



An Anthem Company



# STAR Kids Provider Manual

Amerigroup Insurance Company

Dallas, El Paso, Harris, Lubbock and Medicaid Rural Service Area West



TEXAS  
Health and Human  
Services



1-800-454-3730

<https://providers.amerigroup.com/tx>

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# 1 INTRODUCTION AND DEFINITIONS

Welcome to the Amerigroup provider family. We are pleased that you are part of our network, which represents some of the finest health care providers in the state. As a leader in managed health care services for the public sector, we believe hospitals, physicians and other providers play a pivotal role in managed care. We 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. This manual is designed to assist you with providing quality care to our members. The information in this manual may be updated periodically and changed as needed.

## 1.1 Who is Amerigroup?

Amerigroup refers to both Amerigroup Texas, Inc. and Amerigroup Insurance Company. Amerigroup members in the Medicaid Rural Service Area (RSA) and the STAR Kids program are served by Amerigroup Insurance Company. All other Amerigroup members are served by Amerigroup Texas, Inc. Amerigroup Texas, Inc. is a licensed health maintenance organization (HMO). Amerigroup Insurance Company is a licensed indemnity plan. As a leader in managed health care services for the public sector, the Amerigroup subsidiary health plans provide health care coverage exclusively to low-income families, children, pregnant women, elderly, and disabled persons. Amerigroup also offers Medicare Advantage, including Medicare special needs plans, and participates in the Medicare-Medicaid Dual Demonstration program (MMP). For more information on all the programs Amerigroup offers in Texas, please refer to the other provider manuals available on the provider website:

- *Medicaid and Children's Health Insurance Program (CHIP) Provider Manual*
- *STAR+PLUS Nursing Facility Provider Manual*
- *Medicare Advantage Provider Manual*
- *STAR+PLUS Medicare-Medicaid Plan (MMP) Provider Manual*

We offer these programs in the following service areas (SAs) across Texas:

| Service Area          | STAR | STAR+PLUS | STAR Kids | CHIP | Medicare Advantage | MMP |
|-----------------------|------|-----------|-----------|------|--------------------|-----|
| Bexar                 | X    | X         |           | X    | X                  | X   |
| Dallas                | X    |           | X         | X    |                    |     |
| El Paso               |      | X         | X         |      | X                  | X   |
| Harris                | X    | X         | X         | X    | X                  | X   |
| Jefferson             | X    | X         |           | X    | X                  |     |
| Lubbock               | X    | X         | X         |      | X                  |     |
| Tarrant               | X    | X         |           | X    | X                  | X   |
| Travis                |      | X         |           |      | X                  |     |
| Central Texas Rural   | X    |           |           |      |                    |     |
| Northeast Texas Rural | X    |           |           |      |                    |     |
| West Texas Rural      | X    | X         | X         |      |                    |     |



## **1.2 Objectives of the STAR Kids Program**

STAR Kids is a Medicaid managed care program designed specifically for children and young adults with special needs. Most individuals 20 years old and younger who get supplemental security income (SSI) Medicaid or home- and community-based waiver services will receive some or all of their Medicaid services through STAR Kids. Children enrolled in STAR Kids will receive comprehensive service coordination.

Objectives of the STAR Kids program include:

- Provide Medicaid benefits that are customized to meet the health care needs of recipients through a defined system of care
- Better coordinate care of recipients
- Improve health outcomes
- Improve access to health services
- Achieve cost containment and cost efficiency
- Reduce administrative complexity
- Reduce potentially preventable events, including out-of-home residential care, through provision of care management and appropriate services

## **1.3 Our Mission and Goals**

Our mission is to operate a community-focused managed care company with an emphasis on the public sector health care market. We will coordinate our members' physical and behavioral health care, offering a continuum of education, access, care, and outcome programs, resulting in lower cost, improved quality, and better health for Americans.

Our goals are to:

- Improve access to preventive primary care services by ensuring the selection of a primary care provider who will serve as provider, care manager and coordinator for all basic medical services
- Improve the health status 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
- Discourage medically inappropriate 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 mechanisms that actively involve providers in re-engineering health care delivery
- Encourage a customer service orientation with regular measurement of member and provider satisfaction

#### **1.4 Role of Primary Care Providers (Medical Home)**

The role of the primary care provider is to provide a medical home for members. The primary care provider is also responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

Members that are eligible for both Medicare and Medicaid will receive primary care from their Medicare plan and will not select a Medicaid primary care provider.

Additional information is available in the [Provider Rights and Responsibilities](#) chapter of this manual.

#### **1.5 Role of a Health Home**

A Health Home is a provider practice that manages all of the health care a person needs – physical, mental, and social. The range of Health Home services and supports is more than is normally offered by a primary care provider. This type of care can be of great benefit to persons with one or more serious and ongoing mental or health conditions. The provider practice can be a primary care practice or, in some cases, a specialty care practice. A Health Home uses a team-based approach to care to improve access, coordination between providers, and quality of care.

We will provide access to a Health Home for any member who asks for this service and for any member who would benefit from this type of care. Some of the main kinds of Health Home services are:

- Comprehensive case management
- Care coordination
- Patient self-management education and health promotion
- Transitional care from inpatient or emergency room
- Patient and family-centered care with patient and family support
- Referral to community and social support services
- Use of health information to link services

#### **1.6 Role of Specialty Care Providers**

The role of the specialty care provider is to meet the medical specialty needs of members and provide all medically necessary covered services. Specialty care providers coordinate care with the member's medical home provider. Specialty care providers include behavioral health providers.

Additional information is available in the [Provider Rights and Responsibilities](#) chapter of this manual under [Specialty Care Providers' Roles and Responsibilities](#). Additional information for behavioral health providers is available in the [Behavioral Health Program](#) chapter of this manual.

#### **1.7 Role of Long-term Services and Supports Providers**

Long-term services and supports providers are responsible for, but not limited to, the following:

- Verifying member eligibility
- Obtaining prior authorization for services prior to provision of those services
- Coordinating Medicaid and Medicare benefits

- Notifying us of changes in members' physical condition or eligibility
- Collaborating with the Amerigroup service coordinator in managing members' health care
- Managing continuity of care for members

Additional responsibilities and information are available in the [Long-term Services and Supports](#) chapter of this manual.

## **1.8 Role of Amerigroup Service Coordinator**

Service coordination means specialized care management services that are performed by a licensed, certified, and/or experienced person called a service coordinator. This includes but is not limited to the following activities:

- Identifying a member's needs through an assessment
- Documenting how to meet the member's needs in a care plan
- Arranging for delivery of the needed services
- Establishing a relationship with the member and being an advocate for the member in coordinating care
- Helping with coordination between different types of services
- Making sure the member has a primary care provider

A service coordinator works as a team with the member and the primary care provider to arrange all the services that the member needs to receive, including services from specialists and behavioral health providers (if needed). A service coordinator helps make sure all of the member's health care needs are met.

## **1.9 Role of Amerigroup Transition Specialist**

A transition specialist is an Amerigroup employee who works with adolescent and young adult members and their support network to prepare the member for a successful transition out of STAR Kids and into adulthood. A transition specialist is wholly dedicated to counseling and educating members and others in their support network about issues and resources for transitioning out of STAR Kids after the member's 21<sup>st</sup> birthday. A transition specialist will work with the member's service coordinator to conduct ongoing transition planning activities starting at age 15.

## **1.10 Role of Pharmacy**

Our pharmacy benefit provides coverage for medically necessary medications from licensed prescribers for the purpose of saving lives in emergency situations, for treatment of short-term illness, sustaining life in chronic or long-term illness, or limiting the need for hospitalization. Members have access to most national pharmacy chains and many independent retail pharmacies.

Pharmacy providers are responsible for, but not limited to, the following:

- Filling prescriptions in accordance with the benefit design
- Adhering to the Vendor Drug Program (VDP) formulary and Preferred Drug List (PDL)
- Coordinating with the prescribing physician
- Ensuring members receive all medication for which they are eligible

- Coordinating benefits when a member also receives Medicare Part D services or other insurance benefits
- Providing a 72-hour emergency supply of prescribed medication any time a prior authorization is not available, if the prescribing provider cannot be reached or is unable to request a prior authorization and a prescription must be filled without delay for a medical condition

### **1.11 Role of Main Dental Home**

A member of a managed care dental plan (DMO) may choose a main dental home. A dental plan will assign each member to a main dental home if he or she does not timely choose one. Whether chosen or assigned, each member of a DMO who is 6 months or older must have a designated main dental home.

A main dental home serves as the member's main dentist for all aspects of oral health care. The main dental home has an ongoing relationship with that member to provide comprehensive, continuously accessible, coordinated, and family-centered care. The main dental home provider also makes referrals to dental specialists when appropriate. Federally Qualified Health Centers (FQHCs) and individuals who are general dentists and pediatric dentists can serve as main dental homes.

### **1.12 Network Limitations**

Providers with the following specialties can apply for enrollment with us as primary care providers:

- General practice
- Family practice
- Internal medicine
- Pediatrics
- Obstetrics/gynecology (OB/GYN)
- Advanced practice registered nurses (APRNs) and physician assistants (PAs), when APRNs and PAs are practicing under the supervision of a physician specializing in family practice, internal medicine, pediatrics or OB/GYN, who also qualifies as a primary care provider
- FQHCs
- Rural health clinics (RHCs) and similar community clinics

STAR Kids providers must maintain active Texas Provider Identifiers with the Texas Medicaid & Healthcare Partnership in one of the specialties listed above to serve as a primary care provider.

Specialist physicians may be willing to provide a medical home to selected members with special needs and conditions. Information regarding the circumstances in which a specialist can be designated as a primary care provider is available under the [Specialist as a Primary Care Provider](#) section of this manual.

### **1.13 Definitions**

#### **1915(i) Home and Community Based Services-Adult Mental Health (HCBS-AMH)**

Home and Community Based Services-Adult Mental Health (HCBS-AMH) is a state-wide program that provides home and community-based services to adults with serious mental illness. The HCBS-AMH program provides an array of services, appropriate to each member's needs, to enable him or her to live

and experience successful tenure in their chosen community. Services are designed to support long term recovery from mental illness.

#### **Community Living Assistance and Support Services (CLASS) Waiver Program**

The Community Living Assistance and Support Services (CLASS) program provides home and community-based services to people with related conditions as a cost-effective alternative to an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). A related condition is a disability, other than an intellectual disability, that originated before age 22 that affects the ability to function in daily life.

#### **Deaf Blind with Multiple Disabilities (DBMD) Waiver Program**

The Deaf Blind with Multiple Disabilities (DBMD) program provides home and community-based services to people who are deaf, blind and have another disability. This is a cost-effective alternative to an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). The DBMD program focuses on increasing opportunities for consumers to communicate and interact with their environment.

#### **Dual-Eligible**

Medicaid recipients who are also eligible for Medicare.

#### **Home and Community-based Services (HCS) Waiver Program**

The Home and Community-based Services (HCS) program provides individualized services and supports to people with intellectual disabilities who are living with their families, in their own homes or in other community settings, such as small group homes where no more than four people live. The local authority provides service coordination.

**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)** means an Intermediate Care Facility for Individuals with Intellectual Disabilities or related conditions that provides residential care and services for those individuals based on their functional needs.

#### **Long Term Services and Supports (LTSS)**

LTSS means assistance with daily healthcare and living needs for individuals with a long-lasting illness or disability.

#### **Medical Dependent Children Program (MDCP) Waiver Program**

The Medically Dependent Children Program (MDCP) provides services to support families caring for children who are medically dependent and encourages the transition of children in nursing homes back to the community.

#### **Texas Home Living (TxHmL) Waiver Program**

The Texas Home Living (TxHmL) program provides selected essential services and supports to people with an intellectual disability or a related condition who live in their own home or their family's home.

#### **Youth Empowerment Services (YES) Waiver Program**

The Youth Empowerment Services (YES) waiver provides comprehensive home and community-based mental health services to youth between the ages of 3 and 18, up to a youth's 19th birthday, who have a

serious emotional disturbance. The YES Waiver not only provides flexible supports and specialized services to children and youth at risk of institutionalization and/or out-of-home placement due to their serious emotional disturbance, but also strives to provide hope to families by offering services aimed at keeping children and youth in their homes and communities.

## 2 QUICK REFERENCE INFORMATION

| Quick reference topic         | Description  |
|-------------------------------|--|
| Provider Services             | For more information, call Provider Services at 1-800-454-3730; Fax: 1-800-964-3627.   |
| Amerigroup website            | <p><a href="https://providers.amerigroup.com/TX">https://providers.amerigroup.com/TX</a><br/> <a href="http://www.Availity.com">www.Availity.com</a></p> <p>These sites feature tools for real-time eligibility inquiry, claims submission/status/appeals, and precertification requests/status/appeals. In addition, the sites offer general information and various tools that are helpful to the provider such as:</p> <ul style="list-style-type: none"> <li>• Preferred drug list</li> <li>• List of drugs requiring prior authorization</li> <li>• Provider manuals</li> <li>• Referral directories</li> <li>• Provider newsletters</li> <li>• Precertification Lookup Tool</li> <li>• Electronic remittance advice and electronic funds transfer information</li> <li>• Health plan and industry updates</li> <li>• Clinical practice guidelines</li> <li>• Downloadable forms (including administrative forms)</li> </ul>  |
| Notification/Precertification | <p>May be submitted as indicated below:</p> <p>Inpatient/outpatient surgeries and other general requests fax: 1-800-964-3627</p> <p>Behavioral Health fax – inpatient: 1-877-434-7578</p> <p>Behavioral Health fax – outpatient: 1-800-505-1193</p> <p>Mental Health Rehabilitative and Targeted Case Management services fax: 1-866-877-5229</p> <p>Durable medical equipment (DME) fax: 1-866-249-1271</p> <p>Therapy (physical/occupational/speech) fax: 1-866-249-1271</p> <p>Back and spine procedures fax: 1-800-964-3627</p> <p>Pain management injections fax: 1-866-249-1271</p> <p>Radiology (high-tech) phone: 1-800-714-0040 (AIM Specialty Health)<br/> <a href="http://www.aimspecialtyhealth.com/goweb">www.aimspecialtyhealth.com/goweb</a></p> <p>Home health nursing (other than long-term services and supports) fax: 1-866-249-1271</p> <p>STAR Kids long-term services and supports fax: 1-844-756-4604</p> <p>Nonemergent transportation (other than ambulance) phone: 1-855-295-1636 (Access2Care)</p> <p>Nonemergent ambulance transportation: Refer to the <a href="#">Ambulance Transportation Services (Nonemergent)</a> section of this manual</p> <p>Telephone (if urgent): 1-800-454-3730</p> <p>Website: <a href="https://providers.amerigroup.com/TX">https://providers.amerigroup.com/TX</a></p> <p>Precertification forms are located at <a href="https://providers.amerigroup.com/TX">https://providers.amerigroup.com/TX</a>. The following is required for notification/precertification:</p> <ul style="list-style-type: none"> <li>• Member ID number</li> <li>• Legible name of referring provider and NPI</li> <li>• Legible name of individual referred to provider and NPI</li> <li>• Number of visits/services</li> <li>• Date(s) of service</li> <li>• Diagnosis</li> <li>• CPT/HCPCS codes</li> <li>• Copy of physician's order for services by ancillary providers</li> </ul> |

| Quick reference topic              | Description  |
|------------------------------------|--|
| NPI                                | <p>The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the adoption of a standard, unique provider identifier for health care providers. All Amerigroup participating providers must have an NPI number. 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 states in which they practice or their specialties.</p> <p>For more information about NPIs and the application process, please visit <a href="https://nppes.cms.hhs.gov">https://nppes.cms.hhs.gov</a>.</p> <p>You can complete the application online (estimated time to complete the NPI application is 20 minutes), download a paper application for completion, or call 1-800-465-2003 to request an application.</p>  |
| Claims                             | <p>Electronic claims payer IDs:</p> <ul style="list-style-type: none"> <li>• Emdeon: 27514</li> <li>• Caprio: 28804</li> <li>• Availity: 26375</li> <li>• Smart Data Solutions: 81237</li> </ul> <p>Submit paper claims to:</p> <p>Amerigroup<br/>PO Box 61010<br/>Virginia Beach, VA 23466-1010</p> <p>Timely filing is within 95 days from the date of service, or per the terms of the provider agreement. We provide an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status, and precertification status. Visit our websites at <a href="https://providers.amerigroup.com/TX">https://providers.amerigroup.com/TX</a> and <a href="http://www.Availity.com">www.Availity.com</a>.</p> <p>If you are unable to access the Internet, you may receive claims, eligibility, and precertification status over the phone at any time by calling Provider Services at 1-800-454-3730.</p> |
| Medical appeals                    | <p>Medical appeals can be initiated by the member or the provider, on behalf of the member with the member's signed consent, and must be submitted within 30 calendar days from receipt of an adverse determination. Be sure to include medical charts or other supporting information. Medical appeals must be submitted in writing to:</p> <p>Amerigroup Appeals<br/>2505 N. Highway 360, Suite 300<br/>Grand Prairie, TX 75050</p>  |
| Payment appeals                    | <p>A provider has 120 days from the date of an Explanation of Payment (EOP) to file a payment appeal. Send payment appeals to:</p> <p>Provider Payment Appeals<br/>Amerigroup<br/>PO Box 61599<br/>Virginia Beach, VA 23466-1599<br/>Fax : 1-844-756-4607</p> <p>Providers can also utilize the online payment appeal tool at <a href="http://www.Availity.com">www.Availity.com</a>.</p>  |
| Complaints                         | <p>Provider complaints can be submitted to:</p> <p>Amerigroup<br/>PO Box 61789<br/>Virginia Beach, VA 23466-1789<br/>Fax : 1-844-664-7179<br/>By email at <a href="https://providers.amerigroup.com/TX">https://providers.amerigroup.com/TX</a></p>  |
| Case managers/service coordinators | <p>Our case managers/service coordinators are available from 8 a.m. to 5 p.m. Central time by calling 1-866-696-0710 or Provider Services at 1-800-454-3730. For urgent issues, assistance is available after normal business hours, during weekends, and on holidays through Provider Services at 1-800-454-3730.</p>   |



| Quick reference topic  | Description  |
|--|--|
| Interpreter services   | Telephonic services for those who are deaf or hard of hearing: 711<br>Telephonic services for non-English speaking people: 1-800-454-3730 (language line available)<br>In-person interpretation: 1-800-454-3730                              |
| Behavioral Health services   | 1-800-454-3730   |
| Dental services  | Members 20 years old and younger receive dental services through one of the dental maintenance organizations listed below: <ul style="list-style-type: none"> <li>DentaQuest: 1-800-516-0165</li> <li>MCNA Dental: 1-800-494-6262</li> </ul> |
| 24-hour Nurse HelpLine   | 1-844-756-4600 (TTY 711)   |
| Member Services  | 1-844-756-4600 (TTY 711)   |
| AIM Specialty Health (hi-tech radiology precertification)  | 1-800-714-0040<br><a href="http://www.aimspecialtyhealth.com/goweb">www.aimspecialtyhealth.com/goweb</a>   |
| Pharmacy services  | Pharmacy prior authorization fax : 1-800-601-4829<br>Phone: 1-855-215-4496 (Express Scripts)   |
| Vision services  | Superior Vision of Texas: 1-866-819-4298 for providers and 1-800-428-8789 for members  |
| Electronic data interchange (EDI) hotline  | 1-800-590-5745   |
| Availity Web Portal (for claim filing, claim status inquiries, member eligibility, and benefits information) | <a href="http://www.Availity.com">www.Availity.com</a><br>1-800-AVAILITY (1-800-282-4548)<br>support@Availity.com  |
| Enrollment/disenrollment   | 1-800-964-2777   |
| STAR Kids Help Line  | 1-800-964-2777   |
| Medical Transportation Program (MTP)   | 1-877-633-8747 All areas except Dallas/Fort Worth/Houston/Beaumont<br>1-855-687-3255 Dallas/Fort Worth area<br>1-855-687-4786 Houston/Beaumont area  |
| Access2Care (nonemergent transportation other than ambulance, when MTP is not available)                     | 1-855-295-1636   |
| Texas Health Steps program   | 1-877-847-8377   |

### 3 MEMBER ELIGIBILITY

Eligibility for STAR Kids is determined by the Texas Health and Human Services Commission (HHSC). Once eligible, members enroll into a managed care organization in their area through the administrative services contractor. The eligibility criteria for STAR Kids benefits are:

- Receives Supplemental Security Income (SSI), but is not enrolled in a state waiver program
- Enrolled in the Medically Dependent Children Program (MDCP)
- Enrolled in the Youth Empowerment Services (YES) waiver
- Enrolled in an IDD waiver program:
  - Community Living Assistance and Support Services (CLASS)
  - Deaf-Blind with Multiple Disabilities (DBMD)
  - Home- and Community-Based Services (HCS)
  - Texas Home Living (TxHmL)

#### 3.1 Verifying Member Medicaid Eligibility and MCO Enrollment

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the patient has current Medicaid coverage. Providers should verify the patient's Medicaid eligibility and MCO enrollment for the date of service prior to services being rendered. There are several ways to do this:

- Swipe the patient's Your Texas Benefits Medicaid card through a standard magnetic card reader, if your office uses that technology
- Use TexMedConnect on the TMHP website at [www.tmhp.com](http://www.tmhp.com)
- Call the Your Texas Benefits provider helpline at 1-855-827-3747
- Call Provider Services at the patient's medical or dental plan

**Important:** Do not send patients who forgot or lost their cards to an HHSC benefits office for a paper form. They can request a new card by calling 1-855-827-3748. Medicaid members also can go online to order new cards or print temporary cards.

**Important:** Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by clients or proof of client eligibility from the Your Texas Benefits Medicaid card website at [www.YourTexasBenefitsCard.com](http://www.YourTexasBenefitsCard.com). A copy is required during the appeal process if the client's eligibility becomes an issue.

##### 3.1.1 Your Texas Benefits Medicaid Card

A person approved for Medicaid will get a Your Texas Benefits Medicaid card. This is a plastic card with a magnetic strip that holds the member's Medicaid ID number. A member will only be issued one card, and will only receive a new card if their card is lost or stolen. If the card is lost or stolen, a member can get a new one by calling 1-855-827-3748.

The Your Texas Benefits Medicaid card has these facts printed on the front:

- Member's name and Medicaid ID number

- The date the card was sent to the member
- The name of the Medicaid program if the member gets:
  - Medicare (QMB, MQMB)
  - Texas Women’s Health Program (TWHP)
  - Hospice
  - STAR Health
  - Emergency Medicaid
  - Presumptive Eligibility for Pregnant Women (PE)
- Facts a drugstore will need to bill Medicaid
- The name of the member’s doctor and drugstore if the member is in the Medicaid Lock-in Program

The back of the Your Texas Benefits Medicaid card has a website the member can visit ([www.yourtexasbenefits.com](http://www.yourtexasbenefits.com)) and a phone number they can call toll-free (1-800-252-8263) if there are questions about the card. State-issued ID cards are subject to change without notice.

### **3.1.2 Temporary ID Verification Form**

If the member lost or does not have access to their Your Texas Benefits Medicaid card and needs a temporary one, a temporary verification form (Form 1027-A) can be obtained by calling the local HHSC benefits office. Providers must accept this form as proof of Medicaid eligibility but current coverage should be verified as described in [Verifying Member Medicaid Eligibility](#). Members can also go to [www.yourtexasbenefits.com](http://www.yourtexasbenefits.com) to order a new card or print a temporary card.

### **3.1.3 Additional Documentation and Verification**

In addition to the procedures in [Verifying Member Medicaid Eligibility](#), we suggest providers:

- Photocopy the member’s eligibility identification and retain copies in the member’s file.
- Review the current monthly roster/panel of patients assigned to your practice to determine if the patient’s name and Medicaid number appear on the list (for primary care providers only).

## **3.2 Amerigroup Member Identification Card**

Amerigroup member identification card samples are available in [Appendix A](#). We now offer members the option of downloading a free digital version of their member ID cards to their Apple iOS or Android-based smartphones and tablets. Members can show their mobile ID card as proof of coverage. Providers should treat the digital version the same as the original plastic card.

For STAR Kids dual-eligible members who have Medicare, a primary care provider is not listed on the Amerigroup ID card. Instead, the phrase **Long-term Services and Supports Benefits Only** is listed. Medicare is responsible for primary, acute, and behavioral health care services; therefore, the primary care provider’s name, address, and telephone number are not listed. The member receives long-term services and supports through Amerigroup.

### 3.3 Service Responsibility

#### 3.3.1 STAR Kids Responsibility Table

| Type of service                 | Medicaid coverage only            | Medicaid and Medicare coverage (dual eligible)  |
|---------------------------------|-----------------------------------|---|
| Medical and behavioral health   | Amerigroup                        | Medicare fee-for-service (FFS) or Medicare HMO  |
| Long-term services and supports | Amerigroup and/or waiver program* | Amerigroup and/or waiver program*               |
| Prescription drugs              | Amerigroup                        | Member's chosen Part D prescription drug vendor |
| Transportation coverage         | MTP                               | Medicare FFS or Medicare HMO                    |
| Medicare copays and deductibles | Not applicable                    | Amerigroup                                      |
| Medicaid wrap-around services   | Not applicable                    | State's fiscal agent (TMHP)                     |

\* See the chapter on [Long-term Services and Supports](#) for specific responsibility information.

#### 3.3.2 Newborns

If a newborn is born to a Medicaid-eligible mother enrolled in STAR Kids, the HHSC administrative service contractor will enroll the newborn into the STAR program in the same health plan as the mother (if available in the service area). The newborn will remain enrolled in the mother's health plan for at least 90 days from the date of birth. All rules related to STAR newborn enrollment will apply to the newborn.

If the mother's health plan does not offer a STAR plan in the service area, the newborn will be placed in Medicaid FFS until the mother chooses a STAR plan.

### 3.4 Member Enrollment and Disenrollment from Amerigroup

STAR Kids members may enroll in or disenroll from Amerigroup at any time. If a member asks how to enroll in or disenroll from Amerigroup, the provider can direct the member to either method below:

- Call the state enrollment broker (MAXIMUS) at 1-800-964-2777
- Write to MAXIMUS at the STAR Kids program at MAXIMUS, STAR Kids Program, PO Box 149219, Austin, TX 78714-9965

The effective date of an enrollment or disenrollment is generally no later than the first day of the second month following the month in which a completed enrollment or disenrollment form was received by MAXIMUS. The examples below illustrate how to determine the effective date of an enrollment or disenrollment:

| Example   | Effective date |
|---|----------------|
| MAXIMUS receives the enrollment or disenrollment form by January 15                     | February 1     |
| MAXIMUS receives the enrollment or disenrollment form between January 16 and January 31 | March 1        |

### **3.4.1 Medicaid Automatic Re-enrollment**

Members who are disenrolled because they are temporarily ineligible for Medicaid are automatically re-enrolled in the same HMO. The member may elect to change HMOs at any time. Temporary loss of eligibility is defined as a period of 6 months or less. We notify our members of this procedure through our member handbooks and newsletters.

### **3.4.2 Medicaid Managed Care Program Disenrollment**

Members who request disenrollment from the mandated managed care program to move back into FFS require medical documentation from the primary care provider and/or specialist. HHSC renders a final decision on these types of requests. Providers cannot take retaliatory action against a member who decides to disenroll from Amerigroup.

### **3.4.3 Medicaid Enrollment Changes Due to SSI Status**

When a child STAR member becomes qualified for SSI, the member will move to STAR Kids.

### **3.4.4 Members Enrolled in the DADS Hospice Program**

When a STAR Kids member becomes enrolled in the DADS Medicaid Hospice Program, the member will remain enrolled in managed care with Amerigroup. We will cover services unrelated to the member's terminal illness and furnish case management coordination.

## **3.5 Span of Coverage (Hospital) - Responsibility During a Continuous Inpatient Stay<sup>1</sup>**

If a member is disenrolled from a STAR Kids MCO and enrolled in another STAR Kids MCO during an inpatient stay, then the former STAR Kids MCO will pay all facility charges until the member is discharged from the hospital, residential substance use disorder treatment facility, or residential detoxification for substance use disorder treatment facility, or until the member loses Medicaid eligibility. The new STAR Kids MCO will be responsible for all other covered services on the effective date of coverage with the STAR Kids MCO.

|   | <b>Scenario</b>   | <b>Hospital facility charge</b> | <b>All other covered services</b> |
|---|---|---------------------------------|-----------------------------------|
| 1 | Member moves from FFS to STAR Kids                            | FFS                             | New MCO                           |
| 2 | Member moves from STAR, STAR Health or STAR+PLUS to STAR Kids | Former MCO                      | New MCO                           |
| 3 | Member moves from CHIP to STAR Kids                           | New MCO                         | New MCO                           |
| 4 | Adult member moves from STAR Kids to STAR or STAR+PLUS        | Former STAR Kids MCO            | New STAR or STAR+PLUS MCO         |
| 5 | Member moves from STAR Kids to STAR Health                    | Former STAR Kids MCO            | New STAR Health MCO               |
| 6 | Member retroactively enrolled in STAR Kids                    | New MCO                         | New MCO                           |
| 7 | Member moves between STAR Kids MCOs                           | Former MCO                      | New MCO                           |

<sup>1</sup> This document is not intended to supersede any HHSC contract.

This is a reference tool determining the span of coverage limitation.

For up to date references, please see the STAR Kids contract.

### ***3.5.1 Responsibility for Enrollment Changes with Custom DME and Augmentative Device Prior Authorization***

The following table describes payment responsibility for Medicaid enrollment changes that occur when a prior authorization exists for custom DME, before the delivery of the product.

| Scenario                               | Custom DME | All other covered services |
|--|------------|----------------------------|
| Member moves between STAR Kids MCOs    | Former MCO | New MCO                    |
| Member moves from FFS to STAR Kids MCO | New MCO    | New MCO                    |

### ***3.5.2 Responsibility for Enrollment Changes with Home Modification***

The following table describes payment responsibility for Medicaid enrollment changes that occur during a minor home modification service provided to an MDCP STAR Kids waiver member, before completion of the modification.

| Scenario                            | Minor home modification | All other covered services |
|-------------------------------------|-------------------------|----------------------------|
| Member moves between STAR Kids MCOs | Former MCO              | New MCO                    |

## 4 COVERED SERVICES AND EXTRA BENEFITS

### 4.1 Medicaid Covered Services for STAR Kids

Our coverage of STAR Kids members includes medically necessary services as outlined for the Medicaid FFS program in the Texas Medicaid Provider Procedures Manual (TMPPM), enhanced pharmacy and inpatient coverage, and extra benefits. The table below compares covered services of STAR Kids to traditional FFS Medicaid.

| Covered services  | STAR Kids | Traditional Medicaid FFS |
|---|-----------|--------------------------|
| Core Medicaid benefits as outlined in the Medicaid FFS program (listed below in <a href="#">Acute Care Services Core Medicaid Services</a> )  | X         | X                        |
| Waiver of the 3-prescription-per-month limit (unlimited prescriptions are only available for members not covered by Medicare)   | X         |                          |
| Waiver of the 30-day spell-of-illness limitation under FFS  | X         |                          |
| Extra or value-added benefits   | X         |                          |
| Notes: <ul style="list-style-type: none"><li>STAR Kids dual-eligible members receive their acute care services coverage through Medicare.</li><li>The \$200,000 annual limit on inpatient services does not apply to STAR Kids members.</li></ul> |           |                          |

Covered services are subject to change in accordance with Texas Medicaid requirements. Modifications to covered services are communicated through provider mailings, faxes, newsletters, and/or provider contractual amendments. Medicaid members do not have deductibles or copays for Medicaid covered services, and providers are prohibited from balance billing for Medicaid covered services.

#### 4.1.1 Nondual-Eligible Members

We will cover STAR Kids acute care and long-term services and supports benefits for members who are not eligible for Medicare (Medicaid only).

#### 4.1.2 Dual-Eligible Members

Acute care for dual-eligible members is covered by Medicare or a Medicare HMO. STAR Kids members who are covered by both Medicaid and Medicare will receive most prescription drug services through Medicare. Dual-eligible members receive coverage for STAR Kids long-term services and supports benefits.

#### 4.1.3 STAR Kids Long-term Services and Supports and Waiver Program Benefits

STAR Kids long-term services and supports covered services are based on how the individual qualifies for membership. The member types are:

- Receives Supplemental Security Income (SSI), but is not enrolled in a state waiver program

- Enrolled in the Medically Dependent Children Program (MDCP)
- Enrolled in the Youth Empowerment Services (YES) waiver
- Enrolled in an IDD waiver program:
  - Community Living Assistance and Support Services (CLASS)
  - Deaf-Blind with Multiple Disabilities (DBMD)
  - Home and Community-Based Services (HCS)
  - Texas Home Living (TxHmL)

#### **4.1.4 Acute Care Services (Core Medicaid Services)**

STAR Kids covered acute care services include, but are not limited to, medically necessary:

- Ambulance services – emergency and nonemergency transportation
- Audiology services, including hearing aids
- Behavioral health services, including:
  - Inpatient mental health services (services may be provided in a free-standing psychiatric hospital in lieu of an acute care inpatient setting)
  - Outpatient mental health services
  - Psychiatry services
  - Mental health rehabilitative services
  - Outpatient substance use disorder treatment services, including:
- Assessment
- Detoxification services
- Counseling treatment
- Medication assisted therapy
  - Residential substance use disorder treatment services including:
    - Detoxification services
    - Room and board
- Birthing services provided by a physician and certified nurse-midwife in a licensed birthing center
- Birthing services provided by a licensed birthing center
- Cancer screening, diagnostic, and treatment services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Early childhood intervention (ECI) services
- Emergency services
- Family planning services
- Home health care services
- Hospital services, including inpatient and outpatient
- Laboratory services
- Mastectomy, breast reconstruction, and external breast prosthesis related follow-up procedures, including:
  - Inpatient services, outpatient services provided at an outpatient hospital or ambulatory health care center as clinically appropriate, and physician and professional services provided in an office, inpatient, or outpatient setting for:



- All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed
  - Surgery and reconstruction on the other breast to produce symmetrical appearance
  - Treatment of physical complications from the mastectomy and treatment of lymphedemas
  - Prophylactic mastectomy to prevent the development of breast cancer
- External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed; surgery and reconstruction on the other breast to produce symmetrical appearance
- Medical checkups and Comprehensive Care Program (CCP) services through the Texas Health Steps program
- Mental health targeted case management
- Oral evaluation and fluoride varnish in the medical home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age
- Podiatry
- Prenatal care
- Prescription drugs, medications, and biologicals including pharmacy-dispensed and provider-administered outpatient drugs and biologicals
- Primary care services
- Radiology, imaging, and X-rays
- Specialty physician services
- Telehealth
- Telemonitoring to the extent covered by Texas Government Code §531.01276
- Therapies – physical, occupational, and speech
- Transplantation of organs and tissues
- Vision – includes optometry and glasses; contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses

#### **4.1.5 STAR Kids Coverage Table**

The chart on the next page provides an overview of STAR Kids benefits by type and category of coverage. For the YES and IDD member types, the waiver programs provide some of the long-term services and supports benefits. See the chapter on [Long-term Services and Supports](#) for more information.

| Service types<br>Checkmarks (✓) represent<br>benefits that are covered by<br>Amerigroup   | SSI recipient not in a<br>waiver program   | MDCP                                       | YES waiver  | IDD (CLASS, DBMD, HCS,<br>or TxHmL) waiver            |
|---|--|--|---|---|
| Medical (such as doctor’s visits<br>and hospital services) and<br>behavioral health services  | ✓  | ✓  | ✓   | ✓   |
| Prescription drugs  | ✓  | ✓  | ✓   | ✓   |
| Medicare cost sharing   | ✓  | ✓  | ✓   | ✓   |
| For members covered by both Medicaid and Medicare, Medicare is the primary coverage for medical and behavioral health care services and prescription drugs. |  |  |   |   |
| Long-term services and supports   |  |  |   |   |
| The member should contact a service coordinator or call Member Services to find out if they qualify for services.   |  |  |   |   |
| Personal care services (PCS)  | ✓  |  |   |   |
| Private duty nursing (PDN)  | ✓  | ✓  | ✓   | ✓   |
| Day activity and health<br>services (DAHS) (ages 18 and<br>over)  | ✓  | ✓  | ✓   | ✓   |
| Prescribed pediatric extended<br>care (PPECC) services  | ✓  | ✓  | ✓   | ✓   |
| Personal attendant services<br>(CFC)  | CFC only*                                  | ✓  | ✓   | Waiver program<br>determines and<br>provides benefits |
| Habilitation services   | CFC only*                                  | ✓  | ✓   |   |
| Emergency response services<br>(emergency call button)  | CFC only*                                  | ✓  | ✓   |   |
| Support management  | CFC only*                                  | ✓  | ✓   |   |
| Adaptive aids   | Not covered                                | ✓  | Waiver program<br>determines and<br>provides benefits |   |
| Employment assistance   |  | ✓  |   |   |
| Financial management<br>services  |  | ✓  |   |   |
| Flexible family support<br>services   |  | ✓  |   |   |
| Minor home modifications  |  | ✓  |   |   |
| Respite services  |  | ✓  |   |   |
| Supported employment  |  | ✓  |   |   |
| Transition assistance services  |  | ✓  |   |   |
| Transportation assistance for<br>Medicaid-covered services  | Medical<br>Transportation<br>Program (MTP) | Medical<br>Transportation<br>Program (MTP) | Medical<br>Transportation<br>Program (MTP)            | Medical<br>Transportation<br>Program (MTP)            |

\*The member must qualify for Community First Choice benefits.

For members who reside in a nursing facility or an intermediate care facility for individuals with intellectual disabilities (ICF/IID), we will pay for any Amerigroup covered services that are received outside the facility. We will also provide service coordination for the member.

#### **4.1.6 Medicaid Program Exclusions**

The following services are not covered by Amerigroup or traditional FFS Medicaid:

- All services not medically necessary
- All services not provided, approved, or arranged by a network provider or preauthorized by a nonparticipating provider (with the exception of emergency, Texas Health Steps, and family planning services)
- Cosmetic surgery (except when medically necessary)
- Experimental organ transplants
- Infertility treatments and drugs
- Rest cures, personal comfort and convenience items, and services and supplies not directly related to the care of the patient
- Services provided in federally operated facilities
- Other services listed in the TMPPM as noncovered benefits (located at [www.tmhp.com](http://www.tmhp.com))

#### **4.1.7 Coordination with Non-Medicaid Managed Care Covered Services**

In addition to HMO coverage, STAR Kids members are eligible for the services described below. Amerigroup and our network providers are expected to refer to and coordinate with these programs. These services are described in the TMPPM.

- Texas Health Steps dental (including orthodontia) – Medicaid members can get dental benefits through a dental managed care organization
- Texas Health Steps environmental lead investigation (ELI)
- Early Childhood Intervention (ECI) targeted case management (TCM)
- ECI Specialized Skills Training
- Case Management for Children and Pregnant Women
- Texas School Health and Related Services (SHARS)
- Department of Assistive and Rehabilitative Services Blind Children’s Vocational Discovery and Development program
- Tuberculosis services provided by Department of State Health Services (DSHS) approved providers (directly observed therapy and contact investigation)
- Department of Aging and Disability Services (DADS) hospice services
- Health and Human Services Commission’s Medical Transportation Program (MTP):
  - For the Dallas/Fort Worth service delivery area (Collin, Dallas, Denton, Ellis, Erath, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, and Wise counties) call 1-855-687-3255.
  - For the Houston/Beaumont service delivery area (Austin, Brazoria, Chambers, Fort Bend, Galveston, Hardin, Harris, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Newton, Orange, Polk, San Jacinto, Tyler, Walker, Waller, and Wharton counties) call 1-855-687-4786.
  - For all other areas call 1-877-633-8747

- See additional information in the [Medical Transportation Program](#) section of this manual
- Court-ordered commitments to inpatient mental health facilities as a condition of probation
- Nursing facility services and intermediate care facility (ICF) services
- PASRR screenings, evaluations, and specialized services
- DADS or DSHS HCBS waiver programs authorized under Social Security Act §1915(c) including Youth Empowerment Services (YES), Community Living Assistance and Support Services (CLASS), Deaf-Blind with Multiple Disabilities (DBMD), Texas Home Living (TxHmL), and Home and Community-based Services (HCS)

#### **4.1.8 Dental Services**

Amerigroup STAR Kids members are covered for dental services through their core Medicaid benefits. Members select a dental maintenance organization through HHSC's enrollment broker to provide these services.

