



An Anthem Company



Nursing Facility Provider Manual

Amerigroup Texas, Inc.

Bexar, El Paso, Harris, Jefferson, Lubbock, Tarrant, and Travis Delivery Areas

Amerigroup Insurance Company

West Rural Service Area

February 2020



1-800-454-3730

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



TEXAS
Health and Human
Services

February 2020, Amerigroup Corporation

Amerigroup Texas, Inc. and Amerigroup Insurance Company are wholly owned subsidiaries of Amerigroup Corporation, whose parent company is Anthem, Inc. (Anthem). All rights reserved. This publication, or any part thereof, may not be reproduced or transmitted in any form or by any means, electronic, mechanical, including photocopying, recording, storage in an information retrieval system, or otherwise, without the prior written permission of the National Provider Communications Department, Amerigroup Corporation, 5800 Northampton Blvd., Norfolk, VA 23502, telephone 757-473-2737. The Amerigroup Corporation website is located at <https://www.amerigroup.com>.

Amerigroup retains the right to add to, delete from and otherwise modify this provider manual. Contracted providers must acknowledge this provider manual and any other written materials provided by Amerigroup as proprietary and confidential.

Please note: Material in this provider manual is subject to change. Please visit <https://providers.amerigroup.com/TX> for the most up-to-date information.

Table of Contents

1	INTRODUCTION	6
1.1	WHO IS AMERIGROUP?.....	6
1.2	OUR MISSION AND GOALS.....	8
1.3	LEGISLATIVE BACKGROUND FOR STAR+PLUS NURSING FACILITY MEDICAID	9
1.4	ROLE OF NURSING FACILITIES	9
1.5	ROLE OF PRIMARY CARE PROVIDERS (MEDICAL HOME).....	9
1.6	ROLE OF SPECIALTY CARE PROVIDERS	10
1.7	ROLE OF LONG-TERM SERVICES AND SUPPORTS PROVIDERS	10
1.8	ROLE OF AMERIGROUP SERVICE COORDINATOR	10
1.9	ROLE OF PHARMACY.....	10
1.10	NETWORK LIMITATIONS	11
1.11	NONDISCRIMINATION STATEMENT	12
2	QUICK REFERENCE INFORMATION.....	14
3	MEMBER ELIGIBILITY	17
3.1	VERIFYING MEMBER MEDICAID ELIGIBILITY.....	17
3.2	AMERIGROUP MEMBER IDENTIFICATION CARD	17
3.3	SERVICE RESPONSIBILITY.....	18
3.4	MEMBER ENROLLMENT AND DISENROLLMENT FROM AMERIGROUP.....	19
4	COVERED SERVICES AND EXTRA BENEFITS.....	22
4.1	MEDICAID COVERED SERVICES FOR STAR+PLUS NURSING FACILITY	22
4.2	MEDICAID SERVICES COVERED OUTSIDE OF THE NURSING FACILITY	24
4.3	MEDICAID PROGRAM EXCLUSIONS	25
4.4	COORDINATION WITH NON-MEDICAID MANAGED CARE COVERED SERVICES.....	25
4.5	DENTAL SERVICES	26
4.6	FAMILY PLANNING	27
4.7	PHARMACY	27
4.8	AMBULANCE TRANSPORTATION SERVICES (EMERGENT).....	31
4.9	NONEMERGENCY TRANSPORTATION	32
4.10	VISION SERVICES.....	33
4.11	VALUE-ADDED SERVICES	33
5	PRECERTIFICATION AND UTILIZATION MANAGEMENT	34
5.1	MEDICAL REVIEW CRITERIA	34
5.2	UTILIZATION MANAGEMENT DECISION MAKING AFFIRMATIVE STATEMENTS	35
5.3	MEDICALLY NECESSARY SERVICES.....	36
5.4	PRECERTIFICATION/NOTIFICATION PROCESS.....	37
5.5	NONEMERGENT OUTPATIENT AND ANCILLARY SERVICES – PRECERTIFICATION AND NOTIFICATION REQUIREMENTS	39
5.6	NONEMERGENT INPATIENT ADMISSIONS	39
5.7	ADMINISTRATIVE DENIALS	39
5.8	EMERGENT ADMISSION NOTIFICATION REQUIREMENTS.....	40
5.9	INPATIENT ADMISSION REVIEWS	40
5.10	PEER-TO-PEER REVIEW PROCESS	41
5.11	POSTSTABILIZATION CARE SERVICES.....	41
5.12	DISCHARGE PLANNING FROM INPATIENT SETTING	41
5.13	CONFIDENTIALITY OF INFORMATION	42
5.14	URGENT/AFTER-HOURS CARE.....	42
5.15	UTILIZATION TIMELINESS STANDARDS	42

5.16	LONG-TERM SUPPORT SERVICES PRECERTIFICATION.....	43
5.17	SELF-REFERRALS	43
5.18	HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT	44
5.19	MISROUTED PROTECTED HEALTH INFORMATION.....	45
6	LONG-TERM SERVICES AND SUPPORTS.....	46
6.1	STAR+PLUS ELIGIBILITY.....	46
6.2	MEMBER IDENTIFICATION CARDS.....	47
6.3	COVERED SERVICES	47
6.4	SERVICE COORDINATION	55
6.5	APPLIED INCOME	59
7	BEHAVIORAL HEALTH PROGRAM.....	60
7.1	OVERVIEW.....	60
7.2	COVERED BEHAVIORAL HEALTH SERVICES	60
7.3	PRIMARY AND SPECIALTY SERVICES.....	62
7.4	BEHAVIORAL HEALTH CARE PROVIDER RESPONSIBILITIES	63
7.5	CARE CONTINUITY AND COORDINATION GUIDELINES	64
7.6	EMERGENCY BEHAVIORAL HEALTH SERVICES	64
7.7	URGENT BEHAVIORAL SERVICES.....	65
7.8	PRECERTIFICATION AND REFERRALS FOR BEHAVIORAL HEALTH	65
7.9	COURT-ORDERED SERVICES.....	66
8	MEMBER RIGHTS AND RESPONSIBILITIES	68
8.1	MEMBER’S RIGHT TO DESIGNATE AN OB/GYN	68
8.2	MEMBER RIGHTS AND RESPONSIBILITIES	68
9	COMPLAINTS, APPEALS AND PROVIDER DISPUTES	71
9.1	MEMBER COMPLAINTS AND APPEALS	71
9.2	PROVIDER COMPLAINTS, PAYMENT DISPUTES AND MEDICAL APPEALS	78
9.3	REQUIRED DOCUMENTATION FOR CLAIM PAYMENT DISPUTES	82
9.4	PROVIDER APPEAL PROCESS TO HHSC (RELATED TO CLAIM RECOUPMENT DUE TO MEMBER DISENROLLMENT).....	85
10	PROVIDER RIGHTS AND RESPONSIBILITIES	86
10.1	PROVIDERS’ BILL OF RIGHTS.....	86
10.2	NETWORK PROVIDER GENERAL RESPONSIBILITIES.....	86
10.3	NURSING FACILITY RESPONSIBILITIES.....	87
10.4	ADVANCE DIRECTIVES	88
10.5	AMERICANS WITH DISABILITIES ACT REQUIREMENTS.....	89
10.6	APPOINTMENTS.....	89
10.7	CONTINUITY OF CARE	90
10.8	COVERING PHYSICIANS.....	92
10.9	CREDENTIALING AND RECREDENTIALING	92
10.10	CULTURAL COMPETENCY	101
10.11	ELIGIBILITY VERIFICATION	103
10.12	EMERGENCY SERVICES	103
10.13	FRAUD, WASTE AND ABUSE.....	105
10.14	LABORATORY SERVICES (OUTPATIENT)	110
10.15	LOCUM TENENS.....	111
10.16	MEMBER MISSED APPOINTMENTS	111
10.17	MEMBER RECORD STANDARDS.....	111
10.18	NONCOMPLIANT AMERIGROUP MEMBERS.....	114
10.19	PATIENT VISIT DATA.....	114

10.20	PRIMARY CARE PROVIDERS	115
10.21	PROVIDER DISENROLLMENT PROCESS	119
10.22	PROVIDER MARKETING	120
10.23	PROVIDER QUALITY INCENTIVE PROGRAMS	120
10.24	RADIOLOGY	120
10.25	REFERRALS	120
10.26	REPORTING INVOLVEMENT IN LEGAL OR ADMINISTRATIVE PROCEEDINGS, CHANGES IN ADDRESS AND PRACTICE STATUS	120
10.27	SECOND OPINIONS	121
10.28	SPECIALTY CARE PROVIDERS.....	121
10.29	CANCELLATION OF PRODUCT ORDERS	124
10.30	READING/GRADE LEVEL CONSIDERATION	124
11	MEMBER MANAGEMENT SUPPORT.....	125
11.1	APPOINTMENT SCHEDULING	125
11.2	INTERPRETER SERVICES.....	125
11.3	CASE MANAGEMENT	125
11.4	MEMBERS WITH SPECIAL HEALTH CARE NEEDS (MSHCN)	127
11.5	COMMUNICABLE DISEASE SERVICES.....	128
11.6	HEALTH PROMOTION.....	128
11.7	24-HOUR NURSE HELPLINE.....	128
11.8	TELEMEDICINE, TELEHEALTH AND TELEMONTORING ACCESS	129
11.9	PATIENT360.....	129
12	BILLING AND CLAIMS ADMINISTRATION	130
12.1	NURSING FACILITY CARVED-IN SERVICES.....	130
12.2	COST REPORTING TO HHSC.....	131
12.3	DIRECT CARE STAFF RATE ENHANCEMENT PAYMENT PROGRAM	132
12.4	DIRECT CARE STAFF RATE ENHANCEMENT PAYMENT PROGRAM (DCREAP) REPORTING	132
12.5	CLAIMS SUBMISSION	132
12.6	TIMELY FILING.....	132
12.7	CODING	133
12.8	CLEAN CLAIM	134
12.9	DEFICIENT CLAIM.....	135
12.10	METHODS OF SUBMISSION	135
12.11	CLAIM STATUS	136
12.12	PARTICIPATING, IN-NETWORK PROVIDER REIMBURSEMENT	137
12.13	ELECTRONIC FUNDS TRANSFER AND ELECTRONIC REMITTANCE ADVICE.....	137
12.14	PROVIDER CLAIMS PAYMENT DISPUTES.....	137
12.15	OVERPAYMENTS & PAYMENT WITHHOLD.....	137
12.16	CLAIM AUDITS.....	138
12.17	COORDINATION OF BENEFITS	139
12.18	BILLING MEMBERS	139
12.19	PRIVATE PAY AGREEMENT	140
12.20	MEMBER ACKNOWLEDGMENT STATEMENT.....	140
12.21	COST SHARING	142
12.22	EMERGENCY SERVICES	142
12.23	PROVIDER RELATIONS REPRESENTATIVES	143
13	QUALITY MANAGEMENT	144
13.1	OVERVIEW.....	144
13.2	QUALITY MANAGEMENT COMMITTEE	144
13.3	MEDICAL ADVISORY COMMITTEE	145
13.4	USE OF PERFORMANCE DATA.....	145

13.5	CREDENTIALING COMMITTEE.....	145
13.6	PEER REVIEW	146
13.7	CLINICAL PRACTICE GUIDELINES.....	146
13.8	FOCUS STUDIES AND UTILIZATION MANAGEMENT REPORTING REQUIREMENTS.....	147
13.9	NEW TECHNOLOGY	147
14	OUT-OF-NETWORK PROVIDERS	148
14.1	CLAIMS SUBMISSION	148
14.2	PRECERTIFICATION	148
14.3	REIMBURSEMENT.....	148
APPENDIX A – ID CARDS		149
APPENDIX B – AMERIGROUP WEBSITE USER GUIDE FOR CLAIMS TRANSACTIONS.....		150
APPENDIX C – AVAILITY PORTAL USER GUIDE.....		156
APPENDIX E – STAR+PLUS NURSING FACILITY CARVED IN/CARVED OUT SERVICES.....		160

1 INTRODUCTION

Welcome to the Amerigroup provider family. We're pleased you're 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 nursing facilities, 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., doing business as Amerigroup Community Care, 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, and elderly and disabled persons. Amerigroup also offers Medicare Advantage Plans, including Medicare Special Needs Plans, and participates in the Medicare-Medicaid Dual Demonstration program (MMP). Amerigroup administers the following programs in Texas:

Program	Program Objectives
STAR	<p>The STAR program is a Medicaid managed care program for children, pregnant women, and low income families providing clients with acute care medical assistance. The objectives of the program are to:</p> <ul style="list-style-type: none">• Improve access to care for clients enrolled in the program.• Increase quality and continuity of care for clients.• Decrease inappropriate use of the health care delivery system, such as emergency rooms (ERs) for nonemergencies.• Achieve cost effectiveness and efficiency for the state.• Promote provider and client satisfaction.
STAR+PLUS	<p>The STAR+PLUS program is a Medicaid managed care program providing integrated acute and long-term services and supports in a Medicaid managed care environment for elderly and disabled adults (mainly Supplemental Security Income [SSI]-eligible Medicaid clients). It also covers individuals with intellectual disabilities or related conditions who do not qualify for Medicare and receive services through the ICF-IID program or an IDD Waiver program (acute care and behavioral health services only — long-term services and supports are provided by the Health and Human Services Commission (HHSC). In addition to the objectives of the STAR program, the STAR+PLUS program aims to:</p> <ul style="list-style-type: none">• Integrate acute and long-term care services and supports.• Coordinate Medicare services for clients who are dual eligible.• Offer coverage for both home- and community-based services and nursing facility custodial care in order to provide quality care in the best setting to address each member's individual care needs.

Program	Program Objectives
STAR Kids	<p>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 and young adults enrolled in STAR Kids will receive comprehensive service coordination.</p> <p>Objectives of the STAR Kids program include the following:</p> <ul style="list-style-type: none"> • Provide Medicaid benefits customized to meet recipients' health care needs through a defined system of care. • Improve recipients' coordination of care, health outcomes and 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.
CHIP	<p>The Children's Health Insurance Program (CHIP) provides health coverage for children age 18 and younger in families that earn too much to qualify for Medicaid but cannot afford private health care coverage. A child must be age 18 or younger, a Texas resident, and a U.S. citizen or legal permanent resident. Objectives of the CHIP program are to:</p> <ul style="list-style-type: none"> • Increase the number of insured children in Texas. • Ensure children have access to a medical home, a physician or health care provider who serves the physical, mental and developmental health care needs of a growing child through a continuous and ongoing relationship. <p>Texas residents who are pregnant, uninsured and not able to obtain Medicaid may be eligible for CHIP Perinatal benefits. Coverage starts before the child is born and lasts 12 months from the date the unborn child is enrolled. The objectives of CHIP Perinatal are to improve health status and birth outcomes for Texas by ensuring pregnant women who are ineligible for Medicaid due to income or immigration status receive prenatal care.</p>
Medicare Advantage	<p>We contract with the Centers for Medicare & Medicaid Services (CMS) to provide a Medicare Advantage Dual-eligible Special Needs Plan (SNP) as well as traditional Medicare Advantage health plans. All plans offer full Medicare Part D prescription drug coverage as well as extra benefits covering other health care services beyond what traditional Fee-For-Service (FFS) Medicare may offer. The Amerigroup Amerivantage Special Needs Plans (SNPs) are for Medicare beneficiaries entitled to Medicare Part A, enrolled in Medicare Part B and Medicaid (either as a full-benefit, dual-eligible or qualified-Medicare beneficiary). There are some copays for prescription drugs. The Amerigroup Amerivantage traditional Medicare Advantage plans are for Medicare beneficiaries who are entitled to Medicare Part A and are enrolled in Medicare Part B. The plans have copays for most services. The objectives of all these plans are to:</p> <ul style="list-style-type: none"> • Enhance the coordination of a member's primary and acute care, long-term care, and prescription drug benefits through a unified case management program. • Improve the health status and outcomes of members.
STAR+PLUS Medicare-Medicaid Dual Demonstration Program (MMP)	<p>Amerigroup was selected by the Texas Health and Human Services Commission (HHSC) to participate in a program to provide both Medicare and Medicaid benefits to dual-eligible members. The goals of this program are to:</p> <ul style="list-style-type: none"> • Integrate care and improve quality of care for members by consolidating the responsibility for all the covered services into a single plan. • Maximize the member's ability to remain safely in their home and community. • Improve continuity of care across acute care, long-term care, behavioral health, and home- and community-based services using a patient-centered approach.

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	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				X	
Northeast Texas Rural	X					
West Texas Rural	X	X	X		X	

*selected counties

For more information on the programs Amerigroup offers in Texas, please refer to the other provider manuals available on the provider website:

- Medicaid/CHIP Provider Manual
- Medicare Advantage Provider Manual
- Amerigroup STAR+PLUS Medicare-Medicaid Plan (MMP) Provider Manual

You can also call 1-866-805-4589 for more information about Medicare Advantage or 1-855-878-1785 for more information about the Medicare-Medicaid Dual Demonstration Program.

1.2 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 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.

Our goals are to:

- Improve access to preventive primary care services by ensuring the selection of a primary care provider (PCP) 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.

1.3 Legislative Background for STAR+PLUS Nursing Facility Medicaid

Senate Bill 7 of the 83rd Texas Legislature mandates the following:

SECTION 2.02. Subchapter A, Chapter 533. 00251 (c)

Subject to Section 533.0025 and notwithstanding any other law, [HHSC]...shall provide benefits under the medical assistance program to recipients who reside in nursing facilities through the STAR+PLUS Medicaid managed care program.

In accordance with this law, nursing facility services are a covered benefit for qualifying STAR+PLUS members age 21 and older beginning March 1, 2015.

1.4 Role of Nursing Facilities

The role of the nursing facility is to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, as defined by and in accordance with the comprehensive assessment and plan of care.

In addition, nursing facility responsibilities include but are not limited to:

- Verifying member eligibility
- Obtaining prior authorization for services prior to provision of those services
- Coordinating Medicaid/Medicare benefits
- Notifying us of changes in members' physical condition or eligibility within one business day of identification
- Collaborating with the Amerigroup service coordinator in managing members' health care
- Managing continuity of care for STAR+PLUS members
- Allowing Amerigroup service coordinators and other key personnel access to Amerigroup members in the facility and requested medical records information

1.5 Role of Primary Care Providers (Medical Home)

The role of the primary care physician or primary care provider (PCP) is to provide a medical home for members. The PCP is also responsible for providing initial and primary care to members, maintaining the continuity of member care, and initiating referral for care.

Members who 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.

1.6 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, including behavioral health providers, coordinate care with the member's medical home provider.

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

The responsibilities of long-term services and supports (LTSS) providers include but are not limited to:

- 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 STAR+PLUS members.

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, including community transitions
- Making sure the member has a primary care provider

A service coordinator works as a team with the member, member's family, and/or authorized representative, nursing facility clinical and administrative staff, and the primary care provider to arrange all the services the member needs, including services from specialists and behavioral health providers if needed. A service coordinator helps make sure all of the member's different health care needs are met.

1.9 Role of Pharmacy

Our pharmacy benefit provides coverage for medically necessary medications from licensed prescribers for the purpose of saving lives in emergency situations or during 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 as well as pharmacies supported within the member's chosen nursing facility.

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 when a prior authorization (PA) cannot be resolved within 24 hours for a medication on the Texas Vendor Drug Program (VDP) formulary that is appropriate for the member's medical condition or if the prescribing provider cannot be reached or is unable to request a PA because it is after the prescriber's office hours. The pharmacy should submit an emergency 72-hour prescription if the dispensing pharmacist determines it is an emergency situation. Emergency situations include cases in which, based on the dispensing pharmacist's judgement, a member may experience a detrimental change in health status within 72 hours from when the pharmacy receives the prescription due to the inability to obtain the medication. Pharmacies should not dispense 72 hour emergency supplies on a routine basis.

1.10 Network Limitations

Providers with the following specialties can apply for enrollment with us as PCPs:

- 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 PCP
- Federally qualified health centers (FQHC)
- Rural health clinics (RHCs) and similar community clinics
- Physicians serving members residing in nursing facilities
- Indian Health Care Providers (IHCP) for Indian members

STAR+PLUS providers must maintain active Texas Provider Identifiers with the Texas Medicaid & Healthcare Partnership in one of the specialties listed above to serve as a PCP.

