical service, it will follow appropriate coordination of benefits standards by either rejecting a provider's claim and redirecting the provider to bill the appropriate insurance carrier or, if Amerigroup

does not become aware of the resource until sometime after payment for the service was rendered, by pursuing post payment recovery of the expenditure. Providers must not seek recovery in excess of the applicable Medicare and/or Medicaid payable amounts.

Amerigroup will follow appropriate coordination of benefits standards for trauma-related claims where third-party resources are identified prior to payment. Otherwise, Amerigroup will follow a pay and pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched post-payment to determine likely cases based on information obtained through communications with members and providers. Amerigroup handles the filing of liens and settlement negotiations both internally and externally via its subrogation vendor, Optum.

Amerigroup requires members to cooperate in the identification of any and all other potential sources of payment for services.

Any questions or inquiries regarding paid, denied or pended claims should be directed to Provider Services at the DSU at 1-866-805-4589.

Provider Obligations — denial notification and member complaints, appeals and grievances

Providers are required to adhere to CMS and Amerigroup requirements concerning issuing letters and notices. This includes advanced notice of denials that will result in member liability or cost in accordance with Medicare guidelines for Medicare Advantage Plans.

15.1 Skilled Nursing Facilities, CORFs and Home Health Agencies

The Notice of Medicare Non-Coverage (NOMNC) is a statutorily required notice that is issued to Medicare Advantage members to alert them of a discontinuation of skilled nursing facility, comprehensive outpatient rehabilitation facility (CORF), or home health services. This notice explains the determination that continued coverage after a specific effective date will no longer be covered by the plan. A NOMNC should be issued to a Medicare member at least two days prior to discharge, or in advance of the last two covered visits. This notice informs the member his or her stay or visits no longer meet coverage criteria and will end in two days or after two visits. In most cases, the notice is required to be issued by the provider, and Amerigroup is required to ensure proper delivery and that the member's signature is obtained.

Amerigroup Contracted SNF Provider Responsibility

Contracted SNF providers are responsible for delivering the NOMNC on behalf of Amerigroup to the member or member representative **and** for obtaining signature(s). The member's signature acknowledges receipt of the notice and is not an agreement with the denial. In the event the member is in need of an authorized representative to acknowledge/sign the NOMNC, and the SNF is unable to deliver it to the authorized representative, the SNF should telephone the representative the same day the NOMNC is issued, to advise him/her when the member's services are no longer covered. The date of the conversation is the date of the receipt of the notice. The NOMNC must be annotated to note the name of the staff person initiating the contact, the name of the member representative contacted by telephone, the date and time of the telephone contact, and the telephone number called. If agreed by both parties, the annotated notice can then be emailed or faxed (in accordance with *HIPAA* privacy and security requirements). The notice should be annotated by the person providing the notification to the representative indicating the date, time, person name, relation to the member, telephone number called, and that the notice was read to the representative, including all appeal rights. If a member (or

representative) elects to exercise his or her right to an immediate review, the member (or representative) must submit a request to the appropriate Quality Improvement Organization (QIO) for the state by the deadline indicated in the notice. The provider is responsible for submitting any documents or medical records as requested by the QIO or Amerigroup Complaints, Appeals and Grievance department within the time frame indicated on the request.

15.2 Hospitals

The Important Message from Medicare (IMM) is a statutorily required notice issued to Medicare Advantage members to alert them of a discontinuation of acute inpatient hospital services. Within two days after an admission or at the preadmission visit (but not more than seven calendar days in advance of the admission), the hospital providing the inpatient services is required to issue the IMM. This statutorily required notice explains the Medicare beneficiary's rights as a hospital inpatient, including discharge appeal rights. The hospital is required to deliver the notice in person and obtain the signature of the member or representative and provide them with a copy at that time. The hospital is also responsible for ensuring the member can comprehend the contents of the notice before obtaining the signature. It is the responsibility of the hospital to explain the notice, if necessary, and be able to answer any questions about the notice the member or representative may have. Notices should not be delivered while the member is receiving emergency treatment but should be delivered once the patient is stable. If a member refuses to sign the notice, the hospital may annotate the notice to indicate the refusal and document notification was attempted. If in-person notification cannot be provided to a representative, the hospital is responsible for telephonically contacting the representative to advise him or her of their appeal rights. If agreed by both parties, the notice can be emailed or faxed (in accordance with *HIPAA* privacy and security requirements). Otherwise, the notice must be mailed the same day. In addition, prior to discharge (but not more than two days in advance of discharge), the hospital must deliver another copy of the signed notice to the member or representative in person. If the notice is being given on the day of discharge, the member must be provided at least four hours to consider his or her rights and to request the QIO review. Hospitals should not routinely provide the notice on the day of discharge. If the member requests additional information on the discharge, the detailed notice can be issued prior to an immediate review request being initiated. If discharge occurs within two calendar days of the original notice, no additional copy needs to be delivered. If a member elects to exercise his or her right to an immediate review, he or she must submit a request to the appropriate QIO, as outlined in the notice, by midnight of the day of discharge, either verbally or in writing, before that person leaves the hospital.

15.3 Provider Obligations — In-office Denials

In the event a member disagrees with the provider's decision about a request for service or a course of treatment or is requesting or in need of services that are not covered by the plan or Medicare: At each patient encounter with a Medicare member, the provider must notify the member of his or her right to receive, upon request, a detailed written notice from Amerigroup regarding the member's services. The provider must request us to provide a detailed notice of a provider's decision to deny a service in whole or part; in turn, we must give the member advanced written notice of the determination, by following the prior authorization process (outlined below).

For services that require prior authorization or are noncovered by the plan (i.e., statutory exclusion), it becomes extremely important that Amerigroup authorization procedures are followed. If a member elects to receive such care the member cannot be held financially responsible unless notified in advance of the noncovered services. In such cases when the network physician fails to follow Amerigroup

authorization protocols, Amerigroup may decline to pay the claim in which case the provider will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

The CMS has established guidelines concerning *Advance Notices of Non-Coverage (ABN)*. The ABN is a FFS document and cannot be used for Medicare Advantage denials or notifications. Per CMS, The ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). CMS advised Medicare Advantage plans that contracted providers are required to provide a coverage determination for services that are not covered by the member's Medicare Advantage plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. If there is any doubt about whether a service is not covered, please seek a coverage determination from the plan.

A written coverage determination will help ensure that a claim for noncovered care from a contracted provider is paid accurately. According to CMS, if the appropriate written notice of denial of payment is not given to the Medicare Advantage member regarding a noncovered service, the claim may be denied and the member cannot be held financially responsible. Therefore, your failure to obtain an appropriate coverage determination could result in a denial of payment for the noncovered service.

Please contact Amerigroup prior to services being rendered to comply with this requirement and ensure appropriate claims payment and allow you to bill the Medicare member in the event of noncoverage. As a contracted provider with Amerigroup, you are prevented from billing the Medicare member for any service that is deemed non-covered if you have not ensured this advanced notification has been issued.

15.4 Provider Obligations — Prior Authorization

Providers are responsible for obtaining prior authorization from Amerigroup before performing certain procedures, when rendering noncovered services or when referring members to noncontracted providers. Please refer to the *Summary of Benefits* document for those procedures that require prior authorization or call Provider Services at the DSU at 1-866-805-4589. Amerigroup will render a determination on the request within the appropriate time frame and provide notification of the decision. Requests that are denied will generate a notice that includes the denial rationale and applicable appeal rights. Medicare members will receive a denial letter as well that includes appeal rights. Denials that are the result of contractual issues between Amerigroup and the provider will not generate a member denial letter.

- An initial *organization* determination is any determination (e.g., an approval or denial) made by Amerigroup for coverage of medical services (Part C-covered services).
- An initial *coverage* determination is any determination (e.g., an approval or denial) made by Amerigroup for coverage of prescription drugs (Part D-covered services).

16 AMERIGROUP ADVANTAGE COMPLAINTS, APPEALS AND GRIEVANCES

16.1 Distinguishing between Provider and Medicare Advantage Member Complaints, Appeals and Grievances

Amerigroup has separate and distinct processes for requests to reconsider an Amerigroup decision on an authorization or request for payment upon claims submission. On processing each request, assignment of liability for the service is determined. All Medicare member liability denials are subject to the Medicare Complaints, Appeal & Grievances (MCAG) process as outlined in the Medicare Member

Liability Appeals and Medicare Member Grievances sections. Disputes between the health plan and the provider that do not involve an adverse determination or liability for the Medicare member follow the Amerigroup participating provider appeals and dispute or nonparticipating provider payment dispute processes.

Providers must cooperate with Amerigroup and with members in providing necessary information to resolve the appeals within the required time frames. Providers must provide the pertinent medical records and any other relevant information upon request and when initiating an appeal. In some instances, providers must provide the records and information very quickly in order to allow Amerigroup to make an expedited decision. Your participation in, along with the member's election of the Medicare Advantage plan, are an indication of consent to release those records as part of the health care operations.

Medicare Member Liability — Amerigroup has determined that a Medicare member is responsible for payment as the service(s) are determined to be not covered under the plan to which they are enrolled or is considered Medicare member cost-share. Any time a member liability denial letter is issued, the member appeals process must be followed and **not** the provider appeals process. Medicare member liability is assigned when:

- The *Integrated Denial Notice (IDN)* is issued as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance* with subsequent review by the Independent Review Entity (IRE).
- The *Notice of Denial of Medicare Prescription Drug Coverage* is issued as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance*.
- A decision that inpatient hospital care is no longer necessary with delivery of the *Important Message from Medicare (IMM)* as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance*.
- *Notice of Medicare Non-Coverage (NOMNC)* is delivered as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance* with rights to pursue an appeal via the Quality Improvement Organization (QIO) or the plan directly.
- An *Explanation of Benefits (EOB)* indicates there is member responsibility assigned to a claim processed.
- an *Explanation of Payment (EOP)* indicates there is member responsibility assigned to a claim processed.