##### ***Medicaid Nonemergency Dental Services***

Amerigroup is **not responsible** for paying for routine dental services provided to Medicaid members. These services are paid through dental managed care organizations.

Amerigroup is **responsible** for paying for treatment and devices for craniofacial anomalies, and for Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a Texas Health Steps medical checkup for members aged 6 through 35 months.

Medical providers for Texas Health Steps must complete training and become certified to provide the intermediate oral evaluation and fluoride varnish application before providing these services. FQHC providers will be certified at the facility level. Training for certification is available as a free continuing education course on the THSteps website at [www.txhealthsteps.com](http://www.txhealthsteps.com).

The OEFV benefit includes (during a visit) intermediate oral evaluation, fluoride varnish application, dental anticipatory guidance, and assistance with a main dental home choice.

- OEFV is billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup (99381, 99382, 99391, or 99392 medical checkup procedure code)
- OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier and diagnosis code Z00.121 or Z00.129
- Documentation must include all components of the OEFV
- Texas Health Steps providers must assist members with establishing a main dental home (refer to the [How to Help a Member Find Dental Care](#) section of this manual) and document member's main dental home choice in the member's file

A maximum of 6 services may be billed per member lifetime by any provider. There is no additional reimbursement for OEFV services for FQHCs.

For more information, see <http://www.dshs.state.tx.us/dental/OEFV.shtm>.

### ***Medicaid Emergency Dental Services***

Amerigroup is responsible for emergency dental services provided to Medicaid members in a hospital, free standing emergency room, or an ambulatory surgical center setting. We will pay for hospital, physician and related medical services (e.g., anesthesia and drugs) including but not limited to:

- Treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts
- Treatment of oral abscess of tooth or gum origin

#### ***4.1.9 Family Planning***

Family planning services are a covered benefit of the Medicaid program. We cover family planning services, including medically necessary medications, contraceptives, and supplies not covered by the Texas VDP. We reimburse out-of-network family planning providers in accordance with HHSC administrative rules. Except as otherwise noted, no precertification is required for family planning services.

STAR Kids members must be allowed:

- The freedom to choose medically appropriate contraceptive methods.
- The freedom to accept or reject services without coercion.
- To receive services without regard to age, marital status, sex, race or ethnicity, parenthood, handicap, religion, national origin, or contraceptive preference.
- To self-refer for family planning services to any Texas Department of Health-approved family planning provider listed on the web at [www.dshs.state.tx.us/famplan](http://www.dshs.state.tx.us/famplan).

Only members receiving family planning services, not their parents, spouse or any other individual, may consent to the provision of family planning services. Providers cannot require parental consent for minors to receive family planning and must keep family planning use confidential in accordance with applicable privacy laws. However, counseling should be offered to adolescents to encourage them to discuss their family planning needs with a parent, an adult family member, or other trusted adult.

#### ***4.1.10 Pharmacy***

Our pharmacy benefit provides coverage for medically necessary prescriptions from any licensed prescriber for legend and nonlegend medications that appear in the latest revision of the Texas Drug Code Index for Medicaid and CHIP members. Members have access to most national pharmacy chains and many independent retail pharmacies that are contracted with us. Members may obtain their medications at any network pharmacy unless HHSC has placed the member in the Office of Inspector General (OIG) Lock-in Program.

We have contracted with Express Scripts, Inc. (ESI) to process prescription drug claims using a computerized point-of-sale (POS) system. This system gives participating pharmacies online, real-time access to beneficiary eligibility, drug coverage (including prior authorization requirements), prescription limitations, pricing and payment information, and prospective drug utilization review.

### Prescription Limits

All prescriptions are limited to a maximum 34-day supply per fill, and all prescriptions for noncontrolled substances are valid only for 11 refills or 12 months from the date the prescription was written, whichever is less.

### OIG Lock-in Program

The HHSC OIG Lock-in Program restricts, or locks in, a Medicaid member to a designated pharmacy if it finds that the member used drugs covered by Medicaid at a frequency or in an amount that is duplicative, excessive, contraindicated, or conflicting, or that the member's actions indicate abuse, misuse, or fraud. Some circumstances allow a member to be approved to receive medications from a pharmacy other than the lock-in pharmacy. A pharmacy override occurs when Amerigroup approves a member's request to obtain medication at an alternate pharmacy other than the lock-in pharmacy. In order to request a pharmacy override, the member or pharmacy should call Member Services at 1-844-756-4600.

The following are allowable circumstances for pharmacy override approval:

- The member moved out of the geographical area (more than 15 miles from the lock-in pharmacy)
- The lock-in pharmacy does not have the prescribed medication and the medication will not be available for more than 2-3 days
- The lock-in pharmacy is closed for the day and the member needs the medication urgently

### Covered drugs

The Amerigroup pharmacy program utilizes the Texas Medicaid/CHIP VDP formulary and Preferred Drug List (PDL). The PDL is a list of the preferred drugs within the most commonly prescribed therapeutic categories; it is comprised of drug products reviewed and approved by the Texas Pharmacy and Therapeutics (P&T) Committee. Over-the-counter (OTC) medications specified in the Texas State Medicaid plan are included in the PDL and are covered if prescribed by a licensed prescriber. **To prescribe medications that do not appear on the PDL, please call Express Scripts at 1-855-215-4496** for prior authorization. Please refer to the Texas VDP formulary and PDL at [txvendordrug.com](http://txvendordrug.com).

Only those drugs listed in the latest edition of the Texas Drug Code Index (TDCI) are covered. Venosets, catheters, and other medical accessories are not covered and are not included when submitting claims for intravenous and irrigating solutions.

Except for vitamins K and D3, prenatal vitamins, fluoride preparations, and products containing iron in its various salts, we do not reimburse for vitamins and legend and nonlegend multiple-ingredient anti-anemia products.

We may limit coverage of drugs listed in the TDCI per the VDP. Procedures used to limit utilization may include prior approval, cost containment caps, or adherence to specific dosage limitations according to FDA-approved product labeling. Limitations placed on the specific drugs are indicated in the TDCI.

The following are examples of covered items:

- Legend drugs
- Insulin
- Disposable insulin needles/syringes

- Disposable blood/urine/glucose/acetone testing agents
- Lancets and lancet devices
- Compounded medication of which at least one ingredient is a legend drug and listed on the PDL
- Any other drug, which under the applicable state law, may only be dispensed upon the written prescription of a physician or other lawful prescriber and is listed on the PDL
- PDL listed legend contraceptives, except for injectable contraceptives which may be dispensed up to a 90-day supply

### **Prior Authorization Drugs**

Providers are strongly encouraged to write prescriptions for preferred products as listed on the formulary or PDL. If, for medical reasons, a member cannot use a preferred product, providers are required to contact Express Scripts to obtain prior authorization. Examples of medications that require authorization are listed below (**Note:** This list is not all-inclusive and subject to change):

- Drugs not listed on the formulary or PDL, or drugs that require clinical prior authorization
- Self-administered injectable products
- Drugs that exceed certain cost and/or dosing limits (for information on these limits, please contact Express Scripts at 1-855-215-4496)

### **Obtaining Prior Authorization**

To prescribe medications that do not appear on the formulary or PDL or require clinical prior authorization, please submit a request to Express Scripts by fax at 1-800-601-4829, by phone at 1-855-215-4496, or online at <https://providers.amerigroup.com/TX>. For requests by fax, providers should submit a prior authorization request form available on the provider website at <https://providers.amerigroup.com/TX> or by contacting Provider Services at 1-800-454-3730.

Providers must be prepared to supply relevant clinical information regarding the member's need for a nonformulary or nonpreferred product or a medication requiring prior authorization. Only the prescribing physician or a staff representative can request prior authorization. Decisions are based on medical necessity and are determined according to VDP-established medical criteria. Approved requests for prior authorization will be valid for 1 year.

### **Emergency Prescription Supply**

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a prior authorization (PA), either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

The 72-hour emergency supply should be dispensed anytime a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

A pharmacy can dispense a product packaged in a dosage form that is fixed and unbreakable (e.g., an albuterol inhaler) as a 72-hour emergency supply.

To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit the following information:

- "8" in "Prior Authorization Type Code" (Field 461-EU)
- "801" in "Prior Authorization Number Submitted" (Field 462-EV)
- "3" in "Days Supply" (in the Claim segment of the billing transaction) (Field 405-D5)
- The quantity submitted in "Quantity Dispensed" (Field 442-E7) should not exceed the quantity necessary for a 3 day supply according to the directions for administration given by the prescriber. If the medication is a dosage form that prevents a 3 day supply from being dispensed (e.g. an inhaler), it is still permissible to indicate that the emergency prescription is a 3 day supply and enter the full quantity dispensed

Call the Express Scripts Pharmacy Help Desk at 1-844-367-6115 for more information about the 72-hour emergency prescription supply policy.

### **Dispensing Limitations**

Several drugs have dispensing limitations to ensure appropriate use. The following is an example of some limitations. For a complete list of limitations, please visit the Texas VDP formulary and PDL at [txvendordrug.com](http://txvendordrug.com).

- Prenatal vitamins limitation is for females 49 years and younger only
- Anti-fungal limitation is a 180-day supply per calendar year
- Stadol limitation is 10 ml per calendar month (4 bottles)
- Migraine medications limitations are across strengths per calendar month for each drug

### **Excluded Drugs**

The following drugs are excluded from the pharmacy benefit:

- In accordance with Section 1927 of the Social Security Act, 42 U.S.C.A. §1396r-8, coverage is excluded for any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program
- Drug products that have been classified as less-than-effective by the Food and Drug Administration (FDA) Drug Efficacy Study Implementation (DESI)
- Drugs excluded from coverage following Section 1927 of the Social Security Act, 42 U.S.C.A. §1396r-8 such as:
  - Weight control products (except Alli, which requires prior authorization)
  - Drugs used for cosmetic reasons or hair growth
  - Experimental or investigational drugs
  - Drugs used for experimental or investigational indication
  - Infertility medications
  - Erectile dysfunction drugs to treat impotence
- Nonlegend drugs, other than those listed above or specifically listed under covered nonlegend drugs

### **Specialty Drug Program**

We cover most specialty drugs under the pharmacy benefit, which may be obtained at any network pharmacy that handles these types of drugs. The following conditions are typically treated with specialty



injectable drugs: growth hormone deficiency, cancer, multiple sclerosis, hemophilia, rheumatoid arthritis, hepatitis, and cystic fibrosis.

### **Durable Medical Equipment and Other Products Normally Found in a Pharmacy**

Amerigroup reimburses for covered Durable Medical Equipment (DME) and products commonly found in a pharmacy. For all qualified members, this includes medically necessary items such as nebulizers, ostomy supplies or bedpans, and other supplies and equipment. For items both Medicare and Medicaid cover, Medicare will pay first and we will pay second. For children and young adults (birth through age 20), Amerigroup also reimburses for items typically covered under the Texas Health Steps Program, such as prescribed over-the-counter drugs, diapers, disposable or expendable medical supplies, and some nutritional products.

To be reimbursed for DME or other products normally found in a pharmacy for children and young adults (birth through age 20), a pharmacy must be in the Express Scripts pharmacy network or enrolled with us as a DME provider. Pharmacies that want to join the Express Scripts network should call Network Enrollment at 1-888-571-8182. Pharmacies may apply to become a DME provider with us by calling 713-218-5112 to speak with a Texas credentialing specialist.

Express Scripts network pharmacies that are not Amerigroup DME providers should submit claims to Express Scripts. Refer to the Express Scripts provider manual for information on the claim submission process and call the Express Scripts Pharmacy Help Desk at 1-844-367-6115 for information about DME and other covered products commonly found in a pharmacy for children and young adults (birth through age 20).

Pharmacies enrolled with us as a DME provider should submit medical (CMS 1500) claims in accordance with our standard claims submissions guidelines in Chapter 12, [Billing and Claims Administration](#), of this manual and subsequent updates. DME providers should call Provider Services at 1-800-454-3730 for information about DME and other covered products commonly found in a pharmacy for children and young adults (birth through age 20).

Pharmacies enrolled in both the Express Scripts and the Amerigroup networks have the option to bill these specific DME supplies through either Express Scripts or Amerigroup, but not both. Claims for these supplies may be subject to post-payment desk reviews to ensure that claims from DME providers and pharmacies do not result in a member exceeding the maximum quantity or a duplicate payment for the same member and supply.

### **Preferred Blood Glucose Testing Strips**

We have selected the Trividia Health brand as our single preferred line of test strips for blood glucose testing. Pharmacies can provide Trividia Health meters to our members who have prescriptions. Our clinical policy has several standard exceptions to our preferred product, allowing access to other brands. These exceptions include visual or dexterity impairment and use of insulin pumps not compatible with the preferred brand. We evaluate other requests for exceptions on a case-by-case basis for medical necessity. If a member needs a nonpreferred brand of test strips, a prior authorization request should be submitted by faxing a completed prior authorization form to 1-800-601-4829. If you have questions about prior authorization, call Express Scripts at 1-855-215-4496. Pharmacies can provide 3-day supplies (limited to the smallest package size, typically 25 test strips) of any VDP formulary test strips while a prior

authorization review is pending. Blood glucose test strips and monitors are not covered through DME providers.

#### **4.1.11 Texas Health Steps**

Texas Health Steps is the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Under Texas Health Steps, medical and dental preventive care and dental treatment services are available through Medicaid providers to Medicaid-enrolled children from birth through age 20. The program provides payment for comprehensive, periodic evaluations of a child's health, development, and nutritional status, including vision, hearing, dental, and case management services. For information regarding Texas Health Steps requirements, providers can refer to the resources listed below:

| Resource                                  | Link  |
|---|---|
| Texas Medicaid Provider Procedures Manual | <a href="http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx">http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx</a> |
| Texas Health Steps website                | <a href="http://www.dshs.state.tx.us/thsteps/default.shtm">http://www.dshs.state.tx.us/thsteps/default.shtm</a>   |

Information includes:

- Periodicity schedule
- State and federally mandated elements of the Texas Health Steps exam
- State provider enrollment requirements and TPI requirements
- Dental varnish provider participation requirements
- Advisory Committee on Immunization Practice (ACIP) immunization schedule
- Vaccines for Children (VFC) program description
- ImmTrac (immunization registry)
- Submission of all laboratory specimens (collected as a required component of a Texas Health Steps checkup to the DSHS Laboratory Services Section, or to a laboratory approved by the department under Section 33.016 of the Health and Safety Code for analysis)
- Referrals

Texas Health Steps medical providers (participating and nonparticipating) may perform Texas Health Steps medical checkups on any Amerigroup member, regardless of panel assignment. Claims for these services should be submitted to us. Please fax or mail a copy of the Texas Health Steps record to the member's primary care provider. Texas Health Steps network providers are reimbursed according to their contracts with us. Nonparticipating providers will be paid in accordance with the state's out-of-network rules.

#### **Texas Health Steps and Newly Enrolled Members**

STAR Kids members who are newly enrolled in Amerigroup are informed through welcome calls and new member information of the need to receive a medical checkup within 90 days of enrollment. For newborns, the medical checkup should occur no later than 14 days from the date of enrollment. Throughout the year, we remind members of the need to obtain their periodic Texas Health Steps medical checkups, diagnoses, and treatment for routine and acute care through the following resources:

- The member handbook
- Telephone calls

- Welcome information in the new member packet
- Member newsletters
- Preventive health reminders

The Texas Health Steps annual medical checkup for an existing member age 36 months and older is due on the child's birthday. The annual medical checkup is considered timely if it occurs no later than 364 calendar days after the child's birthday. A checkup for an existing member from birth through 35 months of age is timely if received within 60 days beyond the periodic due date in the TMPPM based on the member's birth date. If a member misses a Texas Health Steps medical checkup appointment, the provider and office staff must:

- Document the missed appointment and efforts to contact the member in the member's medical record.
- Contact the member to reschedule the appointment.

### ***Children of Migrant Farm Workers***

Children of migrant farm workers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service, but should be billed as a check-up.

Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity or an accelerated service. It is considered a late checkup.

#### ***4.1.12 Ambulance Transportation Services (Emergent)***

Ambulance transportation service is a benefit when the member has an emergency medical condition. See the [Emergency Services](#) section in this manual for the definition of emergency medical condition.

Facility-to-facility transport may be considered an emergency if emergency treatment is not available at the first facility and the member still requires emergency care. The transport must be to an appropriate facility, meaning the nearest medical facility equipped in terms of equipment, personnel, and the capacity to provide medical care for the illness or injury of the member.

Transports to out-of-locality providers (1-way transfers of 50 or more miles from the point of pickup to the point of destination) are covered if a local facility is not adequately equipped to treat the condition. Transports may be cut back to the closest appropriate facility.

#### ***4.1.13 Ambulance Transportation Services (Nonemergent)***

Nonemergency ambulance transport is a benefit when provided for a member to or from a scheduled medical appointment, to or from a licensed facility for treatment, or to the member's home after discharge from a hospital if the member has a medical condition such that the use of an ambulance is the only appropriate means of transportation (that is, alternate means of transportation are medically contraindicated). In this circumstance, contraindicated means that the member cannot be transported by any other means from the origin to the destination without endangering the individual's health.

A physician, nursing facility, health-care provider, or other responsible party is required to obtain authorization before an ambulance is used to transport a client in circumstances not involving an emergency. Requests can be faxed, submitted via the provider website at <https://providers.amerigroup.com/TX>, or called into Amerigroup via the contact numbers shown in the table below. All requests require clinical information to support the need for the member to be transported by nonemergent ambulance transportation. The ambulance provider may not submit an authorization request. Transports must be limited to those situations where the transportation of the client is less costly than bringing the service to the client.

Some requests for nonemergent ambulance transportation will occur after business hours. Authorizations that meet medical necessity will be authorized retrospectively if the request is received the next business day. The request can be called in or faxed the next business day to the numbers listed in the table below:

| <b>Request Type</b> | <b>Behavioral health facilities/behavioral health provider and IDD members</b> | <b>All other members for discharge from facility to home or from home to a provider/facility</b> |
|---------------------|--|--|
| Urgent same day     | Call 1-800-325-0011, Ext. 35933  | Call 1-800-325-0011, Ext. 35760  |
| Nonurgent requests  | Fax request to 1-866-877-5229  | Fax request to 1-866-249-1271  |

#### ***4.1.14 Medical Transportation Program***

Medicaid members are eligible for the Medical Transportation Program (MTP), a free service provided through the Texas Department of Health and Human Services. The service provides transportation to appointments with doctors, dentists, pharmacies, or other health care service providers.

To obtain a ride, members or their authorized representatives should call MTP at:

- 1-855-687-3255 for Dallas/Fort Worth
- 1-855-687-4786 for Houston/Beaumont
- 1-877-633-8747 for all other areas

Reservations should be made at least 2 working days before needing a ride and at least 5 working days before requiring out-of-town or long-distance travel. If same- or next-day service is needed, MTP will try to help but a ride is not guaranteed.

When calling MTP, you will need to provide:

- The member's 9-digit Medicaid identification number or Social Security number
- The name, address, and telephone number of the member needing the ride
- The member's pickup address
- The date and time of the health care appointment
- What type of transportation services are needed
- Notification of the member's special needs (for example, the need for accessible transportation if the member is disabled)

If an Amerigroup member is unable to obtain transportation through MTP, he or she should contact Member Services at 1-844-756-4600. Amerigroup includes additional transportation benefits in the value-

added services available to members. A description of these benefits can be found in the member handbooks available at <https://myamerigroup.com/TX>.

#### **4.1.15 Vision Services**

Coverage for STAR Kids nondual members may be obtained by calling Superior Vision of Texas at 1-866-819-4298. Services are available for member self-referral to a network vision provider for basic vision benefits. Members can call 1-800-428-8789.

| Category                        | Benefits   | Contact  |
|---------------------------------|--|--|
| Nondual (Medicaid only) members | 1 eye exam and medically necessary lenses, and frames or contacts once every state fiscal year (September 1 through August 31) | Coverage may be obtained by calling Superior Vision of Texas at 1-866-819-4298 for providers and 1-800-428-8789 for members. |
| Dual-eligible members           | Vision services are not covered under Medicaid managed care.   |  |

## **4.2 Value-added Services**

We cover extra health care benefits for our STAR Kids members. These extra benefits are also called value-added services or value-added benefits. Below is a chart of these benefits that is included in the STAR Kids member handbooks.

| Value-added Benefit   | How to Get It   |
|---|---|
| Rides to medical appointments when your family or representative cannot provide it and the State Medical Transportation Program is not available; a family member or representative may travel with you if needed | Call 1-844-756-4600 (TTY 711) or your service coordinator                                     |
| One sports, school, or camp physical every year   | See your primary care provider  |
| Up to \$50 each year for the cost of activities in a Boys & Girls Club, Boy Scouts, Girls Scouts, or other similar organization contracted with Amerigroup (where available)                                      | Go to your local Boys & Girls Club or call your service coordinator about other organizations |

| Value-added Benefit  | How to Get It  |
|--|--|
| <p>Free cellphone and up to 350 minutes of services each month if you qualify, plus:</p> <ul style="list-style-type: none"> <li>• 200 one-time bonus minutes when you choose to receive health text messages from Amerigroup</li> <li>• 100 annual bonus minutes on your child's birthday</li> <li>• Unlimited inbound text messages plus health and wellness and renewal reminder texts from Amerigroup</li> <li>• Unlimited minutes when calling our Member Services line</li> <li>• Minutes include international calling if available</li> </ul> | <p>Call 1-844-756-4600 (TTY 711) or go to <a href="http://www.myamerigroup.com/TX">www.myamerigroup.com/TX</a> to learn more</p> |
| <p>8 hours of respite services for families and caregivers of members</p>  | <p>Call 1-844-756-4600 (TTY 711) or your service coordinator</p>   |
| <p>Smoking/tobacco cessation help — telephone support with your own personal coach and a full range of nicotine replacement therapies as needed (after all Medicaid benefits are used)</p>   | <p>Call 1-844-756-4600 (TTY 711) or your service coordinator</p>   |
| <p>Free inhaler sensor for members with asthma — to show or prevent health problems by tracking inhaler use</p>  | <p>Call 1-844-756-4600 (TTY 711) or your service coordinator</p>   |
| <p>Allergy-free pillow cover (1 per year) for members who have been diagnosed with asthma and participate in a disease/case management program</p>   | <p>Call 1-844-756-4600 (TTY 711) or your service coordinator</p>   |
| <p>Taking Care of Baby and Me® program — support, assistance, and educational materials for members during and after pregnancy, including:</p> <ul style="list-style-type: none"> <li>• An educational book with tips on taking care of yourself during pregnancy (once the member is identified as pregnant)</li> <li>• A book about caring for yourself and your new baby after birth</li> </ul>   | <p>Call 1-844-756-4600 (TTY 711) or your service coordinator</p>   |

| Value-added Benefit   | How to Get It  |
|---|--|
| <p>Healthy Rewards debit card for these healthy activities:</p> <ul style="list-style-type: none"> <li>• \$120 for a child who completes six well child checkups according to the Texas Health Steps visit schedule for ages 0-15 months (refer to the <b>What is Texas Health Steps?</b> section of this handbook)</li> <li>• \$20 each visit for a child who has a well child checkup at ages 18, 24, or 30 months</li> <li>• \$20 each year for a child who has a well child checkup from ages 3-20 years old</li> <li>• \$20 for a child 42 days through 24 months of age who gets a full series of the rotavirus vaccinations (2-3 visits on different days depending on type of vaccine)</li> <li>• \$20 for a child 6 months through 24 months of age who gets a full series of the flu (influenza) vaccinations (2 vaccinations on different days)</li> <li>• \$20 each year for a member age 18-20 who gets a flu (influenza) vaccination</li> <li>• \$25 for a member who has a prenatal checkup in her first trimester of pregnancy or within 42 days of enrollment</li> <li>• \$50 for a member who has a postpartum checkup within 21 to 56 days after giving birth</li> <li>• \$20 each year for a member age 18-20 with diabetes who has a retinopathy eye exam</li> <li>• \$20 every 6 months for a member age 18-20 with diabetes who has a blood sugar test (HbA1c)</li> <li>• \$20 every 6 months for a member age 18-20 with diabetes who has a blood sugar test (HbA1c) with a result less than 8</li> <li>• \$20 for purchase of a State ID card (1 per lifetime)</li> <li>• \$25 per quarter for member participation in visit with a service coordinator in person or by telephone</li> </ul> | <p>Call 1-877-868-2004 or go to <a href="http://www.myamerigroup.com/HealthyRewards">www.myamerigroup.com/HealthyRewards</a> to learn more</p> |

| <b>Value-added Benefit</b>   | <b>How to Get It</b>  |
|--|---|
| Healthy Families program with free healthy living coach for members age 7-13 diagnosed with obesity (one program per lifetime)   | Call 1-844-756-4600 (TTY 711) or your service coordinator   |
| Six months free mobile and online health coaching and nutrition plans for weight loss and managing chronic health conditions   | Call 1-844-756-4600 (TTY 711) or your service coordinator   |
| Pest control services every 3 months in a single-dwelling home   | Call 1-844-756-4600 (TTY 711) or your service coordinator   |
| Disaster Kits — complete a personal disaster plan online and get a first aid kit (1 kit per member per lifetime)   | Call 1-844-756-4600 (TTY 711) or go to <a href="http://www.myamerigroup.com/TX">www.myamerigroup.com/TX</a> to learn more |
| Non-slip and dexterity products to help with activities of daily living — up to \$50 per year  | Call 1-844-756-4600 (TTY 711) or your service coordinator   |
| Travel training and coaching to learn how to use public transportation (for members who are of appropriate age to use the skills learned and if not available through another program) | Call 1-844-756-4600 (TTY 711) or your service coordinator   |
| Crisis text line — 24/7 emotional support from counselors who give information and advice by text message for members age 13-20  | Call 1-844-756-4600 (TTY 711) or your service coordinator   |



## 5 PRECERTIFICATION AND UTILIZATION MANAGEMENT

We operate a comprehensive medical management program that encompasses both precertification and utilization management. For questions about the Utilization Management (UM) process, including UM criteria, call Provider Services at 1-800-454-3730.

### 5.1 Medical Review Criteria

As a wholly owned subsidiary of Anthem, Inc., Amerigroup uses Anthem's nationally recognized, evidence-based medical policies and clinical utilization management guidelines. These policies are publicly available on the *Amerigroup Medical Policy and Clinical UM Guideline* subsidiary website at <https://medicalpolicies.amerigroup.com>. These policies and guidelines can be obtained in hard copy by contacting Provider Services at 1-800-454-3730.

McKesson InterQual Level of Care criteria is used only for medical necessity review for medical inpatient concurrent review, inpatient site of service appropriateness, home health, and outpatient rehabilitation. The *Anthem Behavioral Health Medical Policies and Clinical Utilization Management Guidelines* are used for all behavioral health reviews.

Federal law, state law, and contract language, including definitions and specific contract provisions and exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. As such, in all cases, state Medicaid contracts or CMS requirements will supersede both Anthem medical policy and McKesson InterQual Level of Care criteria. Medical technology is constantly evolving, and we reserve the right to review and periodically update medical policy and utilization management criteria.

We use nationally recognized standards of care for clinical decision support for medical management coverage decisions. The criteria provides a system for screening proposed medical care based on member-specific best medical care practices and rule-based systems to match appropriate services to member needs based upon clinical appropriateness. We work with providers and other industry experts to develop and/or approve clinical practice guidelines. The Medical Advisory Committee (MAC) assists us in formalizing and monitoring guidelines. Criteria include:

- Acute care
- Rehabilitation
- Subacute care
- Home care
- Surgery and procedures
- Imaging studies and X-rays
- Texas Medicaid Provider Procedures Manual (TMPPM)

If we modify the medical review criteria, the following standards apply to the development of the criteria:

- Criteria are developed with involvement from appropriate providers with current knowledge relevant to the content of treatment guidelines under development.
- Criteria are based on review of market practice, national standards, and best practices.
- Criteria are evaluated at least annually by appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria of treatment guidelines under review

and updated as necessary. The criteria must reflect the names and qualifications of those involved in the development, the process used in the development, and when and how often the criteria will be evaluated and updated.

Our utilization reviewers use these criteria as part of the precertification of scheduled admission, concurrent review, and discharge planning processes. The criteria enable reviewers to determine clinical appropriateness and medical necessity for coverage of continued hospitalization.

**Precertification** is defined as the prospective process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered, a member's severity of illness, medical history, and previous treatment to determine the medical necessity and appropriateness of a given coverage request.

**Prospective** means the coverage request occurred prior to the service being provided.

**Notification** occurs prior to rendering covered medical services to a member. The provider must notify us by telephone or by fax of the intent to render covered medical services. For emergency services, notification should be given within 24 hours or the next business day. There is no review against medical necessity criteria. However, member eligibility and provider status (network or non-network) are verified.

## **5.2 Utilization Management Decision Making Affirmative Statements**

Amerigroup, as a corporation and as individuals involved in Utilization Management (UM) decisions, is governed by the following statements:

- UM decision-making is based only on appropriateness of care and service, and existence of coverage.
- Amerigroup does not specifically reward practitioners or other individuals for issuing denial 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 UM decision-makers do not encourage decisions that result in underutilization, or create barriers to care and service.

## **5.3 Medically Necessary Services**

Medically necessary means:

1) The following Texas Health Steps services:

- a) Screening, vision, and hearing services
- b) Other health care services, including behavioral health services, necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:
  - i) Must comply with the requirements of a final court order that applies to the Texas Medicaid program or the Texas Medicaid managed care program as a whole (including the Alberto N., et al. v. Traylor, et al. partial settlement agreements) and
  - ii) May include consideration of other relevant factors, such as the criteria described in parts 2)(a-f) and 3)(a-f) of this paragraph

- 2) Non-behavioral health-related health care services that are:
  - a) Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions.
  - b) Consistent with health care practice guidelines and standards endorsed by professionally recognized health care organizations or governmental agencies.
  - c) Consistent with the member's diagnoses.
  - d) No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.
  - e) Not experimental or investigative.
  - f) Not primarily for the convenience of the member or provider.
- 3) Behavioral health services that:
  - a) Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care.
  - b) Are furnished in the most appropriate and least restrictive setting in which services can be safely provided.
  - c) Are the most appropriate level or supply of service that can be safely provided.
  - d) Could not be omitted without adversely affecting the member's mental and physical health, and/or the quality of care rendered.
  - e) Are not experimental or investigative.
  - f) Are not primarily for the convenience of the member or provider.

We provide medically necessary covered services to all members beginning on the member's date of enrollment, regardless of pre-existing conditions, prior diagnosis, and/or receipt of any prior health care services. This includes functionally necessary covered long-term supports and services beginning on the member's date of enrollment, regardless of health status, pre-existing conditions, prior diagnosis, receipt of any prior health care services, confinement in a health care facility, and/or previous coverage, if any, or the reason for termination of such coverage. We do not impose any pre-existing condition limitations or exclusions, or require evidence of insurability to provide coverage to any member.

#### **5.4 Precertification/Notification Process**

For services that require precertification, we make case-by-case determinations that consider the individual's health care needs and medical history in conjunction with nationally recognized standards of care and medical necessity criteria. To determine if precertification or notification is required, see our Precertification Lookup Tool at <https://providers.amerigroup.com/TX>.

Requests for precertification may be submitted for review and approval as indicated below:

- Inpatient/outpatient surgeries and other general requests fax: 1-800-964-3627
- Behavioral Health fax – inpatient: 1-877-434-7578
- Behavioral Health fax – outpatient: 1-800-505-1193
- Mental Health Rehabilitative and Targeted Case Management Services fax: 1-866-877-5229
- Durable medical equipment (DME) fax: 1-866-249-1271
- Therapy (physical, occupational, and speech) fax: 1-866-249-1271

- Back and spine procedures fax: 1-800-964-3627
- Pain management injections fax: 1-866-249-1271
- Radiology (high-tech) phone: 1-800-714-0040 (AIM Specialty Health) or [aimspecialtyhealth.com/goweb](http://aimspecialtyhealth.com/goweb)
- Home health nursing fax (non- long-term services and supports): 1-866-249-1271
- STAR Kids long-term services and supports fax: 1-844-756-4604
- Nonemergent transportation (other than ambulance) phone: 1-855-295-1636 (Access2Care)
- Nonemergent ambulance transportation: refer to the [Ambulance Transportation Services \(Nonemergent\)](#) section of this manual
- Telephone (if urgent): 1-800-454-3730
- Website: <https://providers.amerigroup.com/TX> and [www.Availity.com](http://www.Availity.com)

Providers should submit a prior authorization request form (available on the provider website at <https://providers.amerigroup.com/TX> or by contacting Provider Services), including the following information:

- Member's name and ID
- Name, telephone number, and fax number of the physician performing the service
- Name of the facility and telephone number where the service is to be performed
- Date(s) of service
- Diagnosis
- Name of procedure to be performed with CPT/HCPCS codes and applicable modifiers
- Place of service the procedure or service will be performed (office, home, outpatient, inpatient, etc.)
- Medical information to support requested services (current signs/symptoms, past and current treatment plans, response to treatment plans, and medications)

We are staffed with clinical professionals who coordinate services provided to members. These professionals are available 24 hours a day, 7 days a week to accept precertification requests. Upon receipt of a request for precertification, an Amerigroup precertification assistant verifies eligibility and benefits prior to forwarding to the nurse or other qualified reviewer.

The reviewer examines the request and supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. When appropriate, the reviewer will assist the requesting physician in identifying alternatives for health care delivery as supported by an Amerigroup medical director.

When the clinical information received meets medical necessity criteria, we issue a reference number to the requesting physician. If the provider identifies the request as urgent (expedited service authorizations), the decision will be made within 1 business day but not later than 72 hours or 3 calendar days of receipt of the request.

If the precertification documentation is incomplete or inadequate, the reviewer will not approve coverage of the request. In such instances, the reviewer will notify the provider to submit the additional documentation necessary to make a decision. If no additional information is received within the

designated time frame, the Amerigroup medical director will make a determination based on the information previously received. Additionally, if the request does not meet criteria for approval, the requesting provider will be afforded the opportunity to discuss the case with the medical director prior to issuing the denial.

The appropriate notice of proposed action will be mailed to the member, the servicing provider, the requesting/ordering provider, and the member's primary care physician. The notice includes an explanation of the member's appeal rights and fair hearing rights and process.

If a request is submitted for a service for which precertification is not required, the provider will receive a response stating that prior authorization is not required. This is not an approval or a guarantee of payment. Claims for services are subject to all plan provisions, limitations, and patient eligibility at the time services are rendered.

#### **5.5 Nonemergent Outpatient and Ancillary Services – Precertification and Notification Requirements**

We require precertification for coverage of selected nonemergent outpatient and ancillary services. To determine if precertification or notification is required, see our Precertification Lookup Tool at <https://providers.amerigroup.com/TX>.

#### **5.6 Nonemergent Inpatient Admissions**

We require precertification of all inpatient nonemergent admissions, except as prohibited under federal or state law for both in and out-network facility and physician services for a mother and her newborn(s), for a minimum of 48 hours following an uncomplicated vaginal delivery, or 96 hours following an uncomplicated delivery by Cesarean section. We require precertification of maternity inpatient stays for any portion in excess of these time frames. The referring primary care provider or specialist physician is responsible for precertification. Requests for precertification with all supporting documentation should be submitted immediately upon identifying the inpatient request, or at least 72 hours prior to the scheduled admission.

The hospital can confirm that an authorization is on file by calling our automated Provider Inquiry Line at 1-800-454-3730, or at [www.Availity.com](http://www.Availity.com). If coverage of an admission has not been approved, the facility should contact us at 1-800-454-3730 so we can contact the physician directly to resolve the issue.

#### **5.7 Emergent Admission Notification Requirements**

We request immediate notification by network hospitals of emergent admissions. Our medical management staff will verify eligibility and determine benefit coverage.

#### **5.8 Inpatient Admission Reviews**

All inpatient hospital admissions, including urgent and emergent admissions, will be reviewed within 1 business day of notification of admission.

Our utilization review clinician determines the member's medical status through onsite review and/or communication with the hospital's utilization review department. Appropriateness of stay is documented, and concurrent review is initiated. Cases that do not meet medical necessity or have quality care concerns may be referred to the medical director for review. If a case does not meet medical necessity, the attending provider will be afforded the opportunity to discuss the case with the Amerigroup medical director prior to the determination. When appropriate, members may be referred to an Amerigroup disease management program.

### **Inpatient Concurrent Review**

Each network hospital will have an assigned Utilization Management (UM) clinician. Each UM clinician will conduct a concurrent review of the hospital medical record at the hospital, by fax, or by telephone to determine the authorization of coverage for a continued stay.

The UM clinician will conduct continued stay reviews daily and review discharge plans unless the patient's condition is such that it is unlikely to change within the upcoming 24 hours, at which time the reviews can be done less frequently than daily.

We will authorize the covered length of stay 1 day at a time, based on the clinical information that supports the continued stay. Exceptions to the 1-day length of stay authorization will be made for confinements when the length of stay is predetermined by state law. Examples of confinement and/or treatment include Cesarean section or vaginal deliveries. Exceptions are made by the medical director on a case-by-case basis.

When the clinical information received meets medical necessity criteria, approved days and bed level (if appropriate) coverage will be communicated to the hospital for the continued stay. If medical necessity criteria are not met for the ongoing inpatient stay, the medical director will afford the attending physician the opportunity to discuss the case prior to making a determination. If the medical director's decision is to deny the request, the appropriate notice of action will be mailed to the hospital, treating or attending practitioner, member's primary care provider, and member. The notice of action includes an explanation of the member's appeal rights and fair hearing rights and process.

When an Amerigroup UM clinician reviews the medical record at the hospital, he or she also may attempt to meet with the member (and member's family, if appropriate) to discuss any discharge planning needs. The UM clinician will also attempt to verify that the member or family is aware of the member's primary care provider's name, address, and telephone number. The UM clinician will conduct continued-stay reviews daily and review discharge plans, unless the patient's condition is such that it is unlikely to change within the upcoming 24 hours and discharge planning needs cannot be determined. In that situation, reviews can be done less frequently than daily.

## **5.9 Poststabilization Care Services**

Poststabilization care services are covered services related to an emergency condition that are provided after a patient is stabilized, to maintain the stabilized condition or improve or resolve the patient's condition. We will adjudicate emergency and poststabilization care services that are medically necessary until the emergency condition is stabilized and maintained.

## **5.10 Discharge Planning**

Discharge planning is designed to assist the provider in the coordination of the member's discharge when acute care (hospitalization) is no longer necessary. If the discharge is approved, our UM clinician will help coordinate discharge planning needs with the hospital utilization review staff and attending physician. The attending physician is expected to coordinate with the member's primary care provider regarding follow-up care after discharge. The primary care provider is responsible for contacting the member to schedule all necessary follow-up care.

In the case of a behavioral health discharge, the attending physician is also responsible for ensuring that the member has secured an appointment for a follow-up visit with a licensed behavioral health provider. The follow-up visit must occur within 7 calendar days of discharge.