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 PCP is available under the [Specialist as a PCP](#) section of this manual.

1.11 Nondiscrimination Statement

Amerigroup does not engage in, aid or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color or national origin in providing aid, benefits or services to beneficiaries. Amerigroup does not utilize or administer criteria having the effect of discriminatory practices on the basis of gender or gender identity. Amerigroup does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of or subjecting them to discrimination on the basis of gender or gender identity. In addition, in compliance with the Age Act, Amerigroup may not discriminate against any person on the basis of age, or aid or perpetuate age discrimination by providing significant assistance to any agency, organization or person that discriminates on the basis of age. Amerigroup provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, physical or mental disability, or type of illness or condition.

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when an Amerigroup representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and is assisted in doing so if the member requests assistance. We document, track and trend all alleged acts of discrimination.

Members are also advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Through the OCR complaint portal at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201
- By phone at: 1-800-368-1019 (TTY/TTD: 1-800-537-7697)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Amerigroup provides free tools and services to people with disabilities to communicate effectively with us. Amerigroup also provides free language services to people whose primary language isn't English (e.g., qualified interpreters and information written in other languages). These services can be obtained by calling the Member Services number on their member ID card.

If you or your patient believe Amerigroup has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, gender or gender identity, you can file a grievance with our member advocate via:

- Mail: 823 Congress Ave., Suite 1100, Austin, TX 78701
- Phone: 1-800-600-4441 (TTY 711); ask for a member advocate
- Email: dl-txmemberadvocates@anthem.com

Equal Program Access on the Basis of Gender

Amerigroup provides individuals with equal access to health programs and activities without discriminating on the basis of gender. Amerigroup must also treat individuals in a manner that is consistent with their gender identity and is prohibited from discriminating against any individual or entity

on the basis of a relationship with, or association with, a member of a protected class (i.e., race, color, national origin, gender, gender identity, age or disability).

Amerigroup may not deny or limit health services that are ordinarily or exclusively available to individuals of one gender, to a transgender individual based on the fact that a different gender was assigned at birth, or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.

2 QUICK REFERENCE INFORMATION

Quick Reference Topic	Description
Provider Services/Inquiry Line	1-800-454-3730 Fax: 1-800-964-3627
Amerigroup Website	https://providers.amerigroup.com/TX https://www.availity.com 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: <ul style="list-style-type: none"> • Preferred Drug List • List of drugs requiring prior authorization • Provider manuals • Referral directories • Provider newsletters • Precertification Lookup Tool • Electronic remittance advice and electronic funds transfer information • Health plan and industry updates • Clinical Practice Guidelines • Downloadable forms
Notification/Precertification	<p>May be submitted as indicated below:</p> <p>Preferred method is electronic submission via Interactive Care Reviewer which is accessed through the Availity Portal at https://www.availity.com Select Patient Registration Authorizations & Referrals.</p> <p>Nursing facility notification and add-on services fax: 1-844-206-3445 Inpatient/outpatient surgeries and other general requests fax: 1-800-964-3627 Behavioral Health Fax – inpatient: 1-877-434-7578 Behavioral Health Fax – outpatient: 1-866-877-5229 Cardiology, genetic testing, radiation oncology, radiology (high-tech), sleep studies phone: 1-800-714-0040 (AIM Specialty Health) www.aimspecialtyhealth.com/goweb Nonemergent ambulance transportation: Refer to the Nonemergency Transportation section of this manual Medical injectable/infusible drugs fax: 1-844-512-8995</p> <p>General telephone (if urgent): 1-800-454-3730 Nursing facility telephone (if urgent): 1-866-696-0710 Peer-to-peer review request phone: 817-861-7768</p> <p>Precertification forms are located at https://providers.amerigroup.com/TX. Data required for notification/precertification includes:</p> <ul style="list-style-type: none"> • Member ID number • Legible name of referring provider and NPI • Legible name of individual referred to provider and NPI • Number of visits/services • Date(s) of service • Diagnosis • CPT/HCPCS code • Copy of physician's order for services by ancillary providers
National Provider Identifier (NPI)	The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the adoption of a standard, unique provider identifier for health care

Quick Reference Topic	Description
	<p>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 the NPI and the application process, please visit https://nppes.cms.hhs.gov.</p> <p>You can 1) complete the application online (estimated time to complete the NPI application is 20 minutes), 2) download a paper application for completion, or 3) call 1-800-465-3203 to request an application.</p>
Claims Information	<p>Electronic data interchange (EDI):</p> <p>To submit transactions directly to Availity, use the Welcome Application at https://apps.availity.com/web/welcome/#/edi to begin the process of connecting to the Availity EDI Gateway.</p> <p>Use a clearinghouse or billing company to submit your claims to the Availity EDI Gateway. Please work with them to ensure connectivity to the Availity EDI Gateway.</p> <p>Online claims submission:</p> <p>Use our free online claim submission tool at https://www.availity.com</p> <p>Submit paper claims (for providers other than nursing facilities) to:</p> <p>Amerigroup P.O. Box 61010 Virginia Beach, VA 23466-1010</p> <p>Timely filing for STAR+PLUS nursing facility unit rate or Medicare skilled nursing coinsurance claims is within 365 days from the last date of service represented on the claim. All other STAR+PLUS service claims must be filed within 95 days from the date of service or per the terms of the provider agreement.</p> <p>We provide an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status and precertification status; visit https://www.availity.com.</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 our toll-free, automated Provider Inquiry Line at 1-800-454-3730.</p>
Member Medical Appeal Information	<p>Member 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 60 calendar days from the date of an adverse benefit determination. Be sure to include medical charts or other supporting information.</p> <p>Member medical appeals must be submitted in writing to:</p> <p>Amerigroup Appeals 2505 N. Highway 360, Suite 300 Grand Prairie, TX 75050</p> <p>Member medical appeals may also be requested by calling Member Services at 1-800-600-4441 (TTY 711).</p>

Quick Reference Topic	Description
Payment Disputes	A provider has 120 days from the date of an <i>Explanation Of Payment (EOP)</i> to file a payment dispute. Providers can use the online payment dispute tool at https://www.availity.com . Fax the dispute request to 1-844-756-4607 or mail it to: Provider Payment Disputes Amerigroup P.O. Box 61599 Virginia Beach, VA 23466-1599
Complaints	Provider complaints should be faxed to 1-844-664-7179 or mailed to: Amerigroup P.O. Box 61789 Virginia Beach, VA 23466-1789 Providers can also email complaints at https://providers.amerigroup.com/TX .
Case Managers/Service Coordinators	Our Behavioral case managers/service coordinators are available from 8 a.m.-5 p.m. local time by calling 1-800-454-3730 or the local health plan at 1-866-696-0710. For urgent issues, assistance is available after normal business hours, during weekends and on holidays through Provider Services at 1-800-454-3730.
Provider Services Representatives	For more information, call Provider Services at 1-800-454-3730 (fax: 1-800-964-3627).
Interpreter Services	Telephonic services for those who are deaf or hard of hearing: 711 Non-English telephonic services: 1-800-454-3730 (language line available) In person interpretation: 1-800-454-3730
Behavioral Health Services	Phone: 1-800-454-3730
Emergency Dental Services	Members residing in a nursing facility receive emergency dental services through DentaQuest at 1-800-516-0165. Other dental services that may be needed or requested by the member residing in a nursing facility should be discussed with the member's assigned service coordinator.
24-hour Nurse HelpLine	1-800-600-4441 (TTY 711)
Amerigroup Member Services	1-800-600-4441 (TTY 711)
AIM Specialty Health (cardiology, genetic testing, hi-tech radiology, radiation oncology, and sleep studies precertification)	1-800-714-0040 www.aimspecialtyhealth.com/goweb
Pharmacy Services	Online pharmacy prior authorization: https://www.covermymeds.com Pharmacy prior authorization fax: 1-844-474-3341 Phone: 1-800-454-3730 (IngenioRx) Medical injectables/infusible drugs prior authorization fax: 1-844-512-8995
Vision Services (Superior Vision of Texas)	Providers call: 1-866-819-4298 Members call: 1-800-428-8789
Electronic Data Interchange Hotline	1-800-590-5745
Availity Portal (for claim filing, claim status inquiries, member eligibility and benefits information, and precertification)	Website: https://www.availity.com Phone: 1-800-AVAILITY (1-800-282-4548) Email: support@availity.com
Enrollment/Disenrollment	1-800-964-2777
STAR+PLUS HelpLine	1-800-964-2777

3 MEMBER ELIGIBILITY

Eligibility for Medicaid STAR+PLUS is determined by the Texas Health and Human Services Commission. Once eligible, members select enrollment in a managed care organization in their area through the administrative services contractor.

3.1 Verifying Member Medicaid Eligibility

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the member has current Medicaid coverage. A provider should verify the member's eligibility for the date of service before rendering services. There are multiple ways to do this:

- Call Amerigroup or check <https://www.availity.com>.
- Use TexMedConnect on the TMHP website at www.tmhp.com.
- Log into your TMHP user account and access the Medicaid Client Portal for providers.
- Call the TMHP Contact Center or the Automated Inquiry System (AIS) at 1-800-925-9126 or 1-512-335-5986.
- Your Texas Benefits Medicaid Card
 - Temporary ID (Form 1027-A)
 - Amerigroup ID Card
 - STAR+PLUS Dual Eligible - If the member has Medicare, Medicare is responsible for most primary, acute and behavioral health services. Therefore, the primary care provider's name, address and telephone number are not listed on the member's MCO ID card. The member receives long-term services and supports through Amerigroup.

3.1.1 Temporary ID Verification Form

If the member has lost or does not have access to the Your Texas Benefits Medicaid card and needs a temporary Medicaid ID card, 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 the [Verifying Member Medicaid Eligibility](#) section of this manual. Members also can go online to www.yourtexasbenefits.com to order a new card or print a temporary card.

3.2 Amerigroup Member Identification Card

Sample Amerigroup member identification cards are available in [Appendix A](#) for the STAR+PLUS nondual and dual program. 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 may now show their mobile ID card as proof of coverage. Providers should treat the digital version just the same as the original plastic card.

For STAR+PLUS members who have Medicare, a PCP 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 PCP's name, address, and telephone number are not listed. The member receives long-term services and supports through Amerigroup.

3.2.1 STAR+PLUS Newborns

If a newborn is born to a Medicaid-eligible mother enrolled in STAR+PLUS, 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). 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.

3.2.2 STAR+PLUS members in the Medicaid for Breast and Cervical Cancer Program

Effective September 1, 2017, women enrolled in the Medicaid for Breast and Cervical Cancer Program were transitioned from Medicaid FFS to the STAR+PLUS program. These members are not limited to cancer treatment only; they have full STAR+PLUS benefits.

3.2.3 STAR+PLUS ICF-IID Program and IDD Waiver Services Members

STAR+PLUS members with intellectual disabilities or related conditions who do not qualify for Medicare and who receive services through the ICF-IID Program or an IDD Waiver will be covered for acute care services only under STAR+PLUS. Community-based long-term services and supports will be provided through HHSC. The ICF-IID Program is the Medicaid program serving individuals with intellectual disabilities or related conditions who receive care in intermediate care facilities other than a state-supported living center. IDD Waiver means the Community Living Assistance and Support Services Waiver program (CLASS), the Deaf-Blind with Multiple Disabilities Waiver program (DBMD), the Home and Community-Based Services Waiver program (HCS), or the Texas Home Living Waiver program (TxHmL). A personal service coordinator will be assigned to each of these members.

3.3 Service Responsibility

3.3.1 STAR+PLUS Responsibility Table

Type of STAR+PLUS Benefit	Medicaid Coverage Only	Medicaid and Medicare coverage (dual-eligible)
Medicaid nursing facility residential coverage	Amerigroup	Amerigroup or Medicare FFS/ Medicare HMO
Medical and behavioral health coverage	Amerigroup	Medicare FFS or Medicare HMO
Long-term services and supports coverage	Amerigroup*	Amerigroup or Medicare FFS/Medicare HMO
Prescription drugs	Amerigroup	Member's chosen Part D prescription drug plan
Transportation coverage	MTP	Medicare FFS or Medicare HMO
Medicare copays and deductibles	Not applicable	State's fiscal agent (TMHP) for FFS; Medicare HMO
Medicaid wrap-around services	Not applicable	State's fiscal agent (TMHP)

* STAR+PLUS members with intellectual disabilities or related conditions who do not qualify for Medicare and who receive services through the ICF-IID Program or an IDD Waiver will be covered for acute care services only under STAR+PLUS. Long-term services and supports will be provided through HHSC.

3.4 Member Enrollment and Disenrollment from Amerigroup

3.4.1 Medicaid Enrollment

STAR+PLUS 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 P.O. 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 1:	MAXIMUS receives the enrollment or disenrollment form by January 15; the effective date is February 1.
Example 2:	MAXIMUS receives the enrollment or disenrollment form between January 16 and January 31; the effective date is March 1.

3.4.2 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 six months or less. We notify our members of this procedure through our member handbooks.

3.4.3 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 PCP or documentation that indicates sufficiently compelling circumstances that merit disenrollment. HHSC renders a final decision on these types of requests. Providers cannot take retaliatory action against a member who decides to disenroll from Amerigroup.

3.4.4 Effective Date of SSI Status

The Social Security Administration notifies HHSC of a member's SSI status. HHSC will update their eligibility system within 45 days of receiving notice of SSI status for a member. The member will then be able to prospectively move to STAR+PLUS (if the member is an adult) or to STAR Kids (if the member is a child).

HHSC will not retroactively disenroll a member from the STAR, CHIP or CHIP Perinatal programs.

3.4.5 Enrollment Changes During an Inpatient Stay in a Hospital

The following table outlines payment responsibility for Medicaid enrollment changes occurring during an inpatient stay according to the member's effective date of coverage with the receiving MCO (new MCO) or fee-for-service (FFS).

Scenario	Hospital facility charge	All other covered services
Member retroactively enrolled in MCO program	New MCO	New MCO
Member prospectively moves from FFS to MCO program	FFS	New MCO
Member moves between MCOs in the same program	Former MCO	New MCO
Member moves between MCO programs	Former MCO	New MCO
Member moves from MCO program to FFS	Former MCO	FFS

The responsible party will pay the hospital facility charges until the earliest of:

- The date the member is discharged from the hospital.
- The date the member is transferred.
- The date the member loses Medicaid coverage eligibility.

After the date of discharge, transfer or loss of eligibility, the new payer will be responsible for all charges.

Definitions:

- Discharge: formal release of a member from an inpatient hospital stay when the need for continued care at an inpatient level has concluded:
 - Movement or transfer from one acute care hospital or long term care hospital/facility and readmission to another within 24 hours for continued treatment is not a discharge.
- Transfer: movement of the member from one acute care hospital or long term care hospital/facility and readmission to another acute care hospital or long term care hospital/facility within 24 hours for continued treatment.

3.4.6 Enrollment Changes during a Nursing Facility Stay

The following table describes payment responsibility for Medicaid enrollment changes that occur during a nursing facility stay, beginning on the member's effective date of coverage with the new MCO or FFS.

Scenario	Nursing facility unit rate and/or Medicare coinsurance	All other covered services
Member moves from FFS to STAR+PLUS	New MCO	New MCO
Member moves between STAR+PLUS MCOs	New MCO	New MCO
Member moves from STAR+PLUS to Dual Demonstration	New MCO	New MCO
Member moves from Dual Demonstration to STAR+PLUS	New MCO	New MCO

	Member moves from STAR+PLUS to FFS	FFS	FFS
--	------------------------------------	-----	-----

3.4.7 Enrollment Changes with Custom Durable Medical Equipment (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+PLUS MCOs	Former MCO	New MCO
Member moves from FFS to STAR+PLUS MCO	New MCO	New MCO

3.4.10 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 HCBS STAR+PLUS Waiver member before completion of the modification.

Scenario	Minor home modification	All other covered services
Member moves between STAR+PLUS MCOs	Former MCO	New MCO

4 COVERED SERVICES AND EXTRA BENEFITS

4.1 Medicaid Covered Services for STAR+PLUS Nursing Facility

Our coverage of STAR+PLUS Medicaid 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+PLUS to traditional FFS Medicaid.

Covered Services	STAR+PLUS	Traditional Medicaid FFS
Core Medicaid benefits as outlined in the Medicaid FFS program (listed in the Medicaid Services Covered Outside of the Nursing Facility section)	X	X
Waiver of the three-prescription-per-month limit (Unlimited prescriptions for adults is only available for members not covered by Medicare.)	X	
Waiver of the 30-day spell-of-illness limitation under FFS	See notes below	
Extra or value-added benefits	X	
Notes: <ul style="list-style-type: none">STAR+PLUS dual-eligible members receive their acute care services coverage through Medicare.\$200,000 annual limit on inpatient services does not apply for STAR+PLUS members.For STAR+PLUS, waiver of the 30-day spell-of-illness limitation applies only to non-dual members with a diagnosis of bipolar disorder(F31), major depressive disorder(F32), recurrent depressive disorder(F33), schizophrenia (F20) or schizoaffective disorder (F25) as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5). Unspecified diagnosis codes are not exempt from the limitation.STAR+PLUS members with intellectual disabilities or related conditions who do not qualify for Medicare and who receive services through the ICF-IID Program or an IDD Waiver will be covered for acute care services only under STAR+PLUS. Long-term services and supports will be provided through HHSC.		

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 Nursing Facility Unit Rate

The nursing facility unit rate includes the types of services included in the HHSC vendor payment rate for nursing facility providers, such as room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The nursing facility unit rate also includes applicable nursing facility rate enhancements and professional and general liability insurance. Nursing facility unit rates exclude nursing facility add-on services as described below.

4.1.2 Nursing Facility MCO Add-On Services

Ventilator care add-on service: To qualify for supplemental reimbursement, a nursing facility member must require artificial ventilation for at least six consecutive hours daily, and the use must be prescribed by a licensed physician.

Tracheostomy care add-on service: To qualify for supplemental reimbursement, **a nursing facility member must be less than 22 years of age**; require daily cleansing, dressing and suctioning of a tracheostomy; and be unable to do self-care. The daily care of the tracheostomy must be prescribed by a licensed physician.

PT, ST, OT add-on services: Rehabilitative services are physical therapy, occupational therapy, and speech therapy services (not covered under the NF Unit Rate) for Medicaid nursing facility members who are not eligible for Medicare or other insurance. The cost of therapy services for members with Medicare or other insurance coverage or both must be billed to Medicare or other insurance or both. Coverage for physical therapy, occupational therapy, or speech therapy services includes evaluation and treatment of functions that have been impaired by illness. Rehabilitative services must be provided with the expectation that the member's functioning will improve measurably in 30 days.

The provider must ensure that rehabilitative services are provided under a written plan of treatment based on the physician's diagnosis and orders, and that services are documented in the member's clinical record.

Customized power wheelchair (CPWC): To be eligible for a CPWC, a member must be:

- Medicaid eligible.
- Age 21 years or older.
- Residing in a licensed and certified NF that has a Medicaid contract with HHSC.
- Eligible for and receiving Medicaid services in an NF.
- Unable to ambulate independently more than 10 feet.
- Unable to use a manual wheelchair.
- Able to safely operate a power wheelchair.
- Able to use the requested equipment safely in the NF.
- Unable to be positioned in a standard power wheelchair.
- Undergoing a mobility status that would be compromised without the requested CPWC.
- Certified by a signed statement from a physician that the CPWC is medically necessary.

Augmentative communication device (ACD): An ACD is a speech-generating device system. A physician and a licensed speech therapist must determine if the ACD is medically necessary.

Note: For NF add-on therapy services, Amerigroup will accept claims received: 1) from the NF on behalf of employed or contracted therapists, and 2) directly from contracted therapists who are contracted with the MCO. All other NF add-on providers must contract directly with and directly bill the MCO.

NF add-on providers (except NF add-on therapy services providers) must refer to the STAR+PLUS Provider Manual for information, including credentialing and recredentialing.