Participating Provider Liability — Amerigroup has determined that the participating provider has failed to follow the terms and conditions of their contract either administratively or by not providing the clinical information needed to substantiate the services being requested for approval of payment. Participating providers are prohibited from billing a Medicare member for services unless the plan has determined member liability and issued the appropriate notices as above.

Nonparticipating Provider Liability — Amerigroup has determined that the nonparticipating provider with the plan has failed to follow Medicare processing guidelines. Nonparticipating providers are prohibited from billing a Medicare member for services unless the plan has determined member liability and issued the appropriate notices as above and has procedures for nonparticipating provider to follow.

16.2 Amerigroup Advantage Participating Provider Standard Appeals

Amerigroup participating providers may initiate provider appeals under the provider appeal procedures.

Amerigroup typically determines provider appeals within 60 days when sufficient information is received to make a decision.

Medicare Participating Provider Standard Appeal

A formal request for review of a previous Amerigroup decision where medical necessity was not established where provider liability was assigned (see original decision letter) for services already rendered.

Participating Provider Standard Appeals Responsibility

All requests must be:

- Submitted in writing
- Submitted within 180 days* from the Amerigroup decision letter date
- Include a cover letter with:
 - Member Identifiable information
 - Date(s) of service in question
 - Specific rationale as to why the services did in fact meet medical criteria and reference specifics within the medical record to refute the original decision
- Include necessary attachments:
 - Copy of the original Amerigroup decision
 - All applicable medical records

NOTE: Amerigroup will not request additional records to support the provider's argument and expects the provider to submit the necessary information to substantiate their request for payment.

Appeals should be mailed to:

Medicare Complaints, Appeals & Grievances (MCAG)
Attention: Medical Necessity Provider Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

Providing the above information will enable the Amerigroup Participating Provider Appeals team to properly and timely review requests within 60 days. Requests that do not follow the above may be delayed.

*Days from original denial date may differ, depending upon the contract and/or state requirements

16.3 Amerigroup Advantage Nonparticipating Provider Payment Disputes

Nonparticipating Provider Payment Disputes

If, after a claim has been adjudicated, a nonparticipating provider contends that our decision to pay for a different service from the one originally billed or believe they would have received a different payment under Original Medicare, the nonparticipating provider payment dispute resolution process can be used. Notification will be provided to the nonparticipating provider at each step of the process. For more information regarding the disputes process, please see [link to Claims dispute section].

16.4 Amerigroup Advantage Nonparticipating Provider Appeals Rights

If a claim is partially or fully denied for payment with member liability (see original decision letter), the nonparticipating provider must request a reconsideration of the denial within 60 calendar days from the remittance notification. When submitting the reconsideration of the denial of payment on a claim, a signed *Waiver of Liability* form must be included. To obtain this form, please go to:

https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip. The purpose of the *Waiver of Liability* form is to hold the enrollee harmless regardless of the outcome of the appeal.

With the appeal, the nonparticipating provider should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement. **The appeal must be in writing.**

Please mail the appeal to this address.

Medicare Complaints, Appeals, and Grievances
Mailstop: OH0205-A537
4361 Irwin Simpson Rd
Mason, Ohio 45040

16.5 Amerigroup Member Complaints, Appeals and Grievances

Distinguishing Between Member Appeals and Member Grievances

Complaints are considered any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. There are two procedures for resolving MA member complaints: the Medicare member **appeals** process and Medicare member **grievance** process. All member concerns are resolved through one of these mechanisms. The member's specific concern dictates which process is used. Thus, it is important for the physician to be aware of the difference between appeals and grievances.

16.6 Medicare Member Liability Appeals

A member appeal is the type of complaint a member (or authorized representative) makes when the member wants Amerigroup to reconsider and change an initial coverage/organization determination (by Amerigroup or a provider) about what services, benefits or prescription drugs are necessary or covered, or whether Amerigroup will reimburse for a service, benefit, or a prescription drug.

An appeal refers to any of the procedures that deal with a request to review a denial of payment or services. If a member believes he or she is entitled to receive a certain service and Amerigroup denies it, the member has the right to appeal the decision. It is important to follow the directions in the denial letter issued to ensure the proper appeals process is followed.

A member may appeal:

- An adverse initial organization determination by Amerigroup or a provider concerning authorization for or termination of coverage of a health care service
- An adverse initial organization determination by Amerigroup concerning reimbursement for a health care service
- An adverse initial organization determination by Amerigroup concerning a refusal to reimburse for a health service already received if the refusal would result in the member being financially liable for the service

- An adverse coverage determination by Amerigroup or a provider concerning authorization or payment for prescription drugs

Appeals should be sent to:

Medicare Complaints, Appeals & Grievances (MCAG)
 Attention: Member Appeals
 Mailstop: OH0205-A537
 4361 Irwin Simpson Road
 Mason, Ohio 45040
 Fax: 1-888-458-1406 (Part C)
 1-888-458-1407 (Part D)

All Medicare member concerns that do not involve an initial determination are considered grievances and are addressed through the grievance process.

Participating Provider Responsibilities in the Medicare Member Appeals Process

- Physicians can request expedited or standard pre-service appeals on behalf of their members; however, if not requested specifically by the treating physician, an *Appointment of Representative Form* may be required. The *Appointment of Representative Form* can be found online and downloaded at www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.
- When submitting an appeal, provide all medical records and/or documentation to support the appeal at that time. Please note that if additional information is requested, it will delay processing of the appeal.
- Expedited appeals should only be requested if the normal time period for an appeal could jeopardize the member's life, health or ability to regain maximum function.
- The CMS guidelines should be used when requesting services and initiating the appeals process.

Appeal time frames

- Members or their authorized representatives have 60 days from the date of the denial of service to file an appeal. The 60-day filing deadline may be extended if good cause can be shown.
- Standard Part C pre-service appeals that are not for a Part B drug must be resolved within 30 calendar days from the date the request was received, unless it is in the member's interest to extend the timeframe.
 - If the normal time period for an appeal could jeopardize the member's life, health or ability to regain maximum function, a request for an expedited appeals are may be submitted orally or in writing. Such appeals are resolved within 72 hours, unless it is in the member's interest to extend this time period.
 - A standard pre-service appeal for the coverage of a Part B drug must be resolved in 7 days from the date the request was received. Part B drug appeals timeframes cannot be extended.
- Post-service payment appeals must be resolved within 60 calendar days from the date the request was received. All payment appeals must be submitted in writing.
- For Part D appeals:
 - Part D expedited pre-service appeals must be resolved within 72 hours from receipt. Part D standard pre-service appeals must be resolved within 7 days from the date the request was received.
 - Part D payment appeals must be resolved within 14 days from the date the request was received.

- Part D appeals timeframes cannot be extended.

****Note:** Integrated DSNP plans with unified grievance and appeals procedures for Medicare and Medicaid and MMPs may have different timeframes for Part C appeals.

16.7 Further Appeal Rights

If Amerigroup is unable to reverse the original denial decision for a Part C item or service in whole or part, the following additional steps will be taken:

- Amerigroup will forward the appeal to an Independent Review Organization (IRO) contracted with the federal government. The IRO will review the appeal and make a decision:
 - Within 72 hours if expedited
 - Within 30 days if the appeal is related to authorization for health care that is not a Part B drug
 - Within 7 days if the appeal is related to authorization of a Part B drug
 - Within 60 days if the appeal involves reimbursement for care (or 30 days for integrated DSNP plans with unified grievance and appeal procedures)
 - Part D prescription drug appeals are not forwarded to the IRO by Amerigroup but may be requested by the member or representative; information will be provided on this process during the Amerigroup member appeals process
- If the IRO issues an adverse decision (not in the member's favor) and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ)
- If the member is not satisfied with the ALJ's decision, the member may request review by the Medicare Appeals Council. If the Medicare Appeals Council refuses to hear the case or issues an adverse decision, the member may be able to appeal to a federal court

Hospital discharge appeals and QIO review process

Hospital discharges are subject to an expedited member appeal process. CMS has determined that Medicare Advantage members wishing to appeal an inpatient hospital discharge must request an immediate review from the appropriate Quality Improvement Organization (QIO) authorized by Medicare to review the hospital care provided to Medicare patients.

When an Medicare Advantage member does not agree with the physician's decision of discharge from the inpatient hospital setting, then the member must request an immediate review by the QIO. The member or their authorized representative, attorney, or court-appointed guardian must contact the QIO by telephone or in writing. This request must be made no later than midnight of the day of discharge. The QIO will make a decision within one full day after it receives the member's request, the appropriate medical records, and any other information it needs to make a decision. While the member remains in the hospital, Amerigroup continues to be responsible for paying the costs of the stay until noon of the calendar day following the day the QIO notifies the member of its official Medicare coverage decision.

If the QIO agrees with the physician's discharge decision, the member will be responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO provides notification of its decision. If the QIO disagrees with the physician's discharge decision, the member is not responsible for paying the cost of additional hospital days.

If a Medicare Advantage member misses the deadline to file for an immediate QIO review and is still in the hospital, then he/she may request an expedited pre-service appeal. In this case, the member does not have automatic financial protection during the course of the expedited appeal and may be

financially liable for paying for the cost of the additional hospital days if the original decision to discharge is upheld upon appeal.

16.8 Medicare Member Grievances

A Medicare member grievance is the type of complaint a member makes regarding any other type of problem with Amerigroup or a provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room and the cleanliness of the provider's facilities are grievances.

Amerigroup must accept grievances from members orally or in writing within 60 days* of the event. Amerigroup must make a decision and respond to the grievance within 30 days. A member can request an expedited grievance, in which case Amerigroup has 24 hours to respond. An expedited grievance can only be initiated if Amerigroup refuses to grant the member an expedited organization/coverage determination or an expedited reconsideration/redetermination or notifies the member that an extension will be taken in deciding making an organization determination or deciding an appeal (when allowed). Amerigroup can request up to 14 additional days to respond to a grievance if it is in the member's best interest.

*Some plans may not limit the time in which a member grievance is filed (e.g., certain integrated DSNP plans and MMPs). These plans allow the member to file a grievance at any time.