When additional or ongoing care is necessary after discharge, we work with the provider to plan the member's discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital facility, such as:

- Hospice facility
- Convalescent facility
- Home health care program (for example, home I.V. antibiotics) or skilled nursing facility

When the provider identifies medically necessary and appropriate services for the member, we will assist the provider and the discharge planner in providing a timely and effective transfer to the next appropriate level of care.

Discharge plan authorizations for ongoing outpatient care follow nationally recognized standards of care and medical necessity criteria. Authorizations include, but are not limited to, transportation, home health, DME, pharmacy, follow-up visits to practitioners, and outpatient procedures.

## **5.11 Confidentiality of Information**

Utilization management, case management, disease management, discharge planning, quality management, and claims payment activities are designed to ensure that patient-specific information, particularly protected health information (PHI) obtained during review, is kept confidential in accordance with applicable laws, including HIPAA. Information is 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 other activities and processes listed above.

## **5.12 Urgent and After-hours Care**

We require members to contact their primary care provider in situations where urgent, unscheduled care is necessary. If you are unable to see the member, you can refer him or her to one of our participating urgent care centers. If the member needs care during nonbusiness hours, he or she can be seen by a provider who participates in our after-hours care program. Precertification by Amerigroup is not required for a member to access a participating urgent care center or a provider participating in our after-hours care program.

### 5.13 Utilization Timeliness Standards

Utilization review timeliness standards:

- Nonurgent preservice: For precertification of nonurgent care, a decision will be made within 3 business days.
- Urgent preservice: For precertification of urgent preservice care, a decision will be made within 1 business day, but not later than 72 hours from receipt of the request for service.
- Urgent concurrent: For urgent concurrent care, a decision will be made within 24 hours of the receipt of request for service, or notification of inpatient admission.
- Postservice: For postservice care, a decision will be made within 30 calendar days.
- Extensions: If there is insufficient information to make a decision, extensions to the standard time frames may be appropriate and can be used with certain restrictions. Appropriate notifications will be made if an extension is applicable.

### 5.14 Long-term Services and Supports Precertification

All long-term services and supports require precertification before services are rendered.

### 5.15 Self-referrals

We may require members to seek a referral from their primary care provider prior to accessing nonemergency specialty physical health services with the exception of:

| Service   | Authorization for continued services   |
|---|--|
| Obstetric/gynecological services  | <ul style="list-style-type: none"><li>• 1 well-woman checkup each year</li><li>• Care related to pregnancy</li><li>• Care for any female medical condition</li><li>• Referral to specialist doctor within the network</li></ul>  |
| Behavioral health (nonparticipating providers must seek prior approval from Amerigroup) | <p>Members may self-refer to any Amerigroup network behavioral health services provider by calling Member Services at 1-844-756-4600. No prior approval from the primary care provider is required.</p> <p>Providers may refer members for services by:</p> <ul style="list-style-type: none"><li>• Calling Provider Services at 1-800-454-3730.</li><li>• Faxing referral information to our dedicated behavioral health faxes at 1-877-434-7578 for inpatient services and 1-800-505-1193 for outpatient services.</li></ul> <p>Our staff is available to callers 24 hours a day, 7 days a week, 365 days a year for routine, crisis, or emergency calls and authorization requests.</p> |
| Texas Health Steps  | Members may self-refer to any Texas Health Steps certified provider.   |
| Early childhood intervention (ECI)  | Members may self-refer to local, contracted ECI service providers. Amerigroup providers must give referral information to the legally authorized representative of any member birth to 3 years of age suspected of having a developmental disability or delay, or otherwise meeting eligibility criteria for ECI services in accordance with 40 TAC Chapter 108, within 7 calendar days from the day the provider  |



| Service  | Authorization for continued services  |
|--|---|
|  | identifies the member.  |
| Emergent care  | No precertification or notification is required, regardless of network status with Amerigroup.                    |
| Family planning/sexually transmitted disease (STD)           | No precertification or notification is required, regardless of network status with Amerigroup.                    |
| Tuberculosis, STDs, HIV/AIDS testing and counseling services | No precertification or notification is required for these services, regardless of network status with Amerigroup. |

## 5.16 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.

We strive to ensure that both Amerigroup and contracted participating providers conduct business in a manner that safeguards member information in accordance with the privacy regulations enacted pursuant to HIPAA. Contracted providers must implement procedures that demonstrate compliance with the HIPAA privacy regulations. This requirement is described in the following paragraphs.

We recognize our responsibility under the HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting us. However, please note that the privacy regulations allow the transfer or sharing of member information (such as a member's medical record), which we may request to conduct business and make decisions about care, to make an authorization determination, or to 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 us, verify that the receiving fax number is correct, notify the appropriate staff at Amerigroup and verify that the fax was appropriately received.

Internet email (unless encrypted) should not be used to transfer files containing member information to us (for example, 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, PO Box, or department at Amerigroup.

Our voicemail system is secure and password protected. When leaving messages for our associates, providers should only leave the minimum amount of member information required to accomplish the

intended purpose. When contacting us, be prepared to verify the provider's name, address, and tax identification number or Amerigroup provider number.

Medical records standards require that medical records must reflect all aspects of patient care, including ancillary services. The use of electronic medical records must conform to the requirements of HIPAA and other federal and state laws.

#### **5.17 Misrouted Protected Health Information**

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 that a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email, or electronic remittance advice. Providers and facilities are required to immediately destroy 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, please call our Provider Services team at 1-800-454-3730 for help.

## 6 LONG-TERM SERVICES AND SUPPORTS

The STAR Kids program provides an integrated approach to health care delivery that addresses those services members may require in the acute, behavioral, functional, social, and environmental areas. The program administers acute and long-term services and supports to the eligible populations through a managed care system.

Service coordination is a major feature of STAR Kids and involves specialized person-centered thinking for members. Service coordinators provide assistance to members, family members, member representatives, and providers to develop a detailed service plan and provide the following services according to the member's needs:

- Acute care
- Behavioral health
- Environmental care
- Functional care
- Home- and community-based care

### 6.1 Eligibility

#### ***6.1.1 Eligibility Verification***

Providers must verify member eligibility by:

- Calling our automated Provider Inquiry Line at 1-800-454-3730
- Checking [www.Availity.com](http://www.Availity.com)
- Calling the Texas Medicaid & Healthcare Partnership (TMHP) Automated Inquiry Line at 1-800-925-9126
- Using TexMedConnect on the TMHP website at [tmhp.com](http://tmhp.com)
- Calling the Your Texas Benefits provider helpline at 1-855-827-3747

Note: It's the provider's responsibility to ensure eligibility is verified before delivering services.

#### ***6.1.2 STAR Kids Eligibility***

Medicaid populations that must participate in STAR Kids include children and young adults aged 20 and younger who:

- Receive Supplemental Security Income (SSI)
- Receive SSI and Medicare
- Receive Medically Dependent Children Program (MDCP) waiver services
- Receive Youth Empowerment Services (YES) waiver services
- Receive IDD waiver services (for example, CLASS, DBMD, HCBS, or TxHmL)
- Reside in a community-based ICF/IID or in a nursing facility (state plan services and service coordination only; long-term services and supports will continue to be provided through the appropriate institution)

Children and young adults enrolled in STAR Health, receiving adoption assistance or adoption services, or who reside in the Truman Smith Children's Care Center are not eligible to participate in STAR Kids.

## **6.2 Member Identification Cards**

Sample member identification cards can be found in the [Appendix A - ID Cards](#) section of this manual.

## **6.3 The Role of Long-term Services and Supports Providers**

Long-term services and supports providers are responsible for, but not limited to, the following:

- Verifying member eligibility
- Obtaining authorizations for services prior to provision of those services
- Initiating community-based services within 7 days of authorization for non-MDCP STAR Kids waiver members, unless the referring provider or member requests otherwise
- Coordinating Medicaid/Medicare benefits
- Notifying us of changes in a member's physical condition or eligibility
- Partnering with our service coordinator in managing a member's health care
- Managing continuity of care
- Employment assistance providers must develop and update quarterly a plan for delivering employment assistance services
- Supported employment providers must develop and update quarterly a plan for delivering supported employment services
- Report any suspicion or allegation of member abuse, neglect, or exploitation in accordance with Texas Human Resources Code §48.051, Texas Health and Safety Code §260A.002, and Texas Family Code §261.101

All Home and Community Support Services Agency (HCSSA) providers, adult day care providers, and residential care facility providers must notify Amerigroup if a member experiences any of the following:

- A significant change in the member's physical or mental condition or environment
- Hospitalization
- An emergency room visit
- 2 or more missed appointments

### ***6.3.1 Community First Choice (CFC) Provider Responsibilities***

- The CFC services must be delivered in accordance with the member's service plan.
- The program provider must have current documentation which includes the member's service plan, ID/RC (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable), and nursing assessment (if applicable).
- The HCS or TxHmL program provider must ensure that the rights of the members are protected (ex. e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).
- The program provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the member being served. This includes the delegation of nursing tasks, dietary needs, behavioral

needs, mobility needs, allergies, and any other needs specific to the member that are required to ensure the member's health, safety, and welfare. The program provider must maintain documentation of this training in the member's record.

- The program provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation. The program provider must also show documentation regarding required actions that must be taken when from the time they are notified that a Department of Family Protective Services (DFPS) investigation has begun through the completion of the investigation (ex. e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc.). The program provider must also provide the member/legally authorized representative (LAR) with information on how to report acts or suspected acts of abuse, neglect, and exploitation and the DFPS hotline (1-800-647-7418).
- The program provider must address any complaints received from a member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the member/LAR with the appropriate contact information for filing a complaint.
- The program provider must not retaliate against a staff member, service provider, member (or someone on behalf of a member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.
- The program provider must ensure that the service providers meet all of the personnel requirements (age, high school diploma/GED or competency exam and three references from non-relatives, current Texas driver's license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC emergency response services (ERS), the program provider must ensure that the provider of ERS has the appropriate licensure.
- For CFC ERS, the program provider must have the appropriate licensure to deliver the service.
- Per the CFR §441.565 for CFC, the program provider must ensure that any additional training requested by the member/LAR of CFC personal assistance services (PAS) or habilitation (HAB) service providers is procured.
- The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
- The program provider must adhere to the MCO financial accountability standards.
- The program provider must prevent conflicts of interest between the program provider, a staff member, or a service provider and a member, such as the acceptance of payment for goods or services from which the program provider, staff member, or service provider could financially benefit.
- The program provider must prevent financial impropriety toward a member, including unauthorized disclosure of information related to a member's finances and the purchase of goods that a member cannot use with the member's funds.

#### **6.4 Personal Attendant Wage Requirements in Community Settings**

Facilities and agencies that provide personal care services (PCS) or personal attendant services must pay attendants at or above \$8.00 per hour.

This wage requirement applies to personal attendants working as either employees or contractors of a provider, or as employees or contractors of a subcontractor, and regardless of whether the member chooses to self-direct these services. Newly employed or contracted attendants must be notified of the required base wages within 3 days of being hired.

#### **6.5 Services Delivery Options**

STAR Kids members may select how they would like some of their long-term services and supports delivered:

- Agency option (AO): standard service delivery provided by an agency
- Service responsibility option (SRO): member or representative manages day-to-day activities while the provider agency manages business activities
- Consumer directed services (CDS) option: member or representative manages day-to-day and business activities; members electing CDS receive financial management services and may receive support consultation

#### **6.6 Electronic Visit Verification**

##### **What is EVV?**

- Electronic visit verification (EVV) is a telephone and computer-based system that electronically verifies service visits and documents the precise time service provision begins and ends.
- EVV is a method by which a person, including but not limited to a personal care attendant, who enters a STAR Kids member's home to provide a service will document their arrival time and departure time using a telephonic or computer-based application system. This visit information will be recorded and used as an electronic version of a paper time sheet for an attendant and used to support claims to the MCO for targeted EVV services.

##### **Do providers have a choice of EVV vendors?**

- Provider selection of EVV vendor
  - Providers have a choice of EVV vendors. During the contracting and credentialing process with an MCO, a copy of the *Provider Electronic Visit Verification Vendor System Selection* form should be provided in the application packet. Forms are located at <https://providers.amerigroup.com/TX>.
- Provider EVV default process for non-selection
  - Mandated providers that do not make an EVV vendor selection or who do not implement use of their selected vendor, are subject to contract actions and are defaulted to a selected vendor by HHSC. The provider will receive a default letter detailing out the vendor that they have been defaulted to and when they are required to be implemented with the vendor.
- When can a provider change EVV vendors?

- A provider may change EVV vendors 120 calendar days after the submission request by completing the *Medicaid EVV Provider System Selection* form.
- A provider may change EVV vendors twice in the life of their contract with the MCO.

### Can a provider elect not to use EVV?

EVV will be required to document delivery of the following STAR Kids services:

- Personal care services (PCS)
- Community First Choice attendant care and habilitation (PAS /HAB)
- Medically Dependent Children Program (MDCP) in-home respite
- MDCP flexible family support services

### Is EVV required for CDS employers?

If you are a CDS employer, there are 3 EVV options:

- **Phone and computer (full participation):** The telephone portion of EVV will be used by your Consumer Directed Services (CDS) employee(s) and you will use the computer portion of the system to perform visit maintenance.
- **Phone only (partial participation):** This option is available to CDS employers who can participate in EVV, but may need some assistance from the Financial Management Services Agency (FMSA) with visit maintenance. You will use a paper time sheet to document service delivery. Your CDS employee will call-in when they start work and call-out when they end work. Your FMSA will perform visit maintenance to make the EVV system match your paper time sheet.
- **No EVV participation:** If you do not have access to a computer, assistive devices, or other supports, or you do not feel you can fully participate in EVV, you may choose to use a paper time sheet to document service delivery.

### How do providers with assistive technology (ADA) needs use EVV?

If you use assistive technology and need to discuss accommodations related to the EVV system or materials, please contact the HHSC-approved EVV vendors:

#### DataLogic (Vesta) Software, Inc.

| Contact   | Email             | Phone          |
|---|-------------------|----------------|
| Sales and training  | info@vestaevv.com | 1-888-880-2400 |
| Tech support  | support@vesta.net |                |
| Website: <a href="http://www.vestaevv.com">www.vestaevv.com</a> |                   |                |

#### MEDsys Software Solutions, LLC

| Contact   | Email                     | Phone  |
|---|---------------------------|--|
| Texas dedicated support and sales number                          | Sales: info@medsyshcs.com | Support: 1-877-698-9392, option 1<br>Sales: 1-877-698-9392, option 2 |
| Website: <a href="http://www.medsyshcs.com">www.medsyshcs.com</a> |                           |  |

## EVV Use of Small Alternative Device (SAD) Process and Required SAD Forms

- The SAD process is found at <http://www.dads.state.tx.us/evv/formshandbooks.html>. SAD forms can be found at <https://providers.amerigroup.com/TX>.
- Where do I submit the SAD agreement/order form?  
The form is submitted to the provider-selected EVV vendor:
  - DataLogic – email form to: [tokens@vestaevv.com](mailto:tokens@vestaevv.com) or send secure efax to 1-956-290-8728
  - MEDsys – email form to: [tokens@medsyshcs.com](mailto:tokens@medsyshcs.com) or send secure fax to 1-888-521-0692
- Equipment provided by an EVV contractor to a provider, if applicable, must be returned in good condition.

## EVV Compliance

All providers providing the mandated services must use the EVV system and must maintain compliance with the following requirements:

- The provider must enter member information, provider information, and service schedules (scheduled or non-scheduled) into the EVV system for validation either through an automated system or a manual system.
- The provider must ensure that attendants providing services applicable to EVV are trained and comply with all processes required to verify service delivery through the use of EVV.
- 90% Adherence to Provider Compliance Plan
  - **HHSC EVV Initiative Provider Compliance Plan** – A set of requirements that establish a standard for EVV usage that must be adhered to by provider agencies under the HHSC EVV initiative
  - Provider agencies must achieve and maintain a HHSC EVV Initiative Provider Compliance Plan score of at least 90 percent per review period. Reason codes must be used each time a change is made to an EVV visit record in the EVV system.
- Provider agencies must complete any and all required visit maintenance in the EVV system within 60 days of the visit (date of service). Visit maintenance not completed prior to claim submission is subject to claim denial or recoupment. Provider agencies must submit claims in accordance with their contracted entity claim submission policy. No visit maintenance will be allowed more than 60 days after the date of service and before claims submission, unless an exception is granted.
  - The HHSC Compliance Plan is located at:  
<https://www.dads.state.tx.us/evv/complianceplans.html>
  - The MCO Compliance Plan is located at:  
[https://providers.amerigroup.com/Public%20Documents/TXTX\\_EVVInitiative.pdf](https://providers.amerigroup.com/Public%20Documents/TXTX_EVVInitiative.pdf)
- The provider agency must ensure quality and appropriateness of care and services rendered by continuously monitoring for potential administrative quality issues.
- The provider agency must systematically identify, investigate, and resolve compliance and quality of care issues through the corrective action plan process.
- Providers should notify the appropriate MCO, or HHSC, within 48 hours of any ongoing issues with EVV vendors or issues with EVV systems.
- Any corrective action plan required by an MCO is required to be submitted by the network provider to the MCO within 10 calendar days of receipt of request.
- MCO provider agencies may be subject to termination from the MCO network for failure to submit a requested corrective action plan in a timely manner.



## **EVV Complaint Process**

Complaints by either members or providers about EVV will be handled under the same procedures as described in the [Complaints and Appeals](#) chapter for other types of complaints.

## **How much does EVV cost?**

There is no cost to providers or members for using an EVV system.

## **Providers of Home Health Services Responsibilities**

- The HHSC Provider Compliance Plan (excluding Consumer-Directed Services (CDS)) is located at <https://www.dads.state.tx.us/evv/complianceplans.html>.
- Non-CDS EVV providers must adhere to the Amerigroup Provider Compliance Plan found at [https://providers.amerigroup.com/Public%20Documents/TXTX\\_EVVInitiative.pdf](https://providers.amerigroup.com/Public%20Documents/TXTX_EVVInitiative.pdf) or by calling 1-800-454-3730 for the most current version.
- Provider agencies must use the most appropriate visit maintenance codes. If a record is updated, the provider must use the code that most accurately explains why the change was made to the visit record.

## **Will training be offered to providers?**

The selected EVV vendor is responsible for providing necessary system training and support to providers including CDS employers. Amerigroup includes education on EVV procedures and compliance requirements in training programs for long-term services and supports providers.

## **Will claim payment be affected by the use of EVV?**

- Providers must adhere to EVV guidelines in the HHSC Provider Compliance Plan when submitting a claim.
- Claims must be submitted within 95 calendar days of the EVV visit.

## **What if I need assistance?**

If you have questions, call your selected EVV vendor or our Provider Services team at 1-800-454-3730.

## **6.7 Covered Services**

### ***6.7.1 Nondual-Eligible Members***

We will cover STAR Kids acute care and long-term services and supports benefits for members who are not eligible for Medicare (Medicaid only). The [Covered Services and Extra Benefits](#) chapter has information on acute care benefits.

### ***6.7.2 Dual-Eligible Members***

Acute care for dual-eligible members is covered by Medicare or a Medicare HMO. STAR Kids members who are covered by both Medicaid and Medicare will receive most prescription drug services through Medicare. Dual-eligible members receive coverage for STAR Kids long-term services and supports benefits.

### **6.7.3 STAR Kids Long-term Services and Supports and Waiver Program Benefits**

STAR Kids long-term services and supports covered services are based on how the individual qualifies for membership. The member types are:

- Receives Supplemental Security Income (SSI) but is not enrolled in a state waiver program
- Enrolled in the Medically Dependent Children Program (MDCP)
- Enrolled in the Youth Empowerment Services (YES) waiver
- Enrolled in an IDD waiver program:
  - Community Living Assistance and Support Services (CLASS)
  - Deaf-Blind with Multiple Disabilities (DBMD)
  - Home and Community-Based Services (HCS)
  - Texas Home Living (TxHmL)

### **6.7.4 STAR Kids Long-term Services and Supports Coverage Table**

The chart on the next page provides an overview of STAR Kids long-term services and supports benefits by type and category of coverage. For the YES and IDD member types, the waiver program provides some of the long-term services and supports benefits.

Claims for long-term services and supports benefits covered by the YES waiver program should be submitted to the Department of State Health Services (DSHS). Claims for long-term services and supports benefits covered by the IDD waiver programs (CLASS, DBMD, HCS, and TxHmL) should be submitted to the Department of Aging and Disability Services (DADS).

For members who reside in a nursing facility or an intermediate care facility for individuals with intellectual disabilities (ICF/IID), we will pay for any Amerigroup covered services that are received outside the facility. We will also provide service coordination for the member. Claims for the services covered by Amerigroup should be submitted to us as described in the [Billing and Claims Administration](#) chapter.

| Long-term Services and Supports  |                                       |      |   |   |
|--|---------------------------------------|------|---|---|
| Members should contact a service coordinator or call Member Services to find out if they qualify for services. |                                       |      |   |   |
| Service types<br>Checkmarks (✓) represent benefits that are covered by Amerigroup.                             | SSI recipient not in a waiver program | MDCP | YES waiver                                      | IDD (CLASS, DBMD, HCS, or TxHmL) waiver         |
| Personal care services (PCS)   | ✓                                     |      |   |   |
| Private duty nursing (PDN)   | ✓                                     | ✓    | ✓   | ✓   |
| Day activity and health services (DAHS) (ages 18 and over)   | ✓                                     | ✓    | ✓   | ✓   |
| Prescribed pediatric extended care (PPECC) services  | ✓                                     | ✓    | ✓   | ✓   |
| Personal attendant services (CFC)  | CFC only*                             | ✓    | ✓   | Waiver program determines and provides benefits |
| Habilitation services  | CFC only*                             | ✓    | ✓   |   |
| Emergency response services (emergency call button)  | CFC only*                             | ✓    | ✓   |   |
| Support management   | CFC only*                             | ✓    | ✓   |   |
| Adaptive aids  | Not covered                           | ✓    | Waiver program determines and provides benefits |   |
| Employment assistance  |                                       | ✓    |   |   |
| Financial management services  |                                       | ✓    |   |   |
| Flexible family support services   |                                       | ✓    |   |   |
| Minor home modifications   |                                       | ✓    |   |   |
| Respite services   |                                       | ✓    |   |   |
| Supported employment   |                                       | ✓    |   |   |
| Transition assistance services   |                                       | ✓    |   |   |
| Transportation assistance for Medicaid-covered services  | Medical Transportation Program (MTP)  | MTP  | MTP   | MTP   |

\*The member must qualify for Community First Choice benefits.

### **6.7.5 Long-term Services and Supports Benefit Descriptions**

The following descriptions refer to the benefits grid above. Please see the grid for additional information on benefit availability.

**Adaptive aids** are specialized medical equipment, including devices, controls, or appliances specified in the plan of care, that enable individuals to increase their abilities to perform activities of daily living or perceive, control, or communicate with the environment in which they live. Adaptive aids are reimbursed with the goal of providing individuals a safe alternative to nursing facility (NF) placement. Items not of direct remedial benefit (providing a remedy to cure or restore health) or medical benefit to the individual are excluded from reimbursement. The service limit on adaptive aids is \$4,000 per individual service plan period.

Adaptive aids are limited to the most cost-effective items that can:

- Meet the member's needs.

- Directly aid the member in avoiding premature NF placement.
- Provide NF residents an opportunity to return to the community.

**Community First Choice (CFC) services** include the following:

- **Emergency response services** (emergency call button)
- **Habilitation services** (acquisition, maintenance, and enhancement of skills training) are provided to enable the member to accomplish activities of daily living, instrumental activities of daily living, and other health-related tasks.
- **Personal attendant services** is assistance to members in performing the activities of daily living and instrumental activities of daily living necessary to maintain the home in a clean, sanitary, and safe environment. Services are available to members based on medical and functional necessity and provided to members living in their own home and community settings. Personal attendant services include, but are not limited to:
  - Assisting with the activities of daily living (for example, feeding, preparing meals, transferring, and toileting)
  - Assisting with personal maintenance (for example, grooming, bathing, dressing, and routine care of hair and skin)
  - Assisting with general household activities and chores necessary to maintain the home in a clean, sanitary, and safe environment (for example, changing bed linens, housecleaning, laundering, shopping, storing purchased items, and washing dishes)
  - Providing protective supervision
  - Providing extension of therapy services
  - Providing ambulation and exercise
  - Assisting with medications that are normally self-administered
  - Performing nursing tasks delegated by registered nurses
  - Escorting the member on trips to obtain medical diagnosis, treatment, or both
- **Support management** is voluntary training that may be received on how to select, manage, and dismiss attendants

**Day activity and health services (DAHS)** — All members age 18 and older may receive medically and functionally necessary DAHS. DAHS includes nursing and personal care services, physical rehabilitative services, nutrition services, transportation services, and other supportive services. These services are provided at facilities licensed or certified by the Texas Department of Aging and Disability Services (DADS).

**Employment assistance** is assistance provided to a member to help the member locate paid employment in the community. Employment assistance includes:

- Identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions
- Locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements
- Contacting a prospective employer on behalf of a member and negotiating the member's employment

**Financial management services (FMS)** is assistance provided to members who elect to participate in the Consumer Directed Services (CDS) option to manage funds associated with services elected for

self-direction. The assistance is provided by a financial management services agency (FMSA). This includes initial orientation and ongoing training related to the responsibilities of being an employer and adhering to legal requirements for employers. A monthly administrative fee is authorized on the individual service plan and paid to the FMSA.

- **Support consultation** services are also available only to members participating in the CDS option. This is an optional service. A member's service planning team may recommend the service when the employer (the individual or legally authorized representative [LAR]) or the designated representative (DR) would benefit from additional support with employer responsibilities. Support consultation services must not duplicate or replace services to be delivered through a case manager, a service coordinator, the FMSA, or other sources. A support advisor provides skills-specific training, assistance, and supports to the employer or the employer's designated representative (DR) to meet responsibilities of the CDS option.

Examples of services a support advisor may provide include training related to recruiting and screening applicants for employment and verifying employment eligibility, assistance with developing job descriptions, coaching on problem solving and coordinating employee management activities, training on developing and implementing service backup and corrective action plans, and coaching on handling other employer responsibilities.

**Flexible family support services** are individualized, disability-related services that support a member to participate in:

- Child care
- Independent living
- Post-secondary education

Flexible family support services include personal care supports for basic activities of daily living (ADL) and instrumental ADL, skilled task and delegated skilled task supports. Flexible family support services promote community inclusion in typical child and youth activities through the enhancement of natural supports and systems and through recognition that these supports may vary by child, provider, setting, and daily routine.

**Minor home modifications** are those physical adaptations to a member's home necessary to prevent institutionalization or support de-institutionalization and that are necessary to ensure the member's health, welfare, and safety, or that enable the member to function with greater independence in the home. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the member's welfare. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the member, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit.

The minor home modification lifetime limit is \$7,500. All services are provided in accordance with applicable state or local building codes and must adhere to Americans with Disabilities Act (ADA) requirements.

**Personal care services** are support services furnished to a member who has physical, cognitive, or behavioral limitations related to their disability or chronic health condition that limit their ability to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs), or health maintenance activities. Personal care services, also called personal assistance services, include:

- Assistance with feeding, dressing, moving, bathing, or other personal needs or maintenance.
- General supervision or oversight of the physical and mental well-being of a person who needs assistance to maintain a private and independent residence, or who needs assistance to manage his or her personal life, regardless of whether a guardian has been appointed for the person.

**Prescribed pediatric extended care (PPECC)** is daily medical care away from the member's residence for minors from birth to age 20 who have a medically complex condition. If prescribed by a physician, a member can attend a PPECC up to a maximum of 12 hours per day. Care can include medical, nursing, psychosocial, therapeutic, and developmental services. The types of services provided are based on the needs of the individual's medical condition and developmental status.

**Private duty nursing** is nursing services in the home of members who require more individual and continuous care than is available from a visiting nurse. Services are provided by a registered nurse (RN) or licensed vocational nurse (LVN) and include both direct skilled nursing care and care-giver education and training.

**Respite care** is a service that provides temporary relief from caregiving to the member's primary caregiver during the times when the primary caregiver would normally provide care. The primary caregiver may be the member's parent, guardian, family member, or spouse. The following are requirements for this benefit:

- Respite may only be provided during the time the primary caregiver would usually provide care to the member. Respite may not be provided during the time the primary caregiver is at work, attending school, or in job training.
- Respite may not be delivered by the primary caregiver, the member's spouse, or the member's parent, representative, guardian, or managing conservator, if the individual is under 18.
- Respite may be delivered by attendants or nurses employed through the CDS option.
- Respite care is not limited to the member's home.

**Supported employment** is assistance provided in order to sustain paid employment for a member who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which members without disabilities are employed. Supported employment includes employment adaptations, supervision, and training related to a member's assessed need.

**Transition assistance services (TAS)** pays for nonrecurring, set-up expenses for individuals transitioning from nursing facilities to a home in the community. A nursing facility resident discharged from the facility into the MDCP waiver program is eligible to receive up to \$2,500 in TAS. This benefit is available on a one-time only basis. Allowable expenses are those necessary to enable the individual to establish a basic household and may include:

- Payment of security deposits required to lease an apartment or home
- Set-up fees or deposits to establish utility services for the home, including telephone, electricity, gas, and water

- Purchase of essential furnishings for the apartment or home, including table, chairs, window blinds, eating utensils, food preparation items, and bath linens
- Payment of moving expenses required to move into or occupy the home or apartment
- Payment for services to ensure the health and safety of the individual in the apartment or home, such as pest eradication, allergen control, or a one-time cleaning before occupancy

Waiver individuals who are temporarily residing in a nursing facility may also be eligible for TAS. This benefit may be used if the waiver member's living conditions are inadequate. Inadequate living conditions may include situations in which the individual has lost a residence because of moving into the nursing facility or conditions in the previous residence are so inadequate that the individual cannot return.

### ***6.7.6 Settings for Provision of Long-term Services and Supports Benefits***

Community-based long-term services and supports are services provided to members in their home or other community-based settings necessary to provide assistance with activities of daily living to allow the member to remain in the most integrated setting possible.

Community-based long-term services and supports must be provided in settings that allow the member an opportunity to:

- Seek employment and work in competitive integrated settings
- Engage in community life
- Control personal resources
- Receive services in the community to the same degree of access as individuals not receiving Medicaid long-term services and supports

The setting for services must ensure the individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint. The setting should optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to daily activities, physical environment, and the choice of with whom to interact. The setting must facilitate individual choice regarding services and supports and who provides them.

Members should be advised about, and assisted in, accessing the most appropriate, least restrictive, home- and community-based services as alternatives to institutional care. The member must be given an opportunity to make an informed choice among the options for care settings including non-disability specific settings and an option for a private unit in a residential setting. The setting options must be:

- Identified and documented in the member's service plan.
- Based on the member's individual needs and preferences, and for residential settings, resources available for room and board.

In a provider-owned or controlled setting, the following additional rights must be given to individuals:

- The same responsibilities and protections from eviction that tenants have under state and local law
- Privacy in their sleeping or living unit, including locking doors, choice of roommates, and freedom to furnish and decorate sleeping and living areas

- Freedom and support to control schedules and activities, including access to food at any time and having visitors at any time

Settings for community-based long-term services and supports do not include:

- A nursing facility
- An institution for mental diseases
- An intermediate care facility for individuals with intellectual disabilities
- A hospital
- Any other location that has the quality of an institutional setting

### ***6.7.7 Reporting Abuse, Neglect, or Exploitation (ANE) - Medicaid Managed Care***

#### **Report suspected Abuse, Neglect, and Exploitation:**

MCOs and providers must report any allegation or suspicion of ANE that occurs within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include MCO and provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and provider requirements continue to apply.

#### **Report to the Department of Aging and Disability Services (DADS) if the victim is an adult or child who resides in or receives services from:**

- Nursing facilities
- Assisted living facilities
- Home and Community Support Services Agencies (HCSSAs) – Providers are required to report allegations of ANE to both DFPS and DADS
- Adult day care centers
- Licensed adult foster care providers

Contact DADS at 1-800-647-7418.

#### **Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:**

An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:

- Local Intellectual and Developmental Disability Authority (LIDDA), Local Mental Health Authority (LMHAs), community center, or mental health facility operated by the Department of State Health Services
- A person who contracts with a Medicaid managed care organization to provide behavioral health services
- A managed care organization
- An officer, employee, agent, contractor, or subcontractor of a person or entity listed above
- An adult with a disability receiving services through the Consumer Directed Services option

Contact DFPS at 1-800-252-5400 or, in non-emergency situations, online at [www.txabusehotline.org](http://www.txabusehotline.org)



**Report to Local Law Enforcement:**

If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

**Failure to Report or False Reporting:**

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, DADS, or a law enforcement agency (See: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).
- It is a criminal offense to knowingly or intentionally report false information to DFPS, DADS, or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

**6.8 Service Coordination*****6.8.1 Service Coordinator Roles and Responsibilities***

Service coordination is specialized care management services that are performed by a licensed, certified, and/or experienced person called a service coordinator. This includes but is not limited to the following activities:

- Identifying a member's needs through an assessment
- Documenting how to meet the member's needs in a care plan
- Engaging the member, the member's representative, and caregivers in the design of the member's individual service plan (ISP)
- Arranging for delivery of the needed services and monitoring provision and timeliness
- Establishing a relationship with the member and being an advocate for the member in coordinating care
- Helping with coordination between different types of services
- Making sure the member has a primary care provider

The purpose of a service coordinator is to maximize a member's health, well-being, and independence. Service coordination should consider and address the member's situation as a whole, including his or her medical, behavioral, social, and educational needs. The service coordinator must work with the member's primary care provider to coordinate all covered services, noncapitated services, and noncovered services available through other sources. This requirement applies even if the member is dual-eligible and the primary care provider is not in our network. In order to integrate the member's care while remaining informed of the member's needs and condition, the service coordinator must actively involve the member's primary and specialty care providers, including behavioral health service providers, and providers of noncapitated services and noncovered services.

### **6.8.2 STAR Kids Screening and Assessment Process**

**STAR Kids Screening and Assessment Instrument (SAI)** means the electronic assessment and screening tool that we are required to administer to STAR Kids members to help determine personal preferences, service needs, and necessity of additional assessments.

**STAR Kids Screening and Assessment Process** means all screenings, assessments, and other information-gathering methods that we use to inform our decisions about services needed for members.

We conduct an initial telephonic member screening for all new members. The telephonic screening is used to help prioritize which members require the most immediate attention. We also review claims data to prioritize members who may need the most immediate assistance. For all members who are new to Amerigroup on the operational start date of the STAR Kids program, we may take up to 15 business days for the initial telephonic member screening unless notified by the member, the member's representative, or member's primary care provider by phone or in writing of a more urgent need. Members who enroll in STAR Kids 6 months after the operational start date or later must receive the initial telephonic member screening within 5 business days from the day the member is enrolled with Amerigroup.

### **6.8.3 Individual Service Plan (ISP) Description**

We will create and regularly update a comprehensive person-centered ISP for each STAR Kids member. The purpose of the ISP is to articulate assessment findings, short and long-term goals, service needs, and member preferences. The ISP must be used to communicate and help align expectations between the member, the member's representative, Amerigroup, and key service providers. The ISP may also be used by us and HHSC to measure member outcomes over time. The ISP must be informed by findings from the STAR Kids Screening and Assessment Process, in addition to input from the member, the member's family, caregivers, providers, and any other individual with knowledge and understanding of the member's strengths and service needs who is identified by the member, the member's representative, or Amerigroup.

Each member's ISP must be updated:

- At least annually.
- Following a significant change in health condition that impacts service needs.
- Upon request from the member or the member's representative.
- At the recommendation of the member's primary care provider.
- Following a change in life circumstance.
- Following the STAR Kids Screening and Assessment Process or reassessment process.

We will provide a printed or electronic copy of the ISP to each member or member's representative following any significant update and no less than annually. We will provide a copy of the ISP to the member's providers and other individuals specified by the member or member's representative.

### **6.8.4 Service Coordination Services**

We provide a single identified person as a service coordinator to all STAR Kids members who:

- Qualify as level 1 or level 2 under HHSC guidelines (see guidelines below)

- Are enrolled in an IDD waiver program (CLASS, DBMD, HCS, or TxHmL)
- Reside in a nursing facility or community based ICF/IID
- Request a personal service coordinator

Level 1 members include:

- MDCP STAR Kids members
- Members with complex needs or a history of developmental or behavioral health issues (multiple outpatient visits, hospitalization, or institutionalization within the past year)
- Members with a serious emotional disturbance (SED) or severe and persistent mental illness (SPMI)
- Members at risk for institutionalization

All Level 1 members must receive a minimum of 4 face-to-face service coordination contacts annually and monthly phone calls, unless otherwise requested by the member or member's representative.

Level 2 members include:

- Members who do not meet the requirements for level 1 classification, but receive personal care services (PCS), Community First Choice (CFC), or nursing services (including PDN and PPECC)
- Members we believe would benefit from a higher level of service coordination based on results from the STAR Kids SAI and our additional findings
- Members with a history of substance abuse (multiple outpatient visits, hospitalization, or institutionalization within the past year)
- Members without SED or SPMI, but who have another behavioral health condition that significantly impairs function

All level 2 members will receive a minimum of 2 face-to-face and 6 telephonic service coordination contacts annually unless otherwise requested by the member or member's representative.

Level 3 members are those members who do not qualify as level 1 or level 2. Level 3 members are not required to have a single identified person as a service coordinator unless the member requests service coordination services, or the member is enrolled in an IDD waiver program (CLASS, DBMD, HCS, or TxHmL). All level 3 members must receive a minimum of 1 face-to-face visit annually and make at least 3 telephonic service coordination outreach contacts yearly.

Our service coordinators are available from 8 a.m. to 5 p.m. Central time by calling 1-866-696-0710 or Provider Services at 1-800-454-3730. For urgent issues, assistance is available after normal business hours, during weekends, and on holidays through Provider Services.

### **6.8.5 Discharge Planning**

We will promptly assess the needs of a member discharged from a hospital, nursing facility, ICF/IID, inpatient psychiatric facility or other care or treatment facility. A service coordinator will work with the member's primary care provider, the attending physician, the hospital, inpatient psychiatric facility, nursing facility or ICF/IID discharge planner, the member, and the member's family to assess and plan for the member's discharge including appropriate service authorizations. Upon receipt of notice of a

member's discharge from an inpatient psychiatric facility, a service coordinator will contact the member within 1 business day. When long-term services and supports are needed, we will ensure the member's discharge plan includes arrangements for receiving appropriate community-based care. The service coordinator will provide information to the member, the member's family, and the member's primary care provider regarding all service options available to meet the member's needs in the community. For members being discharged from a nursing facility or ICF/IID to the community, we will provide timely access to service coordination and arrange for medically or functionally necessary personal care services (PCS) or nursing services.

#### ***6.8.6 Continuity of Care Transition Plan for New Members***

We will provide a transition plan for a member newly enrolled with Amerigroup in the STAR Kids program who is already receiving long-term services and supports including nursing facility or ICF/IID services. HHSC, or the previous MCO, will give us information such as detailed care plans and names of current providers. We will ensure that current providers are paid for medically necessary and functionally necessary covered services that are delivered in accordance with the member's existing care plan beginning with the member's date of enrollment with Amerigroup until the transition plan is developed and implemented.