4.2 Medicaid Services Covered Outside of the Nursing Facility

The following acute care services are covered by Medicaid for STAR+PLUS nursing facility residents enrolled in Amerigroup, billed by the provider directly and not by the nursing facility:

- Ambulance services — emergency and nonemergency transportation
- Audiology services, including hearing aids
- Behavioral health services, including:
 - Acute inpatient mental health services (services may be provided in a free-standing psychiatric hospital in lieu of an acute care inpatient setting; for members ages 21-64 this is limited to 15 days per month)
 - Outpatient mental health services
 - Psychiatry services
 - Counseling 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
- Birthing services provided by a doctor or 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
- Emergency services
- Family planning 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 and ambulatory health care center as clinically appropriate; 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
- Podiatry
- Prenatal care
- Prenatal care provided by a physician, certified nurse midwife, nurse practitioner, clinical nurse specialist or physician assistant in a licensed birthing center
- Prescription drugs, medications and biologicals including pharmacy-dispensed and provider-administered outpatient drugs and biologicals
- Primary care services
- Preventive services, including an annual adult well check
- Radiology, imaging and X-rays
- Specialty physician services
- Telemedicine
- Transplantation of organs and tissues
- Vision services — includes optometry and glasses; contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses

4.3 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 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)

4.4 Coordination with Non-Medicaid Managed Care Covered Services

In addition to MCO coverage, STAR+PLUS nursing facility 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 Texas Medicaid Provider Procedures Manual (TMPPM). The TMPPM is located online at

www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx.

- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- HHSC hospice services
- Long-term services and supports for individuals who have intellectual or developmental disabilities provided by HHSC contracted providers

- Case management or service coordination services for individuals who have intellectual or developmental disabilities provided by HHSC contracted providers
- For members who are prospectively enrolled in STAR+PLUS from Medicaid FFS during an inpatient stay, hospital facility charges associated with the inpatient stay are noncapitated services except for a stay in a chemical dependency treatment facility
- Preadmission Screening and Resident Review (PASRR) Level 1 screenings, Level 2 evaluations, and specialized services provided by HHSC-contracted local authority (LA) and DSHS-contracted local mental health authority (LMHA). Specialized services provided by the LA include: service coordination, alternate placement, and vocational training. Specialized services provided by the LMHA include mental health rehabilitative services and targeted case management. Specialized services provided by a nursing facility for individuals identified as IDD include physical therapy, occupational therapy, speech therapy, and customized adaptive aids. All PASRR specialized services are noncapitated, fee-for-service.

4.5 Dental Services

4.5.1 Medicaid Nonemergency Dental Services

Amerigroup is **not responsible** for paying for routine dental services provided to Medicaid members.

Amerigroup is **responsible**, however, for paying for treatment and devices for craniofacial anomalies.

4.5.2 Medicaid Emergency Dental Services

Amerigroup is responsible for emergency dental services provided to Medicaid members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for covered emergency dental procedures.

Covered emergency dental procedures include, but are not limited to:

- Alleviation of extreme pain in oral cavity associated with serious infection or swelling;
- Repair of damage from loss of tooth due to trauma (acute care only, no restoration);
- Open or closed reduction of fracture of the maxilla or mandible;
- Repair of laceration in or around oral cavity;
- Excision of neoplasms, including benign, malignant and premalignant lesions, tumors and cysts;
- Incision and drainage of cellulitis;
- Root canal therapy. Payment is subject to dental necessity review and pre- and post-operative x-rays are required; and
- Extractions: single tooth, permanent; single tooth, primary; supernumerary teeth; soft tissue impaction; partial bony impaction; complete bony impaction; surgical extraction of erupted tooth or residual root tip.

4.5.3 STAR+PLUS Waiver Dental Services

HCBS STAR+PLUS Waiver members living in the community are eligible for services provided by a dentist to preserve teeth and meet the medical needs of the member. Allowable services include the following:

- Emergency dental treatment necessary to control bleeding, relieve pain and eliminate acute infection
- Preventive procedures required to prevent the imminent loss of teeth
- The treatment of injuries to teeth or supporting structures
- Dentures and the cost of preparation and fitting
- Routine procedures necessary to maintain good oral health

Dental services for HCBS STAR+PLUS Waiver members are limited to \$5,000 per waiver plan year. This limit may be exceeded upon approval by Amerigroup up to an additional \$5,000 per waiver plan year when medically necessary treatment requires the services of an oral surgeon. Amerigroup may also approve other dental services above the \$5,000 waiver plan year limit on a case-by-case basis due to medical necessity, functional necessity, or the potential for improved health of the member. Amerigroup must review and approve any treatment in excess of the waiver plan year limit prior to services being rendered.

4.6 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 Vendor Drug Program (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+PLUS 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 Health and Human Services Commission - approved family planning provider listed on the web at <https://www.healthytexaswomen.org/family-planning-program>.

Only members receiving family planning services, not their parents, spouses or any other individual, may consent to the provision of family planning services.

4.7 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 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 IngenioRx 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 (to include 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 1-800-600-4441 (TTY 711).

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 Vendor Drug Program (VDP) formulary and Medicaid Preferred Drug List (PDL) at <https://www.txvendordrug.com>. The PDL is a list of the preferred drugs within the most commonly prescribed therapeutic categories. The PDL is comprised of drug products reviewed and approved by the Texas Drug Utilization Review Board. Over-the-counter (OTC) medications specified in the Texas State Medicaid plan are included in the formulary and are covered if prescribed by a licensed prescriber. **To prescribe medications listed as nonpreferred on the PDL, call 1-800-454-3730 for prior authorization.**

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 claiming 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. There are some additional exceptions in the VDP formulary based on the age of the member.

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 listed on the VDP formulary
- 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 VDP formulary
- Legend contraceptives. Exception: Injectable contraceptives 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 PDL. If for medical reasons a member cannot use a preferred product, providers are required to contact Amerigroup at 1-800-454-3730 to obtain prior authorization. Decisions are based on medical necessity and are determined according to certain established medical criteria.

Examples of medications that require authorization are listed below (**Note:** This list is not all-inclusive and is also subject to change):

- Drugs listed as nonpreferred on the PDL or drugs that require clinical prior authorization
- Select self-administered injectable products
- Drugs that exceed certain cost and/or dosing limits (for information on these limits, contact Amerigroup at 1-800-454-3730)

Obtaining Prior Authorization

To prescribe medications that require prior authorization, submit a request online at <https://covermymeds.com>, by fax to 1-844-474-3341, or by phone at 1-800-454-3730. For requests by fax, submit a Pharmacy Prior Authorization Form available on the provider website at <https://providers.amerigroup.com/TX> or by calling Provider Services at 1-800-454-3730.

Providers must be prepared to supply relevant clinical information regarding the member's need for a non-PDL product or a medication requiring prior authorization. Only the prescribing physician or one of their staff representatives can request prior authorization. Decisions are based on medical necessity and are determined according to VDP-established medical criteria. Most approved requests for prior authorization will be valid for one year, although some medications may require review more often.

Emergency Prescription Supply

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

A 72-hour emergency supply may be dispensed when a PA cannot be resolved within 24 hours for a medication on the Texas Vendor Drug Program (VDP) formulary that is appropriate for the member's medical condition or if the prescribing provider cannot be reached or is unable to request a PA because it is after the prescriber's office hours. The pharmacy should submit an emergency 72-hour prescription if the dispensing pharmacist determines it is an emergency situation. Emergency situation includes a case in which, based on the dispensing pharmacist's judgement, a member may experience a detrimental change in health status within 72 hours from when the pharmacy receives the prescription due to the inability to obtain the medication. Pharmacies should not dispense 72 hour emergency supplies on a routine basis.

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 three day supply according to the directions for administration given by the prescriber. If the medication is a dosage form that prevents a three-day supply from being dispensed (e.g., an inhaler), it is still permissible to indicate that the emergency prescription is a three-day supply and enter the full quantity dispensed.

Call the IngenioRx Pharmacy Help Desk at 1-833-252-0329 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 www.txvendordrug.com.

- Prenatal vitamins limitation is for females younger than the age of 50 only.
- Anti-fungal limitation is 180-day supply per calendar year.
- Stadol limitation is 10 ml per calendar month (four 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. §1396r-8, 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 Xenical, 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

Specialty Drug Program

We cover most specialty drugs under the pharmacy benefit, which may be obtained through IngenioRx and other providers in our specialty drug network.. For information on providers in the specialty drug network, call Amerigroup Pharmacy at 1-800-454-3730.

The following is a list of conditions 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 and not covered under the nursing facility unit rate. DME covered under the NF unit rate includes: medically necessary items, such as nebulizers, ostomy supplies or bed pans, and medical accessories (such as canulas, tubes, masks, catheters, ostomy bags and supplies, IV fluids, IV equipment, and equipment that can be used by more than one person, such as wheelchairs, adjustable chairs, crutches, canes, mattresses, hospital-type beds, enteral pumps, trapeze bars, walkers, and oxygen equipment, such as tanks, concentrators, tubing, masks, valves, and regulators).

Preferred Blood Glucose Testing Strips

We have selected the Trividia Health TRUE METRIX® brand as our single preferred line of test strips for blood glucose testing. Pharmacies can provide Trividia Health TRUE METRIX® 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 1-844-474-3341. If you have questions about prior authorization, call Amerigroup] at 1-800-454-3730. Pharmacies can provide three-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.

4.8 Ambulance Transportation Services (Emergent)

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

4.9 Nonemergency Transportation

The nursing facility (NF) is responsible for providing routine nonemergency transportation services. The cost of such transportation is included in the NF unit rate. Transports of NF members for rehabilitative treatment (e.g., physical therapy), to outpatient departments, or to physician's offices for recertification examinations for NF care are not reimbursable services by Amerigroup.

Amerigroup is responsible for authorizing nonemergency ambulance transportation for a nondual member whose medical condition is such that the use of an ambulance is the only appropriate means of transportation (i.e., alternate means of transportation are medically contra-indicated).

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 Interactive Care Reviewer that is accessed through the Availity Portal <https://www.availity.com>, 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.

Request type	Behavioral health facilities/ behavioral health provider and IDD members	All other members for discharge from facility to home or from home to a provider/facility
Urgent same day	Call 1-800-325-0011, ext. 106.103.6237	Call 1-800-454-3730
Nonurgent requests	Fax request to 1-866-877-5229	Fax request to 1-866-249-1271

4.10 Vision Services

Coverage for STAR+PLUS 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 all vision benefits including an ophthalmologist or therapeutic optometrist. Members can call 1-800-428-8789.

Category	Benefits	Contact
STAR+PLUS nondual adult members (age 21 and older)	One eye exam and medically necessary frames and lenses or contact lenses once every 24 months	Coverage may be obtained by calling Superior Vision of Texas at 1-866-819-4298 for providers and 1-800-428-8789 for members.
STAR+PLUS dual adult members (age 21 and older)	Vision services are not covered under Medicaid Managed Care.	

4.11 Value-Added Services

We cover extra health care benefits for our members. These extra benefits are also called value-added services. You can find a list of these benefits in our member handbooks at www.myamerigroup.com/TX. If you have problems accessing the information, please call Provider Services at 1-800-454-3730.

5 PRECERTIFICATION AND UTILIZATION MANAGEMENT

We operate a comprehensive medical management program known as 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

We follow established procedures for applying medical necessity criteria based on individual member needs and an assessment of the availability of services within the local delivery system. Federal law, state law, contract language, including definitions and specific contract provisions/exclusions, Centers for Medicare & Medicaid (CMS) requirements as well as the *Texas Medicaid Provider Procedure Manual* are used when determining eligibility for coverage and supersede any other utilization management criteria.

As a wholly owned subsidiary of Anthem, Inc., Amerigroup uses Anthem's nationally recognized, evidence-based *Medical Policies* and *Clinical Utilization Management (UM) Guidelines*. Amerigroup *Medical Policies* are the primary benefit plan policies for determining whether services are considered to be a) investigational/experimental, b) medically necessary and c) cosmetic or reconstructive. These policies and *Clinical UM Guidelines* are publicly available on the provider website at <https://medicalpolicies.amerigroup.com>. The policies described above will support precertification requirements, clinical-appropriateness claims edits and retrospective review. Medical technology is constantly evolving, and we reserve the right to review and periodically update medical policy and utilization management criteria.

MCG Care Guidelines (based on specific provider contracts, McKesson InterQual® Level of Care criteria) are also used when no specific Amerigroup medical policies exist. AIM Specialty Health® (AIM) guidelines are also utilized for specific types of services (refer to the AIM website at <http://aimspecialtyhealth.com/goweb.html>).

Behavioral health services also utilize American Society for Addiction Medicine Patient Placement Criteria, Second Edition (ASAM) for substance use disorder treatment authorization, with the exception of detoxification which uses Amerigroup *Medical Policies* and *Clinical UM Guidelines*, and other nationally recognized references.

Copies of all criteria utilized can be obtained in hard copy by contacting Provider Services at 1-800-454-3730.

5.1.1 Clinical 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.:

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 and 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 submitting an online request via Interactive Care Reviewer through the Availity Portal <https://www.availity.com>, by fax or by telephone of the intent to render covered medical services. We do not require precertification or notification of emergency services, including emergency room and ambulance services. Notification is required within 24 hours or the next business day for an emergent inpatient admission.

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 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.

5.2.1 Utilization Management Hours of Operation

- Staff are available at least eight hours a day, Monday-Friday, during normal business hours for inbound collect or toll-free calls regarding utilization management issues.
- Staff are available 24 hours a day, 7 days a week to receive inbound communication by fax. Messages left on our telephone system will be returned within one business day.
- TDD/TTY services and language assistance services are available for members as needed, free of charge.

5.3 Medically Necessary Services

Medically necessary means:

- 1) Nonbehavioral health-related health care services that are:
 - a) Reasonable and necessary to prevent illnesses or medical conditions or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life.
 - b) Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions.
 - c) Consistent with health care practice guidelines and standards endorsed by professionally recognized health care organizations or governmental agencies.
 - d) Consistent with the member's diagnoses.
 - e) No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness and efficiency.
 - f) Not experimental or investigative.
 - g) Not primarily for the convenience of the member or provider.
- 2) Behavioral health services that:
 - a) Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain or prevent deterioration of functioning resulting from such a disorder.
 - b) Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care.
 - c) Are furnished in the most appropriate and least restrictive setting in which services can be safely provided.
 - d) Are the most appropriate level or supply of service that can safely be provided.
 - e) Could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered.
 - f) Are not experimental or investigative.
 - g) 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. STAR+PLUS MCOs must also provide functionally necessary community long-term support and services to all members 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> under the *Provider Resources & Documents/Quick Tools* section.

5.4.1 Interactive Care Reviewer

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

- Initiating preauthorization requests online — eliminating the need to fax. The ICR allows detailed text, photo images and attachments to be submitted along with your request.
- Making inquiries on previously submitted requests via phone, fax, ICR or other online tool.
- Having instant accessibility from almost anywhere, including after business hours.
- Utilizing a dashboard that provides a complete view of all utilization management requests with real-time status updates, including email notifications if requested using a valid email address.
- Viewing real-time results for common procedures with immediate decisions.

You can access the ICR under **Authorizations and Referrals** on the Availity Web Portal. For an optimal experience with the ICR, use a browser that supports 128-bit encryption. This includes Internet Explorer, Chrome, Firefox and Safari.

The ICR is not currently available for:

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

We'll update our website as additional functionality is added.

5.4.2 Precertification Requests by Fax or Phone

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

- General fax: 1-800-964-3627
- Nursing facility and add-on services fax: 1-844-206-3445
- Behavioral Health fax – inpatient: 1-877-434-7578
- Behavioral Health fax – outpatient: 1-866-877-5229
- Cardiology, genetic testing, radiation oncology, radiology (high-tech), sleep studies phone: 1-800-714-0040 (AIM Specialty Health) www.aimspecialtyhealth.com/goweb

- Medical injectable/infusible drugs fax: 1-844-512-8995
- Nonemergent ambulance transportation: Refer to the [Nonemergency Transportation](#) section of this manual
- General telephone (if urgent): 1-800-454-3730
- Nursing facility and add-on services telephone (if urgent): 1-866-696-0710
- Peer-to-peer review request phone: 817-861-7768

Providers should submit a *Precertification Request Form*, which is available at <https://providers.amerigroup.com/TX> or by contacting Provider Services, and include the following information:

- Member's name and ID
- Name, telephone number and fax number of 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 and applicable modifiers
- Medical information to support requested services (medical information includes current signs/symptoms, past and current treatment plans, response to treatment plans and medications)
- Signed orders from requesting provider

We are staffed with clinical professionals who coordinate services provided to members. These professionals are available Monday-Friday during normal business hours 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, a decision for cases where the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, an expedited authorization decision will be made no later 72 hours after receipt of the request for service.

If a request is submitted for a service for which precertification is not required, the provider will receive a response stating that precertification 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.

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. For information on this process, refer to the [Peer-to-Peer Review Process](#) section of this manual.

If services are not approved, the appropriate notice of action will be mailed to the requesting provider, the member's primary physician, the facility and the member. The notice includes an explanation of the member's appeal rights, and fair hearing rights and process.

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> under the *Quick Tools* section.

The referring PCP or specialist physician is responsible for precertification. Requests for precertification with all supporting documentation must be submitted a minimum of 72 hours prior to provision of the service. Failure to comply with notification rules will result in an administrative denial. Additional information on administrative denials is contained in the [Administrative Denials](#) section.

5.6 Nonemergent Inpatient Admissions

We require precertification of all inpatient nonemergent admissions, 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 time frames.

The referring PCP 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. Failure to comply with notification rules will result in an administrative denial. Additional information on administrative denials is contained in the next section.

The hospital can confirm that an authorization is on file by calling our automated Provider Inquiry Line at 1-800-454-3730 or by logging in at <https://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 Administrative Denials

An administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions and lack of precertification.

Appeals for administrative denials must address the reason for the denial (i.e., why precertification was not obtained).

If Amerigroup overturns its administrative decision, the case will be reviewed for medical necessity and, if approved, the claim will be reprocessed or the requestor will be notified of the action that needs to be taken.

5.8 Emergent Admission Notification Requirements

We request notification within 24 hours or the next business day by network hospitals of emergent admissions. Our medical management staff will verify eligibility and determine benefit coverage.

5.9 Inpatient Admission Reviews

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

Our utilization review clinician determines the member's medical status through onsite review, electronic record 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. For additional information, refer to the [Peer-to-Peer Review Process](#) section of this manual. 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 to determine the authorization of coverage for a continued stay. The review will be performed either at the hospital or by fax, telephone or through accessing electronic medical records.

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 covered length of stay one day at a time based on the clinical information that supports the continued stay. Exceptions to the one-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. For additional information, refer to the [Peer-to-Peer Review Process](#) section of this manual.

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/or family to discuss any discharge planning needs. The UM clinician will also attempt to verify that the member or family is aware of the name, address and telephone number of the member's PCP. 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. At that time, reviews can be done less frequently than daily.

5.10 Peer-to-Peer Review Process

If you receive a notification that a case is under review and would like to discuss the case with our medical director, call 817-861-7768. Be prepared to provide the following information:

- Name of person/physician our medical director needs to call
- Contact number
- Convenient time for a return call
- Authorization/reference number for the case
- Member's name, DOB and Amerigroup ID number

If you or your office staff reach our voicemail, leave the name of the best contact person and his or her phone number so we can reach out for additional information. The Amerigroup medical director will make every effort to return calls within one business day.

If the notification received indicates the case was denied, you may contact us within two business days of receipt of the notification to set up a peer-to-peer review for possible reconsideration. After two business days, the case will need to follow the appeal process outlined in the denial letter received.

5.11 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.

5.12 Discharge Planning from Inpatient Setting

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 utilizations review staff and attending physician.

The attending physician is expected to coordinate with the member's PCP regarding follow-up care after discharge. The PCP 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 behavioral health provider. The follow-up visit must occur within seven calendar days of discharge.

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

- Hospice facility.
- Convalescent facility.
- Home health care program (e.g., 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 or outpatient procedures.

5.13 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.

5.14 Urgent/After-Hours Care

We require members to contact their PCP in situations where urgent, unscheduled care is necessary. 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 provider participating with after-hours care.

5.15 Utilization Timeliness Standards

Utilization review timeliness standards:

- **Nonurgent preservice:** For precertification of nonurgent care, a decision will be made within three business days. **Urgent/expedited preservice review:** A decision and notification for cases where the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, an expedited authorization decision will be made no later than 72 hours after receipt of the request for service.

- **Urgent concurrent:** For urgent concurrent care, a decision will be made within one business day not to exceed 72 hours from receipt of the 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.