16.9 Resolving Medicare Member Grievances

If a Medicare member has a grievance about Amerigroup, a provider or any other issue, providers should instruct the member to call Member Services at the number located on the back of their ID card or send a written grievance to:

Medicare Complaints, Appeals & Grievances (MCAG)
Attention: Member Grievance Unit
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

16.10 Cost Sharing

Billing Members & Balance Billing

An important protection for beneficiaries when they obtain plan-covered services in an HMO, PPO, or RPPO is that they do not pay more than plan-allowed cost-sharing. Providers who are permitted to balance bill must obtain this balance billing from the MAO. Providers may **not** collect any additional payment for cost-sharing obligations from Medicare members other than those specified in a member's plan *Summary of Benefits*.

Note: Under Original Medicare rules, an Original Medicare participating provider (hereinafter referred to as a participating provider) is a provider that signs an agreement with Medicare to always accept assignment. Participating providers may never balance bill because they have agreed to always accept the Medicare allowed amount as payment in full. An Original Medicare nonparticipating provider (hereinafter referred to as a nonparticipating, or non-par, provider) may accept assignment on a case-by-case basis and indicates this by checking affirmatively field 27 on the *CMS 5010* claims form; in such a case, no balance billing is permitted.

Federal law prohibits providers from charging dually eligible members with full cost sharing coverage under a Medicare Savings Program and members who are in the Qualified Medicare Beneficiary (QMB) program for Medicare cost sharing for covered Part A and Part B services. The chart below indicates how cost sharing is paid, either by Amerigroup or the state Medicaid agency. Amerigroup processes the claim for reimbursement when Amerigroup has an arrangement with state Medicaid to pay Medicare cost sharing for dual-eligible members in its Special Needs Plans (SNP). The state retains responsibility for cost sharing when Amerigroup does not have an arrangement with the state Medicaid agency. In states where Amerigroup pays cost sharing, claims will be processed under the member's account for both Medicare and Medicaid benefits. In the states where Amerigroup does not have an arrangement with the state Medicaid agency, providers should bill cost sharing to the appropriate Medicaid carrier or state Medicaid agency for payment once the claim has been processed by Amerigroup. Please check your *EOP* upon claims adjudication.

16.11 Cost-Sharing Responsibility for Special Needs Plan Members

NOTE: Members that are dually eligible, either as full benefit dual eligible or as part of a Medicare Savings Program, are protected from liability of Medicare premiums, deductible, coinsurance and copayment amounts. Some Medicare Savings Programs cover some but not all of these premium and/or cost sharing amounts. Medicare members who do not receive full Medicare cost sharing assistance under Medicaid may be required to pay some cost sharing amounts for services. In addition, members in the QMB (Qualified Medicare Beneficiary) program have no liability to pay Medicare providers for Medicare Part A or Part B cost sharing. Federal law prohibits providers from charging dually eligible members with full cost sharing coverage and QMBs for Medicare cost sharing for covered Part A and Part B services – even when Medicaid does not fully pay the Medicare cost sharing amount. Providers who balance bill a full eligible dual member or a QMB member are in violation of Federal law and are subject to sanctions. Providers also may not accept dual eligible beneficiaries as 'private pay' in order to bill the patient directly and providers identified as continuing to bill dual eligible beneficiaries inappropriately will be reported to CMS for further action/investigation.

The rules governing balance billing as well as the rules governing the MA payment of MA-plan, noncontracting and Original-Medicare, nonparticipating providers are listed below by type of provider.

Contracted provider

There is no balance billing paid by either the plan or the enrollee.

Noncontracting, Original Medicare, participating provider. There is no balance billing paid by either the plan or the enrollee.

Noncontracting, non-(Medicare) participating provider. The MAO owes the noncontracting, nonparticipating (non-par) provider the difference between the member's cost-sharing and the Original Medicare limiting charge, which is the maximum amount that Original Medicare requires an MAO to reimburse a provider. The enrollee only pays plan-allowed cost-sharing, which equals:

- The copay amount, if the MAO uses a copay for its cost-sharing; or
- The coinsurance percentage multiplied by the limiting charge, if the MAO uses a coinsurance method for its cost-sharing.

- MA-plan, noncontracting, nonparticipating DME supplier. The MAO owes the noncontracting nonparticipating (non-par) DME supplier the difference between the member's cost-sharing and the DME supplier's bill; the enrollee only pays plan-allowed cost-sharing, which equals:
- The copay amount, if the MAO uses a copay for its cost-sharing; or
- The coinsurance percentage multiplied by the total provider bill, if the MAO uses a coinsurance method for its cost-sharing. Note that the total provider bill may include permitted balance billing.

Additional useful information on payment requirements by MAOs to non-network providers may be found in *MA Payment Guide for Out-of-network Payments* at

<https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf>.

MA plans must clearly communicate to enrollees through the *Evidence of Coverage (EOC)* and *Summary of Benefits* their cost-sharing obligations as well as their lack of obligation to pay more than the allowed plan cost-sharing as described above.

If you are a noncontracting nonparticipating Medicare provider, who does not accept Medicare assignment, please contact us if there are any questions regarding your claim(s) payments.

16.12 Loss of Medicaid Coverage for Special Needs Plan Members

Amerivantage D-SNP (Dual Eligible Special Needs Plan) members are eligible for both Medicare and Medicaid; however, they may have different levels of Medicare cost sharing assistance based on their Medicare Savings Program. DSNP members who do not receive full Medicare cost share assistance and who are not enrolled in the Qualified Medicare Beneficiary (QMB) program may be required to pay cost sharing and copayments for services. Members are encouraged to be cognizant of their eligibility to ensure there is no loss or gap in coverage that would result in liability of cost share.

Note: If the Part A deductible and Part B deductible are not already met at the time of the beneficiary's loss of coverage, the member will be responsible for the extended Length of Services (LOS) per diem cost share for inpatient facilities and/or any coinsurance on professional and outpatient services.

16.13 Amerigroup Self-Service Website and the Provider Inquiry Line

The Amerigroup self-service website at <https://providers.amerigroup.com> provides a host of online resources, such as our Online Provider Inquiry Tool for real-time claim status, eligibility verification and prior authorization status. You can also submit a claim or prior authorization request, print referral forms or directories or obtain a member roster. Detailed instructions for use of the Online Provider Inquiry Tool can be found on our website.

16.14 Toll-Free Automated Provider Services at the DSU

To support our providers and members, we have established the Dedicated Service Unit (DSU) to assist with questions and concerns about the Amerivantage plans. The DSU is comprised of Medicare subject matter experts and specializes in first-call resolution for provider and member inquiries. Our DSU representatives can help:

- Resolve payment disputes, some contracted provider appeals and other claims issues
- Verify claims status, member eligibility, preauthorization requirements and the status of health care services
- Identify participating Amerivantage providers for referring members to specialty services

- Refer members to our Disease Management Centralized Care Unit for interpreter services, transitions, care coordination, transfers and terminations
- Support noncompliant members (e.g., members who repeatedly miss appointments, members who are noncompliant with their treatment plans, etc.)

The DSU is available Monday through Friday from 8 a.m. until 10 p.m. Eastern time toll free at 1-866-805-4589. Information is available through the automated system, or you can be transferred to the appropriate department for other needs, such as seeking advice in case/care management.

17 MEMBER RIGHTS AND RESPONSIBILITIES

Providers are required to adhere to CMS and Amerigroup requirements concerning issuing letters and notices. Amerigroup members have the right to timely quality care and treatment with dignity and respect. Each member receives a copy of the *Explanation of Coverage* which outlines the member's rights and responsibilities. Providers must respect the rights of all Amerigroup members.

Members have the right to:

- Be treated with dignity, respect and fairness at all times.
- Receive information about the health plan, services, practitioners, providers and member rights and responsibilities.
- Receive information in a way that works for them (in languages other than English spoken in the plan service area, in Braille, large print or other alternate formats).
- Ensure the privacy of their medical records and personal health information.
- Choose a plan provider.
- Receive care from a women's health care provider.
- Have timely access to their providers and to receive services from specialists when appropriate.
- Obtain information from providers and be advised about all medically appropriate or necessary treatment options available for their condition, regardless of cost or benefit coverage.
- Participate fully in decisions about their health care and be informed about any risks involved in their care.
- Refuse treatment, leave a hospital or medical facility or stop taking medications; the member must accept responsibility and the consequences of his or her decision.
- Complete an advance directive (living will or power of attorney) to help them with decisions related to their health care if they are unable.
- Voice complaints or appeals about the health plan or the care provided.
- Make recommendations regarding the health plan's member rights and responsibilities policy.
- Receive information about the appeals and grievances members have filed against Amerigroup in the past.
- Receive information about the Medicare Advantage plan, plan providers, drugs, health care coverage and costs, including an explanation about any bills received for services or drugs not covered.
- Request information regarding provider compensation by Amerigroup.
- Receive a written or binding advance-coverage determination for health care services, even if the care is requested from a nonparticipating provider.

Members have the responsibility to:

- Be familiar with their coverage and the rules they must follow to obtain health care.
- Notify Amerigroup if they have additional health insurance coverage.

- Notify providers when seeking care that they are Medicare members and present their Amerigroup member ID cards.
- Provide the health plan, doctors and practitioners with accurate information to render care and follow the treatment plans and instructions they agreed to with the provider.
- Understand their health problems and participate in identifying mutually agreed-upon treatment goals to the extent possible.
- Treat their provider, their provider's staff and Amerigroup employees with respect and dignity.
- • Not be disruptive in the provider's office.
- Pay their copayment for covered services.
- Notify Amerigroup if they have questions, concerns, problems or suggestions (Members may call Member Services at the DSU at 1-866-805-4589 and TTY users should call 1-800-855-2880.)

18 BENEFITS

18.1 Summary of Benefits Tables

Amerigroup member benefits are summarized in the Summary of Benefits. To view the Summary of Benefits tables, click the link below for the appropriate market.