The transition planning process will include the following:

- Review of existing care plans and ISPs prepared by a state agency or another MCO, covered services received, and the Individual Plan of Care for members enrolled in MDCP
- Preparation of a transition plan that ensures continuous care under the member's existing treatment plan during the transfer into the Amerigroup network while we conduct an appropriate assessment and development of a new plan or updated ISP, if needed
- If durable medical equipment or supplies had been ordered prior to enrollment but have not been received by the date of enrollment, we will coordinate and follow through to ensure that the member receives the necessary supportive equipment and supplies without undue delay
- Payment to the existing provider of service under any existing authorization, care plan, or service plans for up to 6 months, until we have completed the STAR Kids Screening and Assessment Process and issued a new authorization and ISP
- For members new to the Medicaid program, an initial telephonic communication to the member completed within 5 business days of enrollment

A transition plan will include:

- The member's history
- A summary of current medical, behavioral health, and social needs and concerns
- Immediate and short-term needs and goals
- A list of services required and their frequency
- A description of who will provide the services

The transition plan may include information about services outside the scope of covered services such as how to access affordable, integrated housing. We will ensure the member or the member's representative is involved in the assessment process and fully informed about options, is included in the development of the transition plan, and is in agreement with the plan when completed.

We will review any existing care plan or ISP for a new member and begin to develop a transition plan within 10 business days of receiving notice of the member's enrollment, or receiving the plan of care if not received at the time of enrollment. For existing care plans and ISPs received prior to the STAR Kids operational start date, we will complete the transition plan development within 30 calendar days after the member's enrollment or receipt of the plan of care if not received at the time of enrollment. The transition plan will remain in place until we develop a new or updated ISP with input from the member and/or member's representative. We will ensure that existing services continue and that there is no break in services.

For members enrolling on the operational start date of the STAR Kids program or on the start date of a new service area, we will honor existing long-term services and supports authorizations for up to 6 months, or until we have completed the STAR Kids Screening and Assessment Process and issued new service authorizations.

For members enrolling after the operational start date of the STAR Kids program in an existing service area, we will honor existing long-term services and supports authorizations for up to 90 days, or until we have completed the STAR Kids Screening and Assessment Process and issued new service authorizations.

#### ***6.8.7 Adult Transition Planning***

Amerigroup will help to assure that teens and young adult members receive early and comprehensive transition planning to help prepare them for service and benefit changes that will occur following their 21st birthday. Each MCO is responsible for conducting ongoing transition planning starting when the member turns 15 years old. The MCO must provide transition planning services as a team approach through the named service coordinator if applicable and with a transition specialist within Member Services. A transition specialist must be an employee of the MCO and wholly dedicated to counseling and educating members and others in their support network about considerations and resources for transitioning out of STAR Kids. Transition specialists must be trained on the STAR+PLUS system and maintain current information on local and state resources to assist the member in the transition process. Transition planning must include the following activities:

- Development of a continuity of care plan for transitioning Medicaid services and benefits from STAR Kids to the STAR+PLUS Medicaid managed care model without a break in service
- Prior to the age of 10, the MCO must inform the member and the member's legally authorized representative (LAR) regarding LTSS programs offered through the Department of Aging and Disability Services (DADS) and, if applicable, provide assistance in completing the information needed to apply (DADS LTSS programs include CLASS, DBMD, TxHmL, and HCS)
- Beginning at age 15, the MCO must regularly update the ISP with transition goals
- Coordination with the Department of Assistive and Rehabilitative Services (DARS) to help identify future employment and employment training opportunities
- If desired by the member or the member's LAR, coordination with the member's school and Individual Education Plan (IEP) to ensure consistency of goals
- Health and wellness education to assist the member with self-management
- Identification of other resources to assist the member, the member's LAR, and others in the member's support system to anticipate barriers and opportunities that will impact the member's transition to adulthood

- Assistance applying for community services and other supports under the STAR+PLUS program after the member's 21st birthday
- Assistance identifying adult healthcare providers

## 6.9 Precertification

Precertification forms are available at <https://providers.amerigroup.com/TX>.

**All long-term services and supports require authorization before services are rendered.** Requests may be submitted via fax, telephone, or our website at <https://providers.amerigroup.com/TX> for review and approval. We will send a fax confirmation of the service approval.

STAR Kids long-term services and supports fax: 1-844-756-4604

Telephone (if urgent): 1-800-454-3730

Website: <https://providers.amerigroup.com/TX>

## 6.10 Claims

### 6.10.1 Timely Filing

Providers must ensure clean claims are submitted and received by us within **95 calendar days of the date of service and/or date of discharge**. In the case of other insurance, submit a clean claim within 95 days of receiving a response from the third-party payer. Clean claims for members whose eligibility has not been added to the state's system must be received within 95 days from the date the eligibility is added. We must receive clean claims from out-of-network providers rendering services outside of Texas within 1 year of the date of service and/or date of discharge. Refer to the [Billing and Claims Administration](#) chapter of this manual for the definition of a clean claim.

Claims can be submitted electronically or by paper at the provider's preferred frequency (daily, weekly, etc.), but cannot exceed the filing limit deadline. When billing a span of dates on a single outpatient claim, the filing timeline is calculated from the first or earliest service date on the claim. Acute care and outpatient claims should be submitted in accordance with the requirements in the [Billing and Claims Administration](#) chapter of this manual.

### 6.10.2 Uniform Billing Code Guidelines

Providers must follow the uniform coding guidelines for long-term services and supports services as defined by the Texas Health and Human Services Commission (HHSC). Refer to our website at <https://providers.amerigroup.com/TX> for the current guidelines. Use only the uniform billing defined code, modifier, type, and place of service combinations.

### 6.10.3 Claim Submission

Long-term services and supports providers have 3 options for submitting claims, including claims for services for MDCP and other waiver program members that are covered by Amerigroup under the STAR Kids program: [www.Availity.com](http://www.Availity.com), Electronic Data Interchange, or paper.

### **Website**

We provide a free online claim submission tool at [www.Availity.com](http://www.Availity.com). This tool submits claims directly to us without the use of a clearinghouse. Submission via the website requires provider registration.

### **Electronic Data Interchange (EDI)**

Claims may be submitted electronically through the clearinghouses identified below. The guide for EDI claims submission is located on our website at <https://providers.amerigroup.com/TX>. 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 call the Amerigroup EDI Hotline at 1-800-590-5745.

| Clearinghouse        | Amerigroup payer ID |
|----------------------|---------------------|
| Emdeon               | 27514               |
| Capario              | 28804               |
| Availity             | 26375               |
| Smart Data Solutions | 81237               |

### **Paper Claims**

For more effective claims processing, paper claim forms:

- Must be submitted on original claim forms (CMS-1500 or CMS-1450 [UB-04]) with dropout red ink and printed or typed (not handwritten) in a large, dark font.
- Cannot be submitted with alterations to key billing information; we do not accept claims with information that is marked through, handwritten, or whited out.

Claims that have been altered are rejected, and returned to the provider with an explanation of the reason for the return.

### **Submit long-term services and supports (LTSS) paper claims to us at:**

STAR Kids LTSS Claims

Amerigroup

PO Box 61010

Virginia Beach, VA 23466-1010

### **CMS 1500 Claim Form**

Noninstitutional providers and suppliers must use the CMS 1500 form.

- You may bill either individual dates of service or bill using a span of dates.
  - Example: Claim may be submitted for dates of service from January 1, 2016, to January 15, 2016, on 1 claim. Box 24 should indicate service dates **from** January 1, 2016, **to** January 15, 2016.
- You must include your state-issued LTSS provider ID appropriate for the service being billed. IDs are assigned to specific categories of service. Place the number in Box 33B:
  - Sample ID
  - Statewide = S00000000
  - Facility-based provider (DAHS) = F00000000



This form and instructions are available on the CMS website at <https://www.cms.gov>. The following is a sample:

| HEALTH INSURANCE CLAIM FORM   |  |  |  |  |  |  |  |  |  | CARRIER |
|---|--|--|--|--|--|--|--|--|--|---------|
| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12   |  |  |  |  |  |  |  |  |  | PICA    |
| <div> <div> </div> <div> <b>HEALTH INSURANCE CLAIM FORM</b><br/> APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 </div> </div>  |  |  |  |  |  |  |  |  |  |         |
| <div> <div> <div> <div> <div>1. MEDICARE (Medicare)</div> <div>2. MEDICAID (Medicaid)</div> <div>3. TRICARE (TRICARE)</div> <div>4. CHAMPVA (Member ID)</div> <div>5. GROUP HEALTH PLAN (ID#)</div> <div>6. FECA BLK/LUNG (ID#)</div> <div>7. OTHER (ID#)</div> </div> <div> <div>1a. INSURED'S ID NUMBER (For Program in Item 1)</div> </div> </div> </div> </div>   |  |  |  |  |  |  |  |  |  |         |
| <div> <div> <div> <div>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</div> <div>3. PATIENT'S BIRTH DATE (MM/DD/YY)</div> <div>4. SEX (M/F)</div> </div> <div> <div>5. PATIENT'S ADDRESS (No., Street)</div> <div>6. PATIENT RELATIONSHIP TO INSURED (Self/Spouse/Child/Other)</div> <div>7. RESERVED FOR NUCC USE</div> </div> </div> </div>  |  |  |  |  |  |  |  |  |  |         |
| <div> <div> <div> <div>8. INSURED'S NAME (Last Name, First Name, Middle Initial)</div> <div>9. INSURED'S ADDRESS (No., Street)</div> <div>10. CITY</div> <div>11. STATE</div> <div>12. ZIP CODE</div> <div>13. TELEPHONE (Include Area Code)</div> </div> <div> <div>14. INSURED'S POLICY GROUP OR FECA NUMBER</div> <div>15. INSURED'S DATE OF BIRTH (MM/DD/YY)</div> <div>16. SEX (M/F)</div> <div>17. OTHER CLAIMED (Designated by NUCC)</div> <div>18. INSURANCE PLAN NAME OR PROGRAM NAME</div> <div>19. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES/NO) If yes, complete items 9, 8a, and 9d.</div> </div> </div> </div> |  |  |  |  |  |  |  |  |  |         |
| <div> <div> <div> <div>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)</div> <div>SIGNED _____ DATE _____</div> </div> <div> <div>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)</div> <div>SIGNED _____</div> </div> </div> </div>   |  |  |  |  |  |  |  |  |  |         |
| <div> <div> <div> <div>14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/DD/YY)</div> <div>15. OTHER DATE (MM/DD/YY)</div> </div> <div> <div>16. NAME OF REFERRING PROVIDER OR OTHER SOURCE</div> <div>17a. NPI</div> <div>17b. NPI</div> </div> </div> </div>  |  |  |  |  |  |  |  |  |  |         |
| <div> <div> <div> <div>18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</div> <div>19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate back to service line below (24E))</div> <div>20. ICD-10</div> </div> <div> <div>21. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)</div> <div>22. PLACE OF SERVICE (EMG)</div> <div>23. PROCEDURES, SERVICES, OR SUPPLIES (CPT/HCPCS)</div> <div>24. MODIFIER</div> <div>25. DIAGNOSIS POINTER</div> </div> </div> </div>  |  |  |  |  |  |  |  |  |  |         |
| <div> <div> <div> <div>26. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM/DD/YY TO MM/DD/YY)</div> <div>27. OUTSIDE LAB? (YES/NO) \$ CHARGES</div> <div>28. RESUBMISSION CODE</div> <div>29. ORIGINAL REF. NO.</div> <div>30. PRIOR AUTHORIZATION NUMBER</div> </div> <div> <div>31. \$ CHARGES</div> <div>32. DAYS OF UNITS</div> <div>33. NPI</div> <div>34. QUAL.</div> <div>35. RENDERING PROVIDER ID #</div> </div> </div> </div>  |  |  |  |  |  |  |  |  |  |         |
| <div> <div> <div> <div>36. FEDERAL TAX ID NUMBER</div> <div>37. SSN EIN</div> <div>38. PATIENT'S ACCOUNT NO.</div> <div>39. ACCEPT ASSIGNMENT? (YES/NO)</div> <div>40. TOTAL CHARGE</div> <div>41. AMOUNT PAID</div> <div>42. Revs for NUCC Use</div> </div> <div> <div>43. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS) (I certify that the statements on the reverse apply to this bill and are made a part thereof.)</div> <div>44. SERVICE FACILITY LOCATION INFORMATION</div> <div>45. BILLING PROVIDER INFO &amp; PH #</div> </div> </div> </div>  |  |  |  |  |  |  |  |  |  |         |
| <div> <div> <div> <div>46. SIGNED _____ DATE _____</div> <div>47. NPI</div> <div>48. NPI</div> </div> <div> <div>49. NPI</div> <div>50. NPI</div> </div> </div> </div>  |  |  |  |  |  |  |  |  |  |         |

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org) PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)



### CMS 1450 Claim Form

Institutional and other selected providers must use the CMS 1450 (UB-04) form. This form and instructions are available on the CMS website at <https://www.cms.gov>. The following is a sample:

|                                  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
|----------------------------------|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|------------------------------|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|----|--|--|--|--|--|--|--|--|--|--------------------------------------|--|--|--|--|--|--|--|--|--|---------------|--|--|--|--|--|--|--|--|--|----|--|--|--|--|--|--|--|--|--|
| 1                                |  |  |  |  |  |  |  |  |  | 2                          |  |  |  |  |  |  |  |  |  | 3a PAT. CNTL #<br>b. MED. REG. # |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
|                                  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  | 5 FED. TAX NO.                   |  |  |  |  |  |  |  |  |  | 6 STATEMENT COVERS PERIOD FROM<br>THROUGH |  |  |  |  |  |  |  |  |  | 7                      |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 8 PATIENT NAME                   |  |  |  |  |  |  |  |  |  | 9 PATIENT ADDRESS          |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| b                                |  |  |  |  |  |  |  |  |  | c                          |  |  |  |  |  |  |  |  |  | d                                |  |  |  |  |  |  |  |  |  | e   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 10 BIRTHDATE                     |  |  |  |  |  |  |  |  |  | 11 SEX                     |  |  |  |  |  |  |  |  |  | 12 DATE                          |  |  |  |  |  |  |  |  |  | ADMISSION 13 HR 14 TYPE 15 SRC            |  |  |  |  |  |  |  |  |  | 16 DHR                 |  |  |  |  |  |  |  |  |  | 17 STAT                      |  |  |  |  |  |  |  |  |  | 18                     |  |  |  |  |  |  |  |  |  | 19               |  |  |  |  |  |  |  |  |  | 20    |  |  |  |  |  |  |  |  |  | 21 |  |  |  |  |  |  |  |  |  | CONDITION CODES 22 23 24 25 26 27 28 |  |  |  |  |  |  |  |  |  | 29 ACCT STATE |  |  |  |  |  |  |  |  |  | 30 |  |  |  |  |  |  |  |  |  |
| 31 OCCURRENCE DATE               |  |  |  |  |  |  |  |  |  | 33 OCCURRENCE DATE         |  |  |  |  |  |  |  |  |  | 35 CODE                          |  |  |  |  |  |  |  |  |  | OCCURRENCE SPAN FROM THROUGH              |  |  |  |  |  |  |  |  |  | 38 CODE                |  |  |  |  |  |  |  |  |  | OCCURRENCE SPAN FROM THROUGH |  |  |  |  |  |  |  |  |  | 37                     |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 38                               |  |  |  |  |  |  |  |  |  | 39 CODE                    |  |  |  |  |  |  |  |  |  | VALUE CODES AMOUNT               |  |  |  |  |  |  |  |  |  | 41 CODE                                   |  |  |  |  |  |  |  |  |  | VALUE CODES AMOUNT     |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| a                                |  |  |  |  |  |  |  |  |  | b                          |  |  |  |  |  |  |  |  |  | c                                |  |  |  |  |  |  |  |  |  | d   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 42 REV. CD.                      |  |  |  |  |  |  |  |  |  | 43 DESCRIPTION             |  |  |  |  |  |  |  |  |  | 44 HCPCS / RATE / HIPPS CODE     |  |  |  |  |  |  |  |  |  | 45 SERV. DATE                             |  |  |  |  |  |  |  |  |  | 46 SERV. UNITS         |  |  |  |  |  |  |  |  |  | 47 TOTAL CHARGES             |  |  |  |  |  |  |  |  |  | 48 NON-COVERED CHARGES |  |  |  |  |  |  |  |  |  | 49               |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 1                                |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 1                |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 2                                |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 2                |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 3                                |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 3                |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 4                                |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 4                |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 5                                |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 5                |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 6                                |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 6                |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 7                                |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 7                |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 8                                |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 8                |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 9                                |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 9                |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 10                               |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 10               |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 11                               |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 11               |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 12                               |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 12               |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 13                               |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 13               |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 14                               |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 14               |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 15                               |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 15               |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 16                               |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 16               |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 17                               |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 17               |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 18                               |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 18               |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 19                               |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 19               |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 20                               |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 20               |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 21                               |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 21               |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 22                               |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 22               |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 23                               |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 23               |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| PAGE                             |  |  |  |  |  |  |  |  |  | OF                         |  |  |  |  |  |  |  |  |  | CREATION DATE                    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 50 PAYER NAME                    |  |  |  |  |  |  |  |  |  | 51 HEALTH PLAN ID          |  |  |  |  |  |  |  |  |  | 52 REL. INFO.                    |  |  |  |  |  |  |  |  |  | 53 ASG. BEN.                              |  |  |  |  |  |  |  |  |  | 54 PRIOR PAYMENTS      |  |  |  |  |  |  |  |  |  | 55 EST. AMOUNT DUE           |  |  |  |  |  |  |  |  |  | 56 NPI                 |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| A                                |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  | 57                     |  |  |  |  |  |  |  |  |  | A                |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| B                                |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  | OTHER                  |  |  |  |  |  |  |  |  |  | B                |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| C                                |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  | PRV ID                 |  |  |  |  |  |  |  |  |  | C                |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 58 INSURED'S NAME                |  |  |  |  |  |  |  |  |  | 59 P. REL.                 |  |  |  |  |  |  |  |  |  | 60 INSURED'S UNIQUE ID           |  |  |  |  |  |  |  |  |  | 61 GROUP NAME                             |  |  |  |  |  |  |  |  |  | 62 INSURANCE GROUP NO. |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| A                                |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  | A                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| B                                |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | B                |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| C                                |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | C                |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 63 TREATMENT AUTHORIZATION CODES |  |  |  |  |  |  |  |  |  | 64 DOCUMENT CONTROL NUMBER |  |  |  |  |  |  |  |  |  | 65 EMPLOYER NAME                 |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| A                                |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  | A                      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| B                                |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | B                |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| C                                |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | C                |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 66 DX                            |  |  |  |  |  |  |  |  |  | 67                         |  |  |  |  |  |  |  |  |  | A                                |  |  |  |  |  |  |  |  |  | B   |  |  |  |  |  |  |  |  |  | C                      |  |  |  |  |  |  |  |  |  | D                            |  |  |  |  |  |  |  |  |  | E                      |  |  |  |  |  |  |  |  |  | F                |  |  |  |  |  |  |  |  |  | G     |  |  |  |  |  |  |  |  |  | H  |  |  |  |  |  |  |  |  |  | 68                                   |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 69 ADMIT DX                      |  |  |  |  |  |  |  |  |  | 70 PATIENT REASON DX       |  |  |  |  |  |  |  |  |  | a                                |  |  |  |  |  |  |  |  |  | b   |  |  |  |  |  |  |  |  |  | c                      |  |  |  |  |  |  |  |  |  | 71 PPS CODE                  |  |  |  |  |  |  |  |  |  | 72 ECI                 |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  | 73    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 74 PRINCIPAL PROCEDURE CODE      |  |  |  |  |  |  |  |  |  | DATE                       |  |  |  |  |  |  |  |  |  | b. OTHER PROCEDURE CODE          |  |  |  |  |  |  |  |  |  | DATE                                      |  |  |  |  |  |  |  |  |  | 75                     |  |  |  |  |  |  |  |  |  | 76 ATTENDING NPI             |  |  |  |  |  |  |  |  |  | QUAL                   |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
|                                  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  | LAST                   |  |  |  |  |  |  |  |  |  | FIRST            |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
|                                  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 77 OPERATING NPI |  |  |  |  |  |  |  |  |  | QUAL  |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
|                                  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | LAST             |  |  |  |  |  |  |  |  |  | FIRST |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 80 REMARKS                       |  |  |  |  |  |  |  |  |  | 81CC a                     |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 78 OTHER NPI                 |  |  |  |  |  |  |  |  |  | QUAL                   |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
|                                  |  |  |  |  |  |  |  |  |  | b                          |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  | LAST                   |  |  |  |  |  |  |  |  |  | FIRST            |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
|                                  |  |  |  |  |  |  |  |  |  | c                          |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | 79 OTHER NPI     |  |  |  |  |  |  |  |  |  | QUAL  |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
|                                  |  |  |  |  |  |  |  |  |  | d                          |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  | LAST             |  |  |  |  |  |  |  |  |  | FIRST |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |

UB-04 CMS-1450

APPROVED OMB NO.

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC National Uniform Billing Corporation  
LIC9213257

### ***Claim Adjudication and Reimbursement***

Our members must not be balance billed for covered services. Additional information can be found in the [Billing and Claims Administration](#) chapter of this manual.

Clean claims for Medicaid members are adjudicated within 30 days from the date we receive them. Clean claims not adjudicated within 30 days of receipt by us are subject to interest payments.

Adjudication edits are based on the member's eligibility, benefit plan, authorization status, HIPAA coding compliance, and our claim processing guidelines. Claim coding is subject to review using code-editing software.

Claim reimbursement is based on the provider's contract. We are responsible for paying an enhanced fee to long-term services and supports providers who are part of the Department of Aging and Disability Services (DADS) Attendant Care Enhancement Payment program. When contracted with us for this program, the fees will be built into the provider's fee schedule. We are not required to match the DADS program. Details of this program are provided starting in the [Attendant Care Enhancement Payments Program](#) section below.

#### **6.11 Cost Reporting to HHSC**

Long-term services and supports providers must submit periodic cost reports and supplemental reports to HHSC in accordance with 1 T.A.C. Chapter 355, including Subchapter A (*Cost Determination Process*) and 1 T.A.C. §355.403 (*Vendor Hold*). If a long-term services and supports provider fails to comply with these requirements, HHSC will notify Amerigroup to hold payments to the provider until HHSC instructs us to release the payments.

#### **6.12 Attendant Care Enhancement Payments Program (ACEP)**

The Attendant Care Enhancement Payments program is a legislatively-mandated program providing additional compensation to long-term direct care providers. We administer the enhanced payments for direct care providers rendering services to our members.

##### ***6.12.1 Attendant Care Enhancement Payments Program Enrollment***

Providers are eligible to enroll in the ACEP program for day activity and health services (DAHS). We allow contracted providers in the DADS attendant care enhancement program to enroll in our ACEP program. The agreement between these providers and us includes language defining the requirements for enhancement payments.

Any provider joining our ACEP program or requesting a change in participation level will be required to demonstrate enrollment in good standing in the DADS program. Acceptable documentation includes either a copy of the DADS letter to the provider indicating the level of participation, or the provider's DADS contract number that can be verified with the DADS participation list. A newly contracted provider's enrollment into our program will be effective concurrently with the effective date of his or her provider participation agreement/contract.

A provider with an existing participation agreement/contract with us may request an amendment for participation in our ACEP program during our annual open enrollment period. In some cases, providers in certain counties are no longer afforded the opportunity to hold DADS program contracts because DADS does not administer a particular program in those counties, or DADS has exceeded available funding to support new enrollment or provider movement within their program levels. In these instances, we will allow new or contracted providers to enroll in our ACEP program. This exception is granted under the following conditions:

- The provider is licensed by DADS
- The provider has not been sanctioned, disciplined, restricted, prohibited from contracting and/or disenrolled from the DADS program contracts in the previous 3 fiscal state periods

### ***6.12.2 Attendant Care Enhancement Payment Levels***

We will increase our fee schedule rates for those codes included within the enhancement program for contracted providers who enroll. Services eligible for the additional payment under the program for STAR Kids members are DAHS. Enhancement levels are available in 5 tiers. The amount of the fee schedule increase will be determined based on a financial analysis of the historic costs of the enhancement program to the extent these are available. The enhancement payment amount will be added to the provider's negotiated rate schedule for eligible services. The enhancement payment is made as part of the claim payment. The payment and Explanation of Payment (EOP) issued to the provider will **not** indicate that the provider was paid at the enhanced rate.

We reserve the right to adjust and amend the ACEP program fee schedule at any time with appropriate notice to program participants. The Amerigroup ACEP program administers 5 tiers of payment as defined below:

Tier B (DADS levels 26-35) = \$1.75 per unit  
Tier 1 (DADS levels 16-25) = \$1.25 per unit  
Tier 2 (DADS levels 11-15) = \$ 0.75 per unit  
Tier 3 (DADS levels 6-10) = \$ 0.50 per unit  
Tier 4 (DADS levels 1-5) = \$ 0.25 per unit

Tier amounts are subject to change based on the funds available for our ACEP program. Providers will be notified of rate changes by contract amendment.

Participation in the program will renew each contract year unless the provider disenrolls from the DADS program or changes DADS payment levels.

### ***6.12.3 Attendant Care Enhancement Payments Reporting***

We require each contracted provider participating in the enhancement program to supply a detailed report describing the amount spent and payment distribution. Each provider must submit the required report in the format and by the date required each year by Amerigroup. We will send notification of the requirements to each provider enrolled in the program with Amerigroup. Each report submitted by the provider will be reviewed to ensure funds were distributed in accordance with state guidelines. We will conduct detailed audits as we deem necessary.

If a provider fails to distribute the funds appropriately, we will issue a notice of corrective action to that provider. The provider will then have 45 days to ensure funds are distributed correctly. Should the provider fail to comply with the corrective action, we will take action including, but not limited to:

- Retracting the funds
- Reporting inappropriate use of funds by the provider to HHSC
- Suspending or terminating the provider's participation in the Amerigroup enhancement program
- Terminating the Amerigroup provider participation agreement

### **6.13 Provider Complaints**

A complaint is a written expression of dissatisfaction regarding any aspect of health care services provided by Amerigroup, network providers, or staff, other than a payment appeal. For a description of the provider complaint process, see the [Complaints and Appeals](#) chapter of this manual.

### **6.14 Provider Payment Appeals**

Providers may make the initial attempt to resolve a claim issue by calling Provider Services at 1-800-454-3730 or a local health plan Provider Relations representative. All appeals must be submitted in writing and received by us within 120 calendar days of the printed run date on the Explanation of Payment (EOP). To submit a payment appeal, complete the payment appeal form located online at <https://providers.amerigroup.com/TX>. All appropriate supporting documents (including the EOP, medical records, etc.) must accompany the appeal. Submit the documentation to:

Provider Payment Appeals  
Amerigroup  
PO Box 61599  
Virginia Beach, VA 23466-1599

Providers may also fax a payment appeal to 1-844-756-4607 or utilize the payment appeal tool at [www.Availity.com](http://www.Availity.com). When inquiring on the status of a claim that is considered eligible for appeal due to no or partial payment, a button will display for submission of an appeal. Once this button is clicked, a web form will display for the provider to complete and submit. If all required fields are completed, the provider will receive immediate acknowledgement of his or her submission. When using the online tool, supporting documentation can be uploaded using the attachment feature on the web form. The documentation will attach to the form when submitted.

When submitting a payment appeal, we recommend that providers retain all documentation including fax cover pages, email correspondence, and logs of telephone communications at least until the appeal is resolved.

The results of the review will be communicated in a written decision to the provider within 30 calendar days of the receipt of the appeal. An EOP is used to notify providers of overturned denied claims or additional payments. An upheld denied claim receives a payment appeal determination letter. If the provider disagrees with our determination, he or she may appeal the first level resolution within 30 calendar days of the date of the first level decision letter. Further disagreement must be resolved through

the terms of the provider's participation agreement or via any available state regulatory or legal avenues for disputes. Additional information on the payment appeal process (including acute care claims) is located in the [Complaints and Appeals](#) chapter of this manual.

Changes or errors in CPT codes are not considered payment appeals. Corrected claims should be resubmitted with a notation of **corrected claim** to:

STAR Kids LTSS Claims  
Amerigroup  
PO Box 8668  
Virginia Beach, VA 23466-8668

### **6.15 LTSS Quality Review Compliance Program**

Amerigroup has a quality review program in place to review quality and appropriateness of care for LTSS services rendered by monitoring for potential organizational quality issues. Providers are required to meet our LTSS quality review requirements and to maintain compliance with all federal and state laws, accreditation and licensing requirements, and health plan provider contract provisions. We will systematically identify, investigate, and resolve compliance and quality of care issues through the Quality Review Compliance Program with adult day activity center and home-based personal attendant provider agencies.

A quality compliance review will generally follow these steps:

- Step 1: We will notify you in writing if you have been selected for a review. The letter will provide you with a list of documents we will need you to send by secure fax or email and any documents to be available at the time of the on-site review.
- Step 2: The assigned reviewer will follow up with a phone call to determine the date and time of the review.
- Step 3: We will conduct all onsite reviews during normal business hours.
- Step 4: The results of the audit will be documented with any potential written findings and problem areas identified.
- Step 5: You will receive a copy of the results and possible corrective procedures within 10 business days of the completion of the review.
- Step 6: We will work with you to establish a corrective action plan, if needed, with a deadline to complete all action items and policy updates. Failure to comply with any corrective action plan beyond the plan approval date can affect a provider's current and future status as a participating network provider.

Provider agencies must achieve and maintain a quality review compliance plan score of at least 90 percent, per benchmark requirements. Providers who do not meet the 90 percent compliance standard are subject to the following graduated action levels:

- May be asked to create and submit a corrective action plan
- May be subject to liquidated damages and claims recoupment
- May be subject to contract termination after continued failure to meet the 90 percent compliance level standard

We will assess the following main areas in the review:

- Employee background checks, licenses, qualifications, and any applicable certifications and related documents
- Claims accuracy
- Member charts
- Policies and procedures
- Operational requirements (for example, safety codes, licensing, etc.)

**Below are examples of the standards and elements that may be assessed during a quality review. This is not a complete list of all items that may be reviewed.**

### **Criminal History Checks of Employees and Applicants for Employment**

- Agencies are required to verify the employability of individuals by conducting a criminal history record check within 72 hours of hiring an employee.
- Agencies may obtain criminal history record information directly from the Texas Department of Public Safety (DPS). Texas Health and Safety Code (THSC) Chapter 250 also allows the option of using a private agency to obtain DPS crime record information. A search of the DPS crime record database satisfies the minimum requirement under THSC Chapter 250 for a criminal history check on job applicants and employees. An agency that performs criminal history checks through DPS must use the DPS public *Criminal History Conviction Database* website (not the *DPS Crime Records Service Secure Site*) to perform criminal history checks.
- The Texas Department of Aging and Disability Services (DADS) applies absolute criminal bars to employment that are set out in the Texas Health and Safety Code (THSC) Chapter 250. In addition, there are offenses that have been determined to be absolute criminal bars to employment pursuant to DADS requirements. Information about these bars to employment is located at [www.dads.state.tx.us/hiringbars](http://www.dads.state.tx.us/hiringbars).

### **Employee Misconduct Registry and Nurse Aide Registry**

- A facility must perform an initial search upon an employee's hire of the Nurse Aide Registry and the Employee Misconduct Registry and must search both registries annually for existing employees. This search can be done via the DADS website at <https://www.dads.state.tx.us/providers/employability/index.html>.
- The facility must document the searches and keep a copy of both the initial search and annual searches in the employee's personnel file.

### **List of Excluded Individuals and Entities (LEIE)**

In accordance with Section 1128 of the Social Security Act, the United States Health and Human Services Office of Inspector General (HHS-OIG) excludes individuals and entities who have engaged in certain activities or have been convicted of certain crimes from participation in any federal health care program (that is, Medicare, Medicaid, and CHIP).

The Texas Health and Human Services Commission Office of Inspector General (HHSC-OIG) similarly excludes such individuals and entities from participation in federal and state health care programs.

To ensure compliance with applicable federal and state requirements, a provider must develop and implement written policies and procedures that require the provider to:

- Review, or contract with an entity to perform review, of the federal and state LEIEs **at the following websites** before hiring or contracting with an individual/entity and at least once a month while the provider employs or contracts with the individual/entity, regardless of whether the provider has a written agreement with the individual/entity, to determine if the individual/entity has been excluded:
  - Texas Health and Human Services Commission–OIG List of Excluded Individuals/Entities online searchable database: <https://oig.hhsc.state.tx.us/Exclusions/Search.aspx>
  - HHS – OIG Excluded Individuals/Entities Search database: <http://www.oig.hhs.gov/fraud/exclusions.asp>
- Document the following information to demonstrate compliance with the requirements to review the LEIE and report an excluded individual/entity:
  - Date of an LEIE review
  - Printed name and signature of the person conducting the review
  - First and last name and date of birth of the individual/entity that was the subject of the review
  - Whether the individual/entity was excluded
  - Date an excluded individual was reported to HHSC-OIG
- Maintain the documentation that demonstrates compliance with the reviewing and reporting requirements, and copies of reports submitted to HHSC-OIG, for 6 years after the end of the federal fiscal year in which the documentation or report was created

### Licensing

- A registered nurse (RN) must have a current license from the Board of Nurse Examiners for the State of Texas and must practice in compliance with the Nurse Practice Act and rules and regulations of the Board of Nurse Examiners.
- A licensed vocational nurse (LVN) must have a current license from the Board of Vocational Nurse Examiners of Texas and must practice in compliance with the Vocational Nurse Act and rules and regulations of the Board of Vocational Nurse Examiners.

### Day Activity and Health Services Agency Additional Requirements

- **Staffing ratio:** The ratio of direct service staff to clients must be at least 1 to 8, which must be maintained during provision of all covered services except during facility-provided transportation. At a minimum, one registered nurse or licensed vocational nurse must be working on site, 8 hours per day. The facility may schedule nursing hours according to client needs. Sufficient licensed nursing staff must be on site to meet the nursing needs of the clients.
- **Staff health:** All direct staff must be free of communicable diseases. The facility must screen all employees for tuberculosis within 2 weeks of employment and annually, according to Center for Disease Control (CDC) screening guidelines.
- **Dietitian consultant:** The facility must receive consultation at least 4 hours each month from a dietitian. The dietitian consultant plans and/or reviews menus and develops special diets for individuals that are ordered by their physician.

- **Medication administration:** Clients who choose not to or who cannot self-administer their medications must have medications administered by a person who holds a current license under state law authorizing the licensee to administer medications. Each client's medications must be listed on an individual client's medication profile record. The recorded information obtained from the prescription label must include, but is not limited to, the medication name, strength, dosage, amount received, directions for use, route of administration, prescription number, pharmacy name, and the date each medication was issued by the pharmacy.
- **Menus:** Menus must be planned at least 2 weeks in advance, dated, maintained on file, and posted in the facility. Meals must be served according to posted menus. Special diet meals ordered by the client's physician and developed by the dietician must be labeled with the client's name and type of diet.
- **Training:** The facility must provide and document in the facility's records:
  - All staff training on fire, disaster, and evacuation procedures within 3 work days of employment
  - Direct patient contact staff a minimum of 18 hours of training during the first 3 months of employment that includes:
    - A nationally or locally recognized adult cardiopulmonary resuscitation (CPR) course and certification
    - First aid
    - Orientation to health care delivery including the following components: safe body function and mechanics, personal care techniques and procedures, and overview of client population served at the facility
    - Identification and reporting of abuse, neglect, or exploitation

### **DAHS Claims and Required Forms**

The method of payment is a unit of authorized service and is defined as half a day. One unit of service constitutes 3 hours but less than 6 hours of covered services provided by the DAHS facility. 6 hours or more of service constitutes 2 units of service. Time spent in approved transportation provided by the DAHS facility shall be counted in the unit of service (40 TAC §98.211)

### **Day Activity and Health Services Daily Attendance (Form 3683)**

- To provide a daily record of client attendance
- To be used as a resource document for fiscal, auditing, and service control (not all inclusive)

### **Day Activity and Health Services Daily Transportation Record (Form 3682)**

- To provide a daily record of individual transportation
- To be used as a resource document for fiscal, auditing, and service control (not all inclusive)

The DAHS facility must use DADS forms to maintain a daily record of attendance and transportation to and from the DAHS facility, including the time each client began receiving services and the time he or she left the DAHS facility's care. If transportation is provided by the DAHS facility, driver's transportation records must be used. Arrival and departure times must be documented for clients not using DAHS facility-provided transportation.

The DAHS facility is not entitled to payment if:



- The facility fails to receive prior approval forms or supporting documentation within the required time frames for DAHS facility-initiated referrals
- The facility did not maintain the staff-client ratio for 1 or more days
- The facility exceeded its license capacity
- The facility's monthly claims do not correspond to the facility's service authorizations and DADS *Daily Attendance/Daily Transportation Record* form

### **Member Chart Requirements**

#### **Physician's Orders from the Individual's Primary Care Provider**

Form 3055 is completed for:

- Initial approval for DAHS
- New orders as determined by the DAHS nurse due to changes in the individual's condition
- New supplemental physician's orders for nursing services

The DAHS provider completes *Part I, Individual Information*, and sends 1 copy to the individual's primary care provider. The individual's primary care provider completes the remainder of Form 3055 or the facility staff may complete the form. If services are to be authorized on a time-limited basis, the end date of service must be entered.

### **Health Assessment/Individual Service Plan**

Form 3050 is completed by the DAHS facility nurse for DAHS applicants and individuals:

- Who need initial prior approval
- Who transfer from 1 facility to another
- When the licensed nurse determines an individual needs a new service plan developed
- Whose nursing services needs have been changed to reflect supplemental physician's orders, so long as the form remains legible

### **Home and Community Support Service Agency Additional Requirements**

#### **Attendant Qualifications**

An attendant must:

- Not be a legal parent, foster parent, or spouse of a parent of a minor who receives the service
- Not be the spouse of the individual who receives the service
- Not be designated by a DADS case manager on the DADS Authorization for Community Care Services form as "do not hire"

#### **Attendant Orientation**

A provider must ensure each attendant is oriented. An orientation is not required for a supervisor when providing personal assistance services.

### **Individual Service Plan**

This form is completed each time:

- An applicant's or individual's eligibility is assessed for the program
- There is a change in the individual's service plan
- There is a change in provider delivering services
- The annual reassessment of the ISP is completed

**Financial Management Service Agency (FMSA) Additional Requirements**

Amerigroup may review documents such as policies and procedures, client records, employee training, hiring verification records, and billing documents such as timesheets or records that support billing or related documents for the following FMSA responsibilities:

- Providing initial orientation
- Providing ongoing training, assistance, and support for employer-related responsibilities
- Verifying qualifications of applicants before services are delivered
- Monitoring continued eligibility of service providers
- Approving and monitoring budgets for services delivered through the CDS option
- Managing payroll, including calculations of employee withholdings and employer contributions, and depositing these funds with appropriate agencies
- Complying with applicable government regulations concerning employee withholdings, garnishments, mandated withholdings, and benefits
- Preparing and filing required tax forms and reports
- Paying allowable expenses incurred by the employer
- Providing status reports concerning the individual's budget, expenditures, and compliance with CDS option requirements
- Responding to the employer or designated representative as soon as possible, but at least within 2 working days after receipt of information requiring a response

## **7 BEHAVIORAL HEALTH PROGRAM**

### **7.1 Overview**

Behavioral health services are covered services for the treatment of mental, emotional, or chemical dependency disorders.

We provide coverage of medically necessary behavioral health services as indicated below:

- 1) Texas Health Steps behavioral health services that are necessary to correct or ameliorate a mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a mental illness or condition:
  - a) Must comply with the requirements of a final court order that applies to the Texas Medicaid program or the Texas Medicaid managed care program as a whole (including the Alberto N., et al. v. Traylor, et al. partial settlement agreements) and
  - b) May include consideration of other relevant factors, such as the criteria described in parts (2)(a-f) of this paragraph.
- 2) Behavioral health-related health care services that:
  - a) Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care.
  - b) Are furnished in the most appropriate and least restrictive setting in which services can be safely provided.
  - c) Are the most appropriate level or supply of service that can safely be provided.
  - d) Could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered.
  - e) Are not experimental or investigative.
  - f) Are not primarily for the convenience of the member or provider.