5.16 Long-term Support Services Precertification

All long-term support services (LTSS) require precertification before services are rendered. This does **not** include nursing facility residential services as included in the nursing facility daily unit rate.

5.17 Self-Referrals

We do not require members to seek a referral from their PCP prior to accessing services from other providers in the Amerigroup network. HHSC specifically requires the services in the table below to be available to members through self-referral.

Service	Authorization for services
Obstetric/gynecological services (nonparticipating providers must seek prior approval from Amerigroup)	<ul style="list-style-type: none"> • One well-woman checkup each year • Care related to pregnancy • Care for any female medical condition • Referral to specialist doctor within the network
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 1-800-600-4441 (TTY 711). No prior approval from the PCP is required.</p> <p>Providers may refer members for services by:</p> <ul style="list-style-type: none"> • Calling Provider Services at 1-800-454-3730. • Faxing referral information to our dedicated behavioral health faxes at 1-877-434-7578 for inpatient and 1-866-877-5229 for outpatient. <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>
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
Sterilization	<ul style="list-style-type: none"> • No precertification or notification is required for sterilization procedures, including tubal ligation and vasectomy, for Medicaid members age 21 and older. • A Sterilization Consent Form is required for claims submission.
Tuberculosis, sexually transmitted diseases, HIV/AIDS testing and counseling services	No precertification or notification is required for these services, regardless of network status with Amerigroup

5.18 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, which we may request to conduct business and make decisions about care, such as a member's medical record, to make an authorization determination or resolve a payment appeal. Such requests are considered part of the HIPAA definition of **treatment, payment or health care operations**.

Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to 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 (e.g., Excel spreadsheets with claim information). Such information should be mailed or faxed.

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

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 the HIPAA and other federal and state laws.

5.19 Misrouted Protected Health Information

Providers and facilities are required to review all member information received from Amerigroup to ensure no misrouted Protected Health Information (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+PLUS 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 (persons who are aged and/or persons with disabilities) through a managed care system and includes coverage for both home- and community-based care and nursing facility residential care.

Service coordination is a major feature of STAR+PLUS and involves specialized person-centered service planning 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:

- Nursing facility residential care
- Acute care
- Behavioral health
- Environmental care
- Functional care
- Home- and community-based care

6.1 STAR+PLUS Eligibility

Texas requires enrollment in STAR+PLUS managed care for most nursing facility residents age 21 and older who are enrolled in nursing facility Medicaid (dual or non-dual). Texas also requires enrollment in managed care for the adult Supplemental Security Income (SSI) population, including individuals with Medicaid only, and dually eligible individuals with Medicare and Medicaid. For more information on verifying eligibility, refer to the [Verifying Member Medicaid Eligibility](#) section.

Please note it is the provider's responsibility to ensure eligibility is verified before delivering services.

STAR+PLUS members with intellectual disabilities or related conditions who do not qualify for Medicare and who receive services through the ICF-IID Program or an IDD Waiver will be covered for acute care services only under STAR+PLUS. Long-term services and supports will be provided through HHSC. A personal service coordinator will be assigned to each of these members.

Effective September 1, 2017, women enrolled in the Medicaid for Breast and Cervical Cancer Program transitioned from Medicaid FFS to the STAR+PLUS program. These members are not limited to cancer treatment only; they have full STAR+PLUS benefits.

6.2 Member Identification Cards

Sample member identification cards for STAR+PLUS members can be found in [Appendix A](#) of this manual.

6.3 Covered Services

The services we cover under STAR+PLUS differ according to a member's eligibility for Medicare. STAR+PLUS LTSS benefits include both custodial nursing home care and community-based services. STAR+PLUS members with Medicare also have coverage for nursing facilities and certain community-based services.

The HCBS STAR+PLUS Waiver provides community-based long-term services and supports to Medicaid-eligible adults with disabilities and elderly persons as a cost-effective alternative to living in a nursing facility. Individuals who reside in a nursing facility must be age 21 or older, enrolled in Medicaid or otherwise financially eligible for waiver services.

All LTSS services must be precertified, except nursing facility custodial care. Coverage of these services is limited to members who need assistance with the activities of daily living. Some services are limited to members who meet the nursing home level of care. If you have an Amerigroup patient who needs these services, please direct him or her to contact Member Services at 1-800-600-4441 (TTY 711) or the health plan toll-free numbers given in the [Service Coordination](#) section of this chapter. Our service coordinators will assess the member's needs and develop a service plan.

6.3.1 Nondual-Eligible Members

STAR+PLUS covers acute care and LTSS benefits for nondual-eligible members (Medicaid-only clients).

6.3.2 Dual-Eligible Members

Acute care for dual-eligible members is covered by Medicare or a Medicare HMO. STAR+PLUS members dually eligible for Medicare will receive most prescription drug services through Medicare rather than Medicaid. Dual-eligible members are eligible to receive coverage for LTSS covered by Amerigroup under the STAR+PLUS program.

6.3.3 STAR+PLUS Coverage Table

STAR+PLUS members get benefits for acute care such as doctor visits, hospitalizations, prescriptions and behavioral health services, and they can also get long-term services and supports. If a member residing in a nursing facility is able to transition into the community, the types of LTSS benefits that may be available are shown in the table below. If a member does need long-term services and supports benefits, the kind of benefits they can get is based on their category of Medicaid eligibility. There are three Medicaid eligibility levels:

- Other Community Care (OCC): basic coverage
- Community First Choice (CFC): mid-level coverage
- Home- and Community-Based Services (HCBS) STAR+PLUS Waiver (SPW): highest level of coverage for members with complex need

Service types	Nondual (Medicaid only) + OCC	Nondual (Medicaid only) + CFC	Nondual (Medicaid only) + SPW	Dual Eligibles (Medicaid and Medicare) + OCC ²	Dual Eligibles (Medicaid and Medicare) + CFC ²	Dual Eligibles (Medicaid and Medicare) + SPW ²
Medical/acute care (such as: doctor's visits, PT, OT,ST for acute care conditions, and hospital services) and behavioral health services³	Amerigroup	Amerigroup	Amerigroup	Medicare or Medicare HMO	Medicare or Medicare HMO	Medicare or Medicare HMO
Prescription drugs	Amerigroup	Amerigroup	Amerigroup	Member's chosen Part D prescription drug vendor	Member's chosen Part D prescription drug vendor	Member's chosen Part D prescription drug vendor
Medicare coinsurance and deductibles	Not applicable	Not applicable	Not applicable	State's fiscal agent (TMHP) for regular Medicare; Medicare HMO	State's fiscal agent (TMHP) for regular Medicare; Medicare HMO	State's fiscal agent (TMHP) for regular Medicare; Medicare HMO)
Home and Community Based Long-Term Services and Supports						
Primary home care/Personal assistance services	Amerigroup ¹	Amerigroup ¹	Amerigroup ¹	Amerigroup ¹	Amerigroup ¹	Amerigroup ¹
Day activity and health services (DAHS)	Amerigroup ¹	Amerigroup ¹	Amerigroup ¹	Amerigroup ¹	Amerigroup ¹	Amerigroup ¹
Consumer-directed attendant care (including financial management services)	Amerigroup ¹	Amerigroup ¹	Amerigroup ¹	Amerigroup ¹	Amerigroup ¹	Amerigroup ¹
Nursing services (in home)	N/A	N/A	Amerigroup ¹	Medicare/ Medicare HMO	Medicare/ Medicare HMO	Amerigroup ¹ or Medicare/ Medicare HMO
Habilitation, acquisition, maintenance and enhancement of skills services	N/A	Amerigroup ¹	Amerigroup ¹	N/A	Amerigroup ¹	Amerigroup ¹

Emergency response services (emergency call button)	N/A	Amerigroup ¹	Amerigroup ¹	N/A	Amerigroup ¹	Amerigroup ¹
Dental services	N/A	N/A	Amerigroup ¹	N/A	N/A	Amerigroup ¹
Home-delivered meals	N/A	N/A	Amerigroup ¹	N/A	N/A	Amerigroup ¹
Minor home modifications	N/A	N/A	Amerigroup ¹	N/A	N/A	Amerigroup ¹
Adaptive aids	N/A	N/A	Amerigroup ¹	N/A	N/A	Amerigroup ¹
Durable medical equipment	N/A	N/A	Amerigroup ¹	Medicare/ Medicare HMO	Medicare/ Medicare HMO	Amerigroup ¹
Medical supplies	N/A	N/A	Amerigroup ¹	N/A	N/A	Amerigroup ¹
Physical, occupational and speech therapy	N/A	N/A	Amerigroup ¹	Medicare/ Medicare HMO	Medicare/ Medicare HMO	Amerigroup ¹
Adult foster care/personal home care	N/A	N/A	Amerigroup ¹	N/A	N/A	Amerigroup ¹
Assisted living	N/A	N/A	Amerigroup ¹	N/A	N/A	Amerigroup ¹
Transition assistance services (for members leaving a nursing facility) - \$2,500 maximum	N/A	N/A	Amerigroup ¹	N/A	N/A	Amerigroup ¹
Respite (with or without self-directed models)	N/A	N/A	Amerigroup ¹	N/A	N/A	Amerigroup ¹
Dietitian/nutritional assistance	N/A	N/A	Amerigroup ¹	N/A	N/A	Amerigroup ¹
Transportation assistance	Medical Transportation Program (MTP)	Medical Transportation Program (MTP)	Medical Transportation Program (MTP)	Medical Transportation Program (MTP)	Medical Transportation Program (MTP)	Medical Transportation Program (MTP)
Cognitive rehabilitation therapy	N/A	N/A	Amerigroup ¹	N/A	N/A	Amerigroup ¹
Financial management services	N/A	N/A	Amerigroup ¹	N/A	N/A	Amerigroup ¹
Support consultation/management	N/A	Amerigroup ¹	Amerigroup ¹	N/A	Amerigroup ¹	Amerigroup ¹

Employment assistance	N/A	N/A	Amerigroup ¹	N/A	N/A	Amerigroup ¹
Supported employment	N/A	N/A	Amerigroup ¹	N/A	N/A	Amerigroup ¹

1 Members should contact a service coordinator or call Member Services to find out if they qualify for services.

2 Dual-eligible members (Medicaid and Medicare) are not STAR+PLUS Medicare Medicaid Plan (MMP) MMP members will go through their MCO for Medicare-covered services.

3 For dual-eligible members, mental health targeted case management (MH TCM) and mental health rehabilitative services (MH Rehab) are covered through Fee-for-Service (FFS), but all other behavioral health services are benefits of STAR+PLUS managed care for dual-eligibles. For other behavioral health services, the Medicare plan pays first, and then if the Medicare limit is met, Amerigroup is responsible.

6.3.4 Community-based LTSS Services

STAR+PLUS nursing facility members who wish to transition to the community may qualify for community-based long-term services and supports as described in this section. The following descriptions refer to the STAR+PLUS benefits grid above. Please see the grid for additional information on benefit availability.

Primary home care/personal assistance services (PAS) are available to community-based STAR+PLUS members based on medical and functional necessity and are provided to members living in their own home and community settings. Services include but are not limited to the following:

- Assisting with the activities of daily living, such as feeding, preparing meals, transferring and toileting
- Assisting with personal maintenance, such as 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, such as 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

Day activity and health services (DAHS) — Community-based STAR+PLUS members 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 HHSC.

Habilitation, acquisition, maintenance and enhancement of skills training is available to CFC and SPW members to enable the member to accomplish activities of daily living, instrumental activities of daily living and other health-related tasks.

Adult foster care (AFC) is a benefit for SPW members that provides a 24-hour living arrangement in an HHSC-contracted foster home for persons who, because of physical, mental or emotional limitations, are unable to continue independent functioning in their own homes. Services may include meal preparation, housekeeping, personal care, nursing tasks, supervision, companion services, activities of daily living assistance and provision of, or arrangement for, transportation.

The SPW AFC member must reside in a SPW AFC home. Providers of AFC must live in the household and share a common living area with the member. Detached living quarters do not constitute a common living area. The individual enrolled to provide AFC must be the primary caregiver. AFC home providers may serve up to three adult residents in a qualified AFC home without being licensed as a personal care home or assisted living facility, and may be the AFC home provider's home or the SPW member's home. AFC home providers with four or more residents who are also contracted with HHSC are required to have a Type C Personal Care Home license. AFC homes with four or up to eight more AFC residents who are only contracted with Amerigroup must be licensed as an assisted living facility, with limitations on the number of residents at each level who may reside in one home.

SPW members are required to pay for their own room and board costs and contribute to the cost of their care, if able, through a copay to the AFC provider.

Adaptive aids and medical supplies are covered benefits for SPW members when needs for the member to have optimal function, independence and well-being are identified and approved by the managed care organization in the individual service plan. Adaptive aids and medical supplies are specialized medical equipment and supplies, 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 and medical supplies are reimbursed with waiver funds, when specified in the individual service plan, with the goal of providing individuals a safe alternative to nursing facility (NF) placement.

This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items; and durable and nondurable medical equipment not available under the Texas State Plan, such as vehicle modifications, service animals and supplies, environmental adaptations, aids for daily living, reachers, adapted utensils, and certain types of lifts.

The annual cost limit of this service is \$10,000 per waiver plan year. The \$10,000 cost limit may be waived by HHSC upon request from the managed care organization.

The state allows a member to select a relative or legal guardian, other than a legally responsible individual, to be his or her provider for this service if the relative or legal guardian meets the requirements for this type of service.

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

- Meet the member's needs.
- Directly aid the member to avoid premature NF placement.
- Provide NF residents an opportunity to return to the community.

Amerigroup must provide documentation supporting the medical need for all adaptive aids and medical supplies. The documentation must be provided by the physician, physician assistant, nurse practitioner, registered nurse, physical therapist, occupational therapist or speech pathologist.

Adaptive aids and medical supplies are approved for purchase as a waiver service by Amerigroup only if the documentation supports the requested item(s) as being necessary and related to the member's disability or medical condition.

The HCBS STAR+PLUS Waiver program is not intended to provide every member with any and all adaptive aids or medical supplies the member may receive as a nursing facility resident. Details of items covered under this category can be found in the HHSC STAR+PLUS Handbook at:

<https://hhs.texas.gov/laws-regulations/handbooks/sph/section-6000-specific-starplus-hcbs-program-services>

Assisted living is a benefit for SPW members and is a 24-hour living arrangement in licensed personal care facilities in which personal care; home management; escort, social and recreational activities; 24-hour supervision; provision or arrangement of transportation; and supervision of, assistance with and direct administration of medications are provided.

Cognitive rehabilitation therapy is a service available to SPW members that assists a member in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry to enable the member to compensate for the lost cognitive functions. Cognitive rehabilitation therapy is provided when an appropriate professional assesses the member and determines it is medically necessary. Cognitive rehabilitation therapy is provided in accordance with the plan of care developed by the assessor, and includes reinforcing, strengthening or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems.

Dental services for SPW members are services provided by a dentist to preserve teeth and meet the medical needs of the member. Allowable services include:

- Emergency dental treatment necessary to control bleeding, relieve pain and eliminate acute infection.
- Preventive procedures required to prevent the imminent loss of teeth.
- The treatment of injuries to teeth or supporting structures.
- Dentures and the cost of preparation and fitting.
- Routine procedures necessary to maintain good oral health.

Dental services for SPW members are limited to \$5,000 per waiver plan year. This limit may be exceeded upon approval by Amerigroup up to an additional \$5,000 per waiver plan year when medically necessary treatment requires the services of an oral surgeon. Amerigroup may also approve other dental services above the \$5,000 waiver plan year limit on a case-by-case basis due to medical necessity, functional necessity, or the potential for improved health of the member. Amerigroup must review and approve any treatment in excess of the waiver plan year limit prior to services being rendered.

Emergency response services (emergency call button) is a benefit for SPW and CFC members. It's an electronic monitoring system for use by functionally impaired individuals who live alone or are isolated in

the community or at high risk of institutionalization. In an emergency, the member can press a call button to signal for help. The electronic monitoring system, which has a 24-hour, seven-day-a-week capability, helps ensure the appropriate persons or service provider respond to an alarm call from the member.

Employment assistance means assistance provided to a SPW member to help the member locate paid competitive or self-employment in the community. Employment assistance includes the following:

- 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

Employment assistance is not available to members receiving services through a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.

Financial management services (FMS) is assistance provided to SPW 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 the 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 for FMS.

Home-delivered meals is a benefit for SPW members that provides nutritionally sound meals delivered to the member's home.

Minor home modifications is a benefit for SPW members that assesses the need for, arranges for, and provides modifications and/or improvements to an individual's residence to enable the individual to reside in the community and to ensure safety, security and accessibility.

Nursing services (in-home) is a benefit for SPW members and includes but is not limited to assessing and evaluating health problems and the direct delivery of nursing tasks, providing treatments and health care procedures ordered by a physician and/or required by standards of professional practice or state law, delegating nursing tasks to unlicensed persons according to state rules promulgated by the Texas Board of Nursing, developing the health care plan and teaching individuals about proper health maintenance.

Physical therapy, occupational therapy, speech therapy are benefits for SPW members and include the full range of activities provided by an occupational therapist or a licensed occupational therapy assistant under the direction of a licensed occupational therapist, physical therapist or a licensed physical therapy assistant under the direction of a licensed physical therapist, or by speech and language pathologists within the scope of the therapist's state licensure.

Respite care is a benefit for SPW members and is temporary relief to persons caring for functionally impaired adults in community settings other than adult foster care homes or assisted living facilities.

Respite services are provided in-home and out-of-home and are limited to 30 days per individual service plan year.

Supported employment means assistance provided to a SPW member to sustain paid employment to 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 needs and earning at least minimum wage (if not self-employed).

Supported employment is not available to members receiving services through a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.

Support consultation services are available to SPW members participating in the CDS option. It 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 Financial Management Services Agency (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.

Support management benefits are available to Community First Choice members. Voluntary training may be received on how to select, manage and dismiss attendants.

Transition assistance services living is a benefit for SPW members that assists members with nonrecurring set-up expenses for transitioning from nursing homes to the community. Services may include assistance with security deposits for leases on apartments or homes, essential household furnishings, set-up fees for utilities, moving expenses, pest eradication or one-time cleaning.

6.3.5 Settings for Provision of Long-Term Services and Supports Benefits

Community-based long-term services and supports (LTSS) means services provided to members in their home or other community-based settings necessary to provide assistance with activities of daily living, allowing the member to remain in the most integrated setting possible. Community-based LTSS includes services available to all STAR+PLUS members as well as those services available only to STAR+PLUS members who qualify for HCBS STAR+PLUS Waiver services.

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.

Community-based LTSS for HCBS STAR+PLUS Waiver (SPW) and CFC 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 LTSS.

HCBS STAR+PLUS Waiver members should be advised about and assisted with accessing the most appropriate and 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 nondisability 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 LTSS 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

6.4 Service Coordination

6.4.1 Service Coordination for STAR+PLUS Nursing Facility Residents

We provide a single identified person as a service coordinator to all STAR+PLUS members residing in a nursing facility. We assign the same service coordinator to each Amerigroup member residing at a single nursing facility based on the number of Amerigroup members residing in that facility.

Service coordinators work with members, member's family and/or authorized representative, nursing facility staff and providers to coordinate all STAR+PLUS covered services and any other applicable

services. Service coordinators also provide education to members and families about STAR+PLUS program resources and about their rights and responsibilities within STAR+PLUS. Service coordinators are responsible for making at least four face-to-face visits per calendar year to all STAR+PLUS members residing in a nursing facility in order to provide additional monitoring of member care needs.

The face-to-face assessment includes the following elements:

- The service coordinator shall wear their Amerigroup identification badge at all times.
- The service coordinator completes a visual check of the member's functional capacity at this time.
- The service coordinator explains the assessment process and forms to the member and/or representative.
- During the facility visit, the service coordinator assesses the member's social/environmental supports and resources. The service coordinator inquires if the member is interested in returning to the community.
- The service coordinator discusses the member's needs and whether those needs are currently being met. The service coordinator also discusses the member's current level of independence and to what level the member is able to actively participate in his/her own care.

At the end of the assessment process, the service coordinator closes the visit by educating the member on his or her role in the facility and his or her frequency of future visits.