MARKET	SELECT THE LINK TO ACCESS THE BENEFITS TABLES
Arizona	https://providers.amerigroup.com/ProviderDocuments/AZAZ_CAID_2020MedicareProducts.pdf
Iowa	Dual Special Needs Plan information will be available at https://providers.amerigroup.com/provider documents in 2021
New Jersey	https://providers.amerigroup.com/ProviderDocuments/NJNJ_CAID_2020MedicareProducts.pdf
New Mexico	https://providers.amerigroup.com/ProviderDocuments/NMNM_CAID_2020MedicareProducts.pdf
Tennessee	https://providers.amerigroup.com/ProviderDocuments/TNTN_CAID_2020MedicareProducts.pdf
Texas	https://providers.amerigroup.com/ProviderDocuments/TXTX_CAID_2020MedicareProducts.pdf
Washington	https://providers.amerigroup.com/ProviderDocuments/WAWA_CAID_2020MedicareProducts.pdf

Notations regarding some benefit categories are listed below. Please note availability and limitations of Medicare Advantage supplemental benefits may vary by product and market. Please refer to the appropriate Summary of Benefits documents listed above for detailed information.

Prior authorization requirements are described in later sections and in detail on the Medicare Advantage provider website. All services from noncontracted providers with the exceptions of urgent and emergent care and out-of-area dialysis require prior authorization.

The medical benefits are further explained in the following sections.

18.2 Emergency Care

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Amerigroup covers emergency services if they are:

- Furnished by a provider qualified to provide emergency services.
- Needed to evaluate or stabilize an emergent medical condition in accordance with the prudent layperson standard.

Members with an emergency medical condition should be instructed to call 911 and/or go to the nearest emergency hospital. Prior authorization for an emergency medical condition is not required.

18.3 Urgently Needed Care

Members needing urgent care (but not emergent care) are advised to call their PCP, if possible, prior to obtaining services. However, prior authorization is not required.

Urgently needed services are defined as those that are covered but are not emergent services and are provided:

- When the member is temporarily absent from the Amerivantage service area and such services are medically necessary and immediately required
- As a result of an unforeseen illness, injury or condition
- If it is not reasonable given the circumstances to obtain the services through an Amerivantage network provider

Under unusual and extraordinary circumstances, services may be considered urgently needed services when the member is in the service area but the appropriate provider within the Amerivantage provider network is temporarily unavailable or inaccessible.

18.4 Out-Of-Area Dialysis Services

Members may obtain medically necessary dialysis services from any qualified provider when they are temporarily absent from the Amerivantage service area and cannot reasonably access contracted Amerivantage dialysis providers. Members can obtain dialysis services without prior authorization or notification when outside of the Amerivantage service area.

We suggest members advise Amerigroup if they will temporarily be out of the service area, so a qualified dialysis provider may be recommended.

18.5 Hospital Services

There are two types of admissions:

- Elective inpatient admissions — prior authorization is required for all elective inpatient admissions
- Emergency admissions — admitting physicians must notify us within 24 hours or by the next business day of the admission

The Amerigroup Health Care Management Services, in coordination with admitting physicians and hospital-based physicians, is in charge of:

- Coordinating and conducting continued-stay coverage reviews.
- Providing appropriate referrals for extended-care facilities.
- Coordinating coverage of all services required for adequate discharge.

Amerigroup case managers assist in coordinating all needed services in the discharge planning process, as well as coordinating the required follow-up by the appropriate providers.

18.6 Preventive Services

The following preventive services are offered to members with no member copays or cost sharing:

- Preventive visit
 - Annual physical examination (in addition to the Medicare preventive visits)
 - You may bill for one routine annual visit per year (e.g., 99385–99387, 99395–99397) with diagnosis code V70.0
 - Welcome to Medicare exam
 - Annual wellness exam
- Bone mass measurements
- Colorectal screening
- Diabetic monitoring training
- Cardiovascular disease testing
- Mammography screening
- Pap tests, pelvic exams and clinical breast exams
- Prostate cancer screening exams
- Abdominal aortic aneurysm screening
- Diabetes screening
- EKG screening
- Flu shots
- Glaucoma tests
- Hepatitis B shots
- HIV screenings
- Medical nutrition therapy services
- Pneumococcal shots
- Smoking cessation (counseling to stop smoking)
- Depression screening

18.7 Domestic Violence Services

It is especially important that network providers be vigilant in identifying members who may have been subjected to domestic violence. Domestic violence screening tools are included below. Member Services can help members identify resources to protect themselves from further domestic violence. Providers should report all suspected domestic violence.

An individual can access the National Domestic Violence Hotline number by calling 1-800-799-7233. For text telephone assistance, call 1-800-787-3224.

18.8 Domestic Violence Screening Tools

Domestic Violence — Framing Statements

1. Because violence is so common in many people's lives, I have begun to ask all my patients about it.
2. I'm concerned that someone hurting you may have caused your symptoms.
3. I don't know if this is a problem for you, but many of the people I see as patients are dealing with abusive relationships.

Domestic Violence — Direct Verbal Questions

1. Are you in a relationship with a person who physically hurts or threatens you?
2. Did someone cause these injuries? Was it your partner or spouse?
3. Has your partner or ex-partner ever hit you or physically hurt you? Has he or she ever threatened to hurt you or someone close to you?
4. Do you feel controlled or isolated by your partner?
5. Do you ever feel afraid of your partner? Do you feel you are in danger? Is it safe for you to go home?
6. Has your partner ever forced you to have sex when you did not want to? Has your partner ever refused to practice safe sex?

Domestic Violence — New Member

Option 1:

1. Have you ever been hurt or threatened by your friend, spouse or partner?
2. Have you ever been hit, kicked, slapped, pushed or shoved by your friend, spouse or partner?
3. Have you ever been hit, kicked, slapped, pushed or shoved by your friend, spouse or partner during this pregnancy?
4. Have you ever been raped or forced to engage in sexual activity against your will?

Option 2:

1. Are you currently or have you ever been in a relationship where you were physically hurt, threatened or made to feel afraid?

Option 3:

1. Have you ever been forced or pressured to have sex when you did not want to?
2. Have you ever been hit, kicked, slapped, pushed or shoved by your friend, spouse or partner?

18.9 Sexual Abuse

It is required that each provider contact the applicable local state agency when sex abuse is suspected. If a suspected abuse case arises and a referral is required, the provider or member may call a specialty center directly or may call Amerigroup Member Services at 1-866-805-4589 for a list of the specialty centers near them.

18.10 Supplemental Benefits

Supplemental benefits are benefits in addition to the basic Medicare services offered through Medicare Part A and B; they are not benefits offered under the federal Medicare program. Amerigroup offers limited supplemental benefits to covered members as outlined in the *Summary of Benefits* documents. Please refer to the applicable *Summary of Benefits* for specific supplemental benefits being offered for each plan, as well as any limitations and requirements to utilize specific vendors for services. Providers will not be reimbursed for supplemental benefits that they are either not contracted for or that are required to be rendered by a specific vendor under Amerigroup. Members cannot be billed for non-covered services unless notified in advance. See [Provider Obligations — In-office Denials](#).

Supplemental benefits vary by plan, product and state. Below is a list of supplemental benefits we may choose to offer each calendar year in certain states and plans. Please refer to the *Summary of Benefits* documents for details on which plans cover certain supplemental benefits.

- Routine foot and nail care
- Routine eye examinations and eyeglasses
- Routine hearing examinations and hearing aids
- Dental examinations and cleanings
- Coverage of Over-The-Counter (OTC) items
- Generic drugs covered in the Part D coverage gap with the applicable generic prescription
- Nonemergency transportation
- Personal Emergency Response Systems (PERS) coverage for the service and monitoring equipment but not the actual telephone line
- Routine acupuncture services
- Routine chiropractic care
- Fitness program through Silver Sneakers within their network of centers
- All plans have a Maximum Out-of-Pocket (MOOP) limit for medical services. The MOOP does include out-of-pocket costs for Part B drugs but does **not** include Part D (pharmacy prescriptions) cost-sharing amounts. Once a member reaches his or her MOOP limit, all covered medical services will be covered at 100 percent for the remainder of the year.
- Telemonitoring or Electronic Health Monitoring
- Out-of-country emergency care
- Live Health Online

Everyday Extras — allows members to select a benefit to help them achieve their health goals. These benefits may help your patients with meals, mobility and more. Prior authorization and/or recommendation from a licensed clinician may be required for some of these benefits. Please refer to the member's Evidence of Coverage.

Providers **contracted with the vendor network** associated with that supplemental benefit must bill that vendor directly.

Providers **not contracted with the vendor network** to render such a benefit, please note you will only be reimbursed or able to bill a member for noncovered services if you have provided the member with advanced notice of noncoverage. Please note that contracted providers are required to provide a coverage determination for services that are not covered by the member's Medicare Advantage plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. As per the Medicare Advantage HMO and PPO Provider Guidebook, CMS has stated that the use of an *Advanced Beneficiary Notice* or a similar document is not sufficient in many instances with Medicare Advantage members. Therefore, you are required to seek a coverage determination prior to rendering such services.

Providers are encouraged to call the toll free customer service number on the back of the member ID card with any questions around services that may or may not be covered.

NOTE: Not all supplemental benefits are available in all plans, and some limitations and restrictions apply. Some supplemental benefits must be rendered by the delegated vendor to be covered.

18.11 Dental Services

Some of our plans include preventive dental services that are covered by Amerigroup through a contracted dental vendor, except for dental services covered as emergency services. The Amerigroup managed care programs and dental health benefits complement one another because both emphasize prevention, quality and cost-effectiveness. Amerigroup works with contracted dental providers to ensure access to the full range of preventive, primary and specialty oral health services. Please see the *Summary of Benefits* documents for more information on dental benefits.

18.12 Optometry And Audiology Services

Some of our plans include coverage of routine vision and hearing services, including:

- Routine yearly visual exams.
- Screening for glaucoma.
- Hearing screening.

Contracted network providers, assisted by the Amerigroup Case Management Program, coordinate benefits for lenses and hearing aid devices when covered by the plan. Please see the *Summary of Benefits* documents for more information on vision and hearing benefits.