We do not cover behavioral health services that are experimental or investigative. Covered services are not intended primarily for the convenience of the member or the provider. For more information about behavioral health services, providers should call 1-800-454-3730 and members should call 1-844-756-4600 (TTY 711).

### **7.2 Covered Behavioral Health Services**

Medicaid-covered behavioral health services are not subject to the quantitative treatment limitations that apply under traditional, fee-for-service (FFS) Medicaid coverage. The services may be subject to the HMO's nonquantitative treatment limitations, provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008 behavioral health services, including:

- Inpatient mental health services (services may be provided in a free-standing psychiatric hospital in lieu of an acute care inpatient setting)
- Outpatient mental health services

- Psychiatry services
- Outpatient substance use disorder treatment services, including:
  - Assessment
  - Detoxification services
  - Counseling treatment
  - Medication-assisted therapy
- Residential substance use disorder treatment services, including:
  - Detoxification services
  - Room and board
- Mental health rehabilitative services
- Mental health targeted case management

### ***7.2.1 Mental Health Rehabilitative Services and Mental Health Targeted Case Management***

Mental health rehabilitative services and mental health targeted case management must be available to eligible STAR Kids members who require these services based on the appropriate standardized assessment –the Child and Adolescent Needs and Strengths (CANS) or the Adult Needs and Strengths Assessment (ANSA).

Severe and persistent mental illness (SPMI) means a diagnosis of bipolar disorder, major clinical depression, schizophrenia, or another behavioral health disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) accompanied by:

- Impaired functioning or limitations of daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping, or employment) due to the disorder.
- Impaired emotional or behavioral functioning that interferes substantially with the member’s capacity to remain in the community without supportive treatment or services.

Severe emotional disturbance (SED) means psychiatric disorders in children and adolescents which cause severe disturbances in behavior, thinking, and feeling.

**Mental health rehabilitative (MHR) services** are those age-appropriate services determined by HHSC and federally-approved protocol as medically necessary to reduce a member’s disability resulting from severe mental illness for adults, or serious emotional, behavioral, or mental disorders for children, and to restore the member to his or her best possible functioning level in the community. Services that provide assistance in maintaining functioning may be considered rehabilitative when necessary to help a member achieve a rehabilitation goal as defined in the member’s rehabilitation plan.

MHR services include training and services that help the member maintain independence in the home and community, such as:

- Medication training and support – curriculum-based training and guidance that serves as an initial orientation for the member in understanding the nature of his or her mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and the increased tenure in the community

- Psychosocial rehabilitative services – social, educational, vocational, behavioral, or cognitive interventions to improve the member’s potential for social relationships, occupational or educational achievement, and living skills development
- Skills training and development – skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers, and teachers
- Crisis intervention – intensive community-based one-to-one service provided to members who require services in order to control acute symptoms that place the member at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting
- Day program for acute needs – short-term, intensive, site-based treatment in a group modality to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms, prevent admission to a more restrictive setting, or reduce the amount of time spent in the more restrictive setting

**Mental health targeted case management (TCM)** refers to services designed to assist members with gaining access to needed medical, social, educational, and other services and supports. TCM services include:

- Case management for members who have SED (children 3 through 17 years of age), which includes routine and intensive case management services
- Case management for members who have SPMI (adult, 18 years of age and older)

MHR and TCM services, including any limitations to these services, are described in the most current TMPPM, including the *Behavioral Health, Rehabilitation, and Case Management Services Handbook*. We will authorize these services using the Department of State Health Services (DSHS) Resiliency and Recovery Utilization Management Guidelines (RRUMG), but Amerigroup is not responsible for providing any services listed in the RRUMG that are not covered services.

The *Texas Resilience and Recovery Utilization Management Guidelines for Child and Adolescent Services* can be found at

<http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589979570>.

The *Texas Resilience and Recovery Utilization Management Guidelines for Adult Mental Health Services* can be found at

<http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589981162>.

Providers of MHR and TCM services must use and be trained and certified to administer the Child and Adolescent Needs and Strengths (CANS) and the Adult Needs and Strengths Assessment (ANSA) tools to assess a member’s need for services and recommend a level of care. Providers must use these tools to recommend a level of care to Amerigroup by using the current DSHS Clinical Management for Behavioral Health Services (CMBHS) web-based system. Providers must also complete the *Mental Health Rehabilitative and Mental Health Targeted Case Management Services Request Form* and submit the completed form to us. A provider entity must attest to Amerigroup that the organization has the ability to provide, either directly or through sub-contract, the full array of RRUMG services to members.

HHSC has established qualifications and supervisory protocols for providers of MHR and TCM services. This criteria is located in Chapter 15.1 of the HHSC *Uniform Managed Care Manual*.

### **7.2.2 Attention Deficit Hyperactivity Disorder (ADHD)**

Treatment of children diagnosed with ADHD, including follow-up care for children who are prescribed ADHD medication, is covered as outpatient mental health services. Reimbursement for these services will be determined according to the Provider Agreement. Covered benefits are outlined in the TMPPM.

## **7.3 Primary and Specialty Services**

Members have access to the following primary and specialty services:

- Behavioral health clinicians available 24 hours a day, 7 days a week to assist with identifying the most appropriate and nearest behavioral health service
- Routine or regular laboratory and ancillary medical tests or procedures to monitor behavioral health conditions of members; these services are furnished by the ordering provider at a lab conveniently located at or near the provider's office
- Behavioral health case managers to coordinate with the hospital discharge planner and member to ensure appropriate outpatient services are available
- Support and assistance for network behavioral health care providers in contacting members within 24 hours to reschedule missed appointments

## **7.4 Behavioral Health Care Provider Responsibilities**

We maintain a behavioral health provider network, including psychiatrists, psychologists, and other behavioral health providers experienced in serving children, adolescents, and adults. The network provides accessibility to qualified providers for all eligible individuals in the service area. Our members can self-refer to a participating behavioral health provider by calling Member Services at 1-844-756-4600.

Primary care providers providing behavioral health services must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. Screening and assessment tools to assist with the detection, treatment, and referral of behavioral health care services are found on our website at

<https://providers.amerigroup.com/TX>.

For treatment of children, all providers must comply with the *Psychotropic Medication Utilization Parameters for Foster Children* found at

[https://www.dfps.state.tx.us/Child\\_Protection/Medical\\_Services/guide-psychotropic.asp](https://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-psychotropic.asp).

Providers who furnish routine outpatient behavioral health services must schedule appointments within the earlier of 10 business days or 14 calendar days of a request. Providers who furnish inpatient psychiatric services must schedule outpatient follow-up and/or continuing treatment prior to a patient's discharge. The outpatient treatment must occur within 7 days from the date of discharge. Behavioral health providers must contact members who have missed appointments within 24 hours to reschedule appointments.

Primary care providers should:

- Educate members with behavioral health conditions about the nature of the condition and its treatment.
- Educate members about the relationship between physical and behavioral health conditions.
- Contact a behavioral health clinician when behavioral health needs go beyond his or her scope of practice.

Primary care providers can offer behavioral health services when:

- Clinically appropriate and within the scope of his or her practice.
- The member's current condition is not so severe, confounding or complex as to warrant a referral to a behavioral health provider.
- The member is willing to be treated by the primary care provider.
- The services rendered are within the scope of the benefit plan (for members who have Medicare, most behavioral health services are covered under the member's Medicare plan).

Behavioral health providers must:

- Refer members with known or suspected physical health problems or disorders to the primary care provider for examination and treatment.
- Utilize the most current DSM multi-axial classification when assessing members; HHSC may require the use of other assessment instruments or outcome measures in addition to the DSM. Network providers must document all DSM assessment and outcome information in the member's medical record.
- Send initial and quarterly summary reports of a member's behavioral health status to the primary care provider with the member's consent.
- Be licensed for physical health care services if they are provided.

## **7.5 Care Continuity and Coordination Guidelines**

Primary care providers and behavioral health care providers are responsible for actively coordinating and communicating continuity of care. Appropriate and timely sharing of information is essential when the member is receiving psychotropic medications or has a new or ongoing medical condition. The exchange of information facilitates behavioral and medical health care strategies.

Our care continuity and coordination guidelines for primary care providers and behavioral health providers include:

- Coordinating medical and behavioral health services with the local mental health authority (LMHA) and state psychiatric facilities regarding admission and discharge planning for members with SEDs and SMIs, if applicable
- Completing and sending the member's consent for information release to the collaborating provider
- Using the release as necessary for the administration and provision of care
- Noting contacts and collaboration in the member's chart
- Responding to requests for collaboration within 1 week, or immediately if an emergency is indicated

- Sending a copy of a completed *Coordination of Care/Treatment Summary* form to us and the member's primary care provider when the member has seen a behavioral health provider (the form can be found on our website at <https://providers.amerigroup.com/TX>)
- Sending initial and quarterly (or more frequently, if clinically indicated) summary reports of a member's behavioral health status from the behavioral health provider to the member's primary care provider
- Contacting the primary care provider when a behavioral health provider changes the behavioral health treatment plan
- Contacting the behavioral health provider when the primary care provider determines the member's medical condition could reasonably be expected to affect the member's mental health treatment planning or outcome and documenting the information on the coordination of care and treatment summary

## **7.6 Health Home**

A Health Home is a provider practice that manages all of the health care a person needs – physical, mental, and social. The range of Health Home services and supports is more than is normally offered by a primary care provider. This type of care can be of great benefit to persons with 1 or more serious and ongoing mental or health conditions. The provider practice can be a primary care practice or, in some cases, a specialty care practice. A Health Home uses a team-based approach to improve access, coordination between providers, and quality of care.

We will provide access to a Health Home for any member who asks for this service and for any member who would benefit from this type of care. Some of the main kinds of Health Home services are:

- Comprehensive case management
- Care coordination
- Patient self-management education and health promotion
- Transitional care from inpatient or emergency room
- Patient and family-centered care with patient and family support
- Referral to community and social support services
- Use of health information to link services

## **7.7 Substance Abuse and Dependency Treatment**

Substance use disorder includes substance abuse and dependence as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM).

### **7.7.1 Substance Abuse Service Coordination**

We will provide specialized service coordination to members with a substance use disorder. We will work with providers, facilities, and members to coordinate care for members with a substance use disorder and to ensure members have access to the full continuum of covered services (including without limitation assessment, detoxification, residential treatment, outpatient services, and medication therapy) as medically necessary and appropriate. Amerigroup will also coordinate services with DSHS, DFPS, and their designees for members requiring noncapitated services. Noncapitated services include, without limitation, services that are not available for coverage under the STAR Kids managed care contract, state



plan, or waiver programs that are available under the Federal Substance Abuse and Prevention and Treatment block grant when provided by a DSHS-funded provider or covered by the DFPS under direct contract with a treatment provider. We will work with DSHS, DFPS, and providers to ensure payment for covered services is available to out-of-network providers who also provide related noncapitated services when the covered services are not available through network providers.

## **7.8 Emergency Behavioral Health Services**

An emergency behavioral health condition means any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson possessing an average knowledge of health and medicine requires immediate intervention/medical attention. And in an emergency and without immediate intervention/medical attention, the member would present an immediate danger to himself, herself, or others, or would be rendered incapable of controlling, knowing, or understanding the consequences of his or her actions.

In the event of a behavioral health emergency, the safety of the member and others is paramount. The member should be instructed to seek immediate attention at an emergency room or other behavioral health crisis center. An emergency dispatch service or 911 should be contacted if the member is a danger to self or others and is unable to go to an emergency care facility.

A behavioral health emergency occurs when the member is:

- Suicidal
- Homicidal
- Violent towards others
- Suffering a precipitous decline in functional impairment and is unable to take care of activities of daily living
- Alcohol or drug dependent, with signs of severe withdrawal

We do not require precertification or notification of emergency services, including emergency room and ambulance services.

## **7.9 Urgent Behavioral Services**

An urgent behavioral health situation is defined as a condition that requires attention and assessment within 24 hours. In an urgent situation, the member is not an immediate danger to himself or herself or others, and is able to cooperate with treatment.

Care for non-life-threatening emergencies should be within 6 hours.

## **7.10 Precertification and Referrals for Behavioral Health**

Members may self-refer to any Amerigroup network behavioral health services provider by calling Member Services at 1-844-756-4600. No precertification or referral is required from the primary care provider.

Providers may request precertification or refer members for services by:

- Calling Provider Services at 1-800-454-3730.
- Faxing information to our dedicated behavioral health fax lines at 1-877-434-7578 for inpatient services, 1-800-505-1193 for outpatient services, or 1-866-877-5229 for mental health rehabilitative services and mental health targeted case management.

Our staff is available 24 hours a day, 7 days a week, 365 days a year for routine, crisis or emergency calls and authorization requests. We are responsible for authorized inpatient hospital services, including free-standing psychiatric facilities.

### **7.11 Court-ordered Commitment**

We cover inpatient and outpatient psychiatric services for members who have been ordered by a court of competent jurisdiction under the provisions of the Texas Health and Safety Code, Chapters 573 or 574, to receive the services under a court-ordered commitment to an inpatient mental health facility.

Amerigroup:

- Will not deny, reduce or controvert the medical necessity of any court-ordered inpatient or outpatient psychiatric service for members age 20 and younger; any modification or termination of services will be presented to the court with jurisdiction over the matter for determination.
- Will comply with the utilization review of chemical dependency treatment; chemical dependency treatment must conform to the standards set forth in the Texas Administrative Code.
- Will not allow members ordered to receive treatment under the provisions of the Texas Health and Safety Code to appeal the commitment through our complaint or appeals processes.

A court-order commitment to an inpatient mental health facility as a condition of probation is a noncapitated service payable under Medicaid FFS.

## **8 MEMBER RIGHTS AND RESPONSIBILITIES**

### **8.1 Member Education about Member's Rights to Designate an Obstetrician/Gynecologist**

Our members are informed of their right to select an Obstetrician/Gynecologist (OB/GYN) without a referral from their primary care provider. Our members may access the health services of an OB/GYN for their annual well-woman exam, prenatal care, female medical conditions, and specialist referrals within the network.

The following language or similar information appears in our STAR Kids Nondual member handbook. For members also covered by Medicare, an OB/GYN is selected from Medicare plan providers.

#### **Do I Have the Right to Choose an OB/GYN?**

You have the right to pick an OB/GYN without a referral from your primary care provider. An OB/GYN can give you:

- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- Referral to a specialist doctor within the network

### **8.2 Medicaid Member Rights and Responsibilities**

#### **8.2.1 Member Rights**

(1) You have the right to respect, dignity, privacy, confidentiality and nondiscrimination.

That includes the right to:

- a) Be treated fairly and with respect
- b) Know that your medical records and discussions with your providers will be kept private and confidential

(2) You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:

- a) Be told how to choose and change your health plan and your primary care provider
- b) Choose any health plan you want that is available in your area and choose your primary care provider from that plan
- c) Change your primary care provider
- d) Change your health plan without penalty
- e) Be told how to change your health plan or your primary care provider

(3) You have the right to ask questions and get answers about anything you do not understand. That includes the right to:

- a) Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated
- b) Be told why care or services were denied and not given

- (4) You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
  - a) Work as part of a team with your provider in deciding what health care is best for you
  - b) Say yes or no to the care recommended by your provider
- (5) You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, and fair hearings. That includes the right to:
  - a) Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan
  - b) Get a timely answer to your complaint
  - c) Use the plan's appeal process and be told how to use it
  - d) Ask for a fair hearing from the state Medicaid program and get information about how that process works
- (6) You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
  - a) Have telephone access to a medical professional 24 hours a day, 7 days a week, to get any emergency or urgent care you need
  - b) Get medical care in a timely manner
  - c) Be able to get in and out of a health care provider's office; this includes barrier-free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act
  - d) Have interpreters, if needed, during appointments with your providers and when talking to your health plan; interpreters include people who can speak in your native language, help someone with a disability or help you understand the information
  - e) Be given information you can understand about your health plan rules, including the health care services you can get and how to get them
- (7) You have the right to not be restrained or secluded when it is for someone else's convenience or is meant to force you to do something you do not want to do or is to punish you.
- (8) You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment; your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
- (9) You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

### **8.2.2 Member Responsibilities**

- (1) You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
  - a. Learn and understand your rights under the Medicaid program
  - b. Ask questions if you do not understand your rights
  - c. Learn what choices of health plans are available in your area
- (2) You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
  - a. Learn and follow your health plan's rules and Medicaid rules
  - b. Choose your health plan and primary care provider quickly

- c. Make any changes in your health plan and primary care provider in ways established by Medicaid and by the health plan
  - d. Keep your scheduled appointments
  - e. Cancel appointments in advance when you cannot keep them
  - f. Always contact your primary care provider first for your nonemergency medical needs
  - g. Be sure you have the approval from your primary care provider before going to a specialist
  - h. Understand when you should and should not go to the emergency room
- (3) You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
- a. Tell your primary care provider about your health
  - b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated
  - c. Help your providers get your medical records
- (4) You must be involved in decisions relating to service and treatment options, make personal choices and take action to maintain your health. That includes the responsibility to:
- a. Work as a team with your provider in deciding what health care is best for you
  - b. Understand how the things you do can affect your health
  - c. Do the best you can to stay healthy
  - d. Treat providers and staff with respect
  - e. Talk to your provider about all of your medications

## 9 COMPLAINTS AND APPEALS

We offer four distinct complaint and appeal processes:

- Member complaints
- Member appeals
- Provider complaints
- Provider payment appeals

### 9.1 Member Complaints and Appeals

STAR Kids members or their representatives may contact a member advocate or their service coordinator for assistance with writing or filing a complaint or appeal (including an expedited appeal). The member advocate or service coordinator also works with the member to monitor the process through resolution.

#### Definitions

**Action:** The denial or limited authorization of a requested service, including:

- Type and level of service
- Reduction, suspension, or termination of a previously authorized service
- Denial, in whole or in part, of payment of service
- Failure to provide services in a timely manner
- Failure of the contractor to act within certain time frames
- Denial of a Medicaid member's request to exercise his or her right to obtain services outside the network (for a resident of a rural area with only one managed care organization)

Medical appeals are addressed in the [Medical Appeal Process and Procedures](#) section of this manual.

**Appeal:** The formal process by which a member or his or her representative request a review of the health plan's action as defined above.

**Appellant:** Any member or other person or agency designated in writing to act on behalf of the member who files an appeal.

**Complainant:** Any member (family member or caregiver of a member), provider (treating physician, dentist), or other person or agency designated to act on behalf of the member (including the state's Medicaid Managed Care Division or the state's ombudsman program) who files a complaint.

**Complaint:** An expression of dissatisfaction (orally or in writing) to the health plan about any matter related to the health plan other than an action as defined in this section. Possible subjects for complaints include:

- Quality of care or services provided
- Aspects of patient interaction, such as rudeness of a provider or employee
- Failure of provider or employee(s) to respect a member's rights

**First level review:** Complaints result in a first level review.

**Second level review:** Second level reviews follow the member's right to disagree with the decision of a first level review.

### **9.1.2 Member Complaint Resolution**

The following language or similar information about the **complaint process** appears in our member handbooks:

#### **What should I do if I have a complaint? Who do I call?**

We want to help. If you have a complaint, please call us toll free at 1-844-756-4600 (TTY 711) to tell us about your problem. An Amerigroup Member Services representative or a member advocate can help you file a complaint. Just call 1-844-756-4600 (TTY 711). Most of the time, we can help you right away or at the most within a few days.

#### **Can someone from Amerigroup help me file a complaint?**

Yes, a member advocate or a Member Services representative can help you file a complaint with us or the appropriate state program. Please call Member Services at 1-844-756-4600 (TTY 711).

#### **How long will it take to process my complaint?**

Amerigroup will answer your complaint within 30 days from the date we get it.

#### **What are the requirements and time frames for filing a complaint?**

You can tell us about your complaint by calling us or writing us. We will send you a letter within 5 business days of getting your complaint. This means that we have your complaint and have started to look at it. We will include a complaint form with our letter if your complaint was made by telephone. You must fill out this form and mail it back to us. If you need help filling out the complaint form, please call Member Services.

We will send you a letter within 30 days of when we get your complaint. This letter will tell you what we have done to address your complaint.

If your complaint is about an ongoing emergency or hospital stay, it will be resolved as quickly as needed for the urgency of your case and no later than 1 business day from when we receive your complaint.

#### **How do I file a complaint with the Health and Human Services Commission once I have gone through the Amerigroup complaint process?**

Once you have gone through the Amerigroup complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free 1-866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission  
Health Plan Operations - H-320  
PO Box 85200  
Austin, TX 78708-5200

If you can get on the Internet, you can send your complaint in an email to [HPM\\_Complaints@hhsc.state.tx.us](mailto:HPM_Complaints@hhsc.state.tx.us).

If you file a complaint, Amerigroup will not hold it against you. We will still be here to help you get quality health care.

### ***9.1.3 Medical Appeal Process and Procedures***

Amerigroup has established and maintains a system for resolving dissatisfaction of actions regarding the denial or limitation of coverage of health care services filed by a member or a provider acting on behalf of a member. This process is called a member appeal.

Note: Medical appeals do not apply to nonmedical issues. Nonmedical concerns are classified as complaints.

#### **What can I do if the MCO denies or limits my member's request for a covered service?**

The following language or similar information describing the **appeal process** appears in our member handbooks:

#### **What can I do if my child's doctor asks for a service or medicine that's covered but Amerigroup denies it or limits it?**

There may be times when Amerigroup says we will not pay for or cover all or part of the care that has been recommended. You have the right to ask for an appeal. An appeal is when you or your designated representative asks Amerigroup to look again at the care your doctor asked for and we said we will not pay for.

You can appeal our decision 2 ways:

- You can call Member Services
  - If you call us, you must still send us your appeal in writing. We will send you an appeal form in the mail after your call
    - Fill out the appeal form and send it to us within 30 days of when you received the letter telling you we were denying your request, at:  
Amerigroup Appeals  
2505 N. Highway 360, Suite 300  
Grand Prairie, TX 75050
  - The appeal form must be signed by you or your authorized representative
  - If you need help filling out the appeal form, please call Member Services
  - If you ask for an expedited appeal, you do not have to send your appeal request in writing
- You can send us a letter to:  
Amerigroup Appeals  
2505 N. Highway 360, Suite 300  
Grand Prairie, TX 75050

#### **How will I find out if services are denied?**

If we deny services, we will send you a letter at the same time the denial is made.



**What are the time frames for the appeals process?**

You or a designated representative can file an appeal. You must do this within 30 days of when you get the first letter from Amerigroup that says we will not pay for or cover all or part of the recommended care.

If you ask someone (a designated representative) to file an appeal for you, you must also send a letter to Amerigroup to let us know you have chosen a person to represent you. Amerigroup must have this written letter to be able to consider this person as your representative. We do this for your privacy and security.

When we get your letter or call, we will send you a letter within 5 business days. This letter will let you know we got your appeal. We will also let you know if we need any other information to process your appeal. Amerigroup will contact your doctor if we need medical information about this service.

A doctor who has not seen your case before will look at your appeal. He or she will decide how we should handle your appeal.

We will send you a letter with the answer to your appeal. We will do this within 30 calendar days from when we get your appeal unless we need more information from you or the person you asked to file the appeal for you. If we need more information, we may extend the appeals process for 14 days. If we extend the appeals process, we will send you a letter to let you know about the delay. You may also ask us to extend the process if you know more information that we should consider.

**How can my child continue receiving services that were already approved?**

To continue receiving services that have already been approved by Amerigroup but may be part of the reason for your appeal, you must file the appeal on or before the later of:

- 10 days after we mail the notice to you to let you know we will not pay for or cover all or part of the care that has already been approved
- The date the notice says your service will end

If you request that services continue while your appeal is pending, you need to know that you may have to pay for these services.

If the decision on your appeal upholds our first decision, you will be asked to pay for the services you received during the appeals process.

If the decision on your appeal reverses our first decision, Amerigroup will pay for the services you received while your appeal was pending.

**Can someone from Amerigroup help me file an appeal?**

Yes, a member advocate or Member Services representative can help you file an appeal with Amerigroup or with the appropriate state program. Please call Member Services toll-free at 1-844-756-4600 (TTY 711).

### **Can members request a state fair hearing?**

Yes, you can ask for a fair hearing at any time during or after the Amerigroup appeal process unless you have asked for an expedited appeal.

### ***Expedited Medical Appeal***

An expedited medical appeal will be performed when appropriate. A member can request an expedited medical appeal in cases where time expended in the standard resolution could jeopardize the member's life, health or ability to attain, maintain, or regain maximum function. An expedited medical appeal concerns a decision or action by Amerigroup that relates to:

- Health care services including, but not limited to, procedures or treatments for a member with an ongoing course of treatments ordered by a health care provider, the denial of which, in the provider's opinion, could significantly increase the risk to a member's health or life
- A treatment referral, services, procedure or other health care service that if denied could significantly increase risk to a member's health or life

The following language or similar information about **expedited appeals** appears in our member handbooks:

### **What is an Expedited Appeal?**

An expedited appeal is when the health plan has to make a decision quickly based on the condition of your health and taking the time for a standard appeal could jeopardize your life or health.

### **How Do I Ask for an Expedited Appeal? Does My Request Have To Be in Writing?**

You or the person you ask to file an appeal for you (a designated representative) can request an expedited appeal. You can request an expedited appeal orally or in writing:

- You can call Member Services at 1-844-756-4600 (TTY 711)
- You can send us a letter to:  
Amerigroup Appeals  
2505 N. Highway 360, Suite 300  
Grand Prairie, TX 75050

### **What Are the Time Frames for An Expedited Appeal?**

After we get your letter or call, we will send you a letter with the answer to your appeal. We will do this within 72 hours from receipt of your appeal request.

If your appeal relates to an ongoing emergency or hospital stay, we will call you with an answer within 1 business day or 72 hours, whichever is shorter. We will also send you a letter with the answer to your appeal within 3 business days.

### **What Happens If Amerigroup Denies the Request for an Expedited Appeal?**

If we do not agree that your request for an appeal should be expedited, we will call you right away. We will send you a letter within 3 calendar days to let you know how the decision was made and that your appeal will be reviewed through the standard review process.

If the decision on your expedited appeal upholds our first decision and Amerigroup will not pay for the care your doctor asked for, we will call you and send you a letter to let you know how the decision was made. We will also tell you your rights to request an expedited state fair hearing.

### **Who Can Help Me File an Expedited Appeal?**

A member advocate or Member Services representative can help you file an expedited appeal. Please call Member Services toll-free at 1-844-756-4600 (TTY 711).

### ***Medicaid State Fair Hearing Information***

#### **Can a member ask for a state fair hearing?**

If a member, as a member of the health plan, disagrees with the health plan's decision, the member has the right to ask for a fair hearing. The member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the member wants to represent him or her. A provider may be the member's representative. The member or the member's representative must ask for the fair hearing within 90 days of the date on the health plan's letter that tells of the decision being challenged. If the member does not ask for the fair hearing within 90 days, the member may lose his or her right to a fair hearing. To ask for a fair hearing, the member or the member's representative should either send a letter to the health plan at:

Fair Hearing Coordinator/Amerigroup  
3800 Buffalo Speedway, Suite 400  
Houston, TX 77098,

or call Member Services at 1-844-756-4600 (TTY 711).

If the member asks for a fair hearing within 10 days from the time the member gets the hearing notice from the health plan, the member has the right to keep getting any service the health plan denied, at least until the final hearing decision is made. If the member does not request a fair hearing within 10 days from the time the member gets the hearing notice, the service the health plan denied will be stopped. If the member asks for a fair hearing, the member will get a packet of information letting the member know the date, time and location of the hearing. Most fair hearings are held by telephone. At that time, the member or the member's representative can tell why the member needs the service the health plan denied.

HHSC will give the member a final decision within 90 days from the date the member asked for the hearing.

### ***Medicaid Continuation of Benefits***

Amerigroup Medicaid members may request a continuation of their benefits during the medical appeal process by contacting Amerigroup Member Services at 1-844-756-4600. To ensure continuation of currently authorized services, the member (or person acting on behalf of the member) must file a medical appeal on or before 10 calendar days following the Amerigroup mail date of the notice of action or the intended effective date of the action.

Amerigroup will continue the member's coverage of benefits if the following conditions are met:

- The member or the provider files the appeal timely (as defined above)
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider
- The original period covered by the initial authorization has not expired
- The member requests an extension of benefits

If, at the member's request, Amerigroup continues or reinstates the benefits while the appeal is pending, the benefits will be continued until one of the following occurs:

- The member withdraws the medical appeal or request for the state fair hearing
- The designated calendar days pass after Amerigroup mails the medical appeal determination letter; unless the member has, within the 10 calendar days, requested a state fair hearing with continuation of benefits until a state fair hearing decision is reached
- The time period or service limits of a previously authorized service has been met

The member may be responsible for the continued benefits if the final determination of the medical appeal is not in his or her favor. If the final determination of the medical appeal is in the member's favor, Amerigroup will authorize coverage of and arrange for disputed services promptly and as expeditiously as the member's health condition requires. If the final determination is in the member's favor and the member received the disputed services, Amerigroup will pay for those services.

## **9.2 Provider Complaints and Provider Payment Appeals**

### ***9.2.1 Provider Complaint Resolution***

Amerigroup maintains a system for tracking and resolving provider complaints pertaining to administrative issues and nonpayment-related matters within 30 calendar days of receipt. Amerigroup accepts provider complaints orally through Provider Services at 1-800-454-3730 or through local health plan Provider Relations representatives. Written provider complaints should be submitted to:

Amerigroup  
PO Box 61789  
Virginia Beach, VA 23466-1789

Written complaints may also be sent to the attention of the Provider Relations department of the local health plan or faxed to 1-844-664-7179. Complaints may be sent by email to TXProviderRelations@amerigroup.com or via the provider website at <https://providers.amerigroup.com/TX>. When submitting complaint information, we recommend that providers retain all documentation including fax cover pages, email correspondence, and logs of telephone communications at least until the complaint is resolved.

Amerigroup will contact the complainant by telephone, email, or in writing within 30 calendar days of receipt of the complaint with the resolution.

Amerigroup will not cease coverage of care pending a complaint investigation. If a provider is not satisfied with the resolution of the complaint by Amerigroup, that provider may complain to the state. A complaint

to the state should contain a written explanation of the provider's position on the issue and be accompanied by all materials related to the complaint, including medical records and the written response from Amerigroup. Complaints may be sent to:

Texas Health and Human Services Commission  
Health Plan Operations – H-320  
PO Box 85200  
Austin, TX 78708-5200

### **9.2.2 Provider Payment Appeals**

Amerigroup offers providers a payment appeal resolution process. A payment appeal is any claim payment disagreement between the health care provider and Amerigroup for reason(s) including, but not limited to:

- Denials for timely filing
- The failure of Amerigroup to pay timely
- Contractual payment issues
- Lost or incomplete claim forms or electronic submissions
- Requests for additional explanation as to services or treatment rendered by a provider
- Inappropriate or unapproved referrals initiated by providers (for example, a provider payment appeal may arise if a provider was required to get authorization for a service, did not request the authorization, and then provided the service and submitted the claim)
- Provider medical appeals without the member's consent
- Retrospective review after a claim denial or partial payment
- Request for supporting documentation

**Note: Responses to itemized bill requests, submission of corrected claims and submission of coordination of benefits/third-party liability information are not considered payment appeals. These are considered correspondence and should be addressed to claims correspondence (see the [Billing and Claims Administration](#) chapter for more information).**

No action is required by the member. Provider payment appeals do not include member medical appeals.

Providers may make the initial attempt to resolve a claim issue by calling Provider Services at 1-800-454-3730 or a local health plan Provider Relations representative. Providers will not be penalized for filing a payment appeal. All information will be confidential. The payment appeals team will receive, distribute, and coordinate all payment appeals.

To submit a payment appeal, please complete the payment appeal form located online at <https://providers.amerigroup.com/TX> and submit it to:

Provider Payment Appeals  
Amerigroup  
PO Box 61599  
Virginia Beach, VA 23466-1599

Providers may also fax a payment appeal to 1-844-756-4607 or utilize the payment appeal tool at [www.Availity.com](http://www.Availity.com). When inquiring on the status of a claim that is considered eligible for appeal due to no or partial payment, a button will display for submission of an appeal. Once this button is clicked, a web form will display for the provider to complete and submit. If all required fields are completed, the provider will receive immediate acknowledgement of his or her submission. When using the online tool, supporting documentation can be uploaded using the attachment feature on the web payment appeal form. The documentation will attach to the form when submitted.

A network or non-network provider should file a payment appeal within 120 calendar days of the date of the Explanation of Payment (EOP), or for retroactive medical necessity reviews, as of the date of the denial letter. The appeal should include an explanation of what is being appealed and why. Supporting documentation must be attached to the request. Examples of appropriate supporting documentation include:

- Letter stating the reason(s) why the provider believes the claim reimbursement is incorrect
- Copy of the original claim
- Copy of the Amerigroup EOP
- EOP or EOB from another carrier
- Evidence of eligibility verification (for example, a copy of the ID card, panel report, the TMHP/TexMedNet documentation, or the call log record with the date and name of the Amerigroup person the provider's staff spoke with when verifying eligibility)
- Medical records
- Approved referral and authorization forms from us indicating the authorization number
- Contract rate sheets indicating evidence of payment rates
- Evidence of previous appeal submission or timely filing
- Certified or overnight mail receipt with the claim or appeal log, if more than one claim or appeal was submitted
- EDI claim transmission reports indicating that the claim was **accepted** by Amerigroup; rejection reports are not accepted as proof of timely filing

When submitting a payment appeal, we recommend that providers retain all documentation including fax cover pages, email correspondence, and logs of telephone communications, at least until the appeal is resolved.

The payment appeals team will research and determine the current status of a payment appeal. A determination will be made based on the available documentation submitted with the appeal and a review of Amerigroup systems, policies, and contracts. Payment appeals received with supporting clinical documentation will be retrospectively reviewed by a registered/licensed nurse. Established clinical criteria will be applied to the payment appeal. After retrospective review, the payment appeal may be approved or forwarded to the plan medical director for further review and resolution.

The results of the review will be communicated in a written decision to the provider within 30 calendar days of the receipt of the appeal. An EOP is used to notify providers of overturned denied claims or additional payments. An upheld denied claim receives a payment appeal determination letter. The determination letter includes:

- A statement of the provider's appeal
- 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 documentation that supports the decision
- A description of the method to obtain a second level internal review

If a provider is dissatisfied with the payment appeal resolution, he or she may file a second level payment appeal. This should be a written appeal and must be submitted within 30 days of the date of the first level determination letter. The case is handled by reviewers not involved in the first level review. Once the appeal is reviewed, the results will be communicated in a written decision to the provider within 30 calendar days of receipt of the appeal. An EOP is used to notify providers of overturned denied claims or additional payments. An upheld denied claim receives a payment appeal determination letter. For a decision in which the denial was upheld, the provider should review the Participating Provider Agreement for any other available methods of dispute resolution. The provider may also file a complaint with HHSC or TDI, as applicable.

Questions regarding the Amerigroup provider payment appeal process may be directed to Provider Services or a Provider Relations representative.

### **9.3 Provider Appeal Process to HHSC (Related to Claim Recoupment due to Member Disenrollment)**

A provider may appeal claim recoupment by submitting the following information to HHSC:

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
- **The Explanation of Benefits (EOB) showing the original payment.** Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.
- **The EOB showing the recoupment and/or the plan's "demand" letter for recoupment.** If sending the demand letter, it must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
- **Completed clean claim.** All paper claims must include both the valid NPI and TPI number. Note: In cases where issuance of a prior authorization (PA) is needed, the provider will be contacted with the authorization number and the provider will need to submit a corrected claim that contains the valid authorization number.

Mail appeal requests to:

Texas Health and Human Services Commission  
 HHSC Claims Administrator Contract Management  
 Mail Code-91X  
 PO Box 204077  
 Austin, Texas 78720-4077

## **10 PROVIDER RIGHTS AND RESPONSIBILITIES**

### **10.1 Providers' Bill of Rights**

Each health care provider who contracts with HHSC, or subcontracts with Amerigroup, to furnish services to members will be assured of the following rights:

- To not be prohibited (when acting within the lawful scope of practice) from advising or advocating on behalf of a member who is his or her patient for the following:
  - The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered
  - Any information the member needs in order to decide among all relevant treatment options
  - The risks, benefits, and consequences of treatment or nontreatment
  - The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions
- To receive information on the complaint, appeal, and fair hearing procedures
- To have access to Amerigroup policies and procedures covering the authorization of services
- To be notified of any decision by Amerigroup to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested
- To challenge, on behalf of a Medicaid member, the denial of coverage of or payment for medical assistance
- To be assured that Amerigroup provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment
- To be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law solely on the basis of that license or certification

### **10.2 Network Provider General Responsibilities**

Each health care provider contracted with Amerigroup has the following general responsibilities:

- Provide Amerigroup members with a professionally recognized level of care and efficacy consistent with community standards, compliant with Amerigroup clinical and nonclinical guidelines and within the practice of your professional license
- Treat all Amerigroup members in a fair and nondiscriminatory manner, and with respect and consideration
- Abide by the terms of your Amerigroup Participating Provider Agreement
- Comply with all Amerigroup policies and procedures, including those found in this provider manual and any future updates or supplements
- Facilitate inpatient and ambulatory care services at in-network facilities
- Arrange referrals for care and service within the Amerigroup network
- Verify member eligibility and obtain precertification for services as required by Amerigroup
- Ensure that members understand the right to obtain medication from any network pharmacy



- Maintain confidential medical records consistent with Amerigroup medical records guidelines as outlined in the [Member Record Standards](#) section of this manual and applicable HIPAA regulations
- Maintain a facility that promotes patient safety
- Participate in the Amerigroup Quality Improvement program initiatives
- Participate in provider orientations and continuing education
- Abide by the ethical principles of your profession
- Notify Amerigroup if you are undergoing any type of legal or regulatory investigation or if you have agreed to a written order issued by the state licensing agency for your profession
- Notify Amerigroup if a member has a change in eligibility status by contacting Provider Services
- Maintain professional liability insurance in an amount that meets Amerigroup credentialing requirements and/or state mandated requirements
- Notify Amerigroup promptly if there is a change in your physical office or remittance address, tax identification number, or any other type of demographic change

### **10.3 Advance Directives**

We adhere to the Patient Self-Determination Act and maintain written policies and procedures regarding advance directives. Advance directives are documents signed by a competent person giving direction to health care providers about treatment choices in certain circumstances. There are two 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. We encourage members to request education about advance directives and ask for an advance directive form from their primary care provider at their first appointment.

Members over age 18 and emancipated minors are able to make an advance directive. His or her response is to be documented in the medical record. Amerigroup will not discriminate or retaliate based on whether a member has or has not executed an advance directive.

While each member has the right without condition to formulate an advance directive within certain limited circumstances, a facility or an individual physician may conscientiously object to an advance directive.

We will assist members with questions about advance directives. However, no associate of Amerigroup may serve as witness to an advance directive or as a member's designated agent or representative. Amerigroup notes the presence of advance directives in the medical records when conducting medical chart audits.

### **10.4 Americans with Disabilities Act Requirements**

All providers are expected to meet federal and state accessibility standards and those defined in the Americans with Disabilities Act of 1990. Health care services provided through us must be accessible to all members.

Our policies and procedures are designed to promote compliance with the Americans with Disabilities Act of 1990 (42 U.S.C. §12101 *et seq*). Providers are required to take actions to remove any existing barrier

and accommodate the needs of members who are qualified individuals with a disability. This action plan includes:

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

## **10.5 Appointments**

### **Routine Care**

Health care for covered preventive and medically necessary health care services that are nonemergent or nonurgent is considered routine care.