Plan of Care (POC)

After evaluation of the member, the service coordinator works jointly with the nursing facility in the development or revision of the nursing facility's POC, which:

- Includes services required to satisfy the member's unmet needs, health and safety.
- Documents which services are secured.
- Includes the member/caregiver's involvement in the development of the POC.
- Promotes the highest level of independence possible for the member.

All POCs are reviewed quarterly at the time of the reassessment or sooner if the member's change in condition warrants an early review and revision by the facility.

We will help ensure each STAR+PLUS member has access to a PCP or physician who is responsible for overall clinical direction. The PCP/physician, in conjunction with the service coordinator, serves as a central point of integration and coordination of covered services.

Our service coordinators collaborate with the member's PCP/physician regardless of network status. To speak with a service coordinator, call Provider Services at 1-800-454-3730.

6.4.2 Transition Planning for STAR+PLUS Members

We will provide transition planning for STAR+PLUS members residing in a nursing facility who need or desire to return to a community-based setting. For members newly enrolled to STAR+PLUS or changing MCOs during transition planning, HHSC or the previous STAR+PLUS MCO will give us information such as detailed care plans and names of current providers. We will ensure 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 prepared by a state agency or another STAR+PLUS MCO
- Preparation of a transition plan that ensures continuous care under the member's existing care plan during the transfer to the Amerigroup network while we conduct an appropriate assessment and development of a new plan, 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 the member receives the necessary supportive equipment and supplies without undue delay
- Payment to the existing provider of service under any existing authorization for up to six months until we have completed the assessment and service plan and issued a new authorization

We will review any existing care plan for a new member and develop a transition plan within 30 days of receiving notice of the member's enrollment. The transition plan will remain in place until we contact the member or the member's representative and we coordinate modifications to the member's current care plan. We will ensure existing services continue and there is no break in services. For members enrolling in the STAR+PLUS program on the start date of a new service area, we will review the existing care plan and develop the transition plan within 120 days of enrollment, and we will honor existing LTSS authorizations for up to six months or until we have evaluated and assessed the member and issued new authorizations.

A transition plan will include the following:

- The member's history
- A summary of current medical, behavioral health, and social needs and concerns
- Short-term and long-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.

Service Coordination for STAR+PLUS Community-Based Members

For STAR+PLUS members residing in home- and community-based settings, we provide a single identified person as a service coordinator to all members who qualify as Level 1 or Level 2 under HHSC guidelines, when we determine one is required based on our assessment of the member's health and support needs, and to any member who requests service coordination services. Level 1 members include HCBS STAR+PLUS Waiver recipients, individuals with severe and persistent mental illness (SPMI), and other members with complex medical needs. Level 2 members include those members receiving LTSS for personal assistance services or day activity and health services (PAS and DAHS), members non-SPMI behavioral health issues, Medicaid Breast and Cervical Cancer Program members, and Medicare and Medicaid dual-eligibles who do not qualify as Level 1. 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.

We will help ensure each STAR+PLUS member has access to a PCP or physician who is responsible for overall clinical direction. The PCP/physician, in conjunction with the service coordinator, serves as a central point of integration and coordination of covered services.

Service coordinators work with members and providers to coordinate all STAR+PLUS covered services and any other applicable services. Our service coordinators collaborate with the member's PCP/physician regardless of network status. Members who have an Amerigroup personal service coordinator will be sent a letter to inform them of the name and contact information of their service coordinator. Providers can call 1-866-696-0710 (TTY 711) to get information about service coordination.

6.4.3 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. Both physical and behavioral health needs, including substance use disorder treatment, will be assessed. A service coordinator will work with the member's PCP, 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 one 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 PCP 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.

6.4.4 Continuity of Care Transition Plan for New STAR+PLUS Members

We will provide a transition plan for a member newly enrolled with Amerigroup in the STAR+PLUS program who is already receiving long-term services and supports, including nursing facility or ICF/IID services. Either HHSC or the previous STAR+PLUS MCO will give us information, such as detailed care plans and names of current providers. We will ensure 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 prepared by a state agency or another STAR+PLUS MCO
- Preparation of a transition plan that ensures continuous care under the member's existing care plan during the transfer to the Amerigroup network while we conduct an appropriate assessment and development of a new plan, if needed

- If durable medical equipment or supplies had been ordered prior to enrollment but have not been received by the date of enrollment, coordination and follow-through to ensure the member receives the necessary supportive equipment and supplies without undue delay
- Payment to the existing provider of service under any existing authorization or care plan for up to six months, until we have completed an assessment and service plan and issued a new authorization.

A transition plan will include:

- The member's history.
- A summary of current medical, behavioral health, and social needs and concerns.
- Immediate, short-term and long-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 for a new member and develop a transition plan within 30 days of receiving notice of the member's enrollment. The transition plan will remain in place until we contact the member or the member's representative and we coordinate modifications to the member's current care plan. We will ensure existing services continue and there is no break in services.

For members enrolling in the STAR+PLUS program on the start date of a new service area, we will review the existing care plan and develop the transition plan within 120 days of enrollment and honor existing long-term services and supports authorizations for up to six months or until we have evaluated and assessed the member and issued new authorizations.

For members enrolling in the STAR+PLUS program in an existing service area, we will honor existing long-term services and supports authorizations for up to six months or until we have evaluated and assessed the member and issued new authorizations.

6.5 Applied Income

The nursing facility must make reasonable efforts to collect applied income from residents and document those efforts. The nursing facility should notify the Amerigroup service coordinator when it has made two unsuccessful attempts to collect applied income in a month. Amerigroup cannot enforce the payment of applied income by members. However, the service coordination team will provide member education and/or convene interdisciplinary team (IDT) meetings with the member or member's family/authorized representative to address the causes and risks associated with failure to pay applied income to the facility.

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.

Behavioral health-related health care services that:

- Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain or prevent deterioration of functioning resulting from such a disorder.
- Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care.
- Are furnished in the most appropriate and least restrictive setting in which services can be safely provided.
- Are the most appropriate level or supply of service that can safely be provided.
- Could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered.
- Are not experimental or investigative.
- 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 1-800-600-4441 (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 the following:

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

Note: Behavioral health services and supports provided as follow-up to the PASRR evaluation are not a STAR+PLUS benefit and are covered under FFS Medicaid.

7.2.1 Mental Health Rehabilitative Services and Targeted Case Management

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

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 that cause severe disturbances in behavior, thinking and feeling.

Mental health rehabilitative services (MHR) 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 the following:

- **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 or 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) means 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 SPMI (adult, 18 years of age or older).

MHR services 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.

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 services and TCM services must use and be trained and certified to administer the Adult Needs and Strengths Assessment (ANSA) tool 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 Amerigroup. A provider entity must attest to Amerigroup that the organization has the ability to provide, either directly or through subcontract, 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.

7.3 Primary and Specialty Services

STAR+PLUS 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 located at or near the provider's office; in most cases, our network of reference labs is 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 1-800-600-4441 (TTY 711).

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

We will review prescribing patterns for psychotropic medications. For treatment of adults, we will base our parameters on a peer-reviewed, industry standard such as the DSHS Psychotropic Drug Formulary at www.dshs.state.tx.us/mhprograms/Formulary.shtm.

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. Routine care after the initial visit must be scheduled within three weeks 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 seven days from the date of discharge. Behavioral health providers must contact members who have missed appointments within 24 hours to reschedule appointments.

PCPs 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.

PCPs 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 PCP.
- 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 PCP for examination and treatment.
- Utilize the most current DSM multi-axial classification when assessing members; the Health and Human Services Commission (HHSC) may require the use of other assessment instruments/outcome measures in addition to the DSM; network providers must document DSM and assessment/outcome information in the member's medical record.
- Be licensed for physical health care services if they are provided.
- Send initial and quarterly summary reports of a member's behavioral health status to the PCP with the member's consent.

7.5 Care Continuity and Coordination Guidelines

PCPs 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 PCPs 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 serious emotional disorders (SED) and serious mental illness (SMI), 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 one 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 PCP when the member has seen a behavioral health provider; the form can be found 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 PCP.
- Contacting the PCP when a behavioral health provider changes the behavioral health treatment plan.
- Contacting the behavioral health provider when the PCP 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/treatment summary.

7.6 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 and/or medical attention. And in an emergency and without immediate intervention and/or 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.

Emergency behavioral health conditions include Emergency Detentions as defined under Chapter 573, Subchapter A, of the Texas Health and Safety Code and under Chapter 462, Subchapter C, of the Texas Health and Safety Code.

In the event of a behavioral health emergency, the safety of the member and others is paramount. The nursing facility should arrange for emergency transportation for the member to receive immediate attention at an emergency room or other behavioral health crisis service. 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.

7.7 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 six hours.

7.8 Precertification and Referrals for Behavioral Health

Members may self-refer to any Amerigroup network behavioral health services provider by calling Member Services at 1-800-600-4441 (TTY 711). No precertification or referral is required from the PCP.

Providers may request precertification or refer members for services by:

- Using our preferred method online via Interactive Care Reviewer which is accessed through v the Availity Portal <https://www.availity.com>. Faxing referral information to our dedicated behavioral health fax lines at 1-877-434-7578 for inpatient services and 1-866-877-5229 for outpatient services.
- Calling Provider Services at 1-800-454-3730.

Our staff is available 24 hours a day, 7 days a week, 365 days a year for, crisis or emergency calls and authorization requests. We are responsible for authorizing inpatient hospital services, including freestanding psychiatric facilities for STAR+PLUS members.

7.9 Court-ordered Services

We provide benefits for Medicaid covered services ordered by a court pursuant to the statutory citations listed in the sections below. Amerigroup will:

- Not deny, reduce or controvert a court order for Medicaid inpatient mental health covered services for members ages 65 and older including services ordered as a condition of probation.
- Not deny, reduce or controvert a court order for Medicaid inpatient mental health covered services for members of any age if the court-ordered services are delivered in an acute care hospital.
- Not limit substance use disorder treatment or outpatient mental health services for members of any age that are provided pursuant to a court order or required as a condition of probation.
- Not apply Amerigroup utilization management criteria through prior authorizations, concurrent reviews or retrospective reviews for services required to be covered under a court order or as a condition of probation as detailed in the sections below.
- Accept court order documents from providers at the time of an authorization request.

Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. A member who has been ordered to receive treatment pursuant to a court order can only appeal the court order through the court system.

7.9.1 Court-Ordered Psychiatric Services

We provide benefits for Medicaid covered inpatient psychiatric services to members ages 65 and older, who have been ordered to receive the services:

- By a court of competent jurisdiction including services ordered pursuant to the *Texas Health and Safety Code Chapter 573, Subchapters B and C; Texas Health and Safety Code Chapter 574, Subchapters A through G; Texas Family Code Chapter 55, Subchapter D; or*
- As a condition of probation.

Benefits for Medicaid inpatient mental health covered services will be provided for members of any age if services are required by a court order and are provided in an acute care hospital or free-standing psychiatric hospital in lieu of an acute care hospital.

These requirements do not apply to members who are considered incarcerated as defined by UCMCM *Chapter 16.1, Section 16.1.15.2*.

7.9.2 Court-Ordered Substance Use Disorder Treatment Services

We provide benefits for Medicaid covered substance use disorder treatment services, including residential treatment, required as a:

- Court order consistent with *Chapter 462, Subchapter D* of the *Texas Health and Safety Code*, or
- Condition of probation.

These requirements do not apply to members who are considered incarcerated as defined by UMCM *Chapter 16.1, Section 16.1.15.2*.

8 MEMBER RIGHTS AND RESPONSIBILITIES

8.1 Member's Right to Designate an OB/GYN

Amerigroup allows the member to pick any Amerigroup OB/GYN, whether that doctor is in the same network as the member's primary care provider or not.

The information below is included in member handbooks:

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.

8.2 Member Rights and Responsibilities

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.

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 a primary care provider quickly.
 - c. Make any changes in your health plan and primary care provider in the 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. 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, APPEALS AND PROVIDER DISPUTES

We offer five distinct complaint and appeal processes:

- Member complaints
- Member appeals
- Provider complaints
- Provider payment disputes
- Provider medical appeals

9.1 Member Complaints and Appeals

Medicaid 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). Each of these resources also works with the member to monitor the process through resolution.

9.1.1 Member Complaints and Appeals Definitions

Adverse benefit determination: The denial or limited authorization of a requested service, including:

- Determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit.
- 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 MCO to act within state and federal required 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).
- Denial of a member's request to dispute a financial liability

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

Appeal: means the formal process by which a member or his or her representative requests a review of the health plan's adverse benefit determination 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 adverse benefit determination as defined in this section. Possible subjects for complaints include:

- Quality of care or services provided.

- Aspects of interpersonal relationships, such as rudeness of a provider or employee.
- Failure of provider or employee(s) to respect a member's rights regardless of whether remedial action is requested.

Complaint includes the member's right to dispute an extension of time proposed by the health plan to make an authorization decision. A complainant's oral or written dissatisfaction with an adverse benefit determination is considered a request for an MCO appeal.

First-level review: The initial complaint results 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 appears in our member handbook:

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 1-800-600-4441 (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 1-800-600-4441. Most of the time, we can help you right away or at the most within a few days. Amerigroup cannot take any action against you as a result of you filing a complaint.

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 with the appropriate state program. Please call Member Services at 1-800-600-4441 (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.

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 one business day from when we receive your complaint.

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 five 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.

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
Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, TX 78711-32474

If you can get on the internet, you can submit your complaint at hhs.texas.gov/managed-care-help.

You can also file a complaint with the state's long-term care ombudsman at lrc.ombudsman@hhsc.state.tx.us or 1-800-252-2412. For more information about filing a complaint with the state's long-term care ombudsman, go to https://apps.hhs.texas.gov/news_info/ombudsman.

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

Do I have the right to meet with a complaint appeal panel?

Yes. If you're not happy with the answer to your complaint, you can ask us to look at it again. You must ask for a complaint appeal panel in writing. Write to us at:

Member Advocates
Amerigroup
823 Congress Ave., Suite 1100
Austin, TX 78701

When we get your request, we'll send you a letter within five business days. This means we have your request and started to work on it. You can also call us at 1-800-600-4441 (TTY 711) to ask for a complaint appeal panel request form. You must complete the form and return it to us.

We'll have a meeting with Amerigroup staff, providers in the health plan and other Amerigroup members to look at your complaint. We'll try to find a day and time for the meeting so you can be there. You can bring someone to the meeting if you want to. You don't have to come to the meeting. We'll send you a letter at least five business days before the complaint appeal panel meeting. The letter will have the date, time and place of the meeting. We'll send you all of the information the panel will look at during the meeting.

We'll send you a letter within 30 days of getting your written request. The letter will tell you the complaint appeal panel's final decision. This letter will also give you the information the panel used to make its decision.

9.1.3 Member Medical Appeal Process and Procedures

Amerigroup has established and maintains a system for resolving dissatisfaction with 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?

Medicaid Appeal Process — the following language or similar information describing the appeals process appears in our member handbook:

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

There may be times when Amerigroup says we will not pay for 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. A designated representative can be a family member, your provider, an attorney, a friend or any person you choose.

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.

You can appeal our decision in two 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 at:
Amerigroup Appeals
2505 N. Highway 360, Suite 300
Grand Prairie, TX 75050
 - The appeal form must be signed by you or your designated representative.
 - To be considered in the review, your request form and any additional information must be received before a decision on your appeal is made.
 - If you need help filling out the appeal form, please call Member Services.
- 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 60 days of the date of the first letter from Amerigroup saying we will not pay for or cover all or part of the recommended care.

When we get your letter or call, we will send you a letter within five 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 the service.

A doctor who has not seen the case before will look at your appeal. He or she will decide how we should handle the 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 let you know the reason for the delay. You may also ask us to extend the process if you know more information that we should consider.

How can I continue receiving services that were already approved?

To continue receiving services that had 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:

- Ten business days after we send the notice to you to let you know we will not pay for or cover all or part of the care.
- The date the notice says the 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 may 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 1-800-600-4441 (TTY 711).

Can members request a state fair hearing?

Yes, you can ask for a state fair hearing after the Amerigroup internal appeal process is complete.

9.1.4 Expedited Medical Appeals

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 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 can request an expedited appeal. You can request an expedited appeal orally or in writing.

- You can call Member Services at 1-800-600-4441 (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 and agree your request for an appeal should be expedited, we will call and 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 one business day or 72 hours, whichever is shorter. We will also send you a letter with the answer to your appeal.

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 two calendar days to let you know how the decision was made and that your appeal will be reviewed through the standard review process.

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 1-800-600-4441 (TTY 711).

9.1.5 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 about an appeal, the member has the right to ask for a state fair hearing. The member may name someone to represent

him or her by writing a letter to the health plan telling Amerigroup 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 state fair hearing within 120 days of the date on the health plan's appeal decision letter. If the member does not ask for the state fair hearing within 120 days, the member may lose his or her right to a state fair hearing. To ask for a state fair hearing, the member or the member's representative should send a letter to the health plan at:

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

Or call Member Services at 1-800-600-4441 (TTY 711).

If the member asks for a state fair hearing within 10 business days from the time the health plan sends the appeal decision letter, 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 state fair hearing within 10 business days from the time the health plan sends the appeal decision letter, the service the health plan denied will be stopped.

If the member asks for a state fair hearing, the member will get a packet of information letting the member know the date, time and location of the hearing. Most state 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.

9.1.6 Medicaid Continuation of Benefits

Amerigroup members may request a continuation of their benefits during the medical appeal process by contacting Amerigroup Member Services at 1-800-600-4441 (TTY 711). Appeal requests made by telephone must be confirmed in writing as detailed in the [Member Medical Appeal Process and Procedures](#) section of this manual. To ensure continuation of currently authorized services, the member (or person acting on behalf of the member) must file a medical appeal by the later of:

- Ten business days following the date Amerigroup sends the notice of action.
- The intended effective date of the action as stated in the letter.

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 previously authorized services.
- The services were ordered by an authorized provider.
- The period covered by the original authorization has not expired.
- The member timely requests continuation of benefits.

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

- The member withdraws the appeal or request for the state fair hearing.
- Ten business days pass after Amerigroup sends the appeal determination letter unless the member has, within the 10 business days, requested a state fair hearing with continuation of benefits until a state fair hearing decision is reached.
- A State Fair Hearing Officer issues a hearing decision adverse to the member.

The member may be responsible for the continued benefits if the final determination of the medical appeal or state fair hearing is not in his or her favor. If the final determination of the medical appeal or state fair hearing is in the member's favor, Amerigroup will authorize coverage and arrange for disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours after receipt of notice reversing the determination. If the final determination is in the member's favor and the member received the disputed services, Amerigroup will pay for those services.

9.1.7 Appealing Nursing Facility Level of Care Determinations

Medicaid nursing facility residents have the right to appeal level of care determinations issued by TMHP as part of the minimum data set (MDS) medical necessity level of care determination. The appeal request must be filed within 10 business days of receiving written notification of the medical necessity denial in order to continue nursing facility coverage. The appeal request must be filed within 90 calendar days of the medical necessity denial in order to maintain the right to a state fair hearing. Amerigroup is not responsible for issuing MDS level of care determinations, but we will assist members in the process of filing an appeal with HHSC if the resident contests the denial of medical necessity for nursing facility care. Amerigroup will coordinate with HHSC and with TMHP to continue coverage and reimbursement for nursing facility unit rate services as appropriate during appeal and fair hearing processes.

9.2 Provider Complaints, Payment Disputes and Medical 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 verbally through Provider Services at 1-800-454-3730 or through local health plan Provider Relations representatives. Written provider complaints should be submitted to:

Amerigroup
P.O. 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 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, the 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. Medicaid complaints may be sent to:

Texas Health and Human Services Commission
MCCO Research and Resolution
P.O. Box 149030, MC:0210
Austin, TX 78714-9030
ATTN: Resolution Services

9.2.2 Provider Claim Payment Disputes

Provider Claim Payment Dispute Process

If you disagree with the outcome of a claim, you may utilize the Amerigroup provider payment dispute process. The simplest way to define a claim payment dispute is when a claim is finalized, but you disagree with the outcome.

Please be aware there are four common, claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, we've defined them briefly here:

- **Claim inquiry:** a question about a claim but not a request to change a claim payment
- **Claims correspondence:** when Amerigroup requests further information to finalize a claim; typically includes medical records, itemized bills or information about other insurance a member may have
- **Member medical necessity appeals:** a preservice appeal for a denied service
- **Provider medical appeals:** a postservice medical appeal for a denied service

For more information on each of these, please refer to the appropriate section in this chapter of the provider manual.