18.13 Over-The-Counter Items

Some of our plans include coverage of OTC items and health-related supplies. For those plans that include this benefit, members are provided with a monthly or quarterly allowance to obtain the items and supplies. For plans with a quarterly allowance, the benefit replenishes at the beginning of each quarter and carries across quarters, but any unused portion of the benefit does not carry over to the next year. For plans with a monthly allowance, the benefit replenishes at the beginning of each month, but any unused portion does not carry over to the next month. OTC products are described in a printed catalogue available to members.

18.14 Nonemergent Transportation

In many markets and benefit plans, Amerigroup provides nonemergent transportation through a contracted vendor. In other markets, these services must be arranged through the Amerigroup Case Management Program. See the *Summary of Benefits* documents for more information. Some plans have coverage of trips to obtain the following preventive services:

- Preventive visits
 - Annual physical examination (in addition to the Medicare preventive visits)
 - You may bill for one routine annual visit per year (e.g., 99385–99387, 99395–99397) with diagnosis code V70.0
 - Welcome to Medicare exam
 - Annual wellness exam
- Bone mass measurements
- Colorectal screening
- Diabetic monitoring training
- Cardiovascular disease testing
- Mammography screening
- Pap tests, pelvic exams and clinical breast exams
- Prostate cancer screening exams

- Abdominal aortic aneurysm screening
- Diabetes screening
- EKG screening
- Flu shots
- Glaucoma tests
- Hepatitis B shots
- HIV screening
- Medical nutrition therapy services
- Pneumococcal shot
- Smoking cessation (counseling to stop smoking)
- Depression screening

18.15 Telemonitoring or Electronic Health Monitoring

Telemonitoring is the coverage of in-home equipment (e.g., BP cuff, scale, glucometer and pulse OC) and telecommunication technology from contracted vendors to monitor enrollees with specific health conditions as determined by their physician. Conditions must be appropriate for this service, such as monitoring of weight for CHF and other chronic conditions that require regular monitoring of vital signs and/or other data as required by a physician. This service requires an initial physician visit and a physician's order for data transmission; however, the data will be transmitted at least on a weekly basis. Physicians are trained on monitoring protocols, and follow-up actions are required. The member is instructed on the use of the equipment, proper transmission and related processes. Telemonitoring or Electronic Health Monitoring services supplement but do not replace a face-to-face physician visits.

19 PRESCRIPTION DRUG COVERAGE

All Amerivantage plans include coverage of Medicare Part D prescription drugs, as well as those covered under Medicare Part B.

19.1 Part D Prescription Drugs

In general, Medicare Part D covers drugs that are only available by prescription, are used or sold in the United States and must be used for medically accepted indications. Part D prescription drugs covered by Amerivantage are listed in the Amerigroup five-tier formulary. Medically Accepted Indication for purposes of Part D is an FDA labeled indication or an indication supported by citation in either the American Hospital Formulary System (AHFS), or *DRUGDEX*®. *Exceptions may be possible when used as part of an anti-cancer chemotherapeutic regimen.* The formulary includes most generic drugs covered under the Part D program, as well as many brand-name drugs, nonpreferred brands and specialty drugs. One can view a copy of the formulary on the Amerigroup website at <https://providers.amerigroup.com>. From the *Provider Resources and Documents library*, select **Pharmacy Tools**, then **Medicare Formulary** or request a copy from the Provider Relations department. Some of these drugs may require prior authorization, have step-therapy requirements, or have quantity limits. Providers may request a coverage determination, which can include prior authorization, tiering exception (request for drug to be covered at a lower cost), or for a drug that is not on the formulary by contacting the Provider Services at the DSU at 1-866-805-4589. Members should obtain Part D covered drugs from a network pharmacy pursuant to a physician's prescription.

Please refer to the formulary when prescribing for Amerigroup members. The formulary will tell you if the drug requires prior authorization or has a quantity limit, and, if it is not listed, then it is considered non-formulary and will require a coverage determination. For Amerivantage Part B, contact Provider Services department 1-866-805-4589 Option 5, from 8 a.m. to 8 p.m. local time, Monday through Friday. For Amerivantage Part D, call the IngenioRx pharmacy services phone number on the back of the member ID card.

19.2 Prescription Drugs by Mail Order

Members can use the mail-order service to fill prescriptions for maintenance drugs (i.e., drugs taken on a regular basis for a chronic or long-term medical condition). For mail-order prescriptions, the physician must write on the maintenance drug prescription whether it is for a 30-, 60- 90- or 100-day supply. When mailing in a prescription to the mail-order service for the first time, the member should allow up to two weeks for the prescription to be filled. For refills of the same prescription, members should allow up to two weeks for mailing and processing.

If a member runs out of a medication before receiving a new supply from the mail-order pharmacy, please call the DSU at 1-866-805-4589. They will assist with obtaining an emergency supply of the member's medication until he or she receives the new mail-order supply.

Members are not required to use mail-order prescription drug services to obtain an extended supply of maintenance medications. Members also have the option of using a retail pharmacy in the Amerivantage network to obtain their maintenance medications. Some retail pharmacies may agree to accept the mail-order reimbursement rate for an extended supply of medication, which may result in no out-of-pocket payment difference to the member. The member pays one copayment for each 30-day supply or a reduced copayment for a 60- or 90-day supply when obtaining maintenance drugs via mail

order, unless the member has a Low-Income Subsidy (LIS) level that helps them pay for their Part D prescription drugs. In such cases, one LIS copayment applies for the transaction.

19.3 Part B Prescription Drugs

Prescription drugs covered under the Medicare Part B benefits are very limited. These include the following:

- Injectable medications provided incidental to a physician's service
- Drugs administered through covered durable medical equipment, such as a nebulizer or infusion pump in the home
- Certain oral cancer medications
- Antiemetic drugs administered within 48 hours of chemotherapy
- Immunosuppressive drugs prescribed following a Medicare-covered organ transplant
- Erythropoietin for individuals undergoing chronic renal dialysis
- Parenteral nutrition for members with a permanent dysfunction of the digestive tract

Other drugs may be covered under Part B in certain limited situations. Many Part B drugs and injectable medications provided incidental to a physician's service require Prior Authorization from Amerigroup. Please call the DSU for additional information.

19.4 Covered Vaccines

CMS and Amerigroup, through the Amerivantage plans, cover vaccines and vaccine administration for Medicare recipients. Listed below are the vaccine benefits covered under Medicare Part B, Medicare Part D and those covered under either Medicare Part B or Part D coverage.

19.5 Vaccines and Vaccine Administration Coverage Under Medicare Part B (Medical) Benefits

Medicare Part B benefits include the following routine immunizations:

- Pneumococcal pneumonia vaccine
- Influenza virus vaccine

Claims for Medicare Part B benefits should be submitted to Amerigroup for processing and reimbursement at:

Attn: Claims Department
Amerigroup
P.O. Box 61010
Virginia Beach, VA 23466-1010

19.6 Vaccines and Vaccine Administration Coverage Under Medicare Part D (Pharmacy) Benefits

Medicare Part D generally covers vaccines not available under Medicare Part B. Medicare Part D vaccines are included in the Amerigroup Formulary located online at <https://providers.amerigroup.com>. From the *Quick Tools* link, select **Pharmacy Tools**, then **Medicare Formularies**. Providers who do not

have access to a vaccine on the formulary can call the prescription into a participating pharmacy. If the vaccine is administered in a network pharmacy, the pharmacy will transmit the claim to the Pharmacy Benefit Manager for processing and reimbursement.

Providers who have a supply and administer the vaccine in their office should collect the member's copay at the time of service and submit the claim for the vaccine and administration on a *CMS 1500 (02-12)* form to:

Attn: Claims Department
Amerigroup
P.O. Box 61010
Virginia Beach, VA 23466-1010

To streamline your claim processing and payment (as applicable) for these and other preventive vaccines covered under Part D, providers may use TransactRX, a clearinghouse for claims submission. To use TransactRX please contact the clearinghouse at the web site (<http://www.transactrx.com>) or call Customer Service at 1-866-522-3386. Physicians, facilities, health clinics and pharmacies may use this clearinghouse to process Part D claims. There is no charge to providers who use electronic funds deposit to receive payment. There is a service fee of \$2.50 for check payments on claims.

For member copayment information, please contact the DSU at 1-866-805-4589.

19.7 Vaccines Covered Under Either Part B (Medical) or Part D (Pharmacy) Benefit Coverage

These vaccines may require a coverage determination to determine appropriate coverage. Vaccines administered directly related to the treatment of an injury or direct exposure to a disease or condition would be covered under Part B. Vaccines administered for prevention of an illness and not covered under Medicare Part B (influenza or pneumococcal) would be covered under Part D. Hepatitis B coverage depends on the risk of contracting hepatitis B. Low risk is Part D and moderate or high risk is Part B. Vaccines that may be Part B or Part D are:

- Hepatitis A vaccine
- Hepatitis B vaccine
- Anthrax vaccine
- Rabies vaccine
- Tetanus toxoid, tetanus-diphtheria toxoids

For reimbursement of a vaccine and vaccine administration that could be either Part B or Part D, indicate the reason for immunization (injury and/or direct disease exposure or prevention of an illness) and risk of contracting hepatitis B on a CMS 1500 (02-12) claims form and submit to:

Amerigroup
P.O. Box 61010
Virginia Beach, VA 23466-1010

Additional information can be found on the CMS website under the Medicare Learning Network General Information page at <https://www.cms.gov>.

19.8 Coverage Determinations for Part D Prescription Drug Benefits

Coverage determinations: The first decision made by a plan regarding the prescription drug benefits an enrollee is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request and a decision on the amount of cost sharing for a drug.