### **Urgent Care**

A health condition (including an urgent behavioral health situation) that is not an emergency, but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment by the member's primary care provider or primary care provider designee within 24 hours to prevent serious deterioration of the member's condition or health.

### **Emergency Care**

Emergency care is defined as any medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

- Placing the patient's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement.
- Serious jeopardy to the health of a woman or her unborn child (in the case of a pregnant woman).

### **Appointment and Access Standards**

We are dedicated to arranging access to care for our members. Our ability to provide quality access depends upon the accessibility of network providers. We evaluate HHSC, TDI, and National Committee for Quality Assurance (NCQA) requirements and follow the most stringent standards among the 3 sources. Providers are required to adhere to the following access standards. Standards are measured from the date of presentation or request, whichever occurs first.

| Standard Name          | Amerigroup  |
|------------------------|---|
| Emergency services     | Immediately upon member presentation at the service delivery site |
| Urgent care            | Within 24 hours   |
| Routine primary care   | Within 14 days  |
| Routine specialty care | Within 3 weeks  |

| Standard Name  | Amerigroup   |
|--|--|
| Preventive health: child (new member)                                    | For new members birth through age 20, overdue or upcoming well-child checkups, including Texas Health Steps should be offered as soon as practicable and within 90 days of enrollment.   |
| Preventive health: newborn   | Within 14 days   |
| Texas Health Steps medical checkups - age birth through 35 months of age | For an existing member from birth through 35 months of age, due based on dates in the TMPPM<br>Considered timely if within 60 days of the due date based on the member's date of birth   |
| Texas Health Steps annual medical checkup - age 3 years and older        | For an existing member age 3 years and older, due on the child's birthday<br>Considered timely if no later than 364 calendar days after the child's birthday   |
| Prenatal care  | Within 14 days   |
| Pregnancy high risk/third trimester                                      | Within 5 days or immediately if an emergency exists  |
| Behavioral health: non-life-threatening emergency                        | Within 6 hours   |
| Behavioral health: urgent care   | Within 24 hours  |
| Behavioral health: routine care  | The earlier of 10 business days or 14 calendar days  |
| After-hours care   | For primary care providers: Practitioners accessible 24/7 directly or through answering service<br>Answering service or recording assistance in English and Spanish<br>Member reaches on-call physician or medical staff within 30 minutes |
| Community long-term services and supports                                | Services must be initiated within 7 days of authorization for non-MDCP waiver members unless referring provider or member requests otherwise.  |

Providers may not use discriminatory practices, such as preference to other insured or private-pay patients, including separate waiting rooms, hours of operation, or appointment days. We routinely monitor providers' adherence to the access to care standards through surveys, including the online survey described in the [Online Mandatory Provider Information Survey](#) section of this manual.

## 10.6 Continuity of Care

The care of newly enrolled members may not be disrupted or interrupted. This is true for care that falls within the scope of benefits. We will work to provide continuity in the care of newly enrolled members whose health or behavioral health conditions have been treated by specialty care providers or whose health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted.

We will honor existing service authorizations for new members in the same amount, duration, and scope until the shorter of:

- 90 calendar days
- The end of the current authorization period
- The STAR Kids Screening and Assessment Process has been completed and we have issued or denied a new authorization

For members enrolling on the operational start date of the STAR Kids program or on the start date of a new service area, we will honor existing long-term services and supports authorizations for up to 6 months, or until we have completed the STAR Kids Screening and Assessment Process and issued new service authorizations.

Pregnant Amerigroup members past the 24th week of pregnancy are allowed to remain under the care of their current OB/GYNs through their post-partum checkup. This applies even if the providers are out-of-network. If a member wants to change her OB/GYN to one who is in the network, she will be allowed to do so if the new provider agrees to accept her.

For new members who have been diagnosed with a terminal illness, we will approve out-of-network care by existing providers for up to 12 months while enrolled with Amerigroup.

We will pay a new member's existing out-of-network providers for medically necessary covered services until the member's records, clinical information and care can be transferred to a network provider or until the member is no longer enrolled with us, whichever is shorter. If, at the time of enrollment, the member has an existing scheduled appointment with an out-of-network specialist physician and Amerigroup has not arranged for an earlier alternative appointment with a network provider with a comparable certification, specialty, and expertise, we will authorize and pay the out-of-network specialist physician for any covered service provided to the member during that member's scheduled appointment with the out-of-network specialist physician.

#### **Member Moves Out of Service Area**

We provide or pay out-of-network providers for medically necessary covered services to members who move out of the service area. Members are covered through the end of the period for which he or she is enrolled in Amerigroup.

#### **Pre-existing Condition Not Imposed**

We do not impose any pre-existing condition limitations or exclusions. We do not require evidence of insurability to provide coverage to any member.

### **10.7 Covering Physicians**

During a provider's absence or unavailability, he or she needs to arrange for coverage for his or her members. The provider will either:

- Make arrangements with one or more network providers to provide care for his or her patients
- Make arrangements with another similarly licensed and qualified provider with appropriate medical staff privileges at the same network hospital or medical group as applicable to provide care to the members in question

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 member on the provider's behalf.

### **10.8 Credentialing and Recredentialing**

To be reimbursed for services rendered to Medicaid managed care members, providers must be enrolled in Texas Medicaid. Providers are not considered participating with us until they have enrolled in Texas Medicaid and have been credentialed with a duly executed contract with us.

We adhere to NCQA standards and state requirements for credentialing and recredentialing. In accordance with these standards, providers must submit all requested information necessary to complete the credentialing or recredentialing process. Each provider must cooperate with us as necessary to conduct credentialing and recredentialing pursuant to our policies and procedures.

As an applicant for participation in our network, each provider has the right to review information obtained from other sources during the credentialing process. Upon notification from us of a discrepancy, the provider has the right to explain information obtained from another party that may vary substantially from the information provided in the application and to submit corrections to the facts in dispute. The provider must submit a written explanation or appear before the credentialing committee if deemed necessary.

We will complete the initial credentialing process and our claims system will be able to recognize a newly contracted provider no later than 90 calendar days after receipt of a complete application. If an application does not include required information, we will send the applicant written notice of all missing information no later than 5 business days after receipt of the application.

If a provider qualifies for expedited credentialing under Texas Insurance Code 1452, Subchapters C, D, and E, regarding providers joining established medical groups or professional practices that are already contracted with us, our claims system will be able to process claims from the provider as if the provider was fully contracted, no later than 30 days after receipt of a complete application, even if we have not yet completed the credentialing process.

At least once every 3 years, we will review and approve the credentials of all participating licensed and unlicensed providers who participate in the Amerigroup network. The process will take into consideration provider performance data including member complaints and appeals, quality of care and utilization management.

Providers are required to notify us of a change in address or practice status within 10 days of the effective date of the change. Practice status is defined as a change in office hours, panel status, etc. The inclusion of a new address on a recredentialing application is not an acceptable form of notification. A notice of termination must adhere to the advance notice time lines stated in the provider's agreement. Submit changes to:

Provider Configuration  
Amerigroup  
PO Box 62509  
Virginia Beach, VA 23466-2509

### ***10.8.1 Credentialing Decision Appeal Process***

In the event of a decision by the credentialing committee to limit or restrict the credentials or terminate the participation of a provider in the Amerigroup network as part of the recredentialing process, the provider will be notified in writing of a 30-calendar-day time frame in which the provider may appeal the decision. We have a 2-level appeal process.

The request from the provider for an appeal must set forth in detail those matters the provider believes were improperly determined by the credentialing committee and/or medical director, and the specific reasons why the provider believes the decision to be improper. The provider may include any statement, documents, or other materials the provider would like the credentialing appeals committee (first-level appeals) or credentialing hearing committee (second-level appeals), or appointed hearing officer to consider prior to rendering a final decision. If the provider does not submit a written appeal within the 30-calendar-day time frame, the appeal right expires and the initial determination will stand.

If the credentialing appeals committee does not render a favorable decision to a provider in a first-level recredentialing appeal, the provider may request a second-level appeal. The provider must request the additional appeal in writing within 30 days of the date of the denial notification letter. When we receive the provider's request for a second-level appeal, an acknowledgment letter will be sent to the provider, which sets forth the next steps in the appeal process.

The second-level appeal is reviewed by the credentialing hearing committee, led by a hearing officer. The provider may participate by phone or appear in person and has the right to be represented by an attorney or other representative. The hearing will take place within 30 days of the date of the provider's letter requesting the second-level appeal. We will send a letter to the provider 14 days in advance of the hearing, which will state the date, time, and place of the hearing. The provider will receive an evidence packet that will be used for reference by the credentialing hearing committee. During the hearing, the provider may call, examine, and cross-examine any witnesses. The provider may also submit a written statement at the close of the hearing.

The credentialing hearing committee will consist of individuals who (a) are participating licensed practitioners; (b) are not in direct economic competition with the provider; (c) are not in business with the provider; and (d) have not previously made a recommendation or decision regarding the provider's participation in our network.

The outcome of the second-level appeal may be to reinstate the provider, establish a provisional reinstatement subject to certain conditions, or uphold the decision of the credentialing appeals committee. The provider will be notified in writing of the committee's decision within 15 days of the meeting. The findings of the credentialing hearing committee are final. If a determination to terminate is upheld, termination will be effective the first day of the month following 30 days from the date of the letter detailing the credentialing hearing committee's second-level appeal decision.

### ***10.8.2 Practitioner Office Site Quality***

We establish standards and thresholds for office site criteria and medical and treatment record-keeping practices. This applies to all practitioners within the scope of credentialing.

To protect the health and safety of our members, we developed a process for evaluating a physician office site for one or more of the following reasons:

- Receipt of a member complaint concerning physical accessibility, physical appearance, adequacy of waiting or examining room space, or adequacy of medical/ treatment records
- Receipt of a member complaint determined to be severe enough to potentially endanger or which endangers members' health and well-being

- When a pattern related to the quality of the site is identified
- At the time of initial credentialing or recredentialing, as outlined by contractual requirement
- To complete the open investigation of any quality or quality of service issue

All physicians/practitioners are required to meet standards set forth by us and to comply with state and federal regulations.

If we identify a physician/practitioner office site receiving 3 or more complaints within a 6-month period related to the following components (with the exception of physical accessibility, which has a one complaint threshold), a Practitioner Office Site Quality Assessment will be conducted that will include a review of:

- Physical accessibility
- Physical appearance
- Adequacy of waiting or examining room space
- Adequacy of medical/treatment record-keeping practices

We may choose to conduct an office site quality assessment if a complaint is determined to be severe enough to potentially endanger a member's health or well-being (in this case the threshold is 1 complaint).

The *Amerigroup Practitioner Office Site Evaluation* form is used to score the office site quality measurements. A minimum threshold of 80 percent or greater in each component is considered a passing audit score. The acceptable performance for on-site visits for each office location and medical record reviews for the applicant is a minimum passing score of 80 percent in each of the 4 designated components outlined above. Any exception to the minimum passing score is at the discretion of the health plan credentialing committee and must be based on compelling circumstances.

| Practitioner Office Site Assessment Criteria |   |  |
|--|---|--|
| Scoring information                          |   |  |
| Physical accessibility                       |   |  |
| 1  | Is there accessibility for people with disabilities? If not, does staff have an alternative plan of action?                                   | Must have first-floor ramp or elevator access. Bathroom and hallways must accommodate a wheelchair.<br>If yes, 2 points; if no, 0 points.  |
| 2  | Is accessible parking clearly marked?   | Off-street accessible parking is identified by a sign or a painted symbol on the pavement. Score as N/A if street-side parking only is available.<br>If yes, 1 point; if no, 0 points.                             |
| 3  | Are doorways and stairways that provide access free from obstructions at all times, and do they allow easy access by wheelchair or stretcher? | There should be no boxes, furniture, etc. blocking doorways or stairways<br>If yes, 2 points; if no, 0 points.   |
| 4  | Are exits clearly marked, and is there emergency lighting in instances of power failure?  | Exits are marked with appropriate chevrons and emergency powered in case of power outage.<br>There is a posted evacuation plan by either staff design or building management<br>If yes, 2 points; if no, 0 points. |
| 5  | Are building and office suite clearly identifiable (clearly marked office sign)?  | The sign identifying the office is clearly posted.<br>If yes, 1 point; if no, 0 points.  |

| Practitioner Office Site Assessment Criteria |  |   |
|--|--|---|
| Scoring information                          |  |   |
| Physical appearance                          |  |   |
| 1  | Is the office clean, well-kept and smoke-free?   | Mark yes if there are no significant spills on furniture or floor, the trash is confined, and the office and waiting area appears neat. Does the office prevent hazards that might lead to slipping, falling, electrical shock, burns, poisoning, and other trauma?<br>If yes, 2 points; if no, 0 points. |
| 2  | Is treatment area clean and well kept? (No significant spills on floors, counters or furnishings, no trash on floor)   | Mark yes if there are no significant spills on furniture or floor, the trash is confined, the treatment area appears neat.<br>If yes, 2 points; if no, 0 points.  |
| 3  | Does office have smoke detector(s)?  | Smoke detectors should be in place and tested twice yearly. How does the office log the twice-yearly check? Is the office a smoke-free facility?<br>If yes, 2 points; if no, 0 points.  |
| 4  | Is there easy access to a clean, supplied bathroom?)   | <ul style="list-style-type: none"> <li>• Soap, toilet paper, and hand towels are available</li> <li>• Hand washing instructions are posted</li> <li>• Lavatory is clean; toilet is functioning</li> </ul> If yes, 1 point; if no, 0 points.   |
| 5  | Is the waiting room well lit?  | Is there adequate lighting and comfort level for reading?<br>If yes, 1 point; if no, 0 points.  |
| 6  | Are fire extinguishers clearly present and fully charged with a current inspection (even if the office has a sprinkler system)?  | Fire extinguisher tag is dated within the last year; there should be an adequate number of fire extinguishers for the square footage placed at opposite ends of office.<br>If yes, 1 point; if no, 0 points.  |
| Adequacy of waiting/examining room space     |  |   |
| 1  | Is there adequate seating in the waiting area (based on the number of physicians/practitioners)?   | 1 provider = 6 seats, 2 providers = 8 seats, 3 providers = 11 seats, 4 providers = 14 seats, 5 providers = 17 seats<br>If yes, 1 point; if no, 0 points.  |
| 2  | Does the staff provide extra seating when the waiting room is full?  | Ask the staff where patients go when waiting area is full.<br>If yes, 1 point; if no, 0 points.   |
| 3  | Is there a minimum of 2 exam rooms per scheduled provider? (2 consultation rooms for behavioral health providers)  | Count exam/consultation rooms and compare against provider schedule.<br>If yes, 1 point; if no, 0 points.   |
| 4  | Is there privacy in exam/consultation rooms?   | There must be door or curtain closures, exam/consultation rooms cannot be seen from waiting room.<br>If yes, 1 point; if no, 0 points.  |
| 5  | Are exam/consultation rooms reasonably sound proof to ensure patient privacy during interviews/examinations?   | Conversations cannot be heard from waiting room or other exam/consultation rooms.<br>If yes, 2 points; if no, 0 points.   |
| 6  | Is an otoscope, an ophthalmoscope, a blood pressure cuff, and a scale readily accessible?  | Applies to all physicians/practitioners except behavioral health providers<br>If yes, 1 point; if no, 0 points.   |
| 7  | 7a - For OB/GYNs only or any physician/practitioner providing OB care:<br>7b - Is a fetalscope (DeLee and/or Dopler) and a measuring tape for fundal height measurement readily accessible<br>- Supplies for dipstick urine analysis (glucose, protein)? | Score 7a and 7b as N/A if provider does not provide OB services<br>If yes, 1 point for each; if no, 0 points.   |
| Adequacy of medical records                  |  |   |
| 1  | Are there individual patient records?  | Each patient has an individual record. There should be no family charts.<br>If yes, 2 points; if no, 0 points.  |
| 2  | Are records stored in a manner that ensures confidentiality? Who is the designated person in charge of clinical records? (provide name)  | Records are maintained in locations not easily accessible to patients and office visitors.<br>If yes, 2 points; if no, 0 points.  |
| 3  | Are all items secured in the chart?  | All patient medical information must be secured within the chart.<br>If yes, 2 points; if no, 0 points.   |



| Practitioner Office Site Assessment Criteria |   |  |
|--|---|--|
| Scoring information                          |   |  |
| 4  | Are medical records readily available?  | Medical records should be available within 15 minutes of request. Providers with more than one office location must have a mechanism to assure the medical record is available for reference if a patient is seen at an alternate site to the usual office.<br>If yes, 2 points; if no, 0 points.  |
| 5  | Medical recordkeeping practices:  | We are only determining there is a place within a blank chart to document the information in 5a thru 5f. Due to HIPAA regulations and other reasons related to the legal right to access, we <b>MUST NOT</b> ask to review an actual patient chart for providers in the initial credentialing process. We may only review charts of those Amerigroup members actually assigned or currently being seen by the providers/practitioners. There would be none for initial providers. When medical records are retired, what is the procedure for storage and final destruction? |
| 5a   | Is there a place to document allergies?   | Allergies or the absence of allergies, along with the reactions, should be prominently displayed in or on the medical record. The absence of medicine sensitivities should also be noted.<br>If yes, 2 points; if no, 0 points.  |
| 5b   | Is there a place to document a current medication list?   | All medications, both prescription and over-the-counter/herbal medications, should be documented in the chart along with the dosages. A notation should also include No Medications to attest that the inquiry was made.<br>If yes, 2 points; if no, 0 points.   |
| 5c   | Is there a place to document current chronic problems list?   | A problem list would be generated as part of each visit's assessment.<br>If yes, 2 points; if no, 0 points.  |
| 5d   | Is there an immunization record on pediatric charts? N/A for behavioral health providers  | The immunization record should be completed to the age the child has reached at the time of the last encounter. If shots were completed prior to the first encounter with the current physician/practitioner, the notation <i>Immunizations are up-to-date</i> is acceptable.<br>If yes, 2 points; if no, 0 points.  |
| 5e   | Is there a growth chart on pediatric charts? N/A for behavioral health providers  | Height and weight are documented annually; head circumference is documented until age 2.<br>If yes, 2 points; if no, 0 points.   |
| 5f   | Is there a place to document presence/absence and discussion of a patient self-determination/advance directive?                             | There is a place for documentation that an advance directive has been executed or that the physician/practitioner has inquired as to whether the patient has a written advance directive.<br>If yes, 2 points; if no, 0 points.<br>Score as N/A if patient is 20 years old or younger.   |
| Appointment availability                     |   |  |
| 1  | Please see specific appointment availability requirements   | If yes, 1 point for each; if no, 0 points.   |
| Documentation evaluation                     |   |  |
| 1  | Is there a no-show follow-up procedure/policy?  | A written policy should be available. If not, the staff should verbally describe the follow-up process. Staff should be encouraged to adapt policy into a written format.<br>If yes, 2 points; if no, 0 points.  |
| 2  | Is there a chaperone policy? May not apply to some specific behavioral health situations – ask for clarification and document same on form. | A written policy should be available. If a written policy is not in place, the staff should verbally describe the process and provide a statement on the office letterhead stating a chaperone will be in the exam room. Staff should be encouraged to adapt the policy into a written format.<br><b>The provider must have this element in place to pass the site evaluation and participate with Amerigroup.</b><br>If yes, 2 points; if no, 0 points.   |
| 3  | Is the Patient Bill of Rights posted? Are copies available upon request?  | A notice should be posted in a prominent location, and copies should be available upon request.<br>If yes, 1 point; if no, 0 points.   |
| 4  | Is a medical license/occupational license displayed? Are the hours of operation posted?   | Licensures and hours of operation should be posted within the office.<br>If yes, 1 point; if no, 0 points.   |
| 5  | Is there a notice of member complaint process?  | A notice should be posted in a prominent location.<br>If yes, 1 point; if no, 0 points.  |

| Practitioner Office Site Assessment Criteria |   |   |
|--|---|---|
| Scoring information                          |   |   |
| 6  | Is there a written policy for hand washing, gloved procedures, and disposal of sharps? May not be applicable for behavioral health providers in private practice setting.   | A written policy for hand washing should be available (1 point)<br>A written policy for sharp disposal should be available (1 point). Sharps should be disposed of immediately. Reusable containers must not be opened, emptied, or cleaned manually. Policies may be located in the office OSHA manual.<br>If yes, 2 points; if no, 0 points.  |
| 7  | Is there a written OSHA exposure control plan that includes universal precautions and blood-borne pathogen exposure procedures for staff?   | A written policy should be in place detailing the process to protect staff from exposure to hazardous waste materials and the cleanup/disposal of same. Are MSDS sheets available?<br>If yes, 2 points; if no, 0 points.  |
| 8  | Is a copy of the Clinical Laboratory Improvement Amendments (CLIA) Certificate or Certificate of Waiver if applicable posted? <b>If the primary care provider provides Texas Health Steps services, must have CLIA/waiver or lab services within the same building.</b> | If the provider offers laboratory services that require a CLIA or Certificate of Waiver, the current notice should be posted and a copy obtained and attached to the site visit form.<br>If yes, 1 point; if no, 0 points.  |
| 9  | Is there a copy of the current radiology services certification or licensure if applicable posted?  | If the provider offers radiology services, current licensure and / or certification must be posted and copy obtained and attached to the site visit form. Are pregnancy signs posted?<br>If yes, 1 point; if no, 0 points.  |
| 10   | If the provider employs nurse practitioners, physicians' assistants, or other mid-level providers that will assess health care needs of members, do they have written policies describing the duties and supervision of such providers?                                 | A written policy should be available describing the level / type of care provided by the mid-level practitioners within the physician's / practitioner's office and the level / type of supervision of same.<br>If yes, 2 points; if no, 0 points.  |
| HIPAA requirements/regulations               |   |   |
| 1  | Is there a written policy and procedure addressing permitted uses / disclosures and required disclosures of patient Personal Health Information (PHI) / Individually Identifiable Health Information (IIHI)?  | There should a written policy and procedure addressing permitted uses and disclosures as well as required disclosures of patient PHI / IIHI, as required by HIPAA regulations. Providers should have appropriate forms available for members and patients.<br>If yes, 2 points; if no, 0 points.  |
| 2  | Does the provider have authorization forms available to designate personal representative(s) to which PHI / IIHI may be released and / or disclosed?  | Does the provider have an authorization form for disclosure of PHI / IIHI, as required by HIPAA regulations? Form should include an expiration date. Forms should also include description of how members / patients may revoke authorization in writing.<br>If yes, 2 points; if no, 0 points.   |
| 3  | Are there physical safeguards in place to protect the privacy of patient PHI / IIHI?  | There should be no papers with PHI in areas accessible to other patients. Examples: All patient information is securely placed in locked cabinet. No confidential information is left out in the open for other patients or staff members to see (for example, patient sign-in sheet).<br>Is there a shredding machine and policy on storage and disposal of medical records?<br>Computer has safeguards in place: security codes for access, safety.<br>If yes, 2 points; if no, 0 points. |
| 4  | Is there a designated compliance and privacy person?  | <b>You must include the name of the individual in the space provided on the site evaluation form.</b><br>If yes, 2 points; if no, 0 points.   |
| Office evaluation                            |   |   |
| 1  | Is there an approved process for biohazardous disposal?   | There is a written policy for biohazardous waste disposal in a manner that protects employees from occupational exposure. Biohazardous waste includes liquid or semi-liquid blood or other potentially infectious materials. Bio-hazardous items include contaminated items that would release blood if compressed, items caked with blood, contaminated sharps, and pathological and microbiological waste.<br>If yes, 2 points; if no, 0 points.  |

| Practitioner Office Site Assessment Criteria |   |   |
|--|---|---|
| Scoring information                          |   |   |
| 2  | Are pharmaceutical supplies and medication stored in a locked area that is not readily accessible to patients?  | <ul style="list-style-type: none"> <li>• Medications are in a locked area, including samples</li> <li>• Prescription pads are kept in a secured location away from patient access; pads should not be found in exam rooms or left on countertops unsupervised by office staff</li> </ul> If yes, 2 points; if no, 0 points.                   |
| 3  | Is there a plan / procedure for narcotic inventory, control and disposal?   | There is a plan to randomly check that sample medications are current and there is a procedure for disposing of expired medications – wasting of medications.<br>If yes, 1 point; if no, 0 points.  |
| 4  | Are vaccines and other biologicals refrigerated as appropriate?   | If refrigeration is required for medication, there is a separate space provided. There should be no other items – including food and biological specimens – on the same shelf as medication (preferably these are in a separate refrigerator). Look for Penny Test in freezer to document power outages.<br>If yes, 1 point; if no, 0 points. |
| 5  | Is emergency equipment available? If not, note how the staff accommodates emergency situations.   | The minimum requirement is an oral airway and Ambu bag (for children and / or adults based on age range).<br>If the office has an emergency kit or cart, check for routine inspections and expired supplies or medications.<br>If yes, 1 point; if no, 0 points.  |
| 6  | Observe 2-3 office staff interactions: Are they professional and helpful? Are CPR-trained staff in the office at all times when patients are present? | If yes, 2 points; if no, 0 points.  |

## 10.9 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 to enable effective work in cross-cultural situations. Cultural competency helps providers and members:

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

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. It also impacts the member's adherence to recommended treatment. Some of the reasons that justify a provider's need for cultural competency include:

- The perception that illness and disease and their causes vary by culture
- The diversity of belief systems related to health, healing, and wellness
- 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 underrepresented in the current service delivery system

Cultural barriers between the provider and the member can impact the patient-provider relationship in many ways, including:

- 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 U.S. 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, we expect providers serving members within this geographic location to demonstrate the characteristics described below.

### **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

### **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
- 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 utilized by members with various cultural and ethnic differences

### **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 an 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 process 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 utilize 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 recognize challenges related to literacy and provide appropriate and understandable information
- 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 ability to accept ethnic differences among people and understand how these differences affect the treatment process
- A willingness to work with clients of various ethnic minority groups

#### **10.10 Early Childhood Intervention (ECI)**

We contract with qualified ECI providers to provide ECI covered services to members from birth to 3 years of age who have been determined eligible for ECI services. Members are permitted to self-refer to local ECI service providers without a referral from the member's primary care provider. Our providers are required to identify and provide referral information to the legally authorized representative (LAR) of any member birth to 3 years of age suspected of having a developmental disability or delay, or otherwise meeting eligibility criteria for ECI services in accordance with 40 TAC Chapter 108, within 7 calendar days from the day the provider identifies the member. The Department of Assistive and Rehabilitative Services – Division for Early Childhood Intervention Services provides information and publications on its website at [www.dars.state.tx.us/ecis/index.shtml](http://www.dars.state.tx.us/ecis/index.shtml). These resources should be used as by providers to identify children in need of ECI services. The local ECI program will determine eligibility for ECI services using the criteria contained in 40 TAC Chapter 108.

The member's LAR must be informed that ECI participation is voluntary. Amerigroup must provide medically necessary services to a member if the member's LAR chooses not to participate in ECI.

The Individual Family Service Plan (IFSP) is an agreement developed by an interdisciplinary team that includes the member's LAR, the ECI service coordinator, ECI professionals directly involved in the eligibility determination and member assessment, ECI professionals who will be providing direct services to the child, and other family members, advocates, or other persons as requested by the LAR. If the member's LAR provides written consent, the member's primary care provider or Amerigroup staff may be included in IFSP meetings. The IFSP identifies the member's present level of development based on assessment, describes the services to be provided to the child to meet the needs of the child and the family, and identifies the person or persons responsible for each service required by the plan.

The IFSP is a contract between the ECI contractor and the member's LAR. The LAR signs the IFSP to consent to receive the services established by the IFSP. The IFSP contains information specific to the member as well as information related to family needs and concerns. If the member's LAR provides written consent, the ECI program may share a copy of IFSP sections relevant only to the member with Amerigroup and their primary care provider to enhance coordination of the plan of care. These sections of the IFSP may be included in the member's medical record or service plan.

The IFSP is the authorization for the program-provided services (services provided by the ECI contractor) included in the plan. Preauthorization is not required for the initial ECI assessment or for the services in the plan after the IFSP is finalized. All medically necessary health and behavioral health program-provided services contained in the IFSP must be provided to the member in the amount, duration, scope, and service setting established by the IFSP. Medical diagnostic procedures required by ECI, including diagnostic specific evaluations so that ECI can meet the 45-day timeline established by federal rule, will be covered by Amerigroup.

ECI providers must submit claims for all covered services that are program-provided outlined in the IFSP to Amerigroup. Amerigroup must pay claims for ECI covered services in the amount, duration, scope, and service setting established by the IFSP.

Amerigroup coordinates with local ECI programs that perform assessment, case management, and non-health related services required by a member's IFSP when needs are identified (or as requested). ECI Targeted Case Management services and ECI Specialized Skills Training are not Amerigroup capitated services, as described in the *STAR Kids Managed Care Contract*. Amerigroup is not responsible for payment of these services; ECI providers are to bill Texas Medicaid & Healthcare Partnership (TMHP).

#### **10.11 Eligibility Verification**

Primary care providers can obtain listings of members assigned to their panels online at [www.Availity.com](http://www.Availity.com). If a member calls Amerigroup to change his or her primary care provider, the change will be effective the same business day. The primary care provider should verify that each Amerigroup member receiving treatment in his or her office is on the membership listing. For questions regarding a member's eligibility, providers may visit [www.Availity.com](http://www.Availity.com) or call the automated Provider Inquiry Line at 1-800-454-3730.

#### **10.12 Emergency Services**

We provide a Nurse HelpLine service with clinical staff to provide triage advice, referrals (if necessary), and make treatment arrangements for the member. The service is available 24 hours a day, 7 days a week. The staff has access to qualified behavioral health professionals to assess behavioral health emergencies.

We do not discourage members from using the 911 emergency system, and we do not deny access to emergency services. Emergency services are provided to members without requiring precertification. Any hospital or provider calling for an authorization for emergency services will be granted one immediately upon request. Emergency services coverage includes services that are 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 medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

- Serious jeopardy to the health of the individual (or, with respect to 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
- Serious disfigurement

An emergency behavioral health condition is defined as any condition, without regard to the nature or cause of the condition which, in the opinion of a prudent layperson possessing average knowledge of medicine and health:

- Requires immediate intervention or medical attention without which the member would present an immediate danger to themselves or others
- Renders the member incapable of controlling, knowing, or understanding the consequences of their actions

Emergency response is coordinated with community services, including (if applicable):

- Police, fire, and EMS departments
- Juvenile probation
- The judicial system
- Child protective services
- Chemical dependency agencies
- Emergency services
- Local mental health authorities

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. The determination is made 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 the results of the emergency medical screening examination in the member's chart. We will compensate the provider for the screenings, evaluations, and examinations that are reasonable and calculated to assist the health care provider in determining whether or not the patient's condition is an emergency medical condition.

If there is concern surrounding the transfer of a patient (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 patient at the treating facility prevails and is binding on Amerigroup. If the emergency department is unable to stabilize and release the member, we 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. The transferring facility should make all attempts to transfer our members to a network facility. If the member is admitted, the Amerigroup concurrent review nurse will implement the concurrent review process to ensure coordination of care.

## **10.13 Fraud, Waste, and Abuse**

### **General Obligation to Prevent, Detect, and Deter Fraud, Waste, and Abuse**

As recipients of funds from state and federally sponsored health care programs, we each have a duty to help prevent, detect, and deter fraud, waste, and abuse. Our commitment to detecting, mitigating, and preventing fraud, waste, and abuse is outlined in our corporate compliance program. As part of the requirements of the federal Deficit Reduction Act, each Amerigroup provider is required to adopt our policies on detecting, preventing, and mitigating fraud, waste, and abuse in all the federally and state-funded health care programs in which we participate. Electronic copies of this policy and our Code of Business Conduct and Ethics are available at our website at <https://providers.amerigroup.com/TX>.

To meet the Deficit Reduction Act requirements, providers must adopt our fraud, waste, and abuse policies. Additionally, providers must distribute the policies to any staff members or contractors who work with us. If you have questions or would like to have more details concerning our fraud, waste, and abuse detection, prevention, and mitigation program, please contact our chief compliance officer.

If a network provider receives annual Medicaid payments of at least \$5 million (cumulative, from all sources), the network provider must:

- Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the network provider; the policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws as described in Section 1902(a)(68)(A) of the Social Security Act.
- Include as part of such written policies, detailed provisions regarding the network provider's policies and procedures for detecting and preventing fraud, waste, and abuse.
- Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A) of the Social Security Act, the rights of employees to be protected as whistleblowers and the provider's policies and procedures for detecting and preventing fraud, waste, and abuse.

### **Importance of Detecting, Deterring, and Preventing Fraud, Waste, and Abuse**

Health care fraud increasingly costs taxpayers more money every year. There are state and federal laws 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, we educate providers on how to help prevent member and provider fraud by identifying the different types.

There are many types of fraud, waste, and abuse including:

#### **Provider Fraud, Waste, and Abuse**

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



- Upcoding

Providers can help prevent fraud, waste, and abuse by ensuring that the services rendered are medically necessary, accurately documented in 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 the 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. An important step to help prevent member fraud is simply reviewing our member identification card. It is the first line of defense against fraud. We may not accept responsibility for the costs incurred by providers rendering services to a patient who is not a member, even if that patient presents an Amerigroup member identification card. Providers should take measures to ensure the cardholder is the person named on the card.

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

#### **10.13.1 Fraud Information**

### **Reporting Waste, Abuse or Fraud by a Provider or Member**

#### **Medicaid Managed Care**

#### **Do you want to report waste, abuse or fraud?**

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary
- Not telling the truth about a medical condition to get medical treatment
- Letting someone else use their Medicaid ID
- Using someone else's Medicaid ID
- Not telling the truth about the amount of money or resources he or she has to get benefits

**To report waste, abuse or fraud, choose one of the following:**

- Call the OIG Hotline at 1-800-436-6184
- Visit <https://oig.hhsc.state.tx.us> Under the box labeled “I WANT TO” click “Report Waste, Abuse and Fraud” to complete the online form; or
- You can report directly to your health plan:

Compliance Officer  
Amerigroup  
823 Congress Ave, Suite 400  
Austin, TX 78701  
1-800-315-5385

Other reporting options include:

- Amerigroup Provider Services: 1-800-454-3730
- External Anonymous Compliance Hotline: 1-877-660-7890 or [amerigroup.silentwhistle.com](https://amerigroup.silentwhistle.com)  
Email: [corpinvest@amerigroup.com](mailto:corpinvest@amerigroup.com), or [obe@amerigroup.com](mailto:obe@amerigroup.com)

**To report waste, abuse or fraud, gather as much information as possible.**

When reporting about a provider (a doctor, dentist, counselor, etc.), include:

- Name, address and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

When reporting about someone who receives benefits, include:

- The person’s name
- The person’s date of birth, Social Security number or case number if you have it
- The city where the person lives
- Specific details about the waste, abuse or fraud

## **10.14 ImmTrac**

ImmTrac is the DSHS statewide immunization and tracking database system that:

- Consolidates immunization records from multiple providers into one easily accessible record.
- Enables immunization providers to review patient immunization histories (providing records have been forwarded to the system), and enter information on administered vaccines.
- Assists providers in dealing with complex vaccination schedule requirements, and produces recall and reminder notices for vaccines that are due and overdue.

Providers are required to:

- Submit immunization information to ImmTrac
- Obtain written consent to release a child’s individual immunization data to ImmTrac

- Verify that the Texas birth certificate registration form includes a parental consent statement

Providers should register with ImmTrac at <https://www.dshs.state.tx.us/immunize/#immtrac>.

## **10.15 Laboratory Services (Outpatient)**

All outpatient laboratory tests should be performed at an Amerigroup-preferred network lab (LabCorp or Quest Diagnostics) or a network facility outpatient lab. The exception to this requirement is when the service being performed is a Clinical Laboratory Improvement Amendments (CLIA)-approved office test or for Texas Health Steps. Visit the CMS website at [cms.gov](https://www.cms.gov) for a complete list of CLIA-approved tests.

CLIA requires all laboratories serving Medicaid clients to maintain a certificate of registration or a certificate of waiver. Those laboratories with a certificate of waiver may only provide the following 9 tests:

1. Dipstick or tablet reagent urinalysis for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen
2. Fecal occult blood
3. Ovulation tests
4. Urine pregnancy tests
5. Erythrocyte sedimentation rate, nonautomated
6. Hemoglobin-copper sulfate, nonautomated
7. Blood glucose by glucose monitoring devices cleared by the FDA specifically for home use
8. Spun microhematocrit
9. Hemoglobin by single analyte instruments with self-contained or component features to perform specimen/reagent interaction, providing direct measurement and readout

Texas Health Steps requires providers to use DSHS laboratory services for specimens obtained as part of a Texas Health Steps medical checkup, including Texas Health Steps newborn screens, blood lead testing, hemoglobin electrophoresis, and total hemoglobin tests that are processed at the Austin Laboratory; and pap smear, gonorrhea, and chlamydia screening processed at the Women's Health Laboratories in San Antonio. Providers may submit specimens for glucose, cholesterol, HDL, lipid profile, HIV, and RPR to the DSHS laboratory or to a laboratory of the provider's choice. Hematocrit may be performed at the provider's clinic if the provider needs an immediate result for anemia screening. The Texas Health Steps online provider training modules referencing specimen collection on the DSHS website and the *Texas Medicaid Provider Procedures Manual, Children Services Handbook*, should be referenced for the most current information and any updates.

If we reimburse you and the capitation rate includes outpatient laboratory tests, you will not receive additional payments. All other outpatient laboratory tests not contained in this listing or under your capitated arrangement should be referred to a contracted lab vendor. If a laboratory test cannot be directed to or provided by a network provider, precertification is required for coverage.

## **10.16 Locum Tenens**

We allow reimbursement of locum tenens physicians in accordance with CMS guidelines, subject to benefit design, medical necessity, and authorization guidelines.

We will reimburse the member's regular physician or medical group for all services (including emergency visits) of a locum tenens physician during the absence of the regular physician. This applies in cases where the regular physician pays the locum tenens physician on a per diem or similar fee-for-time basis. Reimbursement to the regular physician or medical group is based on the applicable fee schedule or contracted rate. The locum tenens physician may not provide services to a member for more than a period of 60 continuous days.

A member's regular physician or medical group should bill the appropriate procedure code(s) identifying the service(s) provided by the locum tenens physician. A Q6 modifier must be appended to each procedure code.

If a locum tenens physician only performs postoperative services furnished during the period covered by the global fee, these services are not identified on the claim as substitution services. Additionally, these services do not require the Q6 modifier.

#### **10.17 Member Missed Appointments**

Amerigroup members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. We require providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling the appointment. The contact must be by telephone, allowing the provider to educate the member about the importance of keeping appointments. It's also a good time for the provider to encourage the member to reschedule the appointment.

Amerigroup 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, providers can call Provider Services at 1-800-454-3730 or the local health plan member advocate to address the situation. Our staff will contact the member and provide more extensive education and/or case management as appropriate. Our goal is for members to recognize the importance of maintaining preventive health visits and adhering to the primary care provider's recommended plan of care. Providers may not bill us or our members for missed appointments.

#### **10.18 Member Record Standards**

Our providers are required to maintain medical records that conform to good professional medical practice and appropriate health management. A permanent medical record is maintained at the primary care site for every member and is available to the primary care provider and other providers. Medical records must be kept in accordance with Amerigroup and state standards as outlined below:

The records reflect all aspects of patient care, including ancillary services. The use of electronic medical records must conform to HIPAA requirements and other federal and state laws.

Documentation of each visit must include:

1. Date of service
2. Complaint or purpose of visit

3. Diagnosis or medical impression
4. Objective finding
5. Assessment of patient's findings
6. Plan of treatment, diagnostic tests, therapies, and other prescribed regimens
7. Medications prescribed
8. Health education provided
9. Signature or initials and title of the provider rendering the service; if more than one person documents in the medical record, there must be a record on file as to which signature is represented by which initials.