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

1. **Claim payment reconsideration:** This is a convenient option in the Amerigroup provider claim payment dispute process. The reconsideration is an initial request for an investigation into the outcome of the claim. Most issues are resolved with a claim payment reconsideration.
2. **Claim payment appeal:** This is an additional option in the Amerigroup provider claim payment dispute process. If you disagree with the outcome of a reconsideration or you choose not to ask for a reconsideration, you may request a claim payment appeal. Please note: If you did not ask for a claim payment reconsideration first, this will be the only internal appeal option available for your dispute.

For a claim payment appeal decision in which the denial is 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.

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

- Contractual payment.
- Disagreements over reduced or zero-paid claims.
- Other health insurance denial.
- Claim code editing.
- Duplicate claim.
- Retro-eligibility.
- Experimental/investigational procedure.
- Claim data.
- Timely filing.*

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

Claim Payment Reconsideration

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

We accept reconsideration requests in writing, verbally or online through the Availity Appeals feature at <https://www.availity.com> within 120 calendar days from the date on the *Explanation of Payment (EOP)* (see below for further details on how to submit). Reconsiderations filed more than 120 calendar days from the *EOP* will be considered untimely and denied unless good cause can be established.

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

Amerigroup will resolve the claim payment reconsideration within 30 calendar days of receipt. We will send you a decision in a determination letter, which will include:

- A statement of the provider's reconsideration request.
- A statement of what action Amerigroup intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes or provider manual references.
- An explanation of the provider's right to request a claim payment appeal within 30 calendar days of the date of the reconsideration determination letter or 120 calendar days from the original *EOP* if later.
- How to submit a claim payment appeal.

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

Claim Payment Appeal

If you are dissatisfied with the outcome of a reconsideration determination or if you wish to bypass the reconsideration process altogether, you may submit a claim payment appeal.

We accept claim payment appeals online through the Availity Appeals feature at <https://www.availity.com> or in writing within the later of:

- 30 calendar days from the date on the reconsideration determination letter or
- 120 calendar days from the date of the original *EOP*

Claim payment appeals received later than these time frames will be considered untimely and upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the original denial or reconsideration determination was in error.

Amerigroup will resolve the claim payment appeal within 30 calendar days of receipt. We will send you a decision in a determination letter, which will include:

- A statement of the provider's claim payment appeal request.
- A statement of what action Amerigroup intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes or provider manual references.

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

How to Submit a Claim Payment Dispute

We have several options to file a claim payment dispute:

- Online (for reconsiderations and claim payment appeals): Use the secure Availity Provider Payment Appeal Tool at <https://www.availity.com>. Through Availity, you can upload supporting documentation and will receive immediate acknowledgement of your submission.
- Verbally (for reconsiderations only): Call Provider Services at 1-800-454-3730.
- Written (for reconsiderations and claim payment appeals): Mail all required documentation (see below for more details), including the *Provider Payment Dispute and Correspondence Submission Form* to:
Payment Dispute Unit
Amerigroup
P.O. Box 61599
Virginia Beach, VA 23466-1599
- Fax (for reconsiderations and claim payment appeals) all required documentation to 1-844-756-4607

9.3 Required Documentation for Claim Payment Disputes

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

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

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

Claim Inquiries

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

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

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

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

Claim Correspondence

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

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

Type of issue	What do i need to do?
Rejected claim(s)	Use the EDI Hotline at 1-800-590-5745 when your claim was submitted electronically but was never paid or was rejected. We're available to assist you with setup

Type of issue	What do i need to do?
	questions and help resolve submission issues or electronic claims rejections.
<i>EOP</i> Requests for supporting documentation (<i>Sterilization/Hysterectomy/Abortion Consent Forms</i> , itemized bills and invoices)	Submit a <i>Provider Payment Dispute and Correspondence Submission Form</i> , a copy of your <i>EOP</i> and the supporting documentation to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
<i>EOP</i> requests for medical records	Submit a <i>Provider Payment Dispute and Correspondence Submission Form</i> , a copy of your <i>EOP</i> and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Need to submit a corrected claim due to errors or changes on original submission	Submit a <i>Provider Payment Dispute and Correspondence Submission Form</i>] and your corrected claim to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 120 calendar days of the <i>EOP</i> . In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Amerigroup to adjust the other health insurance (OHI) payment information, the 95 day timely filing period starts with the date of the most recent OHI <i>EOB</i> .
Submission of coordination of benefits (COB)/third-party liability (TPL) information	Submit a <i>Provider Payment Dispute and Correspondence Submission Form</i> , a copy of your <i>EOP</i> and the COB/TPL information to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Emergency room payment review	Submit a <i>Provider Payment Dispute and Correspondence Submission Form</i> , a copy of your <i>EOP</i> and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599

Member Medical Necessity Appeals

A member medical necessity appeal refers to a situation in which an authorization for a service was denied prior to the service. Member medical necessity appeals/prior authorization appeals are different than claim payment disputes and should be submitted in accordance with the Member Medical Appeal Process and Procedures section of this chapter.

9.2.3 Provider Medical Appeals

This type of appeal is available to providers with respect to a denial of services that have already been provided to the member and determined to be not medically necessary or appropriate. These appeals do not include member medical necessity appeals as described in the Member Medical Appeal Process and Procedures section of this chapter.

Provider medical appeals should be submitted in writing to:

Amerigroup
Appeals Team
P.O. Box 61599
Virginia Beach, VA 23466-1599

A provider must file a medical appeal within 120 calendar days of the date of the denial letter or *EOP*. The appeal must include an explanation of what is being appealed and why. Appropriate supporting documentation must be attached to the appeal request.

The appeals team will research and determine the current status of a medical appeal. A determination will be made based on the available documentation submitted with the appeal and a review of Amerigroup systems, policies and contracts. Appeals received with supporting clinical documentation will be retrospectively reviewed by a registered/licensed nurse. Established clinical criteria will be applied to the appeal. After retrospective review, the 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 our receipt of the appeal. If the appeal is approved, the provider will receive a denial overturn letter. An upheld denial of services decision receives an appeal determination letter. The determination letter includes the following:

- 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 appeal resolution, he or she may file a second-level appeal. This must be a written appeal submitted within 30 calendar days of the date of the first-level determination letter. The case is handled by reviewers not involved in the first-level review. The results of the review are communicated in a written decision to the provider within 30 calendar days of receipt of the appeal. If the appeal is approved, the provider will receive a denial overturn letter. An upheld denial of services decision

receives an 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.

9.4 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 the appeal is related to a managed care disenrollment/recoupment and 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
P.O. Box 204077
Austin, TX 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 of 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
- Notify Amerigroup immediately if unable to render authorized services to the full extent authorized

- 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 promptly both Amerigroup and the HHSC administrative services contractor of any changes to the provider's address, telephone number, group affiliation, or any other change that affects provider directory information
- Immediately notify the HHSC administrative services contractor of demographic changes when requested by Amerigroup

Notify Amerigroup promptly of any change that affects reimbursement such as remittance address and tax identification number

10.3 Nursing Facility Responsibilities

It is the responsibility of the nursing facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being of the member as defined by and in accordance with the comprehensive assessment and plan of care.

In addition, nursing facilities are responsible for but not limited to the following:

- Contacting us to verify member eligibility
- Obtaining precertification for services requiring prior authorization
- Coordinating Medicaid/Medicare benefits
- Notifying us of changes in members' physical condition or eligibility within one business day of identification
- Collaborating with the Amerigroup service coordinator in managing members' health care
- Managing continuity of care for members
- Documenting coordination of referrals and services provided between primary care providers and specialists
- Allowing Amerigroup service coordinators and other key personnel access to Amerigroup members and complete medical records information
 - Medical records documentation must comply with the timelines, definitions, formats and instructions specified by HHSC.
 - Medical records must be made available within three business days of request by Amerigroup.

- If at the time of request for access to medical records HHSC or OIG or another state or federal agency believes records are about to be altered or destroyed, the nursing facility must provide records at the time of request or in less than 24 hours.
- Allowing Amerigroup service coordinators to participate in plan of care (POC) development and interdisciplinary team (IDT) meetings involving Amerigroup members
- Ensuring 24-hour availability of clinical staff to identify and respond to member needs
- Coordinating with the member's primary care provider
- Providing notice to the Amerigroup designated service coordinator via phone, fax, email or other electronic means no later than one business day after the following events:
 - A significant, adverse change in the member's physical or mental condition or environment that could potentially lead to hospitalization
 - An admission to or discharge from the nursing facility, including admission or discharge to a hospital or other acute facility, skilled bed, long-term services and supports provider, noncontracted bed, another nursing or long-term care facility
 - An emergency room visit
 - Nursing facility-initiated, involuntary discharge of a member from a facility
- Submitting Form 3618 or Form 3619, as applicable, to HHSC's administrative services contractor
- Submitting MDS assessments, as required to federal CMS, and associated MDS Long Term Care Medicaid Information Section to HHSC's administrative services contractor
- Completing and submitting PASRR level I screening information to HHSC's administrative services contractor
- Coordinating with local authorities (LAs) and local mental health authorities (LMHAs) to complete a PASRR Level 2 Evaluation when an individual has been identified through the PASRR level 1 screen as potentially eligible for PASRR specialized services
- Informing members of covered services and the costs for noncovered services prior to rendering these services by obtaining a signed private pay form from the member
- Informing members on how to report abuse, neglect or exploitation
- Training staff on how to recognize and report abuse, neglect, or exploitation
- Informing both Amerigroup and Health and Human Services Commission (HHSC) of any changes to the provider's address, telephone number, group affiliation, or other key demographic or licensing information.

10.4 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 PCP at their first appointment.

Members age 18 and over 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.

10.5 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 an existing barrier and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes the following:

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

10.6 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 his or her condition requires medical treatment evaluation or treatment by the member's PCP or PCP 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 any of the following:

- 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 three 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
Post-emergency room or hospital discharge (nonbehavioral health)	Within 14 days of discharge
Primary routine care	Within 14 days
Specialty routine care	Within 3 weeks
Preventive health	Within 90 days
Prenatal care: initial visit	Within 14 days
Prenatal care: high-risk/third trimester — initial visit	Within 5 days or immediately if an emergency exists
Prenatal care: after initial visit	Based on the provider's treatment plan
Behavioral health: nonlife-threatening emergency	Within 6 hours (NCQA)
Behavioral health: urgent care	Within 24 hours
Post-hospital discharge (behavioral health)	Within 7 days of discharge (For missed appointments, provider must contact member within 24 hours to reschedule appointment.)
Behavioral health: routine care — initial visit	The earlier of 10 business days or 14 calendar days
Behavioral health: routine care — follow-up visits	Within 3 weeks
After-hours care	For PCPs: practitioners must be accessible 24/7 directly or through answering service <ul style="list-style-type: none"> • Answering service or recording assistance in English and Spanish • Member reaches on-call physician or medical staff within 30 minutes

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.

10.7 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.

For acute care and add-on services:

In the case of a newly enrolled member who is receiving a service that did not require authorization from the prior plan, we will authorize services in the same amount, duration and scope until the shorter of:

- 90 calendar days.
- The time it takes for us to evaluate and assess the member and issue or deny a new authorization.

For members enrolling on the operational start date of an HHSC program or on the start date of a new service area, we will honor existing acute-care authorizations for the earlier of 90 days or the expiration of the current authorization. We will honor existing long-term services and supports authorizations for up to six months or until we have completed a new assessment for the member 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 delivery. 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 provider to whom she wishes to transfer 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 nine months while enrolled with Amerigroup.

We pay a member's existing out-of-network providers for medically necessary covered services, including inpatient and nursing facility 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.

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.

When a member's nursing facility address is not located in the member's enrolled service area, we will pay out-of-network providers for medically necessary covered services while working with the member, his or her legal guardian, HHSC and the nursing facility to determine on a case-by-case basis if updates are needed to the member's plan enrollment or if transfer to an in-network facility is necessary.

Nursing Facility Transfers

Residential nursing facility stays are not preauthorized by Amerigroup for STAR+PLUS nursing facility members. As such, nursing facilities are not required to obtain prior authorization or approval from Amerigroup for the transfer of Amerigroup residents between facilities, regardless of whether the sending or receiving nursing facility is a participating Amerigroup provider. Nursing facilities are required to notify Amerigroup within one business day of admission, discharge or transfer of Amerigroup members in their facilities. Continuity of care, the authorization waiver period and standard prior authorization rules apply to acute, LTSS and add-on services for members transferring between nursing facilities.

Hospitalizations

There is no prior authorization requirement for Amerigroup STAR+PLUS nursing facility residents admitted or readmitted to nursing facilities for residential care following hospitalization. Emergency services, including emergency transportation, do not require prior authorization from Amerigroup.

Skilled Nursing Facility Admission and Discharge

Prior authorization from Amerigroup is always required for admission to a skilled nursing facility (SNF) for non-dual members. SNF stays for non-dual members are excluded from the authorization waiver period for acute care services. Admissions or readmissions to residential nursing facility care following discharge from an SNF do not require prior authorization from 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.

10.8 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.

10.9 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.

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. Amerigroup follows the nursing facility credentialing standards outlined in Chapter 8.6 of HHSC's Uniform Managed Care Manual.

If an application does not include required information, we will send the applicant written notice of all missing information no later than five business days after receipt of the application.

A provider has the right to inquire about the status of an application by the following methods:

- Email: TXCredentialing@amerigroup.com

Effective April 2018, Amerigroup will utilize the Texas Association of Health Plans (TAHP's) contracted credentialing verification organization (CVO) as part of our credentialing and recredentialing process. The CVO, Aperture Credentialing, LLC, is responsible for receiving completed applications, attestations and primary source verification documents.

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 submit corrections to the facts in dispute. The provider must submit a written explanation or appear before the credentialing committee if deemed necessary.

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 within 30 days to the Texas credentialing address above or appear before the credentialing committee if deemed necessary.

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 a network provider, no later than 30 days after receipt of a complete application, even the credentialing process has not yet been completed.

Amerigroup will provide expedited credentialing for certain provider types and allow services to members on a provisional basis as required by Texas Government Code §533.0064 and our state contract with HHSC. Provider types included are dentists, dental specialists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, and psychologists. To qualify for expedited credentialing, the provider must meet the following criteria:

- Be a member of a provider group that has a current contract in place with Amerigroup
- Be Medicaid-enrolled
- Agree to comply with the terms of the existing provider group contract
- Timely submit all documentation and other information required to begin the credentialing process

Amerigroup will provide expedited credentialing for nursing facilities that successfully underwent a change of ownership (CHOW). To qualify, the nursing facility must be a Medicaid-enrolled provider, submit all documentation and information timely, and agree to comply with the terms of the contract.

At least once every three 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
P.O. Box 62509
Virginia Beach, VA 23466-2509

10.9.1 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 request an informal review/reconsideration by the Credentials Committee. In addition, the provider has the right to waive the informal review/reconsideration process and proceed directly to a formal appeal hearing as described below.

The Credentials Committee will review the information obtained during the credentialing process and the basis for its initial decision, along with any additional information the provider submitted for reconsideration of the initial decision.

Second, if the decision is upheld after the informal review/reconsideration process, the provider has the right to request a formal appeal hearing. Such a request must be made in writing and received via certified mail with any additional information that the provider wishes to have considered within 30 calendar days following receipt of notification of the result of the informal review/reconsideration decision.

Upon receipt of the request for a formal appeal hearing, an acknowledgement letter will be sent to the provider outlining the next steps. The provider has to respond within five business days of receipt of the acknowledgement letter to confirm his/her attendance at the formal appeal hearing. The provider's right to a hearing will be forfeited if he/she fails to attend a confirmed meeting in person or by telephone without good cause.

If a written request for a reconsideration or formal appeal hearing is not received within 30 calendar days of the provider's receipt of the notice, the provider will have waived any right to appeal, and the file will

be closed. The proposed decredentialing will become final, and the provider will not be afforded any additional appeal rights. Amerigroup will proceed with reporting this action to the National Practitioner Databank (NPDB) if required under applicable law.

Once the formal hearing is scheduled, the provider has the following rights:

- Have a record made of the proceedings
- Call, examine and cross-examine witnesses
- Present evidence determined to be relevant by the hearing panel, regardless of its admissibility in a court of law
- Have representation by an attorney or another person of his/her choice
- Submit a written statement at the close of the hearing
- Receive, on completion of the hearing, the written decision of the panel, including a statement of the basis for the decision

The hearing panel will be a panel of three physicians not involved in any prior review or decision in the provider's case. The conclusion of the hearing panel may be to uphold the decision of the Credentials Committee or overturn the original decision of the Credentials Committee and the provider will remain a credentialed practitioner in Amerigroup networks. If the decision is to uphold the original decision, then the effective date of the provider's decredentialing will be 30 days from the date the provider receives the decision letter. Amerigroup will proceed with reporting this action to the NPDB, if required under applicable law. The provider would be eligible to apply for reinstatement one year from the date of the hearing. However, reinstatement is not guaranteed. Any such application will be subject to review by the Credentials Committee and must meet Amerigroup current standards, terms and conditions for network participation in effect at that time.

10.9.2 Practitioner Office Site Quality

We establish standards and thresholds for office site criteria and medical/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 and/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 three or more complaints within a six-month period related to the following components (with the exception of physical accessibility for which the

complaint threshold is one), a Practitioner Office Site Quality Assessment will be conducted that will include a review of the following:

- 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 one 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 four 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		
Criteria		Scoring
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. 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. 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. 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. There is a posted evacuation plan by either staff design or building management. 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. If yes, 1 point; if no, 0 points
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? If yes, 2 points; if no, 0 points

Practitioner Office Site Assessment Criteria		
Criteria		Scoring
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 and the treatment area appears neat. 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? If yes, 2 points; if no, 0 points
4	Is there easy access to a clean, supplied bathroom?	<ul style="list-style-type: none"> • Soap, toilet paper and hand towels are available. • Hand washing instructions are posted. • Lavatory is clean; toilet is functioning. If yes, 1 point; if no, 0 points
5	Is the waiting room well-lit?	Is there adequate lighting and comfort level for reading? 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. 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. 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. If yes, 1 point; if no, 0 points
3	Is there a minimum of two exam rooms per scheduled provider? (two consultation rooms for BH providers)	Count exam/consultation rooms and compare against provider schedule. 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. 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. 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 BH providers. If yes, 1 point; if no, 0 points
7	7a - For OB/GYNs only or any physician/practitioner providing OB care: 7b – Is a fetalscope (DeLee and/or Dopler) and a measuring tape for fundal height measurement readily accessible? - Supplies for dipstick urine analysis (glucose, protein)?	Score 7a and 7b as N/A if provider does not provide OB services. If yes, 1 point for each; if no, 0 points

Practitioner Office Site Assessment Criteria		
Criteria		Scoring
Adequacy of Medical Records		
1	Are there individual patient records?	Each patient has an individual record. There should be no family charts. 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. 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. If yes, 2 points; if no, 0 points
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. 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 MUST NOT 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. 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 <i>No Medications</i> to attest that the inquiry was made. 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. If yes, 2 points; if no, 0 points
5d	Is there an immunization record on pediatric charts? N/A for BH 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. If yes, 2 points; if no, 0 points
5e	Is there a growth chart on pediatric charts? N/A for BH providers	Height and weight are documented annually; head circumference is documented until age 2. 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. If yes, 2 points; if no, 0 points Score as N/A if patient is < 21 years old.

Practitioner Office Site Assessment Criteria		
Criteria		Scoring
Appointment Availability		
	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. If yes, 2 points; if no, 0 points
2	Is there a chaperone policy? May not apply to some specific BH 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. The provider must have this element in place to pass the site evaluation and participate with Amerigroup. 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. 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. 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. If yes, 1 points; if no, 0 points
6	Is there a written policy for hand washing, gloved procedures and disposal of sharps? May not be applicable for BH providers in private practice setting.	A written policy for hand washing should be available (1 point). 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. 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? 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?	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. 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? If yes, 1 point; if no, 0 points

Practitioner Office Site Assessment Criteria		
Criteria		Scoring
10	If 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. 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 be 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. 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. Should also include description of how members/patients may revoke authorization in writing. 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 (e.g., patient sign-in sheet). Is there a shredding machine and policy on storage and disposal of medical records? Computer has safeguards in place (security codes for access, safety). If yes, 2 points; if no, 0 points
4	Is there a designated compliance and privacy person?	You must include the name of the individual in the space provided on the site evaluation form. 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. If yes, 2 points; if no, 0 points
2	Are pharmaceutical supplies and medication stored in a locked area that is not readily accessible to patients?	<ul style="list-style-type: none"> • Medications are in a locked area, including samples. • 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. If yes, 2 points; if no, 0 points

Practitioner Office Site Assessment Criteria		
Criteria		Scoring
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. 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. 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). If the office has an emergency kit or cart, check for routine inspections and expired supplies or medications. 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

10.10 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 can help providers:

- 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 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 needed:

- 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 a professional level of respect and objectivity.