A coverage determination is any decision Amerigroup makes regarding:

- A decision about whether to provide or pay for a Part D drug, including a decision not to pay because the drug is not on the plan's formulary, the drug is determined not to be medically necessary, the drug is furnished by an out-of-network pharmacy or we determine the drug is otherwise excluded, but the member believes it may be covered by the plan
- Failure to provide a coverage determination in a timely manner, when a delay would adversely affect the member's health
- A decision concerning a tiering exception request
- A decision concerning a formulary exception request
- A decision on the amount of cost sharing for a drug
- A decision on whether a member has satisfied a prior authorization or other utilization management requirement

Two decisions govern the need for prescription drugs the member has not yet received:

- A standard decision made within the standard 72-hour time frame
- An expedited decision made within 24 hours

An expedited decision can only be requested if the member or any physician believes waiting for a standard decision could jeopardize the member's life, health or ability to regain maximum function. This is called the expedited criteria.

The member or a physician can request an expedited decision. If a physician requests an expedited decision or supports a member in asking for one and if the physician indicates the situation meets the expedited criteria, Amerigroup will automatically provide an expedited decision within 24 hours from the initial request.

19.9 Formulary Exceptions

If a prescription drug is not listed in the Amerigroup formulary, please check the updated formulary on the Amerigroup website. The website formulary is updated frequently with any changes. In addition, providers may contact the Amerigroup Pharmacy department to be sure a drug is covered. If the Pharmacy department confirms the drug is not on the formulary, there are two options:

- The prescribing physician can prescribe another drug that is covered on the formulary.
- The patient or prescribing physician may ask Amerigroup to make an exception (a type of coverage determination) to cover the non-formulary drug. If the member pays out-of-pocket for a nonformulary drug and requests an exception Amerigroup approves, Amerigroup will reimburse the member. If the exception is not approved, the member may appeal the plan's denial. See the [Medicare Member Liability Appeals section](#) for more information on requesting exceptions and appeals.

In some cases, Amerigroup will contact a member who is taking a drug that is not on the formulary. Amerigroup will give the member the names of covered drugs used to treat his or her condition and encourage the member to ask his or her physician if any of those drugs would be appropriate options for treatment. Also, members who recently joined an Amerigroup plan may be able to get a temporary supply of a drug they are taking if the drug is not on the Amerigroup formulary.

19.10 Transition Policy

New members in Amerigroup plans may be taking drugs that are not on the formulary or that are subject to certain restrictions, such as prior authorization or step-therapy. Current members may also be affected by changes in the formulary from one year to the next. Members are encouraged to talk to their providers to decide if they should switch to a different drug Amerigroup covers or request a formulary exception in order to get coverage for the drug (as described above).

During the period of time members are talking to their providers to determine the right course of action, Amerigroup may provide a temporary supply of the nonformulary drug if those members need a refill for the drug during the first 90 days of new membership in an Amerigroup plan. For current members affected by a formulary change from one year to the next, Amerigroup will provide a temporary supply of the nonformulary drug for members needing a refill for the drug during the first 90 days of the new plan year.

When a member goes to a network pharmacy and Amerigroup provides a temporary supply of a drug that is not on the formulary or that has coverage restrictions or limits (but is otherwise considered a Part D drug), Amerigroup will cover at least a one time, 30-day supply (unless the prescription is written for fewer days). After we cover the temporary 30-day supply, Amerigroup generally will not pay for these drugs again as part of the transition policy. Amerigroup will provide the member and the provider with a written notice after it covers a temporary supply. The notice will explain the steps the member can take to request an exception and the way to work with the prescribing physician to decide if switching to an appropriate formulary drug is feasible.

If a new member is a resident of a long-term care facility (like a nursing home), Amerigroup will cover a temporary 34-day transition supply (unless the prescription is written for fewer days). If necessary, Amerigroup will cover more than one refill of these drugs during the first 90 days a member is enrolled in our plan. If the member has been enrolled in the plan for more than 90 days and needs a drug that is not on the formulary or is subject to other restrictions such as step therapy or dosage limits, Amerigroup will cover a temporary 34-day emergency supply of that drug (unless the prescription is for fewer days) while the new member requests a formulary exception.

This policy also applies to current Medicare members who experience a change in the level of their care. For example, if a member leaves the hospital and enters a long-term care facility or leaves hospice status and reverts back to standard care, the member may receive a temporary transition supply of the nonformulary drug for up to 30 days, unless the prescription is written for fewer days.

Please note the Amerigroup transition policy applies only to those prescription drugs that are Part D drugs.

19.11 Medication Therapy Management

The [*Medicare Modernization Act of 2003*](#) requires [*Medicare Part D*](#) prescription drug plans to include medication therapy management services delivered by a qualified health care professional, including pharmacists. MTM services target beneficiaries who have multiple chronic conditions (such as diabetes, asthma, hypertension, hyperlipidemia and congestive heart failure), take multiple medications or are likely to incur annual costs above a predetermined level. Amerigroup supports Medicare MTM in a variety of ways:

- Medication Management Services (Amerigroup Amerivantage Members)
- In-House Consults by Amerigroup Pharmacists

1 PROVIDER DIGITAL ENGAGEMENT

10.1 Purpose

The purpose of this provider digital engagement chapter is to establish the standards to increase utilization of secure digital provider tools and applications that are accessible to participating and non-participating providers to improve efficiencies for providers and Amerigroup. This chapter is applicable medical, dental and vision services.

In support of this digital supplement, the following efficiencies have been documented as industry averages per the annual CAQH CORE Efficiency Index study:

Table 10: Average, Minimum, and Maximum Time Spent by Providers Conducting Manual, Partial and Electronic Transactions, Medical, 2019 CAQH Index

Transaction	Method	Average Time Providers Spend per Transaction (minutes)	Min Time Providers Spend per Transaction (minutes)	Max Time Providers Spend per Transaction (minutes)	Potential Average Time Saving (minutes)
Eligibility and Benefit Verification	Manual	10	3	30	8
	Partial	5	1	15	3
	Electronic	2	<1	10	
Prior Authorization	Manual	21	3	45	17
	Partial	8	1	20	4
	Electronic	4	<1	18	
Claim Submission	Manual	6	1	25	4
	Electronic	2	<1	6	
Attachments	Manual	11	1	30	6
	Electronic	5	1	10	
Claim Status Inquiry	Manual	12	1	20	8
	Partial	4	1	10	0
	Electronic	4	<1	11	
Claim Payment	Manual	5	<1	11	2
	Electronic	3	<1	10	
Remittance Advice	Manual	7	<1	19	5
	Partial	4	<1	10	2
	Electronic	2	<1	10	
Total Potential Time Savings (Manual)					50
Total Potential Time Savings (Partial)					9

10.2 Supplement Statement

This Supplement outlines the digital tools Amerigroup has available to providers who serve its members, whether par or non-par. It is the expectation of Amerigroup that providers will utilize these digital tools unless mandated by law or other legal requirement no later than January 1, 2021. The electronic tools and applications include the secure Provider Portal, Electronic Data Interchange (EDI)

Transaction Gateway and available Business-to-Business Application Programming Interfaces (B2B APIs) - all hosted via Availity. This Supplement addresses the following processes:

- Acceptance of digital ID cards
- Eligibility and benefit inquiry and response
- Prior authorization submissions including updates, attachments and authorization status
- Claim submission, including attachments and claim status
- Remittances and payments

It is preferred, that in markets where these tools are currently available, these digital alternatives are used:

- Disputes
- Grievances and Appeals
- Demographic updates
- Pharmacy Prior Authorization drug requests
- Services through Amerigroup affiliates, AIM and Beacon
- Provider Enrollment

Amerigroup expects that all providers seeking any functions and processes above will use available electronic self-service tools including EDI X12 transactions, the secure Provider Portal or direct desktop integration via B2B APIs in lieu of manual channels (paper, mail, fax, call, etc.). Availity provides access to all Amerigroup self-service tools across all electronic channels outlined above. All digital channels are consistent with industry standards.

Access to all Amerigroup digital tools and capabilities is available on the secure Provider Portal via <https://www.availity.com>. Please access Availity to learn more about available EDI, Portal and B2B API options. Administration Simplification standard transaction requirements: <https://www.hhs.gov/hipaa/for-professionals/other-administration-simplification-rules/index.html>

NOTE: As a mandatory requirement, all trading partners who currently transmit directly to an Amerigroup EDI Gateway must transition to the Availity EDI Gateway and have an active Availity Trading Partner Agreement in place.

10.3 Acceptance of Digital ID Cards

As Amerigroup members transition to using electronic member identification cards, providers may need to implement changes in their processes to accept this new format. Amerigroup expects that providers will accept the electronic version of the member identification card in lieu of a physical member identification card. If providers require a copy of a physical member identification card, members can fax or email a copy of the electronic member identification card from their phone/app, or providers can access it directly from the secure Provider Portal through Availity.

10.4 Eligibility and benefit inquiry and response

Providers may leverage any of the following Availity-hosted channels for electronic Eligibility & Benefit inquiry and response:

- EDI Transaction: X12 270/271 Eligibility Inquiry and Response (version 5010)

- Amerigroup supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by HIPAA.
- Secure Provider Portal via Availity
 - Eligibility and Benefit verification utility – This utility allows a provider to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.
- Provider desktop integration via B2B APIs
 - Amerigroup has also enabled real-time access to Eligibility and Benefit verification APIs, that can be directly integrated within participating vendors' practice management software, revenue cycle management software and some electronic medical records software. Contact Availity for available vendor integration opportunities at <https://www.availity.com/Healthcare-APIs>.

10.5 Authorizations

Prior Authorization Submission, Attachment and Status

Providers may leverage any of the following channels for Prior Authorization submission, status inquiries and submission of electronic attachments (solicited or unsolicited) on the secure Provider Portal via Availity:

- EDI Transaction: X12 278 Prior Authorization and Referral (version 5010)
 - Amerigroup supports the industry standard X12 278 transaction for prior auth submission and status inquiry as mandated per HIPAA.
- EDI Transaction: X12 275 Patient Information including HL7 payload (version 5010) for authorization attachments
 - Amerigroup supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation including medical records via the HL7 payload.
- Secure Provider Portal via Availity
 - Interactive Care Reviewer (ICR) – The authorization ICR utility allows a provider to key a prior authorization request including an attachment or status inquiry directly into an online form.
 - Additionally, providers can use ICR to make inquiries on previously submitted requests regardless of how the original prior authorization was submitted (phone, fax, eReview, secure email, etc.).
- Provider desktop integration via B2B APIs
 - Amerigroup has also enabled real-time access to Prior Authorization APIs, that can be directly integrated within participating vendors' practice management software, revenue cycle management software and some electronic medical records software. Contact Availity for available vendor integration at <https://www.availity.com/Healthcare-APIs>.