These standards will, at a minimum, meet the following medical record requirements:

1. **Patient identification information:** Each page or electronic file in the record must contain the patient's name or patient ID number.
2. **Personal/biographical data:** The record must include the patient's age, sex, address, employer, home and work telephone numbers, and marital status.
3. **Date and corroboration:** All entries must be dated and author-identified.
4. **Legibility:** Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
5. **Allergies:** Medication allergies and adverse reactions must be prominently noted on the record. Absence of allergies (no known allergies – NKA) must be noted in an easily recognizable location.
6. **Past medical history for patients seen 3 or more times:** Past medical history must be easily identified, including serious accidents, operations, and illnesses. For children, the history must include prenatal care of the mother and birth.
7. **Physical examination:** A record of physical examination(s) appropriate to the presenting complaint or condition must be noted.
8. **Immunizations:** For pediatric records of members age 13 and younger, a completed immunization record or a notation of prior immunization must be recorded. This should include vaccines and their dates of administration when possible.
9. **Diagnostic information:** Documentation of clinical findings and evaluation for each visit should be noted.
10. **Medication information:** This notation includes medication information and instruction(s) to the patient.
11. **Identification of current problems:** Significant illnesses, medical and behavioral health conditions, and health maintenance concerns must be identified in the medical record. A current problem list must be included in each patient record.
12. **Instructions:** The record must include evidence that the patient was provided with basic teaching/instructions regarding physical/behavioral health condition.
13. **Smoking/alcohol/substance abuse:** A notation concerning cigarettes and alcohol use and substance abuse must be stated if present for patients age 12 and older. Abbreviations and symbols may be appropriate.
14. **Preventive services/risk screening:** The record must include consultation and provision of appropriate preventive health services and appropriate risk screening activities.
15. **Consultations, referrals, and specialist reports:** Notes from any referrals and consultations must be in the record. Consultation, lab and X-ray reports filed in the chart must have the ordering

physician's initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results must have an explicit notation in the record of follow-up plans.

16. **Emergencies:** All emergency care provided directly by the contracted provider or through an emergency room and the hospital discharge summaries for all hospital admissions while the patient is part of the primary care provider's panel must be noted.
17. **Hospital discharge summaries:** Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the patient is enrolled and for prior admissions as appropriate. Prior admissions pertaining to admissions that may have occurred prior to the patient being enrolled may be pertinent to the patient's current medical condition.
18. **Advance directive:** Medical records of adult patients must document whether or not the individual has executed an advance directive. An advance directive is a written instruction, such as a living will or durable power of attorney, which directs health care decision-making for individuals who are incapacitated.
19. **Security:** Providers must maintain a written policy to ensure that medical records are safeguarded against loss, destruction, or unauthorized use. Physical safeguards require records to be stored in a secure manner that allows access for easy retrieval by authorized personnel only. Staff receives periodic training in member information confidentiality.
20. **Release of information:** Written procedures are required for the release of information and obtaining consent for treatment.
21. **Documentation:** Documentation is required setting forth the results of medical, preventive, and behavioral health screening and of all treatment provided and results of such treatment.
22. **Multidisciplinary teams:** Documentation of the team members involved in the multidisciplinary team of a patient needing specialty care is required.
23. **Integration of clinical care:** Documentation of the integration of clinical care in both the physical and behavioral health records is required. Such documentation must include:
  - Notation of screening for behavioral health conditions (including those which may be affecting physical health care and vice versa) and referral to behavioral health providers when problems are indicated
  - Notation of screening and referral by behavioral health providers to primary care providers when appropriate
  - Notation of receipt of behavioral health referrals from physical medicine providers and the disposition and outcome of those referrals
  - A summary (at least quarterly or more often if clinically indicated) of the status/progress from the behavioral health provider to the primary care provider
  - A written release of information that will permit specific information-sharing between providers
  - Documentation that behavioral health professionals are included in primary and specialty care service teams when a patient with disabilities, or chronic, complex physical or developmental conditions has a co-occurring behavioral disorder

#### **10.19 Member's Right to Designate an OB/GYN**

Amerigroup allows the member to pick any OB/GYN, whether that doctor is in the same network as the member's primary care provider or not.

### **ATTENTION FEMALE MEMBERS**

Members have the right to pick an OB/GYN without a referral from their primary care provider. An OB/GYN can give the member:

- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- A referral to a specialist doctor within the network

For members who also have Medicare, an OB/GYN is selected from Medicare plan providers.

### **10.20 Noncompliant Amerigroup Members**

Call Provider Services at 1-800-454-3730 if you need help working with a member regarding:

- Behavior
- Treatment cooperation or completion
- Appointment compliance

A member advocate will contact the member to address the situation with education and counseling. The outcome of the counseling efforts will be reported back to you.

To remove a member from your panel after efforts with the member have been unsuccessful, you must:

- Not make a removal decision based on the member's health status or utilization of services which are medically necessary for treatment of the member's condition.
- Send a certified letter to the member or head of household stating that the member must select a new primary care provider within 30 days of the notice.
- Send a copy of the letter to:  
Amerigroup  
Member Advocates  
2505 N. Highway 360, Suite 300  
Grand Prairie, TX 75050
- Continue to provide care to the member until the effective date of the assignment to a new primary care provider.
- Not take any retaliatory action against a noncompliant member.

In extreme situations where a member consistently refuses to cooperate with us and our providers, misuses or loans their member ID card to another person to obtain services, or refuses to comply with managed care restrictions, we may request that HHSC disenroll the member from Amerigroup. If the member disagrees with the disenrollment, they may engage in our member complaint process and the HHSC fair hearing process.

### **10.21 Patient Visit Data**

Documentation of individual encounters must provide adequate evidence of (at a minimum):

- A history and physical exam that includes appropriate subjective and objective information obtained for the presenting complaints

- Behavioral health treatment that includes **at-risk** factors (danger to self/others, ability to care for self, affect/perceptual disorders, cognitive functioning, and significant social health) for behavioral health patients
- An admission or initial assessment that must include current support systems or lack of support systems
- An assessment for behavioral health patients (performed at each visit) of client status/symptoms regarding the treatment process; assessment may indicate initial symptoms of the behavioral health condition as decreased, increased, or unchanged during the treatment period
- A plan of treatment that includes activities/therapies and goals to be carried out
- Diagnostic tests
- Therapies and other prescribed regimens for patients who receive behavioral health treatment, including evidence of:
  - Family involvement, as applicable
  - Family inclusion in therapy sessions when appropriate
- Follow-up care encounter forms or notes indicating when follow-up care, a call or a visit (noted in weeks, months, or PRN when necessary) should occur; notes should include the specific time to return with unresolved problems from any previous visits
- Referrals and results including all other aspects of patient care, such as ancillary services

We will systematically review medical records to ensure compliance with these standards. Compliance with medical record performance standards is a medical record score of 80 percent, including 6 clinical elements that must be met. Clinical medical record audit and office site visit forms are available on our website at <https://providers.amerigroup.com/TX>. We will institute actions for improvement when standards are not met.

We maintain an appropriate record keeping system for services to members. This system will collect all pertinent information relating to the medical management of each member and make that information readily available to appropriate health professionals and appropriate state agencies. All records will be retained in accordance with the record retention requirements of 45 CFR 74.164 (that is, records must be retained for 7 years from the date of service).

## **10.22 Primary Care Providers**

Members that are eligible for both Medicare and Medicaid will receive primary care from their Medicare plan and will not select a Medicaid primary care provider.

### **10.22.1 Medical Home**

The primary care provider is the foundation of the medical home, responsible for providing, managing, and coordinating all aspects of the member's medical care. The primary care provider must provide all care that is within the scope of his or her practice. Additionally, the primary care provider is responsible for coordinating member care with specialists and conferring and collaborating with the specialists, using a collaborative concept known as a medical home.



We promote the medical home concept to all of our members. The primary care provider is the member's and family's initial contact point when accessing health care. The primary care provider has an ongoing and collaborative contractual relationship with:

- The member and family
- The health care providers within the medical home
- The extended network of consultants and specialists with whom the medical home works

The providers in the medical home are knowledgeable about the member's and family's special, health-related social and educational needs. The medical home providers are connected to community resources that will assist the family in meeting those needs. When a primary care provider refers a member for a consultation, specialty/hospital services, or health and health-related services through the medical home, the medical home provider maintains the primary relationship with the member and family. He or she keeps abreast of the current status of the member and family through the primary care provider.

#### ***10.22.2 Primary Care Provider Provider Types (Network Limitations)***

Physicians with the following specialties can apply for enrollment with us as primary care providers:

- Family practitioners
- General practitioners
- General pediatricians
- General internists
- Advanced practice registered nurses (APRNs) and physician assistants (PAs), when practicing under the supervision of a physician specializing in family practice, internal medicine, pediatrics, or obstetrics/gynecology who also qualifies as a primary care provider
- Nurse practitioners certified as specialists in family practice or pediatrics
- FQHCs, RHCs, and similar clinics
- Obstetricians/gynecologists
- Specialist physicians who are willing to provide a medical home to selected members with special needs and conditions

The provider must be enrolled in the Medicaid program at the service location where he or she wishes to practice as a primary care provider before contracting with us.

#### ***10.22.3 Primary Care Provider Responsibilities***

The primary care provider is a network physician who has the responsibility for the complete care of his or her patients, whether providing it himself or herself or by referral to the appropriate provider of care within the network. FQHCs and RHCs may be included as primary care providers. The primary care provider shall:

- Manage the medical and health care needs of members, including: monitoring and following up on care provided by other providers (both in and out of network), providing coordination necessary for referrals to specialists (both in and out of network), and maintaining a medical record of all services rendered, including those rendered by other providers

- Make referrals for specialty care for members on a timely basis, based on the urgency of the member's medical condition, but no later than 30 calendar days from the date the need is identified or requested
- Provide 24-hour-a-day, 7-day-a-week coverage in accordance with the [After-hours Coverage](#) section of this manual; regular hours of operation should be clearly defined and communicated to members
- Be available to provide medically necessary services
- Ensure that covering physicians follow the referral/precertification guidelines
- Provide services ethically and legally in a culturally competent manner; meet the unique needs of members with special health care needs
- Participate in any system 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 patients
- Participate and cooperate with Amerigroup in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by Amerigroup
- Participate in and cooperate with the Amerigroup complaint procedures; we will notify the provider of any member complaint
- Not balance-bill members; Medicaid members do not have an out-of-pocket expense for covered services
- Continue care in progress during and after termination of his or her contract for up to 60 days until a continuity of care plan is in place to transition the member to another provider, or through postpartum care for pregnant members in accordance with applicable state laws and regulations
- 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 standards, regarding blood-borne pathogens
- Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act
- Support, cooperate, and comply with the Amerigroup quality improvement program initiatives and any related policies and procedures
- Provide quality care in a cost-effective and reasonable manner
- Inform Amerigroup if a member objects to provision of any counseling, treatments, or referral services for religious reasons
- Treat all members with respect and dignity; provide members with appropriate privacy and treat member disclosures and records confidentially, giving the member the opportunity to approve or refuse their release
- Provide members complete information concerning their diagnosis, evaluation, treatment, and prognosis; give members 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
- Advise members on treatments which may be self-administered
- When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems, abnormal laboratory, or abnormal 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 that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of clinical research shall be clearly contrasted with entries regarding the provision of nonresearch-related care
- Inform both Amerigroup and the HHSC administrative services contractor of any changes to the provider's address, telephone number, group affiliation, etc.
- Report any suspicion or allegation of member abuse, neglect, or exploitation in accordance with Texas Human Resources Code §48.051, Texas Health and Safety Code §260A.002 and Texas Family Code §261.101

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

#### **10.22.4 After-hours Coverage**

We encourage primary care providers to offer extended office hours to include nights and weekends.

To ensure continuous 24-hour coverage, primary care providers must maintain one of the following arrangements after normal business hours:

- Have the office telephone answered after-hours by an answering service that can contact the primary care provider or another designated network medical practitioner; all calls answered by an answering service must be returned within 30 minutes. The answering service must meet the language requirements of the major population groups served.
- Have the office telephone answered after normal business hours by a recording in the language of each of the major population groups served by the primary care provider; the recorded message should direct the member to call another number to reach the primary care provider or another provider designated by the primary care provider; someone must be available to answer the designated provider's telephone; another recording is not acceptable.
- Have the office telephone transferred after office hours to another location where someone will answer the telephone; the person answering the calls must be able to contact the primary care provider or a designated Amerigroup network medical practitioner who can return the call within 30 minutes.

The following telephone answering procedures are **NOT** acceptable:

- Answering the office telephone only during office hours
- Answering the office telephone after-hours by a recording that tells members to leave a message
- Answering the office telephone after-hours by a recording that directs members to go to an emergency room for any services needed
- Returning after-hours calls outside of 30 minutes

#### **10.22.5 New Members**

We encourage enrollees to select a primary care provider for preventive and primary medical care, and to ensure authorization and coordination of all medically necessary specialty services. Medicaid members age 20 and younger are encouraged to obtain a well-child visit within 60 days of the date of enrollment. Members who have both Medicaid and Medicare benefits will select a primary care provider from their Medicare plan.

#### **10.22.6 Primary Care Provider Changes and Transfers**

We encourage members to remain with their primary care providers to maintain continuity of care. However, members may request to change a primary care provider for any reason by contacting Member Services at 1-844-756-4600. The member's name will be provided to the primary care provider on the membership roster.

Members can call to request a primary care provider change any day of the month. Primary care provider change requests will be processed generally on the same day or by the next business day. Members will receive a new ID card within 10 days.

#### **10.22.7 Specialist as a Primary Care Provider**

Under certain circumstances, a member may require the regular care of a specialist. We may approve that specialist to serve as a member's primary care provider. The criteria for a specialist to serve as a member's primary care provider include the member having a disability, special health care needs, or a chronic, life-threatening illness or condition of such complexity whereby:

- The need for multiple hospitalizations exists
- The majority of care needs to be given by a specialist
- The administrative requirements arranging for care exceed the capacity of the nonspecialist primary care provider; this would include members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis, etc.

A member who resides in a nursing facility may also designate a specialist as their primary care provider.

The specialist must:

- Agree to serve as the member's primary care provider
- Meet the requirements for primary care provider participation (including contractual obligations and credentialing)
- Provide 24/7 access to care
- Coordinate the member's health care, including preventive care

When such a need is identified, the member or specialist must contact the Amerigroup Case Management department and complete a *Specialist as PCP Request* form. A case manager will review the request and submit it to our medical director. We will notify the member and the provider of our determination in writing within 30 days of receiving the request.

If the request is approved, we will not reduce the compensation that is owed to the original primary care provider before the date of the new designation of the specialist as primary care provider. If we deny the request, the member may appeal the decision through our member complaint process. Under that process, we must respond to the member's complaint in writing within 30 days. The designation cannot be retroactive. For more information, call Provider Services at 1-800-454-3730.

Members that are eligible for both Medicare and Medicaid will receive primary care from their Medicare plan and will not select a Medicaid primary care provider.

#### **10.22.8 Health Homes**

A Health Home is a provider practice that manages all the health care a person needs – physical, mental, and social. The range of Health Home services and supports is more than is normally offered by a primary care provider. This type of care can be of great benefit to persons with one or more serious and ongoing mental or health conditions. The provider practice can be a primary care practice or, in some cases, a specialty care practice. A Health Home uses a team-based approach to improve access, coordination between providers, and quality of care.

We will provide access to a Health Home for any member who asks for this service and for any member who would benefit from this type of care. Some of the main kinds of Health Home services are:

- Comprehensive case management
- Care coordination
- Patient self-management education and health promotion
- Transitional care from inpatient or emergency room
- Patient and family-centered care with patient and family support
- Referral to community and social support services
- Use of health information to link services

#### **10.23 Provider Disenrollment Process**

Providers may cease participating with us for either mandatory or voluntary reasons. Mandatory disenrollment occurs when a provider becomes unavailable due to immediate, unforeseen reasons. Examples of this include death or loss of license. Members are assigned to another primary care provider to ensure continued access to our covered services as appropriate. We will notify members of any termination of primary care providers or other providers from whom they receive ongoing care.

We will provide notice to affected members when a provider disenrolls for voluntary reasons, such as retirement. Providers must furnish written notice to us within the time frames specified in the Participating Provider Agreement. Members linked to a primary care provider who disenrolled for voluntary reasons will be notified to select a new primary care provider. We are responsible for submitting notification of all provider disenrollments to the Texas Health and Human Services Commission (HHSC).

#### **10.24 Provider Marketing**

Providers are prohibited from engaging in direct marketing to members to increase enrollment in a particular health plan. The prohibition should not constrain network providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

Providers must comply with HHSC's marketing policies and procedures as set forth in Chapter 4.3 of the HHSC Uniform Managed Care Manual available at [www.hhsc.state.tx.us/Medicaid/Managed-Care/UMCM](http://www.hhsc.state.tx.us/Medicaid/Managed-Care/UMCM).

#### **10.25 Provider Quality Incentive Programs**

We have provider quality incentive programs to reward primary care providers and other provider types for the provision of quality medically appropriate health care services to our members. The programs vary by the provider's panel size and use of predefined measures, such as HEDIS<sup>®</sup>\* and access measures. Providers must be in good standing and meet the eligibility criteria of the given program to participate. For additional information regarding the programs, call the local Amerigroup Provider Relations department.

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

#### **10.26 Radiology**

When both a physician and a radiologist read an X-ray, only the radiologist can submit a claim for reading the film. If the physician feels there is a problem with the reading diagnosis, he or she should contact the radiological facility to discuss the concern.

#### **10.27 Referrals**

Providers shall refer patients to participating providers and facilities when available. We will provide members with timely and adequate access to out-of-network services if those services are necessary and covered but not available within the network. We have in place a mechanism that allows members with special health care needs to have direct access to a specialist as appropriate for their conditions and identified needs.

#### **10.28 Reporting Involvement in Legal or Administrative Proceedings, Changes in Address, and Practice Status**

Within 30 days of occurrence, a provider shall give written notice to us if he or she is named as a party in any civil, criminal, or administrative proceeding. Failure to provide such timely notice to us constitutes grounds for termination of the provider's contract with us.

Providers are required to notify us of a change in address or practice status within 10 days of the effective date of the change. Practice status is defined as a change in office hours, panel status, etc. The inclusion of a new address on a recredentialing application is not an acceptable form of notification. A notice of termination must adhere to the advance notice time lines stated in the provider's agreement. Please submit changes to:

Provider Configuration  
Amerigroup  
PO Box 62509  
Virginia Beach, VA 23466-2509

## **10.29 Second Opinions**

A member, parent, legally appointed representative (LAR), or the member's primary care provider may request a second opinion. A second opinion may be requested in any situation where there is a question concerning a diagnosis, surgery options, or other treatment of a health condition. The second opinion shall be provided at no cost to the member.

The second opinion must be obtained from a network provider (see the provider referral directory) or a non-network provider if there is not a network provider with the expertise required for the condition. Once approved, the primary care provider will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The primary care provider will notify the member of the outcome of the second opinion.

We may also request a second opinion at our own discretion. This may occur under the following circumstances:

- Whenever there is a concern about care expressed by the member or the provider
- Whenever potential risks or outcomes of recommended or requested care are discovered by the plan during its regular course of business
- Before initiating a denial of coverage of service
- When denied coverage is appealed
- When an experimental or investigational service is requested

When we request a second opinion, we will make the necessary arrangements for the appointment, payment, and reporting. We will inform the member and the primary care provider of the results of the second opinion and the consulting provider's conclusion and recommendation(s) regarding further action.

## **10.30 Specialty Referrals**

To reduce the administrative burden on the provider's office staff, we have established procedures to permit a member to request an extended authorization. This applies to a member with a condition that requires ongoing care from a specialist physician or other health care provider.

The provider can request an extended authorization by contacting the member's primary care provider. The provider must supply the necessary clinical information for review by the primary care provider in order to complete the authorization review.

Extended authorizations are approved on a case-by-case basis. In the event of termination of a contract with the treating provider, the continuity of care provisions in the provider's contract with us will apply. The provider may renew the authorization by submitting a new request to the primary care provider. Additionally, we require the specialist physician or other health care provider to furnish regular updates to the member's primary care provider (unless acting also as the designated primary care provider for the

member). Should the need arise for a secondary referral, the specialist physician or other health care provider must contact us for a coverage determination.

If the specialist or other health care provider needed to furnish ongoing care for a specific condition is not available in our network, the referring physician shall request authorization from us for services outside the network. Access will be approved to a qualified non-network health care provider within a reasonable distance and travel time at no additional cost if medical necessity is met. If a provider's application for an extended authorization is denied, the member (or the provider on behalf of the member) may appeal the decision through our medical appeal process.

### **10.31 Specialty Care Providers**

To participate in the Medicaid managed care model, the provider must have applied for enrollment in the Texas Medicaid program. The provider must be licensed by the state before signing a contract with us.

We contract with a network of provider specialty types to meet the medical specialty needs of members and provide all medically necessary covered services. The specialty care provider is a network physician who has the responsibility for providing specialized care for members, usually upon appropriate referral from a primary care provider, within the network. See the [Specialty Care Providers' Roles and Responsibilities](#) section of this manual for more information. In addition to sharing many of the same responsibilities as the primary care provider (see [Primary Care Provider Responsibilities](#)), the specialty care provider furnishes services that include:

- Allergy and immunology services
- Burn services
- Community behavioral health (for example, mental health and substance abuse) services
- Cardiology services
- Clinical nurse specialists, psychologists, clinical social workers (behavioral health)
- Critical care medical services
- Dermatology services
- Endocrinology services
- Gastroenterology services
- General surgery
- Hematology/oncology services
- Neonatal services
- Nephrology services
- Neurology services
- Neurosurgery services
- Ophthalmology services
- Orthopedic surgery services
- Otolaryngology services
- Pediatric services
- Perinatal services
- Psychiatry (adult) assessment services
- Psychiatry (child and adolescent) assessment services
- Trauma services



- Urology services

### **10.31.1 Specialty Care Providers' Roles and Responsibilities**

Specialist providers will only treat members who have been referred to them by network primary care providers. The exceptions are mental health and substance abuse providers, and services for which a member may self-refer. These providers will render covered services only to the extent and duration indicated on the referral. Members that are eligible for both Medicare and Medicaid will receive specialist care from their Medicare plan. Obligations of specialists include:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program
- Accepting all members referred to them
- Submitting required claims information, including source of referral and referral number to Amerigroup
- Arranging for coverage with network providers while off duty or on vacation
- Verifying member eligibility and precertification of services (if required) at each visit
- Providing consultation summaries or appropriate periodic progress notes to the member's primary care provider on a timely basis following a referral or routinely scheduled consultative visit
- Notifying the member's primary care provider when scheduling a hospital admission or any procedure requiring the primary care provider's approval
- Coordinating care (as appropriate) with other providers involved in rendering care for members, especially in cases involving medical and behavioral health comorbidities, or co-occurring mental health and substance abuse disorders

The specialist shall:

- Manage the medical and health care needs of members to encompass:
  - Monitoring and following up on care provided by other providers
  - Coordinating referrals to other specialists and providers (both in and out-of-network)
  - Maintaining a medical record of all services rendered by the specialist and other providers
- Provide coverage 24 hours a day, 7 days a week and maintain regular hours of operation that are clearly defined and communicated to members
- Provide services ethically, legally, and in a culturally competent manner that meets the unique needs of members with special health care requirements
- Participate in Amerigroup systems that facilitate record sharing (subject to applicable confidentiality and HIPAA requirements)
- Participate in and cooperate with Amerigroup in any reasonable internal or external quality assurance, utilization review, continuing education, or other similar programs established by Amerigroup
- Make reasonable efforts to communicate, coordinate, and collaborate with other specialty care providers (including behavioral health providers) involved in delivering care and services to members
- Participate in and cooperate with the Amerigroup complaint processes and procedures; we will notify the specialist of any member complaint brought against the specialist
- Not balance bill members
- Continue care in progress during and after termination of his or her contract for up to 60 days until a continuity of care plan is in place to transition the member to another provider, or through

postpartum care for pregnant members; this is to occur in accordance with applicable state laws and regulations

- Comply with all applicable federal and state laws regarding the confidentiality of patient records
- Develop and have an exposure control plan regarding blood-borne pathogens in compliance with Occupational Safety and Health Administration standards
- Make best efforts to fulfill the obligations under the Americans with Disabilities Act applicable to his or her practice location
- Support, cooperate, and comply with Amerigroup quality improvement program initiatives, and any related policies and procedures designed to provide quality care in a cost-effective and reasonable manner
- Inform Amerigroup if a member objects for religious reasons to the provision of any counseling, treatment, or referral services
- Treat all members with respect, dignity, and appropriate privacy; treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release as allowed under applicable laws and regulations
- Provide members complete information concerning diagnosis, evaluation, treatment, and prognosis; give members the opportunity to participate in decisions involving health care, except when contraindicated for medical reasons
- Advise members about their health status, medical care, and treatment options, regardless of whether benefits for such care are provided under the program
- Advise members on treatments that may be self-administered
- Contact members (when clinically indicated) as quickly as possible for follow-up regarding significant problems and abnormal laboratory or radiological findings
- Establish and maintain 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 quality patient care
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention that is part of a clinical research study is clearly distinguished from entries pertaining to nonresearch-related care
- Within 30 days of occurrence, provide written notice to Amerigroup if the specialist is named as a party in any civil, criminal, or administrative proceeding; failure to provide timely notice to Amerigroup constitutes grounds for termination of the specialist's contract with Amerigroup
- Report any suspicion or allegation of member abuse, neglect, or exploitation in accordance with Texas Human Resources Code §48.051, Texas Health and Safety Code §260A.002 and Texas Family Code §261.101

Note: We do **not** cover the use of any experimental procedures or experimental medications except under certain precertified circumstances.

### **10.32 Texas Department of Family and Protective Services' Coordination**

Providers are required to cooperate and coordinate with the Texas Department of Family and Protective Services (TDFPS) for the care of a child receiving services from or placed in the conservatorship of TDFPS. Provider cooperation and coordination are demonstrated by:

- Providing medical records to TDFPS
- Scheduling medical and behavioral health appointments within 14 days (unless requested earlier by TDFPS)
- Recognizing abuse and neglect and appropriately referring those cases to TDFPS
- Providing all covered services defined in court orders or a TDFPS service plan until the member has been disenrolled from Amerigroup; reasons for disenrollment include loss of Medicaid managed care eligibility or enrollment in STAR Health (HHSC's managed care program for children in foster care)

### **10.33 Texas Vaccines for Children Program**

The Texas Vaccines for Children (TVFC) program provides free vaccines for Medicaid members from birth through 18 years of age. The free vaccines are provided according to the *Recommended Childhood and Adolescent Immunization Schedule* established by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). Vaccines/toxoids must be obtained from TVFC for eligible members from birth through age 18. Providers must enroll in TVFC to obtain the vaccines.

### **10.34 How to Help a Member Find Dental Care**

The dental plan member ID card lists the name and phone number of a member's main dental home provider. The member can contact the dental plan to select a different main dental home provider at any time. If the member selects a different main dental home provider, the change is reflected immediately in the dental plan's system, and the member is mailed a new ID card within 5 business days.

If a member does not have a dental plan assigned or is missing a card from a dental plan, the member can call the Medicaid Enrollment Broker's toll-free telephone number at 1-800-964-2777.

### **10.35 Cancellation of Product Orders**

If a network provider offers delivery services for covered products, such as durable medical equipment (DME), home health supplies, outpatient drugs, or biological products, then the provider must reduce, cancel, or stop delivery at the member's or the member's authorized representative's written or oral request. The provider must maintain records documenting the request.

### **10.36 Reading/Grade Level Consideration**

Millions of Americans are functionally illiterate and many millions more are only marginally literate. Many of our members may have limited ability to understand and read instructions but most people with literacy problems are ashamed and will try to hide their problem from providers. Low literacy may mean that your patient may not be able to comply with your medical advice and course of treatment because they do not understand your instructions. Materials provided to members should be written at a fourth to

sixth grade reading level. Be sensitive to the fact that the member may not be able to read instructions for taking medicine or for treatment and to the embarrassment the member may feel about limited literacy. If interpreter services are needed, call Provider Services at 1-800-454-3730.

#### **10.37 Online Mandatory Provider Information Survey**

We are required by our state contract with HHSC to perform verification of provider information on a periodic basis through our provider website. If the online survey is not completed within the required timeframe, a provider's access to the provider website may be affected. The survey will include verification of at least the following items:

- Provider name
- Address
- Phone number
- Office hours
- Days of operation
- Practice limitations
- Languages spoken
- Provider type/provider specialty
- Pediatric services
- Wait times for appointments
- Closed or open panel (primary care providers only)
- Texas Health Steps provider (primary care provider only)

You will be notified when completion of the survey is required and given 90 days to provide the required information.

## **11 MEMBER MANAGEMENT SUPPORT**

### **11.1 Appointment Scheduling**

We, through our participating providers, ensure members have access to primary care services for routine, urgent, and emergency services, as well as specialty care services for chronic and complex care. Providers will respond to an Amerigroup member's needs and requests in a timely manner. The primary care provider should make every effort to schedule our members for appointments using the guidelines outlined in the [Provider Rights and Responsibilities](#) chapter of this manual.

### **11.2 Interpreter Services**

We can provide interpreter services in many different languages and dialects for members who do not speak English. This service is available at no cost to providers or members. Interpreter services should be requested at least 24 hours before the appointment. For information on interpreter services, members can call Member Services at 1-844-756-4600 (TTY 711).

We will set up and pay for a sign language interpreter to assist members who are deaf or hard of hearing. The service can be arranged by calling Provider Services at 1-800-454-3730 or your local health plan. Interpreter services should be requested at least 24 hours before the appointment.

### **11.3 Case Management**

Our case management program is part of a comprehensive health care management services program offering a continuum of services that include case management, disease management, care coordination, and utilization management. The program helps to reduce barriers by identifying the unmet needs of members and assisting them in meeting those needs. This may involve coordinating care, assisting members to access community resources, providing disease-specific education, or any number of interventions designed to improve the quality of life and functionality of members. The programs are designed to make more efficient use of limited health care resources.

#### **Scope of the Case Management Program**

- Member identification and screening
- Initial and ongoing assessment
- Problem-based, comprehensive care planning that includes measurable goals and interventions tailored to the acuity level of the member as determined by the initial assessment
- Coordination of care with primary care providers and specialty providers
- Member education
- Effective member and provider communication
- Program monitoring and evaluation using quantitative and qualitative analysis of data
- Satisfaction and quality of life measurement

#### **Objectives of the Case Management Program**

- Maintain a cost-effective case management system for members with high case management needs in one or more domains (physical, behavioral, or social)

- Utilize targeted high intensity interventions that include the option of in-person interactions with a specific identified group of members defined by the state as “super-utilizers” due to excessive utilization patterns
- Identify barriers that may impede members from achieving optimal health
- Implement agreed-upon interventions to increase the likelihood of improved health outcomes, improving quality of life
- Reach out to effectively engage members and their families as partners in the case management process
- Reduce unnecessary, duplicated, and/or fragmented utilization of health care resources
- Promote collaboration and coordination (at all levels of the health care delivery system) between physical health, behavioral health, the pharmacy program, and community-based social programs
- Foster improved coordination and communication among providers and with Amerigroup staff
- Improve member and provider satisfaction and retention
- Comply with applicable contractual and regulatory requirements related to case management
- Identify opportunities to transition members to more appropriate federal/state programs (for example, STAR/CHIP to STAR Kids)
- Serve as advocates for members
- Assist members to match available benefits to their health care needs
- Promote effective strategies to prevent or delay relapse or recurrence through interventions, such as member education and improved member self-management
- Coordinate case management interventions with ongoing health promotion initiatives, such as dissemination of member education literature
- Help members and their families mobilize internal and external resources and strengths to improve their health outcomes and manage the costs of care
- Provide culturally-competent case management services to members, families, and providers
- Maintain the highest quality of ethical standards, including maintenance of confidentiality, in all dealings with members
- Conduct quality management and improvement activities to ensure the highest possible level of service to members and their families
- Monitor outcomes of interventions to assist in evaluating and improving programs

### **Eligibility for Case Management**

Any Amerigroup member is eligible for case management. Members are identified through continuous case-finding methods that include, but are not limited to, precertification, admission review, and/or provider or member requests.

### **Hours of Operation**

Our case managers are licensed nurses and social workers, available Monday through Friday from 8 a.m. to 5 p.m. Central time. Confidential voicemail is available 24 hours a day.

### **Contact Information**

To contact a case manager, please call Provider Services at 1-800-454-3730 or your local health plan.

### **11.3.1 Comprehensive Member Assessment**

A case manager will conduct a comprehensive assessment to further determine a member's needs. The assessment will include a range of questions identifying and evaluating the member's:

- Medical condition
- Functional status
- Goals
- Life environment
- Support systems
- Emotional status
- Capability for self-care
- Current treatment plan

Using the structured assessment tool, a case manager will conduct a telephone interview or home visit to collect and assess information from the member or their representative. To complete the assessment, the case manager will obtain information from the primary care provider and specialists, our continuous case finding information, and other sources to coordinate and determine current medical needs and needed nonmedical services. This information is used to develop a comprehensive individualized plan of care.

### **11.4 Members with Special Health Care Needs (MSHCN)**

MSHCN:

- Have a serious ongoing illness, a chronic or complex condition, or a disability that has lasted (or is anticipated to last) for a significant period of time.
- Require regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel.

All STAR Kids members qualify as MSHCN and will receive care management including the development of a care plan that ensures the provision of covered services to meet the special preventive, primary acute care, and specialty health care needs appropriate for treatment of the member's condition and access to treatment by a multidisciplinary team when needed.

We have a process in place for members to have direct access to a specialist as appropriate for the member's condition and identified needs, such as a standing referral to a specialist (see the [Specialty Referrals](#) section of this manual). Members may also have a specialist designated to serve as a primary care provider (see the [Specialist as a Primary Care Provider](#) section of this manual).

### **11.5 Communicable Disease Services**

We cover communicable disease services to members. Communicable disease services help control and prevent diseases such as tuberculosis (TB), sexually transmitted diseases (STDs), and HIV/AIDS infection. Members can receive TB, STD, and HIV/AIDS services outside of our provider network through the Texas Department of Health and Environmental Control clinics without any restrictions. Providers should encourage members to receive TB, STD, and HIV/AIDS services through Amerigroup to ensure continuity and coordination of a member's total care.

Providers must report all known cases of TB, STD, and HIV/AIDS infection to the state public health agency within 24 hours. Providers must report all diseases **reportable by health care workers**, regardless of whether the case is also reportable by laboratories.

### **Control and Prevention of Communicable Diseases**

We will coordinate with public health entities in each service area regarding the provision of essential public health care services. We must meet the following requirements:

- Report to public health entities regarding communicable diseases and/or diseases that are preventable by immunization as defined by state law
- Notify the local public health entity, as defined by state law, of communicable disease outbreaks involving members
- Coordinate with local public health entities that have a child lead program, or with DSHS regional staff when the local public health entity does not have a child lead program, for follow-up of suspected or confirmed cases of childhood lead exposure

## **11.6 Health Promotion**

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

We offer our members education and information regarding their health. Ongoing projects include:

- Our annual member newsletter for members
- *Ameritips*, our 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
- Relationship development with community-based organizations to enhance opportunities for members

## **11.7 Disease Management Centralized Care Unit**

Our Disease Management Centralized Care Unit (DMCCU) services are based on a system of coordinated care management interventions and communications. These resources are designed to assist physicians and other health care professionals in managing members with chronic conditions. DMCCU services include a holistic, member-centric care management approach that allows care managers to focus on multiple needs of members. Disease management programs include:

- |  |                             |
|--|-----------------------------|
| • Asthma                                       | • HIV/AIDS                  |
| • Bipolar disorder                             | • Hypertension              |
| • Chronic obstructive pulmonary disease (COPD) | • Major depressive disorder |
| • Congestive heart failure (CHF)               | • Obesity                   |
| • Coronary artery disease (CAD)                | • Schizophrenia             |
| • Diabetes                                     | • Substance abuse disorder  |



### **Who Is Eligible?**

All members with diagnoses of the above conditions are eligible for DMCCU services with the exception of dual eligible members. Members are identified through, but not limited to, continuous case finding, welcome calls, and referrals.

### **Referring Patients to Disease Management Programs**

As a valued provider, you can refer patients who would benefit from additional education and care management support.

### **Program Features**

- Proactive population identification processes
- Evidence-based national practice guidelines from recognized sources
- Collaborative practice models that include physician and support-service providers in treatment planning for members
- Ongoing process and outcomes measurement, evaluation and management
- Ongoing communication with providers regarding patient status
- Continuous patient self-management education, including:
  - Primary prevention
  - Behavior modification programs and compliance/surveillance
  - Home visits and case management for high-risk members

All Amerigroup disease management programs are based on nationally approved clinical practice guidelines located at <https://providers.amerigroup.com/TX>. A copy of the guidelines can be printed from the website or requested by contacting Provider Services at 1-800-454-3730.

### **Providing Input for Patient Care Plans**

Our care managers will collaborate with you to develop care plans. Members identified for participation in any of the programs are assessed and risk-stratified based on the severity of their disease. Once enrolled in a program, members are provided with continuous education on self-management concepts that include primary prevention, behavior modification and compliance/surveillance, and case/care management for high-risk members.

### **Provider Feedback**

Program evaluation, outcome measurement, and process improvement are built into all the programs. Provider feedback regarding patient status and progress is given on a scheduled basis or as needed.

### **Disease Management Centralized Care Unit Provider Rights and Responsibilities**

The provider has the right to:

- Receive information about Amerigroup, specific disease management programs and services, our staff, and their qualifications and any contractual relationships
- Decline participation in Amerigroup programs and services for their patients (if contractually possible)
- Be informed of how Amerigroup coordinates our disease management-related interventions with individual patient treatment plans
- Be informed of how to contact the person responsible for managing and communicating with his or her patients

- Be supported by the organization to make decisions interactively with patients regarding their health care
- Receive courteous and respectful treatment from Amerigroup staff
- Communicate complaints regarding DMCCU as outlined in the Amerigroup provider complaint procedure

### **Hours of Operation**

Our care managers are licensed nurses/social workers available Monday through Friday from 8 a.m. to 5 p.m. Central time. Confidential voicemail is available 24 hours a day. The Nurse HelpLine is available for our members 24 hours a day, 7 days a week.

### **Contact Information**

Please call 1-888-830-4300 to reach an Amerigroup care manager. Additional information about disease management can be obtained by visiting <https://providers.amerigroup.com/TX>. Printed copies of information located on the website can be obtained by calling DMCCU. Members can obtain information about our DMCCU program by visiting <https://www.myamerigroup.com> or calling 1-888-830-4300.

## **11.8 Nurse HelpLine**

The Amerigroup Nurse HelpLine is a telephonic, 24-hour triage service your Amerigroup patients can call to speak with a registered nurse who can help them:

- Find doctors when your office is closed, whether after-hours or on weekends
- Schedule appointments with you or other network doctors
- Get to urgent care centers or walk-in clinics

We encourage you to tell your Amerigroup patients about this service and share with them the advantages of avoiding the emergency room when a trip there isn't necessary or the best alternative.

Members can reach the Nurse HelpLine at 1-844-756-4600. TTY services are available for members who are deaf or hard of hearing by calling 711. Language translation services are also available.

## **11.9 Women Infants and Children Program**

The Women, Infants, and Children (WIC) program provides supplemental foods and nutrition education to:

- Pregnant women
- Women who are breastfeeding a baby under 1 year of age
- Women who have had a baby in the past 6 months
- Parents, step parents, and foster parents of infants and children age 4 and younger

These members are automatically eligible for WIC services if they:

- Are Medicaid eligible
- Have a family income up to 185 percent of the federal poverty level

Providers must coordinate with the WIC Special Supplemental Nutrition program to provide medical information necessary for WIC program operations such as height, weight, hematocrit, or hemoglobin. Please call 1-800-942-3678 for program details.