Knowledge needed:

- Culture plays a crucial role in the formation of health or illness beliefs.
- 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 needed:

- 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 groups

Cultural competency training and other resource materials are available at <https://providers.amerigroup.com/TX>.

10.11 Eligibility Verification

PCPs can obtain listings of members assigned to their panels from our Provider Online Reporting tool assessed via Payer Spaces located on the Availity Portal at <https://www.availity.com>. If a member calls Amerigroup to change his or her PCP, the change will be effective the same business day. The PCP 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 or call the automated Provider Inquiry Line at 1-800-454-3730.

10.12 Emergency Services

We provide a 24-hour Nurse Helpline service with clinical staff to provide triage advice, referral (if necessary) and make arrangements for treatment of 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 and/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 the following (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 is sent by a nursing facility for 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 (i.e., whether the patient is stable enough for discharge or transfer or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) actually caring for the 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

First Line of Defense Against Fraud

We are committed to protecting the integrity of our health care program and the effectiveness of our operations by preventing, detecting and investigating fraud, waste and abuse. Combating fraud, waste and abuse begins with knowledge and awareness.

- *Fraud* — any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it or any other person. The attempt itself is fraud, regardless of whether or not it is successful.
- *Waste* — includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- *Abuse* — when health care providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

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 are available at our website, <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.

False Claims Act

We are committed to complying with all applicable federal and state laws, including the federal *False Claims Act (FCA)*. The *FCA* is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the *FCA*, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of \$5,500 to \$11,000 per false claim.

The *FCA* also contains Qui Tam or whistleblower provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government, or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the *FCA* and may be entitled to a percentage of the funds recovered by the government.

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

Health care fraud costs taxpayers increasingly 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.

Examples of Provider Fraud, Waste and Abuse

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling — when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code.
- Upcoding — when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

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

Examples of Member Fraud, Waste and Abuse

- Forging, altering or selling prescriptions
- Letting someone else use the member's ID (identification) card
- Obtaining controlled substances from multiple providers
- Relocating to out-of-service plan area
- Using someone else's ID card

To help prevent fraud, waste and abuse, providers can assist by educating members. For example, spending time with patients and reviewing their records for prescription administration will help minimize drug fraud and abuse. One of the most important steps to help prevent member fraud is 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. Understanding the various opportunities for fraud and working with members to protect their health benefit ID card can help prevent fraudulent activities. If you or a patient suspect ID theft, call our Amerigroup compliance hotline at 1-866-847-8247

10.13.1 Fraud Reporting Information

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 Health and Human Services Commission (HHSC) 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 HHSC;
- Adult day care centers; or
- Licensed adult foster care providers

Contact HHSC at 1-800-458-9858.

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

- An adult who is elderly or has a disability, receiving services from:
 - Home and Community Support Services Agencies (HCSSAs) — also required to report any HCSSA allegation to HHSC
 - Unlicensed adult foster care provider with three or fewer beds
- 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; and
- An adult with a disability receiving services through the Consumer Directed Services option

Contact DFPS at 1-800-252-5400 or, in nonemergency situations, online at 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, HHSC 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, HHSC or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.053; 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.

Reporting Waste, Abuse Or Fraud By A Provider Or Client

Medicaid Managed Care

Do you want to report waste, abuse or fraud?

Let us know if you think a doctor, dentist, pharmacist at the 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> and click the red Report Fraud box to complete the online form.
- You can report directly to your health plan:
Compliance Officer

Amerigroup
2505 N. Highway 360, Suite 300
Grand Prairie, TX 75050
1-800-839-6275

- Other reporting options include:
 - Amerigroup Provider Services: 1-800-454-3730
- Special Investigations Fraud Hotline: 1-866-847-8247 (reporting can be anonymous)

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 gets 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

10.13.2 *Fraud Investigation Process of Providers and Member Allegations*

Our Special Investigations Unit (SIU) investigate all reports of provider and member fraud, abuse and waste for all services provided under the contract. If appropriate, allegations and the investigative findings are reported to all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste or abuse, which may include, but is not limited to:

- *Written warning and/or education:* We send certified letters to the provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries, or may advise of further action.
- *Medical record audit:* We review medical records to substantiate allegations or validate claims submissions.
- *Special claims review:* A certified professional coder or investigator evaluates claims and places payment or system edits on file. This type of review prevents automatic claim payment in specific situations.
- *Recoveries:* We recover overpayments directly from the provider. Failure of the provider to return the overpayment within the required time may result in reduced payment of future claims or further legal action.

Acting on Investigative Findings

We refer all criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

If a provider appears to have committed fraud, waste, or abuse, the provider:

- Will be referred to the Special Investigations Unit.
- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination.

Failure to comply with program policy or procedures, or any violation of the provider contract, may result in termination from our plan.

If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily disenrolled from our health plan, with state approval.

10.14 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 CLIA-approved office test. Visit the CMS website at www.cms.hhs.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 nine 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

If a laboratory test cannot be directed to or provided by a network provider, precertification is required for coverage.

10.15 Locum Tenens

We allow reimbursement of locum tenens physicians in accordance with the Centers for Medicare & Medicaid Services (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 Modifier Q6 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 Modifier Q6.

10.16 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 PCP's recommended plan of care. Providers may not bill us or our members for missed appointments.

10.17 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 PCP 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 the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws.

Documentation of each visit must include the following:

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

Note: 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 three 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. Diagnostic information. Documentation of clinical findings and evaluation for each visit should be noted.
9. Medication information. This notation includes medication information/instruction(s) to the patient.
10. 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.
11. Instructions. The record must include evidence that the patient was provided with basic teaching/instructions regarding physical and/or behavioral health condition.
12. Smoking/alcohol/substance use disorder. A notation concerning cigarettes and alcohol use and substance use disorder must be stated if present for patients age 12 and older. Abbreviations and symbols may be appropriate.

13. Preventive services/risk screening. The record must include consultation and provision of appropriate preventive health services and appropriate risk screening activities.
14. 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.
15. 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 PCP's panel must be noted.
16. 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.
17. 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.
18. 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.
19. Release of information. Written procedures are required for the release of information and obtaining consent for treatment.
20. 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.
21. Multidisciplinary teams. Documentation of the team members involved in the multidisciplinary team of a patient needing specialty care is required.
22. 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 the following:
 - 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 PCPs when appropriate
 - Notation of receipt of behavioral health referrals from physical medicine providers and the disposition/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 PCP
 - 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 or complex physical or developmental conditions, has a co-occurring behavioral disorder
 - Documentation of the member's power of attorney (POA), durable power of attorney (DPOA) or guardianship paperwork as applicable.

10.18 Noncompliant Amerigroup Members

Call Provider Services at 1-800-454-3730 if you need help working with a member regarding:

- Behavior.
- Treatment cooperation and/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 that are medically necessary for treatment of the member's condition.
- Send a certified letter to the member or head of household stating the member must select a new PCP within 30 days of the notice.
- Send a copy of the letter to:
Member Advocates
Amerigroup
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 PCP.
- 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 utilize our member complaint process and the HHSC state fair hearing process.

10.19 Patient Visit Data

Documentation of individual encounters must provide adequate evidence of (at a minimum):

1. A history and physical exam that includes appropriate subjective and objective information obtained for the presenting complaints.
2. 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.
3. An admission or initial assessment that must include current support systems or lack of support systems.
4. 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.
5. A plan of treatment that includes activities/therapies and goals to be carried out.
6. Diagnostic tests.

7. 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.
8. Follow-up care encounter forms or notes indicating when follow-up care, a call or a visit (noted in weeks, months or PRN) should occur; notes should include the specific time to return with unresolved problems from any previous visits.
9. 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. To be considered compliant with medical record performance standards, your medical record score must be 80 percent, including six clinical elements that must be met. Clinical medical record audit and office site visit forms are available on our website by logging in at <https://providers.amerigroup.com/TX> and going to Medical > Forms. 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 compliance with applicable federal and state laws and contract requirements.

10.20 Primary Care Providers

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

10.20.1 Medical Home

The PCP is the foundation of the medical home, responsible for providing, managing and coordinating all aspects of the member's medical care. The PCP must provide all care that is within the scope of his or her practice. Additionally, the PCP 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 PCP is the member's and family's initial contact point when accessing health care. The PCP 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 PCP 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 PCP.

10.20.2 PCP Provider Types (Network Limitations)

Physicians with the following specialties can apply for enrollment with us as PCPs:

- 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 PCP
- 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
- Indian Health Care Providers (IHCP) for Indian members

The provider must be enrolled in the Medicaid program at the service location where he or she wishes to practice as a PCP before contracting with us for STAR+PLUS.

10.20.3 PCP Responsibilities

The PCP 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 PCPs. The PCP 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 by the PCP and other providers.
- Make referrals for specialty care for members on a timely basis, based on the urgency of the member's medical condition, but within 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 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 process 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 PCP of any member complaint.
- Not bill members for any outstanding balance; 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 90 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 and/or abnormal laboratory or radiological findings.
- Have a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
- Agree to maintain communication with the appropriate agencies, such as local police, social services agencies and poison control centers to provide high-quality patient care.
- Agree 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.
- 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.

10.20.4 *After-hours Coverage*

We encourage PCPs to offer extended office hours to include nights and weekends.

To ensure continuous 24-hour coverage, PCPs 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 PCP or another designated network medical practitioner; all calls answered by an answering service must be returned within 30 minutes. The answering service must have both English and Spanish language capability.
- Have the office telephone answered after normal business hours by a recording in both English and Spanish; the recorded message should direct the member to call another number to reach the PCP or another provider designated by the PCP; 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 PCP or a designated Amerigroup network medical practitioner who can return the call within 30 minutes.

The following telephone answering procedures are **NOT** acceptable:

- Answering office telephone only during office hours
- Answering office telephone after hours by a recording that tells members to leave a message
- Answering 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

10.20.5 *New Members*

We encourage enrollees to select a PCP for preventive and primary medical care. PCPs also ensure authorization and coordination of all medically necessary specialty services. Dual-eligible STAR+PLUS members will not be assigned to an Amerigroup PCP but will select a PCP through their primary coverage through Medicare.

10.20.6 *PCP Changes and Transfers*

We encourage members to remain with their PCPs to maintain continuity of care. However, members may request to change a PCP for any reason by contacting Member Services at 1-800-600-4441 (TTY 711). The member's name will be provided to the PCP on the membership roster.

Members can call to request a PCP change any day of the month. PCP 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. Members who have Medicare and Medicaid should call their Medicare plan to make a PCP change.

10.20.7 *Specialist as a PCP*

Under certain circumstances, a member may require the regular care of the specialist. We may approve that specialist to serve as a member's PCP. The criteria for a specialist to serve as a member's PCP 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 PCP; 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 designate a specialist as their PCP.

Note: Providers who follow NF residents should adhere to Texas Administrative Code guidelines for frequency of visits and documentation in the resident medical record.

The specialist must:

- Agree to serve as the member's primary care provider.
- Meet the requirements for PCP participation (including contractual obligations and credentialing).
- Provide access to care 24 hours a day, 7 days a week.
- 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.

The designation cannot be retroactive. If the request is approved, we will not reduce the compensation that is owed to the original PCP before the date of the new designation of the specialist as PCP. If we deny the request, however, 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. Specialists serving as PCPs will continue to be paid fee-for-service while serving as the member's PCP. For further information, call Provider Services at 1-800-454-3730.

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

10.21 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 PCP to ensure continued access to our covered services as appropriate. We will notify members of any termination of PCPs 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 Amerigroup Participating Provider Agreement. Members linked to a PCP who disenrolled for voluntary reasons will be notified to select a new PCP. We are responsible for submitting notification of all provider disenrollments to the Texas Health and Human Services Commission (HHSC).

10.22 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 <https://hhs.texas.gov/services/health/medicaid-chip/provider-information/managed-care-contracts-manuals>

10.23 Provider Quality Incentive Programs

We have several provider quality incentive programs to reward various facility and 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® 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).

10.24 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.

10.25 Referrals

Providers shall refer patients to participating providers and facilities when available. We will provide its members with timely and adequate access to out-of-network services if those services are necessary and covered but not available within the network.

10.26 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
P.O. Box 62509
Virginia Beach, VA 23466-2509

10.27 Second Opinions

A member, parent, and/or legally appointed representative (LAR) or the member's PCP may request a second opinion. A second opinion may be requested in any situation where there is a question concerning a diagnosis, the options for surgery 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 or a non-network provider if there is not a network provider with the expertise required for the condition. Once approved, the PCP will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The PCP 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 PCP of the results of the second opinion and the consulting provider's conclusion and recommendation(s) regarding further action.

10.28 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 PCP, 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 PCP (see [PCP Responsibilities](#)), the specialty care provider furnishes services that can include any of the following:

- Allergy and immunology services
- Burn services
- Community behavioral health (e.g., mental health and substance use disorder) 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

10.28.1 *Specialty Care Providers' Roles and Responsibilities*

Responsibilities of specialists contracted with Amerigroup 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 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 PCP on a timely basis; following a referral or routinely scheduled consultative visit.
- Notifying the member's PCP when scheduling a hospital admission..
- 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 use 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 and 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; 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 90 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; treating 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; giving members the opportunity to participate in decisions involving 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; advising members on treatments that may be self-administered.
- Contact members (when clinically indicated) as quickly as possible for follow-up regarding significant problems and/or 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.

10.29 Cancellation of Product Orders

If a network provider offers delivery services for covered products, such as durable medical equipment (DME), home health supplies, or 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.

10.30 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 may feel embarrassment about limited literacy. If interpreter services are needed, call Provider Services at 1-800-454-3730.

11 MEMBER MANAGEMENT SUPPORT

11.1 Appointment Scheduling

Through our participating providers, we 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 and must schedule our members for appointments using the guidelines outlined in the [Appointments](#) section 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. We will set up and pay for a sign language interpreter to assist members who are deaf or hard of hearing. These services are available at no cost to providers or members. Interpreter services should be requested at least 24 hours before the appointment. Services can be arranged by calling Provider Services at 1-800-454-3730.

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, hospital discharge case management and utilization management. These programs help 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. Participation in case management is voluntary and member consent must be obtained prior to enrollment. All members have the option to opt out of case management at any time.

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 PCPs 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 to manage the needs of members with increased case management needs in one or more domains (physical, behavioral or social)
- Empower members and their families by providing information and education that promote condition specific self-care management to facilitate member behavior change

- 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
- Provide members with connection and coordination of community resources to address member needs including social determinants of health throughout the case management process but especially when benefits end and the member still needs care
- 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 (e.g., STAR to STAR+PLUS)
- 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 referrals or member requests.

For STAR+PLUS members who receive services through the ICF-IID Program or an IDD Waiver, primary case management responsibilities will remain with the state for development of the service plan and the coordination of services:

- For individuals who live in ICF-IID facilities, the qualified intellectual disabilities professional (QIDP)
- For CLASS and DBMD Waiver members, a case manager
- For HCS and TxHmL Waiver members, a local authority service coordinator

We will also assign these members an Amerigroup personal service coordinator.

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.
- Social determinants of health.
- 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.

Hours of Operation

Our case managers are licensed nurses and social workers, available Monday-Friday from 8 a.m.- 5 p.m. local time. Confidential voicemail is available 24 hours a day.

Contact Information

To contact a case manager, please call 1-800-454-3730 or your local health plan.

11.4 Members with Special Health Care Needs (MSHCN)

MSHCN means a member who both:

- Has 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.
- Requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel.

All STAR+PLUS members qualify as MSHCN.

For MSHCN, we develop a service plan to provide care and services to meet your special needs. We also provide access to treatment by a multidisciplinary team when needed. MSHCN members may have a specialist designated to serve as a PCP (see the [Specialist as a PCP](#) 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 human immunodeficiency virus/acquired immune deficiency syndrome (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:

- Annual member newsletter
- 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 24-Hour Nurse HelpLine

The Amerigroup 24-Hour 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 24-Hour Nurse HelpLine at 1-800-600-4441. TTY services are available for members who are deaf or hard of hearing by calling 711. Language interpretation services are also available.

11.8 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.

11.9 Patient360

Patient360 is a read-only dashboard available at <https://www.availity.com> that gives instant access to detailed information about your Amerigroup patients. By selecting each tab in the dashboard, you can drill down to specific items in a patient's medical record:

- Demographic information — member eligibility, other health insurance, assigned PCP and assigned case managers
- Care summaries — emergency department visit history, lab results, immunization history, and due or overdue preventive care screenings
- Claims details — status, assigned diagnoses and services rendered
- Authorization details — status, assigned diagnoses and assigned services
- Pharmacy information — prescription history, prescriber, pharmacy and quantity
- Care management-related activities — assessment, care plans and care goals

To access Patient360, log in to <https://www.availity.com>, select **Amerigroup** under *Payer Spaces*, and it will appear under the *Applications* tab on the bottom portion of the screen.

12 BILLING AND CLAIMS ADMINISTRATION

Overview

Amerigroup strives to ensure providers can submit and receive reimbursement for claims efficiently and timely. In the following sections, we outline our general guidelines for nursing facilities.

Nursing facilities (NFs) may bill Amerigroup at any frequency they wish. We provide several electronic vehicles to facilitate your submissions. Please note the important information below:

- Clean claims for NF unit rate and NF Medicare Coinsurance submitted for Medicaid members are adjudicated within 10 days from the date the provider submits a clean claim. Clean claims not adjudicated within 10 days of submission by us are subject to interest payments. Claims must be filed within 365 days of the date of service.
- Clean claims for NF add-on services or other services negotiated into the provider's contract and submitted for Medicaid members are adjudicated within 30 days from the date we receive a clean claim. Clean claims not adjudicated within 30 days of receipt by us are subject to interest payments. Claims must be filed within 95 days of the date of service.
- 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 qualified providers their liability insurance and an enhanced fee to NF providers who are part of the HHSC Direct Care Staff Rate Enhancement Payment program. The fees will be built into the provider's unit rate payment fee schedule.
- Claims submitted by an NF must meet the HHSC criteria for clean claims submission as described in UCM Chapter 2.3, Nursing Facility Claims Manual.

12.1 Nursing Facility Carved-in Services

The following services are reimbursable by Amerigroup for STAR+PLUS members:

12.1.1 Nursing Facility Unit Rate

Daily unit rate services include services traditionally provided by NFs as defined by HHSC Vendor Payment services. The following service categories are included in the NF unit rate and are not reimbursable separately:

- Computation of the NF daily unit rate = direct care staff + other resident care + dietary + general & administration costs + fixed capital
- Full or partial ventilator services
- Child tracheostomy for adults ages 21-22
- Liability insurance
- Direct care staff rate enhancement

Individual NF rates are established by HHSC and supplied to Amerigroup regularly from TMHP.

Claims submitted for the daily unit rate will continue to be authorized by TMHP. Amerigroup will not reassess or authorize services resulting from the MDS and covered under the daily unit rate.

12.1.2 Add-On Services

The following Add-on Services are covered benefits for STAR+PLUS members residing in the nursing facility:

- Tracheostomy care for members age 21
- Ventilator care
- Physician-ordered rehabilitative therapy services (including assessments) provided by therapists who are either employed by the nursing facility or subcontracted by the facility
 - Rehabilitative therapy services should be billed by the nursing facility when authorized by Amerigroup and provided in the nursing facility.

The following add-on services are covered benefits that must be billed by the rendering provider of the service and not by the nursing facility:

- Emergency dental services
- Augmentative communication devices
- Customized power wheel chairs

12.1.3 Medicare SNF Coinsurance

Medicare SNF coinsurance amounts should be billed by the nursing facility to Amerigroup.