10.6 Claims: Submissions, Attachments and Status

Claim Submissions, Attachment and Status

Providers may leverage any of the following channels for electronic Claim submission, attachments (for both pre and post payment) and status on the secure Provider Portal via Availity:

- EDI Transaction: X12 837 Professional, Institutional and Dental Claim submission (version 5010)
 - Amerigroup supports the industry standard X12 837 transactions for all Fee-For-Service and Encounter billing as mandated per HIPAA.

- EDI Transaction: X12 275 Patient Information including HL7 payload attachment (version 5010)
 - Amerigroup supports the industry standard X12 275 transaction for electronic transmission of supporting claims documentation including medical records via the HL7 payload.
- EDI Transaction: X12 276/277 Claim status Inquiry and Response (version 5010)
 - Amerigroup supports the industry standard X12 276/277 transaction set for claim status inquiry and response as mandated by HIPAA.
 - Secure Provider Portal via Availity: Direct Data Entry (DDE) – The claim DDE utility provider allows a provider to key a claim directly into an online claim form and also upload supporting documentation for a defined claim (solicited or unsolicited)
 - 837 Claim batch upload – The claim batch upload utility allows a provider to upload an entire batch/file of claims (must be in X12 837 standard format).
 - Claim Status Inquiry utility – This utility allows a provider to key an inquiry directly into an online claim status form with real-time responses.
- Provider desktop integration via B2B APIs –
 - Amerigroup has also enabled real-time access to Claim Status via APIs, which can be directly integrated within participating vendor’s practice management software, revenue cycle management software and some electronic medical records software. Contact Availity for available vendor integration at <https://www.availity.com/Healthcare-APIs>.

10.7 Remittances & Payments Electronic Funds Transfer (EFT)

Like the payroll direct deposit service that most businesses offer their employees, Electronic Funds Transfer (EFT) uses the Automated Clearing House (ACH) Network to transmit health care payments from a health plan to a health care provider’s bank account. Health plans can use a provider’s banking information only to deposit funds, not to withdraw funds. Amerigroup expects providers to accept payment via Electronic Funds Transfer (EFT) in lieu of paper checks. Providers can register or manage account changes for EFT via the Council for Affordable Quality Health Care (CAQH) Enrollment Tool called [EnrollHub](#). This tool will help eliminate the need for paper registration, reduce administrative time and costs and allows physicians and facilities to register with multiple payers at one time. EFT payments are deposited faster and are generally the lowest cost payment method.

To facilitate quicker reimbursement for providers who have not enrolled for EFT, Amerigroup may move paper checks to a virtual card payment method. Virtual cards allow physicians and facilities to process payments as credit card transactions.

Using the same Trace Identifier Segment (TRN) helps to match the payment to the correct remittance advice, a process called reassociation. Health plans are required to input the X12 835 TRN Segment into Field 3 of the Addenda Record of the CCD+Addenda. The TRN Segment in the Addenda Record of the CCD+Addenda should be the same as the TRN Segment in the associated ERA that describes the payment.

Electronic Remittance Advice (ERA)

Providers may leverage any of the following channels for Electronic Remittance Advice on the secure Provider Portal via Availity:

- EDI Transaction: X12 835 Electronic Remittance Advice (version 5010)
 - Amerigroup supports the industry standard X12 835 transaction as mandated per HIPAA.
- Secure Provider Portal via Availity - Remittance Inquiry:

- The Remittance Inquiry application provides a digital version (PDF) of paper payment remittance that can be downloaded.

20 GLOSSARY OF TERMS

Appeal: As defined by the CMS Parts C & D Grievances, Organization/Coverage Determinations, and Appeals Guidance, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 C.F.R. §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council and judicial review. This process is separate from the participating provider appeals/dispute process.

Balance + Rx Plan: the Balance + Rx Plan provides coverage of major medical services after satisfaction of an annual deductible. Outpatient services, such as primary care and specialist visits, are covered with reasonable copays for professional services outside of the deductible. This includes Medicare Part D prescription coverage. This plan has no out-of-network benefits

Basic benefits: services covered for all Medicare beneficiaries under Medicare Part A and Part B. All Medicare Advantage members receive all basic benefits, including all health care services covered under Medicare Part A and B programs, except for hospice services. Amerigroup also provides supplemental benefits not covered by fee-for-service Medicare

CMS: Centers for Medicare & Medicaid Services; the federal agency responsible for administering the Medicare program.

Contracting hospital: a hospital that has a contract to provide services and/or supplies to Medicare members

Contracting medical group: a group of physicians organized as a legal entity for the purpose of providing medical care with a contract to provide medical services to Medicare members

Contracting pharmacy: a pharmacy that has a contract to provide Medicare members with medications prescribed by their providers in accordance with the Amerigroup contract

Cost sharing obligations: Medicare deductibles, premiums, copays and coinsurance that the state plan is obligated to pay for certain Medicare beneficiaries (QMBs, SLMB-Plus, and other Medicare/Medicaid dual eligibles). For SLMB-Plus and Other Medicare/Medicaid dual eligibles, the state plan is not required to pay Medicare coinsurance on those Medicare services that are not covered by the state plan unless the enrollee is a child under 21 or an SSI beneficiary. No plan can impose cost-sharing obligations on its members greater than those that would be imposed on the member if they were not a member of the plan.

Coverage determination: As defined by the CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, a determination made by a Part D plan sponsor or its delegated entity with respect to the following:

- A decision about whether to provide or pay for a drug that an enrollee believes may be covered by the plan sponsor, including a decision related to a Part D drug that is: not on the plan's formulary; determined not to be medically necessary; furnished by an out-of-network pharmacy; or otherwise excluded under Federal law if applied to Medicare Part D;
- A decision on the amount of cost sharing for a drug;
- Failure to provide a coverage determination in a timely manner when a delay would adversely affect the health of the member;
- A decision about a tiering exception request; or
- A decision about a formulary exception request.

Covered services: those benefits, services or supplies that are:

- Provided or furnished by providers or authorized by Amerigroup or its providers
- Emergency services and urgently needed services that may be provided by nonproviders
- Renal dialysis services provided while members are temporarily outside the service area
- Basic and supplemental benefits

Dual-eligible: a Medicare enrollee who is eligible for Medical Assistance from the state under Medicaid and for whom the state may have responsibility for payment of Medicare cost-sharing obligations under the state plan. Dual-eligibles include the following categories of recipients: Qualified Medicare Beneficiary (QMB) Only, QMB Plus, Specified Low-income Medicare Beneficiary (SLMB) Plus, Qualified Disabled and Working Individuals (QDWI), Qualified Individual (QI), or other Full Benefit Dual-Eligible (FBDE) recipients. Check the specific plan's eligibility requirements for those eligible to enroll into the specific plan.

Emergency medical condition: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency services: covered inpatient or outpatient services furnished by a provider qualified to furnish emergency services and needed to evaluate or stabilize an emergency medical condition in accordance with the prudent layperson standard

Experimental procedures and items: procedures and items determined by Amerigroup and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, Amerigroup will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable or CMS guidance already made by Medicare.

Section 1862(a)(1)(E) of the *Social Security Act*, prohibits payment for procedures that are deemed experimental and/or investigational in nature

Exceptions: an exception request is a type of coverage determination request. Through the exception process, the member can request an off-formulary drug, an exception to the Amerigroup tiered cost-sharing structure or an exception to the application of a cost utilization management tool (e.g., step therapy requirement, dose restriction or prior authorization requirement).

Fee-for-service Medicare: Medicare coverage managed by the federal government and not through a CMS-contracted private health plan (also known as traditional and/or original Medicare)

Full Benefit Dual-Eligible (FBDE): an individual who is eligible for both Medicare Part A and/or Part B and for state benefits (services), including those who are categorically eligible and those who qualify as medically needy under the state plan.

Grievance: As defined by the CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, an expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.

Home health agency: a Medicare-certified home health agency is one that provides intermittent skilled nursing care and other therapeutic services in a member's home when medically necessary, when members are confined to their home and when authorized by their primary care physician

Hospice: a Medicare-certified organization or agency primarily engaged in providing pain relief, symptom management and support services to terminally ill people and their families

Hospital: a Medicare-certified institution licensed by the state that provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term hospital does not include a convalescent nursing home, rest facility or facility for the aged that furnishes primarily custodial care, including training in routines of daily living

Independent practice association: a group of physicians that function as a contracting medical provider/group but in which the individual member physicians operate their respective independent medical offices

Medicaid: the federal health insurance program established by *Title XIX of the Social Security Act* and administered by states for low-income individuals

Medicaid-Only Dual Eligibles (Non QMB, SLMB, QDWI, QI) – an individual who is entitled to Medicare Part A and/or Part B and is eligible for full Medicaid benefits. A Medicaid-Only Dual Eligible is not eligible for Medicaid as a QMB, SLMB, QDWI, QI. Typically, the individual needs to spend down to qualify for Medicaid or fall into a Medicaid eligibility poverty group that exceeds the limits listed above. Medicaid provides full Medicaid benefits and pays for Medicaid services provided by Medicaid providers, but Medicaid will only pay for services also covered by Medicare if the Medicaid payment rate is higher than the amount paid by Medicare, and, within this limit, will only pay to the extent necessary to pay the beneficiary's Medicare cost sharing liability. Payment by Medicaid of Medicare Part B premiums is a State option; however, States may not receive federal financial participation (FFP) for Medicaid services also covered by Medicare Part B for certain individuals who could have been covered under Medicare

Part B had they been enrolled. The Federal government will pay its cost-share according to the standard Federal medical assistance percentage (FMAP).