#### **11.10 Taking Care of Baby and Me® Program**

We offer the Taking Care of Baby and Me® program to expectant mothers. The objective is to provide coordinated, comprehensive prenatal management with the intent of identifying members prior to an adverse health event. The goal is to provide members with care management, education, and incentive gift rewards to promote healthy outcomes.

Taking Care of Baby and Me includes an OB case management program to improve birth outcomes of high-risk pregnant members. A team of experienced OB registered nurses supplements the care and information you provide to your patients. Members with the following conditions and issues will benefit most from case management:

- Multiple gestation
- History of preterm delivery with a past pregnancy
- Current preterm labor
- Noncompliant in keeping appointments
- Noncompliant in following their prescribed plan of care

Notification to Amerigroup at 1-800-454-3730 is required at the first prenatal visit. Taking Care of Baby and Me provides care management to:

- Improve the level of knowledge of the member about her pregnancy stage
- Create systems that support the delivery of quality care
- Measure and maintain or improve member outcomes related to the care delivered
- Facilitate care with providers to promote collaboration, coordination, and continuity of care

As part of the Taking Care of Baby and Me program, members are offered the My Advocate™ program. This program provides pregnant women proactive, culturally appropriate outreach and education through interactive voice response (IVR), text or smart phone application. This program does not replace the high-touch case management approach for high-risk pregnant women. However, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high-risk, to facilitate connections between them and our case managers, and improve member and baby outcomes. Eligible members receive regular calls with tailored content from a voice personality (Mary Beth). For more information on My Advocate visit [www.myadvocatehelps.com](http://www.myadvocatehelps.com).

Please help us identify Amerigroup members who may benefit from OB case management. You can make referrals to the case management program by calling 1-800-454-3730 and asking for an OB case manager.

Our members receive information about Taking Care of Baby and Me (including a pregnancy book) upon notification of their pregnancy. Upon completing certain checkups, members are eligible for merchandise debit cards through the Healthy Rewards program which is part of our value-added services.

Health education is provided and encouraged through prenatal and postpartum health promotion packets. Information about available health-related community services is provided to members as appropriate. All identified pregnant members will automatically receive information on Taking Care of Baby and Me.

#### **11.11 Texas Health Steps**

Texas Health Steps is for children from birth through 20 years of age who have Medicaid. Texas Health Steps provides regular medical and dental checkups and case management services to babies, children, teens, and young adults. Texas Health Steps services must be offered for all new members age 20 and younger who are due, soon due, or overdue for checkups or case management services. These services must be performed no later than:

- 14 days from the date of enrollment for newborns
- 90 days from the date of enrollment for all other eligible child members

The Texas Health Steps annual medical checkup for an existing member 3 years of age (36 months) and older is due on the child's birthday. The annual medical checkup is considered timely if it occurs no later than 364 calendar days after the child's birthday. A checkup for an existing member from birth through 35 months of age is timely if received within 60 days beyond the periodic due date in the Texas Medicaid Provider Procedures Manual, based on the member's birth date.

Our members are encouraged to contact their physician within the first 90 days of enrollment to schedule a well-child visit. We encourage physician contact within 24 hours for newborns. Our members are eligible to receive these services from birth through age 20. The program provides the following:

- Comprehensive health and development history
- Physical and mental development assessment
- Comprehensive unclothed physical examination
- Age-appropriate immunizations
- Appropriate laboratory tests
- Health education

#### **11.12 Welcome Call**

As part of our member management strategy, we make welcome calls to new members. We conduct an initial telephonic member screening for all new STAR Kids members. The telephonic screening is used to help prioritize which members require the most immediate attention. Another type of welcome call is an automated call designed to identify problems encountered by the member with enrollment and initiating services. If needed, based on the answers given by the member during the call, a member advocate will perform a follow-up call to resolve any issues.

#### **11.13 Well-child Visits Reminder Program**

A list of Amerigroup members who, based on our claims data, may not have received well-child services according to schedule is sent to primary care providers each month. Additionally, we mail information to

these members encouraging them to contact their primary care provider's office to set up appointments for needed services. Please note the following:

- The specific service(s) needed for each member is listed in the report. Reports are based only on services received during the time the member is enrolled with us.
- Services must be rendered on or after the due date in accordance with federal Early Periodic Screening, Diagnosis, and Treatment (EPSDT) and Texas Department of State Health Services guidelines. In accordance with these guidelines, services received prior to the specified schedule date do not fulfill EPSDT requirements.
- This list of needed services is generated based on our claims data received prior to the date printed on the list. In some instances, the appropriate services may have been provided after the report run date.
- To ensure accuracy in tracking preventive services, please submit a completed claim form for the dates of service to the Amerigroup Claims department at:

Claims  
Amerigroup  
PO Box 61010  
Virginia Beach, VA 23466-1010

#### **11.14 Telemedicine, Telehealth, and Telemonitoring Access**

We encourage our network providers to offer telemedicine, telehealth, and telemonitoring capabilities to our members. Information will be included in our provider directories as to which providers have these services available.

School-based telemedicine medical services are a covered service for members. We will reimburse the distant site physician providing treatment even if the physician is not the patient's primary care provider or is an out-of-network physician. Prior authorization is not required for school-based telemedicine medical services.

## **12 BILLING AND CLAIMS ADMINISTRATION**

### **12.1 Claims Submission**

Providers have 3 options for submitting claims to us, including long-term services and supports claims for the Medically Dependent Children Program (MDCP) and other waiver program members that are covered by Amerigroup under the STAR Kids program:

- Electronic Data Interchange (EDI)
- [www.Availity.com](http://www.Availity.com) website
- Paper

#### **Timely Filing**

Providers must adhere to the following guidelines and time limits for claims to be considered for payment:

- Submit clean claims within 95 calendar days from the date of discharge for inpatient services or within 95 calendar days from the date of service for outpatient services
- In the case of other insurance or coordination of benefits/subrogation, submit clean claims within 95 calendar days of receiving a response from the third-party payer
- In the case of retroactive member eligibility, submit clean claims within 95 calendar days for members whose eligibility has not been added to the state's eligibility system
- Corrected claims must be submitted within 120 days from the date of the EOP

Note: Claims submitted after the filing timelines outlined above will be denied. We must receive claims from out-of-network providers rendering services outside of Texas within 1 year of the date of service and/or the date of discharge.

#### **Coding**

Providers must use HIPAA-compliant codes when billing us for electronic, online, and paper claim submissions. When billing codes are updated, the provider is required to use appropriate replacement codes. We will not accept claims submitted with noncompliant codes. We edit claims using SNIP level 5 and 6 edits.

All claims submitted are processed using generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by sources that include the National Correct Coding Initiative, the uniform billing editor, CPT-4 and ICD-10 manuals, and successor documents. In addition, we reserve the right to use code-editing software to determine which services are considered part of, incidental to, or inclusive of the primary procedure. Our clinical policies and bulletins are posted on our provider website at <https://providers.amerigroup.com/TX>.

#### **International Classification of Diseases, 10<sup>th</sup> Revision (ICD-10) Description**

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with HIPAA requirements, and in accordance with the rule issued by the U.S. Department of Health and Human Services (HHS).

ICD-10 is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9) which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes. In the United States, the codes are the foundation for documenting the diagnosis and associated services provided across health care settings.

Although we often use the term ICD-10 alone, there are actually 2 parts to ICD-10:

- Clinical modification (CM): ICD-10-CM is used for diagnosis coding.
- Procedure coding system (PCS): ICD-10-PCS is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaces the code sets ICD-9-CM, volumes 1 and 2 for diagnosis coding, and ICD-10-PCS replaces ICD-9-CM, volume 3 for inpatient hospital procedure coding.

### **Clean Claim**

A clean claim is one submitted for medical care or health care services rendered to a member with the data necessary for the MCO, or its subcontracted claims processor, to adjudicate and accurately report the claim. A clean claim must meet all requirements for accurate and complete data as defined in the appropriate 837-(claim type) encounter guides as follows:

- 837 Professional Combined Implementation Guide
- 837 Institutional Combined Implementation Guide
- 837 Professional Companion Guide
- 837 Institutional Companion Guide

Note: Additional clean claim definitions are provided in 21 TAC §21.2803.

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

- Is submitted timely
- Is accurate
- Is submitted in a HIPAA-compliant format or using the standard claim form, including a UB-04 CMS-1450 or CMS-1500 (02-12), 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 us

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

- Patient's ID number
- Patient's name
- Patient's date of birth
- ICD-10 diagnosis code/revenue codes
- Date of service
- Place of service
- CPT-4 codes/HCPCS procedure codes
- Modifiers

- Diagnosis pointers
- Itemized charges
- Days or units
- Provider's tax ID number
- Total charge
- Provider's name according to the contract
- NPI of billing provider
- Billing provider's taxonomy codes
- NPI of rendering provider
- Rendering provider taxonomy codes
- State Medicaid ID number (optional)
- COB/other insurance information
- Authorization/precertification number or copy of authorization/precertification
- Name of referring physician
- NPI of ordering/referring/supervising provider when applicable
- Any other state-required data
- National drug codes (NDCs)

As part of our compliance with Texas Medicaid contract requirements, ordering /referring claim requirements are applied per Texas Government Code §531.024161 and Texas Medicaid Provider Procedures Manual Sections 6.4.2.3 and 6.4.2.4 for all services.

Clean claims are adjudicated within 30 calendar days of receipt (18 days for electronic pharmacy claims submission and 21 days for nonelectronic pharmacy claims). If we do not adjudicate the clean claim within the time frames specified above, we will pay all applicable interest as required by law.

We produce and distribute Explanation of Payments (EOPs) on a bi-weekly basis. The EOP delineates the status of each claim that has been adjudicated during the payment cycle.

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

### **Deficient Claim**

Also known as an unclean claim, a deficient claim is one submitted for medical care or health care services rendered to a member that does not contain the data necessary for the MCO or its subcontracted claims processor to adjudicate and accurately report the claim.

## **12.2 Methods of Submission**

### ***12.2.1 Electronic Data Interchange Submission***

We encourage electronic submission of claims through Electronic Data Interchange (EDI). Electronic claims submission is available through:



| Clearinghouse        | Amerigroup payer ID | Phone           |
|----------------------|---------------------|-----------------|
| Emdeon               | 27514               | 1-866-858-8938  |
| Capario              | 28804               | 1-800-586-6938  |
| Availity             | 26375               | 1- 800-282-4548 |
| Smart Data Solutions | 81237               | 1-855-650-6590  |

The guide for EDI claims submission is located on our website at <https://providers.amerigroup.com/TX>. The guide includes additional information related to the EDI claim process. To initiate the electronic claims submission process or obtain additional information, please call the Amerigroup EDI Hotline at 1-800-590-5745.

Providers must complete the trading partner agreement before submitting claims by a batch 837 file. To find the trading partner agreement for your service area, visit our website at <https://providers.amerigroup.com/TX>. Once you complete the agreement, fax the form to our EDI department at 1-757-226-7469. Upon receipt of the form, a member of the EDI team will review it and follow up with you to initiate the process for allowing batch submissions.

### **12.2.2 Online Claims Submission**

We offer a free online claim submission tool for all providers at [www.Availity.com](http://www.Availity.com). This tool submits claims directly to us without the use of a clearinghouse. Submission via this website requires provider registration.

### **12.2.3 Paper Claims Submission**

We accept paper claim submissions on the following forms:

- CMS-1450 (UB-04) claim form for institutional or facility claim submissions
- CMS-1500 (02-12) claim form for professional claim submissions

The forms and instructions are available at the CMS website at [www.cms.hhs.gov](http://www.cms.hhs.gov).

We use optical character recognition (OCR) technology as part of our front-end claims processing procedures. Claims must be submitted on original red claim forms (not black and white or photocopied forms) with laser printed or typed (not handwritten) information in a large, dark font. We cannot accept claims with alterations to billing information. Altered claims will be returned to the provider with an explanation of the reason for the return. We will not accept handwritten claims.

Submit paper claims to:

Texas Claims  
Amerigroup  
PO Box 61010  
Virginia Beach, VA 23466-1010

### **12.3 Itemized Bills**

An itemized bill is required under the following circumstances:

- Any claim that meets or exceeds the stop-loss provision in the provider agreement
- Any claim with charges that meet or exceed \$5,000

We cannot accept itemized bills with alterations. Altered itemized bills will be returned to the provider with an explanation of the reason for the return.

Submit all itemized bills to:

Amerigroup  
PO Box 61010  
Virginia Beach, VA 23466-1010

### **12.4 Capitation**

Providers contracted under capitated reimbursement methodologies receive payment on a per-member-per-month (PMPM) basis. Payment is issued at the beginning of the month for members assigned to the provider. The payment is adjusted for those members retroactively disenrolled by the state. Only services outlined in the contract are reimbursed above the capitation payment. Providers receiving capitation are required to submit encounter data for services covered under capitation.

### **12.5 Encounter Data**

Providers who are reimbursed by capitation must submit encounter data to us for each member encounter. Encounter data must be submitted in a manner similar to claims submissions as outlined above.

### **12.6 Claims Status**

We offer 2 methods for accessing claim status 24 hours a day, 365 days a year:

- Online: [www.Availity.com](http://www.Availity.com)
- Phone: 1-800-454-3730

### **12.7 Provider Reimbursement**

We cannot pay providers or assign Medicaid members to providers for Medicaid services unless they are included on the state master file as provided by the Texas Medicaid & Healthcare Partnership (TMHP). State master files are updated weekly.

Federal regulations require state Medicaid agencies to revalidate provider enrollment information every 3 to 5 years. If a provider's re-enrollment is not complete by the required date, the provider will not be able to receive payments for Medicaid services. Compliance with the re-enrollment process is solely the responsibility of the provider. Additional information is available through the state agencies responsible for provider enrollment, either TMHP or DADS for long-term services and supports providers.

### **Electronic Funds Transfer and Electronic Remittance Advice**

We offer electronic funds transfer (EFT) and electronic remittance advice (ERA) with online viewing capability. Providers can elect to receive our payments electronically through direct-deposit. In addition, providers can select from a variety of remittance information options, including:

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

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

### **Primary Care Provider Reimbursement**

We reimburse primary care providers according to their contractual arrangement.

### **Specialist Reimbursement**

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

Specialty care providers will obtain primary care provider and Amerigroup approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized by the primary care provider's referral. This also applies to treatment that is beyond the scope of self-referral permitted under the program.

Specialty care provider services will be covered only when there is documentation of appropriate notification or precertification. We must be in receipt of the required claims and encounter information.

## **12.8 Overpayments**

We are entitled to offset an amount equal to any overpayments made by us to a provider against any payments due and payable by us. Overpayments may be identified by our Cost Containment Unit (CCU), an Amerigroup vendor, or the provider. When an overpayment is identified by the CCU or an Amerigroup vendor, the provider will receive written notification. The notification will include a *Refund Notification* form specifying the reason for the return, to be completed by the provider and returned along with the refund check. This form can be found on our provider website at <https://providers.amerigroup.com/TX>. The submission of the *Refund Notification* form allows us to process and reconcile the overpayment in a timely manner. Providers can also proactively notify us of an overpayment. It is not uncommon for a provider to identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

### **12.8.1 Provider Preventable Conditions**

We are required to use the present on admission (POA) indicator information submitted on inpatient hospital claims and encounters to reduce or deny payment for provider-preventable conditions. This includes any hospital-acquired conditions or health care-acquired conditions identified in the Texas

Medicaid Provider Procedures Manual. Reductions are required regardless of payment methodology and apply to all hospitals including behavioral health hospitals.

Potentially preventable complications (PPCs) are harmful events or negative outcomes that develop after hospital admission and may result from processes of care and treatment rather than the natural progression of the underlying medical conditions. Potentially preventable readmissions (PPRs) are return hospitalizations of a person within a period specified by HHSC that results from deficiencies in the care or treatment provided to the person during a previous hospital stay or from deficiencies in post-hospital discharge follow-up.

HHSC sends reports of PPR and PPC performance to Amerigroup including hospital lists, effective dates, and reduction data. We apply those reductions for each hospital on the report including behavioral health hospitals. Amerigroup notifies each hospital on the list in writing of the applicable reduction amounts. As a payer of last resort, overpayments are subject to recovery and/or recoupment.

## **12.9 Claim Audits**

Except as specified in this section or by future changes in our contract with the state of Texas, we must complete all audits of a provider claim no later than 2 years after receipt of a clean claim, regardless of whether the provider participates in our network. This limitation does not apply in cases of provider fraud, waste, or abuse that we did not discover within the 2-year period following receipt of the claim. In addition, the 2-year limitation does not apply when an examination, audit, or inspection of a provider by an official or entity that we are required to allow access to records by our contract with the state of Texas, is concluded more than 2 years after we received the claim. Also, the 2-year limitation does not apply when HHSC has recovered a capitation from us based on a member's ineligibility. If any exception to the 2-year limitation applies, then we may recoup related payments from providers.

If an additional payment is due to a provider as a result of an audit, we must make the payment no later than 30 days after the audit is completed. If the audit indicates we are due a refund from the provider, we must send the provider written notice of the basis and specific reasons for the recovery no later than 30 days after the audit is completed. If the provider disagrees with the refund request, we must give the provider an opportunity to appeal and may not attempt to recover the payment until the provider has exhausted all appeal rights.

## **12.10 Coordination of Benefits**

Federal and state laws require Medicaid, including the STAR Kids program, be the payer of last resort. All other available third-party resources (including Medicare) must meet their legal obligation to pay claims before Medicaid funds are used to pay for the care of an individual eligible for Medicaid. Providers must submit claims to other health insurers for consideration prior to billing us. A copy of the other health insurer's EOB/EOP or rejection letter should be submitted with the claim to us. If we are aware of other third-party resources at the time of claim submission, we will deny the claim and redirect the provider to bill the appropriate insurance carrier. If we become aware of the resource after payment for the service was rendered, we will pursue post-payment recovery.

We will avoid payment of trauma-related claims where third-party resources are identified prior to payment. Otherwise, we 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. Review and research encompasses generating multiple letters and phone calls to document the appropriate details. The filing of liens and settlement negotiations are handled internally and externally via our subrogation vendor.

## **12.11 Billing Members**

Our members must not be balance billed for the amount above that which is paid by us for covered services.

In addition, providers may not bill a member if any of the following occurs:

- Failure to timely submit a claim, including claims not received by us
- Failure to submit a claim to us for initial processing within the 95-day filing deadline
- Failure to submit a corrected claim within the 95-day filing resubmission period
- Failure to appeal a claim within the 120-day administrative appeal period
- Failure to appeal a utilization review determination within 30 calendar days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made in claims preparation, claims submission, or the appeal process

A member cannot be billed for failing to show for an appointment. Providers may not bill Amerigroup Medicaid members for a third-party insurance copay. Medicaid members do not have any out-of-pocket expense for covered services.

Before rendering services, providers should always inform members that they will be charged for the cost of services not covered by us. A provider who chooses to deliver services not covered by us must:

- Understand we only reimburse for services that are medically necessary, including hospital admissions and other services
- Obtain the member's signature on the client acknowledgment statement, specifying he or she will be held responsible for payment of services
- Understand he or she may not bill for or take recourse against a member for denied or reduced claims for services that are within the amount, duration, and scope of benefits of the Medicaid program

## **12.12 Private Pay Agreement**

Providers:

- Must advise members they are accepted as private-pay patients, and as such, these members are financially responsible for all services received; providers must advise members of this at the time the service is rendered.
- May bill for any service that is not a benefit of an Amerigroup program (like personal care items) without obtaining a signed client acknowledgment statement.
- May bill a member as a private pay patient if retroactive eligibility is not granted.

- Must have private pay members agree in writing (see sample documentation shown below) to avoid being asked questions about how the member was accepted; without written, signed documentation that the member has been properly notified of the private pay status, the provider should not seek payment from an eligible program member.

#### **Sample Private Pay Agreement**

"I understand [provider's name] is accepting me as a private pay patient for the period of \_\_\_\_\_, and I am responsible for paying for any services I receive. The provider will not file a claim to Medicaid or Amerigroup for services provided to me."

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

### **12.13 Member Acknowledgment Statement**

Providers may bill an Amerigroup member for a service denied as not medically necessary or not a covered benefit **only if both** of the following conditions are met:

- The member requests the specific service or item
- The provider obtains and keeps a written acknowledgment statement signed by the member and the provider (as shown on the following page); the signed statement must be obtained prior to the provision of the service in question

## Client Acknowledgment Statement Form

I understand my doctor, \_\_\_\_\_, or Amerigroup has said the services  
Provider name

or items I have asked for on \_\_\_\_\_ are not covered under my Amerigroup plan.  
Dates of service

Amerigroup will not pay for these services. Amerigroup has set up the administrative rules and medical necessity standards for the services or items I get. I may have to pay for them if Amerigroup decides they are not medically necessary or are not a covered benefit, and if I sign an agreement with my provider prior to the service being rendered that I understand I am liable for payment.

\_\_\_\_\_  
Date: \_\_\_\_\_  
Member name (print)

\_\_\_\_\_  
Member signature

Participating providers may bill a member for a service that has been denied as not medically necessary or not a covered benefit **only if the following conditions are true:**

- The member requests the specific service or item
- The member was notified by the provider of the financial liability in advance of the service
- The provider obtains and keeps a written acknowledgment statement signed by the provider and by the member, above, prior to the service being rendered

\_\_\_\_\_  
Date: \_\_\_\_\_  
Provider name (print)

\_\_\_\_\_  
Provider signature

### 12.14 Medicaid Cost Sharing

Medicaid members do not have copays.

### 12.15 Emergency Services

Precertification is not required for coverage of emergency services. Any hospital or provider request for authorization of emergency services is granted immediately. Emergency services coverage includes services that are 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.

## **12.16 Special Billing**

When billing a newborn claim, please use the newborn's Medicaid ID. If no ID has been assigned yet, call us at 1-800-454-3730 for assistance. Please do not submit a claim under the mother's global ID.

## **12.17 Provider Payment Appeals**

Information on the payment appeal process, including acute care claims, is located in the [Complaints and Appeals](#) chapter of this manual.



## **13 QUALITY MANAGEMENT**

### **13.1 Overview**

We maintain a comprehensive quality management program to objectively monitor and systematically evaluate the care and service provided to members. The scope and content of the program reflects the demographic and epidemiological needs of the population served. Members and providers have opportunities to make recommendations for areas of improvement. The quality management program goals and outcomes are available to both providers and members upon request. Studies are planned across the continuum of care and service with ongoing proactive evaluation and refinement of the program. If you would like more information about our quality management program goals, processes, and outcomes, call Provider Services at 1-800-454-3730.

The initial program development was based on a review of the needs of the population served. Systematic re-evaluation of the needs of the plan's specific population occurs on an annual basis. This includes not only age and gender distribution but also a review of utilization data — inpatient, emergent, urgent care and office visits by type, cost, and volume. This information is used to define high-volume or problem-prone areas. HEDIS performance is evaluated annually and compared against national benchmarks. The Consumer Assessment of Healthcare Providers and Systems (CAHPS<sup>®</sup> \*) evaluates member satisfaction and experience annually. Performance is analyzed for barriers and best practices, and interventions are developed to improve performance.

We maintain a quality committee structure that includes a medical advisory committee (MAC), a credentialing committee (with participation from network physicians and practitioners), and a peer review committee. These committees are overseen by the quality management committee structure.

### **13.2 Quality Management Committee**

The purpose of the quality management committee (QMC) is to maintain quality as a cornerstone of our culture. The committee serves as 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 NCQA, HHSC, and TDI compliance
- Review planning, implementation, measurement, and outcomes of clinical/service quality improvement studies
- 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

*\*CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.*

- 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

### **13.3 Medical Advisory Committee**

The medical advisory committee (MAC) assesses levels and quality of care provided to members and recommends, evaluates, and monitors standards of care. It oversees the peer-review process that provides a systematic approach for monitoring the quality and appropriateness of care. The MAC conducts a systematic process for network maintenance through the credentialing and recredentialing process. The MAC advises the health plan administration in any aspect of its policy or operation affecting network providers or members. The MAC approves and provides oversight of the peer-review process, the quality management program, and the health care management services program.

The MAC's responsibilities are to:

- Utilize an ongoing peer-review system to monitor practice patterns, identify appropriateness of care, and improve risk prevention activities
- Review clinical study design and results
- Develop action plans and recommendations regarding clinical quality improvement studies
- Consider (and act in response to) provider sanctions
- Provide oversight of credentialing committee decisions to credential and recredential providers for participation in the plan
- Approve credentialing and recredentialing policies and procedures
- Oversee member access to care
- Review and provide feedback regarding new technologies
- Approve recommendations from subordinate committees

In addition to the Texas-based MAC, we maintain a super MAC comprised of actively practicing practitioners from each Amerigroup health plan. The super MAC identifies opportunities to improve services and clinical performance. The group establishes, reviews, and/or updates national clinical practice guidelines. The super MAC is chaired by an Amerigroup national medical director.

### **13.4 STAR Kids Clinical and Administrative Advisory Committees**

The STAR Kids Clinical and Administrative Advisory Committees (CAACs) provide specialized review, expertise, and consultation on a variety of health issues related to the STAR Kids population. The purpose of these committees is to monitor, evaluate, and improve performance and quality of health care services delivered to STAR Kids members.

The CAAC responsibilities are to:

- Assist Amerigroup in developing, reviewing, and revising policies and procedures and clinical practice guidelines (CPGs) based on the needs of STAR Kids members, clinical best practices, and community standards
- Assist Amerigroup in reviewing general clinical practice patterns and assessing provider compliance with clinical guidelines

- Assist Amerigroup, HHSC, and the state's External Quality Review Organization (EQRO) in developing quality improvement strategies and studies
- Assist Amerigroup in development of improved administrative procedures
- Provide Amerigroup with recommendations on how to improve care based on member feedback
- Connect network providers and Amerigroup clinical experts for peer support and sharing of best practices

### **13.5 Use of Performance Data**

All providers must allow Amerigroup to use performance data in cooperation with our quality improvement program and activities.

### **13.6 Credentialing Committee**

The credentialing committee's purpose is to credential and recredential all participating physicians according to plan, state, and federal accreditation standards.

Committee responsibilities:

- Conduct reviews for all providers who apply for participation in the network
- Review all participating providers for recredentialing purposes, including the review of any quality or utilization data/reports
- Approve or deny providers submitted by a delegated credentialing entity
- Review and update credentialing policies and procedures
- Report physician corrective actions and sanctions imposed based upon recredentialing activity to the MAC
- Approve or deny providers for participation in the network and report decisions to the MAC
- Oversee delegated credentialing relationships

### **13.7 Peer Review**

The peer review process provides a systematic approach for monitoring the quality and appropriateness of care. Peer review responsibilities are:

- To participate in the implementation of the established peer review system
- To review and make recommendations regarding individual provider peer-review cases
- To work in accordance with the executive medical director

Should investigation of a member complaint result in concern regarding a physician's compliance with community standards of care or service, all elements of peer review will be followed.

Dissatisfaction severity codes and levels of severity are applied to quality issues. The medical director assigns a level of severity to the complaint. Peer review includes investigation of physician actions by or at the discretion of the medical director. The medical director takes action based on the quality issue and the level of severity, invites the cooperation of the physician, and consults and informs the MAC and peer review committee. The medical director informs the physician of the committee's decision, recommendations, follow-up actions and/or disciplinary actions to be taken. Outcomes are reported to

the appropriate internal and external entities, which include the quality management committee. The peer review process is a major component of the MAC monthly agenda. The peer review policy is available upon request.

### **13.8 Clinical Practice Guidelines**

Using nationally recognized, scientific, evidence-based standards of care, we work with providers to develop clinical policies and guidelines for the care of members. The super MAC oversees and directs us in formulating, adopting, and monitoring guidelines.

Clinical practice guidelines are located on our website at <https://providers.amerigroup.com/TX>. A copy of the guidelines can be printed from the website, or you may call Provider Services at 1-800-454-3730 to receive a printed copy.

We select at least 4 evidence-based clinical practice guidelines that are relevant to the member population. We measure performance against at least 2 important aspects of each of the 4 clinical practice guidelines annually. The guidelines must be reviewed and revised at least every 2 years, or whenever the guidelines change.

### **13.9 Focus Studies and Utilization Management Reporting Requirements**

Quality management is involved in conducting clinical and service utilization studies that may or may not require medical record review. We conduct gap analysis of the data and share opportunities for improvement with our network providers.

### **13.10 New Technology**

Our medical director and participating providers review and evaluate new medical advances in technology (or the new application of existing technology) in medical procedures, behavioral health procedures, pharmaceuticals, and devices to determine their appropriateness for covered benefits. Scientific literature and government approval are reviewed for determining if the treatment is safe and effective. The new medical advance or treatment (or new application of existing technology) must provide equal or better outcomes than the existing covered benefit treatment or therapy for it to be considered for coverage by Amerigroup.

## **14 OUT-OF-NETWORK PROVIDERS**

### **14.1 Claims Submission**

Nonparticipating providers located in Texas must submit clean claims to us within 95 days of service. Nonparticipating providers located outside of Texas must submit clean claims to us within 365 days of the date of service (Refer to the definition of clean claim in the [Billing and Claims Administration](#) chapter of this manual). To submit claims for services provided to Medicaid members, providers must have an active Texas provider identifier on file with TMHP, the state's contracted administrator.

### **14.2 Precertification**

Nonparticipating providers must obtain precertification for all nonemergent services except as prohibited under federal or state law for in-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery or 96 hours following an uncomplicated delivery by Cesarean section. We require precertification of maternity inpatient stays for any portion in excess of these timeframes.

### **14.3 Reimbursement**

Nonparticipating providers are reimbursed in accordance with a negotiated case rate or, in absence of a negotiated rate, as follows:

For Medicaid, we reimburse:

- Out-of-network, in-area service providers at no less than the prevailing Medicaid FFS rate, less 5 percent
- Out-of-network, out-of-area service providers at no less than 100 percent of the Medicaid FFS rate

## 15 APPENDIX A – ID CARDS

Identification cards for our STAR Kids members with Medicare do not list a primary care provider. The phrase **Long-Term Services and Supports Benefits Only** appears on the card. These members obtain their acute care services through Medicare.



PCP Effective Date:  
Date of Birth:  
Subscriber #:

**AMERIGROUP INSURANCE COMPANY**

Member Name:  
Medicaid Number:  
Amerigroup Service Coordination: 1-866-696-0710  
Primary Care Provider (PCP):  
PCP Telephone #:  
PCP Address:

Vision: 1-800-428-8789 Pharmacy: 1-844-756-4600  
Amerigroup STAR Kids Only Member Services and Behavioral Health  
(24 hours a day, 7 days a week): 1-844-756-4600  
24-Hour Nurse HelpLine: 1-844-756-4600

**TEXAS  
STAR Kids**  
Your Health Plan ★ Your Choice

**MEMBERS:** Please carry this card at all times. Show this card before you get medical care. You do not need to show this card before you get emergency care. In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible. If you have questions or suspect fraud or abuse, call Member Services at 1-844-756-4600. If you are deaf or hard of hearing, call 711.

**MIEMBROS:** Porte esta tarjeta en todo momento. Muestrela antes de recibir cuidado de la salud. No tiene que mostrar esta tarjeta antes de recibir cuidado de emergencia. En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después del tratamiento, llame a su PCP en un plazo de 24 horas o lo más pronto posible. Si tiene alguna pregunta o sospechas de fraude o abuso, llame a Servicios al Miembro al 1-844-756-4600. Si es sordo(a) o tiene problemas auditivos, llame al 711.

**HOSPITALS:** Preadmission certification is required for all nonemergency admissions, including outpatient surgery. For emergency admissions, notify Amerigroup within 24 hours after treatment at 1-800-454-3730.

**PROVIDERS:** Certain services and medications must be preauthorized. If preauthorization is required and has not been obtained, the services may not be covered by Amerigroup. For preauthorization of medical services, call 1-800-454-3730. For preauthorizations of medications, call 1-855-215-4496.

**PHARMACIES:** Submit claims using Express Scripts RXBIN: 003856; RXPCN: MA; and RXGRP: WKEA. For technical help, call Express Scripts at 1-844-367-6115.

**SUBMIT CLAIMS TO:**  
AMERIGROUP • PO BOX 61010 • VIRGINIA BEACH, VA 23466-1010

**USE OF THIS CARD BY ANY PERSON OTHER THAN THE MEMBER IS FRAUD.**  
**EL USO DE ESTA TARJETA POR CUALQUIER PERSONA QUE NO SEA EL MIEMBRO CONSTITUYE FRAUDE.**

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Effective Date:  
Date of Birth:  
Subscriber #:

**AMERIGROUP INSURANCE COMPANY**

Member Name:  
Medicaid Number:  
Amerigroup Service Coordination: 1-866-696-0710  
Pharmacy: 1-844-756-4600

**LONG-TERM SERVICES AND SUPPORTS BENEFITS ONLY**  
You receive primary, acute, and behavioral health services through Medicare.  
You receive only long-term services and supports through Amerigroup.  
**SOLO BENEFICIOS DE SERVICIOS Y APOYOS A LARGO PLAZO**  
Usted recibe servicios de cuidado primario, aguda y del comportamiento a través de Medicare. Solo recibe servicios y apoyos a largo plazo a través de Amerigroup.

**TEXAS  
STAR Kids**  
Your Health Plan ★ Your Choice

Amerigroup STAR Kids Only Member Services/STAR Kids solo Servicios al Miembro de Amerigroup: 1-844-756-4600

Nurse HelpLine/Línea de ayuda de enfermería: 1-844-756-4600  
24 hours a day, 7 days a week/las 24 horas del día, los 7 días de la semana  
Please carry this card at all times. Present this card before getting long-term care services. Porte esta tarjeta en todo momento. Presente esta tarjeta antes de recibir servicios de cuidado a largo plazo.

If you have questions or suspect fraud or abuse, call Member Services at 1-844-756-4600. If you are deaf or hard of hearing, call 711.

Si tiene alguna pregunta o sospechas de fraude o abuso, llame a Servicios al Miembro al 1-844-756-4600. Si es sordo(a) o tiene problemas auditivos, llame al 711.

In case of emergency, call 911 or go to the closest emergency room.  
En caso de emergencia, llame al 911 o vaya a la sala de emergencia más cercana.

**PROVIDERS & HOSPITALS:** Medicare is responsible for primary, acute, and behavioral health services. Please follow their preauthorization requirements. Contact Amerigroup for authorization of long-term care services only.

**PHARMACIES:** Submit claims using Express Scripts RXBIN: 003856; RXPCN: MA; and RXGRP: WKEA. For technical help, call Express Scripts at 1-844-367-6115.

**SUBMIT LONG-TERM SERVICES AND SUPPORTS CLAIMS TO:**  
AMERIGROUP • PO BOX 61010 • VIRGINIA BEACH, VA 23466-1010

**USE OF THIS CARD BY ANY PERSON OTHER THAN THE MEMBER IS FRAUD.**  
**EL USO DE ESTA TARJETA POR CUALQUIER PERSONA QUE NO SEA EL MIEMBRO CONSTITUYE FRAUDE.**

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## Medicaid Rural Service Area West ID Cards



PCP Effective Date:  
Date of Birth:  
Subscriber #:

**AMERIGROUP INSURANCE COMPANY**




Member Name:  
Medicaid Number:  
Amerigroup Service Coordination: 1-866-696-0710  
Primary Care Provider (PCP):  
PCP Telephone #:  
PCP Address:

Vision: 1-800-428-8789 Pharmacy: 1-844-756-4600  
Amerigroup STAR Kids Only Member Services and Behavioral Health  
(24 hours a day, 7 days a week): 1-844-756-4600  
24-Hour Nurse HelpLine: 1-844-756-4600

**MEMBERS:** Please carry this card at all times. Show this card before you get medical care. You do not need to show this card before you get emergency care. In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible. If you have questions or suspect fraud or abuse, call Member Services at 1-844-756-4600. If you are deaf or hard of hearing, call 711.

**MIEMBROS:** Por favor, lleve esta tarjeta en todo momento. Muéstrela antes de recibir cuidado de la salud. No tiene que mostrar esta tarjeta antes de recibir cuidado de emergencia. En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después del tratamiento, llame a su PCP en un plazo de 24 horas o lo más pronto posible. Si tiene alguna pregunta o sospechas de fraude o abuso, llame a Servicios al Miembro al 1-844-756-4600. Si es sordo(a) o tiene problemas auditivos, llame al 711.

**HOSPITALS:** Preadmission certification is required for all nonemergency admissions, including outpatient surgery. For emergency admissions, notify Amerigroup within 24 hours after treatment at 1-800-454-3730.

**PROVIDERS:** Certain services and medications must be preauthorized. If preauthorization is required and has not been obtained, the services may not be covered by Amerigroup. For preauthorization of medical services, call 1-800-454-3730. For preauthorizations of medications, call 1-855-215-4496.

**PHARMACIES:** Submit claims using Express Scripts RXBIN: 003856; RXPCN: MA; and RXGRP: WKEA. For technical help, call Express Scripts at 1-844-367-6115.

**SUBMIT CLAIMS TO:**  
AMERIGROUP • PO BOX 61010 • VIRGINIA BEACH, VA 23466-1010

**USE OF THIS CARD BY ANY PERSON OTHER THAN THE MEMBER IS FRAUD.**  
**EL USO DE ESTA TARJETA POR CUALQUIER PERSONA QUE NO SEA EL MIEMBRO CONSTITUYE FRAUDE.**

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Effective Date:  
Date of Birth:  
Subscriber #:

**AMERIGROUP INSURANCE COMPANY**




Member Name:  
Medicaid Number:  
Amerigroup Service Coordination: 1-866-696-0710  
Pharmacy: 1-844-756-4600

**LONG-TERM SERVICES AND SUPPORTS BENEFITS ONLY**  
You receive primary, acute, and behavioral health services through Medicare.  
You receive only long-term services and supports through Amerigroup.  
**SOLO BENEFICIOS DE SERVICIOS Y APOYOS A LARGO PLAZO**  
Usted recibe servicios de cuidado primario, aguda y del comportamiento a través de Medicare. Solo recibe servicios y apoyos a largo plazo a través de Amerigroup.

Amerigroup STAR Kids Only Member Services/STAR Kids solo Servicios al Miembro de Amerigroup: 1-844-756-4600  
Nurse HelpLine/Línea de ayuda de enfermería: 1-844-756-4600  
24 hours a day, 7 days a week/24 horas del día, los 7 días de la semana  
Please carry this card at all times. Present this card before getting long-term care services. Por favor, lleve esta tarjeta en todo momento. Presente esta tarjeta antes de recibir servicios de cuidado a largo plazo.

If you have questions or suspect fraud or abuse, call Member Services at 1-844-756-4600. If you are deaf or hard of hearing, call 711.

Si tiene alguna pregunta o sospechas de fraude o abuso, llame a Servicios al Miembro al 1-844-756-4600. Si es sordo(a) o tiene problemas auditivos, llame al 711.

In case of emergency, call 911 or go to the closest emergency room.

En caso de emergencia, llame al 911 o vaya a la sala de emergencia más cercana.

**PROVIDERS & HOSPITALS:** Medicare is responsible for primary, acute, and behavioral health services. Please follow their preauthorization requirements. Contact Amerigroup for authorization of long-term care services only.

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**EL USO DE ESTA TARJETA POR CUALQUIER PERSONA QUE NO SEA EL MIEMBRO CONSTITUYE FRAUDE.**

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## **16 APPENDIX B – FORMS**

Please visit our provider website at <https://providers.amerigroup.com/TX> for all Amerigroup forms. You may download them for your use as needed.