Medically necessary: medical services or hospital services determined by Amerigroup to be:

- Rendered for the diagnosis or treatment of an injury or illness.
- Appropriate for the symptoms, consistent with diagnosis and otherwise in accordance with sufficient scientific evidence and professionally recognized standards.
- Not furnished primarily for the convenience of the member, the attending provider or other provider of service.

We make determinations of medical necessity based on peer-reviewed medical literature, publications, reports and evaluations; regulations and other types of policies issued by federal government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by Amerigroup. *Section 1862(a)(1)(A) of the Social Security Act*, states that Medicare payment can only be made for services/items that are medically necessary and reasonable.

Medicare: the federal health insurance program established by *Title XVIII of the Social Security Act* and administered by the federal government for elderly and disabled individuals

Medicare Part A: Medicare Part A covers hospital insurance benefits, including inpatient hospital care, skilled nursing facility care, home health agency care and hospice care offered through Medicare.

Medicare Part A premium: Medicare Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the self-employment tax paid by self-employed persons. If members are entitled to benefits under either the Social Security or Railroad Retirement systems or worked long enough in federal, island or local government employment to be insured, they do not have to pay a monthly premium. If members do not qualify for premium-free Part A benefits, members may buy the coverage from Social Security if they are at least 65 years old and meet certain other requirements.

Medicare Part B: optional, supplemental medical insurance requiring a monthly premium. Medicare Part B covers physician (in both hospital and nonhospital settings) and certain nonphysician services. Other Part B services include lab testing, durable medical equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services and blood products not covered under Part A.

Medicare Part B premium: a monthly premium paid to Medicare (usually deducted from a member's Social Security check) to cover Part B services. Members must continue to pay this premium to Medicare to receive covered services, whether members are covered by a Medicare Advantage plan or by original Medicare.

Medicare Part C: optional coverage that can be elected by the Medicare beneficiary. Coverage under Part C is provided by private health care plans. The health plan must provide all Part A and B services and may offer additional benefits to the beneficiary. Also known as Medicare Advantage.

Medicare Part D: the prescription drug coverage provided by a Medicare Advantage (MA) plan or by a stand-alone Prescription Drug Plan (PDP) contracted with CMS. The MA plan or PDP may charge the beneficiary premiums and cost sharing for this coverage. Amerigroup offers MA-PD plans in specific markets.

Medicare Advantage (MA) agreement: the agreement between Amerigroup and CMS to provide Medicare Part C and other health plan services to Amerigroup members.

Medicare Advantage (MA) plan: a policy or benefit package offered by a Medicare Advantage Organization (MAO) in which a specific set of health benefits are offered at a uniform premium level of cost sharing to all Medicare beneficiaries residing in the corresponding service area. An MAO may offer more than one benefit plan in the same service area. The Amerivantage plan is a kind of MA plan.

Member: a Medicare beneficiary entitled to receive covered services who has voluntarily elected to enroll in the Amerivantage plan and whose enrollment has been confirmed by CMS

Noncontracting medical provider or facility: any professional person, organization, health facility, hospital or other person or institution that is licensed and/or certified by the state and/or Medicare to deliver or furnish health care services; and that is neither employed, owned, operated by nor under contract with Amerigroup to deliver covered services to Medicare members.

Provider: any professional person, organization, health facility, hospital or other person or institution licensed and/or certified by the state and/or Medicare to deliver or furnish health care services. This individual or organization has a contract directly or indirectly with Amerigroup to provide services directly or indirectly to Medicare members pursuant to the terms of the participating provider agreement.

Provider liability appeal: a request for Amerigroup to review a decision by the Amerigroup Health Care Management Services to deny payment without member liability for services already rendered.

Provider payment dispute: a formal request from a provider contesting the paid amount on a claim which does not include a medical necessity or administrative denial and claims payment determinations have already been rendered. The claim has been finalized but the provider disagrees with the amount paid.

Primary Care Provider (PCP): a provider physician selected by a member to coordinate the member's health care. The PCP is responsible for providing covered services for Medicare members and coordinating referrals to specialists. PCPs usually practice internal medicine, family practice or general practice medicine.

Qualified Disabled and Working Individual (QDWI): an individual who has lost their Medicare Part A benefits due to their return to work. A QDWI is eligible to purchase Medicare Part A benefits, have income of 200 percent of the FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only. The federal government will pay its cost-share according to the standard Federal medical assistance percentage (FMAP).

Qualifying Individuals (QI): an individual who is entitled to Medicare Part A, have income of at least 120 percent of the FPL, but less than 135 percent of the FPL, resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays his or her Medicare Part B premiums only. The federal government will pay its cost-share according to the standard Federal medical assistance percentage (FMAP) at 100 percent.

Qualified Medicare Beneficiary (QMB): an individual who is entitled to Medicare Part A, has income that does not exceed 100 percent of the FPL and whose resources do not exceed twice the SSI limit. A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, coinsurance and copays (except for Medicare Part D). Collectively these benefits (services) are called QMB Medicaid benefits (services). Categories of QMBs are as follows:

- QMB Only — QMB who is not otherwise eligible for full Medicaid
- QMB Plus — QMB who also meets the criteria for full Medicaid coverage and is entitled to all benefits (services) under the state plan for fully eligible Medicaid recipients

Specified Low-income Medicare Beneficiary (SLMB) without full Medicaid (SLMB only): an individual who is entitled to Medicare Part A, has an income of greater than 100 percent of the Federal Poverty Level (FPL) but less than 120 percent of the FPL, and his or her resources do not exceed twice the limit for Supplement Security Income (SSI) eligibility and who is not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only.

Specified Low-income Medicare Beneficiary with full Medicaid (SLMB Plus): an individual who is entitled to Medicare Part A, has an income of greater than 100 percent of the FPL but less than 120 percent of the FPL, and his or her resources do not exceed twice the limit for SSI eligibility and who is eligible for full Medicaid benefits. Medicaid pays their Medicare Part B premiums and provides full Medicaid benefits.

Service area: a geographic area approved by CMS within which an eligible individual may enroll in a Medicare Advantage plan. The geographic area for each Medicare Advantage plan is located in the Summary of Benefits document.

Special Needs Plan (SNP): a type of Medicare Advantage plan that also incorporates services designed for a certain class of members. Plans offering SNPs receive special approval from CMS. A SNP also provides Medicare Part D drug coverage.

Dual Coordination, Dual Premier, and Dual Secure Plan: the Amerigroup dual-eligible special needs plan available to dual-eligibles. Although this plan has cost sharing for certain services, cost sharing may be paid by the state Medicaid agency or by Amerigroup through an arrangement with Medicaid. There are low copays for Medicare Part D prescription coverage. This plan has no out-of-network benefits.

Urgently needed services: those covered services provided when the member is temporarily absent from the Medicare Advantage service area, or under unusual and extraordinary circumstances, services provided when the member is in the service area but the member's PCP is temporarily unavailable or inaccessible, when such services are medically necessary and immediately required as a result of an unforeseen illness, injury or condition; and it is not reasonable given the circumstances to obtain the services through the PCP.

21 FORMS

Forms can also be found on our website <https://providers.amerigroup.com>.

Authorization Form

Submit this completed *Authorization Form* with all supporting documentation to ensure proper processing of your request to adjust claims as detailed below. The adjustments will result in overpayments being withheld from future claims payments.

Provider name	
Provider NPI	
Provider tax identification number	
Provider contact information	
Cost Containment project number (if applicable)	
Document identification number (if applicable)	
Total recoupment dollar amount	

Please list claim information below if the *Cost Containment Letter* or other supporting claim/member detail is not provided with this request.

Claim number	Member number	Service dates	Recoupment amount
Recoupment reason			
Claim number	Member number	Service dates	Recoupment amount
Recoupment reason			
Claim number	Member number	Service dates	Recoupment amount
Recoupment reason			

Claim number	Member number	Service dates	Recoupment amount
Recoupment reason			
Claim number	Member number	Service dates	Recoupment amount
Recoupment reason			
Claim number	Member number	Service dates	Recoupment amount
Recoupment reason			

If your request for recoupment exceeds the space provided, please attach an excel file that includes all the data noted above. For questions related to the completion of this form, please call Provider Services at 1-800-454-3730.

I authorize Amerigroup to proceed with adjusting the claims as listed on this form or per separate document that supports this request.

Print name

Signature

Mail this form to:

Attn: Cost Containment – Disputes

Amerigroup

P. O. Box 62427

Virginia Beach, VA 23466-2437

Note: Do not use this form if you are submitting a refund check. If you would like to submit a refund, please use the *Refund Notification Form* on the provider website. Mail a check along with the supporting documentation to:

Attn: Cost Containment – Payments

Amerigroup

P.O. Box 933657

Atlanta, GA 31193-3657

Overpayment Refund Notification Form

In order for an overpayment refund to be processed in a timely manner, please submit a completed form with all refund checks and supporting documentation. If the refund check you are submitting is an Amerigroup check, please include a completed form specifying the reason for the check return.

Provider name/contact	
Contact number	
Provider ID	
Provider tax ID	
Subscriber ID	
DCN number (Displayed on CCU Letter)	
Member name	
Member account number	
Date of service	
Total billed charges	

Total check amount: \$ _____

Claim number(s):

Reason for refund or check return:

- ☐ Health plan letter
- ☐ Contract rate change
- ☐ Duplicate payment
- ☐ Incorrect member
- ☐ Incorrect provider
- ☐ Negative balance
- ☐ Other health insurance/third-party liability
- ☐ Payment error
- ☐ Billed in error/adjusted charge
- ☐ Other: _____

All refund checks should be mailed with a copy of this form to:

Amerigroup
 P.O. Box 933657
 Atlanta, GA 31193-3657

Once the Cost Containment Unit has reviewed the overpayment, you will receive a letter explaining the details of the reconciliation. Thank you for completing this *Overpayment Refund Notification Form*.