12.1.4 Other Negotiated Services

Other negotiated services contained in the nursing facility provider's contract should be billed to Amerigroup.

12.1.5 Carved-Out Services

The following list of services is carved out of our responsibility and should be billed to fee-for-service Medicaid:

- PASSR specialized services
- Hospice services
- Nursing facility daily care for a veterans' home
- Hospice care for a veterans' home

Questions related to the services included can be addressed to the nursing facility's assigned Provider Relations representative by calling 1-800-454-3730.

12.2 Cost Reporting to HHSC

The nursing facility provider must submit cost reports to HHSC or its designee in the manner and format required by HHSC. If the provider fails to comply with this requirement, Amerigroup will hold payments to the provider as directed by HHSC until HHSC instructs Amerigroup to release payments.

12.3 Direct Care Staff Rate Enhancement Payment Program

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

12.4 Direct Care Staff Rate Enhancement Payment Program (DCREAP) 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 HHSC or its designee. Each report submitted by the provider will be reviewed by HHSC or its designee to ensure funds were distributed in accordance with state and federal guidelines.

If a provider fails to distribute the funds appropriately, HHSC will instruct us how to address the noncompliance, which can include but is 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 enhancement program.
- Terminating the Amerigroup Provider Participation Agreement.

12.5 Claims Submission

Providers have three options for submitting claims to us:

- Electronic Data Interchange (EDI) using the Availity EDI Gateway
- Availity Provider Portal
- TMHP website claim portal
- Paper (for claims filed by providers other than a nursing facility)

12.6 Timely Filing

Providers must adhere to the following guidelines and time limits for nursing facility unit rate claims to be considered for payment:

- **Submit clean claims for nursing facility unit rate claims within 365 calendar days from the date of service.**
- In the case of other insurance or coordination of benefits/subrogation, submit clean claims within 365 calendar days of receiving a response from the third-party payer.
- In the case of retroactive member eligibility, submit clean claims within 365 calendar days from the date of service 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 Explanation of Payment (EOP).
- Amerigroup will pay providers interest at a rate of 18 percent per annum on all clean claims that are not adjudicated within the 10-day requirement.

Providers must adhere to the following guidelines and time limits for nursing facility add-on service claims or other negotiated services claims to be considered for payment:

- Submit clean claims for nursing facility add-on service claims or other negotiated services within 95 calendar days from the date of service or date of discharge.
- 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 from the date the member is added to the state's eligibility system but no later than 365 days from the date of service or the inpatient date of discharge.
- For a provider who is issued a new or changed Texas Provider Identification Number (TPIN), clean claims must be submitted within 95 days of issuance of the TPIN but no later than 365 days from the date of service.
- If a provider first submits a claim to the wrong health plan within the 95-day period and produces documentation of the filing, the provider may resubmit the claim to the correct health plan within 95 calendar days of the date of the denial from the wrong health plan.
- Corrected claims must be submitted within 120 days from the date of the Explanation of Payment (EOP).
- Amerigroup will pay providers interest at a rate of 18 percent per annum on all clean claims that are not adjudicated within the 30-day requirement.

Note: We will make adjustments to previously adjudicated claims within 30 days from the date of receipt of an adjustment from the state using an automated process to reflect changes to such things as: nursing facility daily rates, provider contracts, service authorizations, applied income, and level of service (RUG).

Claims submitted after the filing time lines outlined above will be denied. We must receive claims from out-of-network providers rendering services outside of Texas within one year of the date of service and/or date of discharge.

12.7 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 One through and Six edits. HHSC has defined the allowable codes to be billed for unit rate services and add-on services. This list can be found in the [Appendix](#) of this manual, entitled "Carved-in Services for NF Transition to STAR+PLUS".

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/bulletins are posted on our provider portal.

12.8 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 other than a nursing facility unit rate clean claim must meet all requirements for accurate and complete data as defined in the appropriate 837-(claim type) encounter guides as follows:

- 837 Institutional Combined Implementation Guide
- 837 Professional Combined Implementation Guide
- 837 Institutional Companion Guide
- 837 Professional Companion Guide

Claims submitted by a nursing facility for nursing facility unit rate or Medicare coinsurance must meet the HHSC criteria for clean claims submission as described in UCMCM Chapter 2.3, *Nursing Facility Claims Manual*.

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 *CMS-1450* (UB-04), *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 to be processed and paid by us.
- For a nursing facility unit rate or Medicare coinsurance claim, is submitted including all data as defined in the HHSC criteria for clean claims submission as described in UCMCM Chapter 2.3, *Nursing Facility Claims Manual*.

CMS-1450 (UB-04) and *CMS-1500* (02-12) forms must include the following information (-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)

A claim that is deemed unclean is returned to the provider or submitter along with the reason for rejection.

For STAR+PLUS nursing facility daily unit rate and Medicare Coinsurance claims, clean claims are adjudicated within 10 calendar days of initial clean claim submission.

All other clean claims are adjudicated within 30 calendar days of receipt (18 days for electronic pharmacy claims submission, 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 daily basis except Sundays for our nursing facility providers. EOPs for other provider claims are produced on a biweekly basis. The EOP delineates the status of each claim that has been adjudicated during the payment cycle. EOPs are available in a format of the provider's choice, paper or electronic, and are available for printing and/or download.

12.9 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.

12.10 Methods of Submission

12.10.1 Electronic Data Interchange Submission

Nursing facility claims may only be filed via electronic submission of claims through the Availity Provider Portal, the TMHP Claim Portal or by an Electronic Data Interchange (EDI) vendor. Amerigroup has designated Availity to operate and service your EDI entry point (EDI Gateway).

To submit transactions directly to Availity, use the Welcome Application at <https://apps.availity.com/web/welcome/#/edi> to begin the process of connecting to the Availity EDI Gateway. The Payer ID list can be found on the Availity website at <https://apps.availity.com/public/apps/payer-list/#/basic>.

Providers who wish to use a clearing house or billing company should work with that organization to ensure connectivity to the Availity EDI Gateway.

Additional information related to the EDI claim process is located on the Amerigroup provider website at <https://providers.amerigroup.com/TX>. Availity Client Services can be contacted for assistance at 1-800-Availity (1-800-282-4548) Monday through Friday from 7 a.m. to 6:30 p.m. Central time.

12.10.2 Online Claims Submission

We offer a free online claim submission tool for all providers at <https://www.availity.com>. This tool submits claims directly to us without the use of a clearinghouse. Submission via this website requires provider registration. More information about the claims submission tool and a guide for using the Availity Provider Portal can be found in the [Appendices](#) of this manual.

12.10.3 Paper Claims Submission

Paper claims will not be accepted for claims submitted by a nursing facility.

For claims submitted by providers other than a nursing facility, 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 <https://www.cms.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
P.O. Box 61010
Virginia Beach, VA 23466-1010

12.11 Claim Status

We offer two methods for accessing claim status 24 hours a day, 365 days a year:

- Provider website: <https://www.availity.com>
- Provider Inquiry Line: 1-800-454-3730

12.12 Participating, In-Network Provider Reimbursement

Claim reimbursement is based on the provider's contract.

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), which includes the state master file for nursing facilities. State master files are updated weekly.

Amerigroup will automatically adjust previously adjudicated daily care claims within 30 days from the date of receipt of a change in data from the state to reflect adjustments to such items as nursing facility daily rates, provider contracts, service authorizations, applied income and level of service (resource utilization group [RUG]). Any adjustments, besides the ones listed previously and some denials, may require a corrected claim by the nursing facility provider.

12.13 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.

Process to enroll or update electronic transactions		
Type of transaction	How to enroll, update, change or cancel	Contact to resolve issues
EFT only	Use the CAQH EFT EnrollHub tool available at http://www.caqh.org/solutions/enrollhub	CAQH Provider Help Desk 1-844-815-9763
ERA only	Register for ERAs at https://www.availity.com	Availity 1-800-282-4548

12.14 Provider Claims Payment Disputes

Information on the payment dispute process (including acute care claims) is located in the [Complaints, Appeals And Provider Disputes](#) chapter of this manual.

12.15 Overpayments & Payment Withhold

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. The submission of the Refund Notification form allows us to process and reconcile the overpayment in a timely manner.

HHSC requires that providers must report identified overpayments and submit a refund to Amerigroup within 60 days from the time of identification. HHSC defines identification as when the provider has or should have, through reasonable diligence, determined that the provider has received an overpayment and quantified the overpayment amount. Overpayments should be reported and refunds submitted using the Refund Notification Form. This form can be found on our provider website at <https://providers.amerigroup.com/TX> in the *Provider Resources & Documents* section under *Forms*.

Amerigroup will withhold or reject all or part of payment for a claim submitted by the provider if:

- The provider has been excluded or suspended from the Medicare, Medicaid or CHIP programs for fraud, waste, or abuse.
- The provider is on full or partial payment hold under the authority of HHSC or its authorized agent(s).
- The provider has debts, settlements or pending payments due to HHSC or the state or federal government.
- A claim for nursing facility unit rates does not comply with the HHSC criteria for clean claims.
- The provider understands and agrees claims for Medicare-covered services for dual-eligible members must be submitted to the Medicare payer.

12.16 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 two 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 two-year period following receipt of the claim. In addition, the two-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 two years after we received the claim. Also, the two-year limitation does not apply when HHSC has recovered a capitation from us based on a member's ineligibility. If any exception to the two-year limitation applies, 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.

12.17 Coordination of Benefits

Federal and state laws require Medicaid, including the STAR+PLUS programs, to 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. 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 postpayment 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 postpayment 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.

12.18 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 365-day filing deadline for nursing facility unit rate claims or 95-day filing deadline for nursing facility add-on services and other claims
- Failure to submit a corrected claim within the 120-day filing resubmission period
- Failure to appeal a claim within the 120-day payment dispute period
- Failure to submit a member appeal for a pre-service utilization review determination within 60 calendar days of the date of coverage denial
- Submission of an 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 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 prior to the provision of the services, specifying the member 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.

12.19 Private Pay Agreement

Providers:

- Must advise members at the time the service is rendered that they are accepted as private-pay patients, and as such, are financially responsible for all services received.
- 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 _____

12.20 Member Acknowledgment Statement

Providers may bill an Amerigroup member for a service denied as not medically necessary or not a covered benefit **only if** all of the following conditions are met:

- 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 member and the provider (as shown below); 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
Dates of service

Amerigroup plan. 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

12.21 Cost Sharing

12.21.1 Medicaid Cost Sharing

Medicaid members do not have copays.

12.21.2 Medicare Coinsurance

Amerigroup will pay the state's Medicare coinsurance obligation for a qualified dual-eligible member's Medicare-covered stay in a nursing facility. Amerigroup is not responsible for the state's Medicare cost-sharing obligation for a dual-eligible member's Medicare-covered nursing facility add-on services, which are adjudicated by either the state's fee-for-service claims administrator or the dual-eligible member's Medicare plan as applicable to the member. The nursing facility provider must submit an electronic version of the Medicare Remittances and Advice form.

If the provider files a claim for Medicare coinsurance with a third-party insurance resource, the wrong health plan or with the wrong HHSC portal and produces documentation verifying the initial filing met the timeliness standards described in the [Timely Filing](#) section of this manual, Amerigroup will process the claim without denying the resubmission for failure to timely file. The provider must file the claim with Amerigroup by the later of: 1) 365 days after the date of service, or 2) 95 days after the date on the remittance and status report or Explanation of Payment from the other carrier or contractor.

12.21.3 Applied Income (AI) and Incurred Medical Expenses (IME)

We will include the application of AI and IME at the time of claim adjudication and based on the amounts reported to us from HHSC/TMHP for each member during the period in which the AI or IME applies. Providers are required to place the expected AI or IME amounts in the appropriate location on the claim submission.

Collection of Applied Income

The provider must make reasonable efforts to collect AI, document those efforts, and notify the service coordinator or the Amerigroup designated representative when it has made two unsuccessful attempts to collect applied income in a month. This provision in no way subrogates the provider's existing regulatory and licensing responsibilities related to the collection of AI, including the requirements of 40 TAC §19.2316.

We will provide each nursing facility the name and contact information of a service coordinator or other designated representative who will assist with the collection of applied income from members. Amerigroup must notify the provider within 10 days of any change to the assigned service coordinator or representative.

12.22 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.

12.23 Provider Relations Representatives

Amerigroup will designate a Provider Relations representative to support each contracted nursing facility with coverage questions, payment and billing support, education and training needs, and overall contract management. Questions and inquiries can be directed to the assigned Provider Relations representative by calling 1-800-454-3730 or using the individual contact information provided to each nursing facility by their designated Amerigroup representative.

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, upon request, to providers and members. 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 and 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®) 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.

CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

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 Texas Department of Insurance (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.
- 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/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/recommendations regarding clinical quality improvement studies.
- Consider/act in response to provider sanctions.
- Provide oversight of credentialing committee decisions to credential/recredential providers for participation in the plan.
- Approve credentialing/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 updates national Clinical Practice Guidelines. The super MAC is chaired by an Amerigroup national medical director.

13.4 Use of Performance Data

All providers must allow Amerigroup to use performance data in cooperation with our Quality Management program and activities.

13.5 Credentialing Committee

The Credentials Committee's purpose is to credential and recredential all participating providers according to plan, state and federal accreditation standards.

Committee responsibilities include:

- Conducting reviews for all providers who apply for participation in the network.
- Reviewing all participating providers for recredentialing purposes, including the review of any quality or utilization data/reports.
- Approving or denying providers submitted by a delegated credentialing entity.
- Reviewing and updating credentialing policies and procedures.
- Reporting physician corrective actions and sanctions imposed based upon recredentialing activity to the MAC.
- Approving or denying providers for participation in the network and report decisions to the MAC.
- Overseeing delegated credentialing relationships.

13.6 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.
- Review and make recommendations regarding individual provider peer-review cases.
- 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.

13.7 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 four evidence-based Clinical Practice Guidelines that are relevant to the member population. We measure performance against at least two important aspects of each of the four Clinical

Practice Guidelines annually. The guidelines must be reviewed and revised at least every two years or whenever the guidelines change.

13.8 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.

13.9 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 nursing facility providers must submit clean claims to us within 365 days of service for daily unit rate services and within 95 days of service for add-on services. Nonparticipating providers located outside of Texas must submit clean claims for nursing facility unit rate services or add-on services 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 STAR+PLUS members, providers must have an active Texas provider identifier on file with TMHP, the state's contracted administrator.

14.2 Precertification

Nursing facility residential services included in the nursing facility daily unit rate and Medicare coinsurance do not require precertification by Amerigroup.

Nonparticipating providers must obtain precertification for all other 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 time frames.

14.3 Reimbursement

Nonparticipating providers are reimbursed in accordance with a negotiated case rate or, in absence of a negotiated rate, as follows:

For STAR+PLUS, we reimburse:

- Out-of-network, in-area service providers at no less than the prevailing Medicaid FFS rate, less five percent.
- Out-of-network, out-of-area service providers at no less than 100 percent of the Medicaid FFS rate.

APPENDIX A – ID CARDS

Below are sample ID cards for: 1) members who have Medicaid only and 2) members who have both Medicaid and Medicare.

 Amerigroup An Anthem Company	PCP Effective Date: Date of Birth: Subscriber #: 1234567890 Type of Coverage: STAR+PLUS
	AMERIGROUP TEXAS, INC.
Member Name: John Q Sample Medicaid Number: 1234567890 Amerigroup Service Coordination: 1-800-600-4441 Primary Care Provider (PCP): PCP Telephone #: PCP Address: Vision: 1-800-428-8789 Pharmacy: 1-800-600-4441 Amerigroup Member Services and Behavioral Health (24 hours a day, 7 days a week): 1-800-600-4441 24-Hour Nurse HelpLine: 1-800-600-4441	

 Amerigroup An Anthem Company	Effective Date: Date of Birth: Subscriber #: 1234567890 Type of Coverage: STAR+PLUS
	AMERIGROUP TEXAS, INC.
Member Name: John Q Sample Medicaid Number: 1234567890 Amerigroup Service Coordination: 1-800-600-4441 Pharmacy: 1-800-600-4441	
<p>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.</p>	

Sample ID cards for Amerigroup members in the Medicaid Rural Service Area for: 1) members who have Medicaid only and 2) members who have both Medicaid and Medicare:

 Amerigroup An Anthem Company	PCP Effective Date: Date of Birth: Subscriber #: 1234567890 Type of Coverage: STAR+PLUS
	AMERIGROUP INSURANCE COMPANY
Member Name: John Q Sample Medicaid Number: 1234567890 Amerigroup Service Coordination: 1-800-600-4441 Primary Care Provider (PCP): PCP Telephone #: PCP Address: Vision: 1-800-428-8789 Pharmacy: 1-800-600-4441 Amerigroup Member Services and Behavioral Health (24 hours a day, 7 days a week): 1-800-600-4441 24-Hour Nurse HelpLine: 1-800-600-4441	
	

 Amerigroup An Anthem Company	Effective Date: Date of Birth: Subscriber #: 1234567890 Type of Coverage: STAR+PLUS
	AMERIGROUP INSURANCE COMPANY
Member Name: John Q Sample Medicaid Number: 1234567890 Amerigroup Service Coordination: 1-800-600-4441 Pharmacy: 1-800-600-4441	
<p>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.</p>	
	

APPENDIX B – AMERIGROUP WEBSITE USER GUIDE FOR CLAIMS TRANSACTIONS

**GET THE MOST
OUT OF THE
AVAILITY WEB
PORTAL**

©Availity, LLC | AV1207-0913



QUICK REFERENCE GUIDE

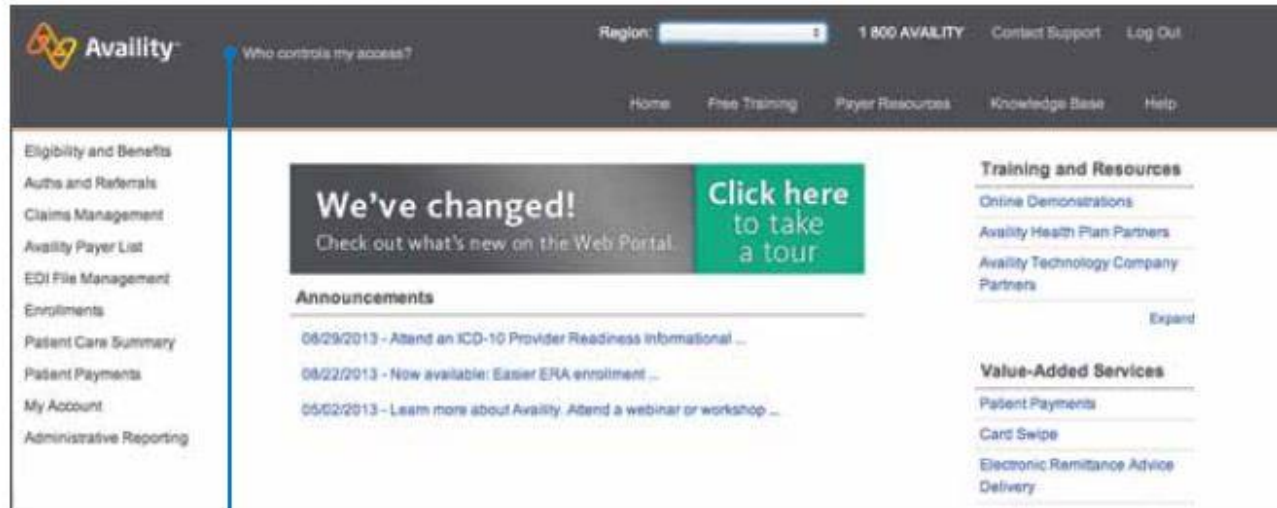
Availity's Web Portal gives you the tools you need to drive measurable and meaningful organizational improvements, to enjoy the vitality of a healthy business. Use this guide to help you get started.



THE AVAILITY WEB PORTAL

RESOURCES AND TRANSACTIONS

Your Web Portal Home Page

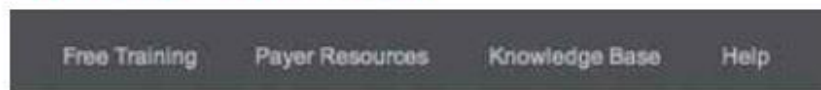


Who controls my access? — View the name of your PAA. Every Availity organization has a Primary Access Administrator (PAA) who sets up and maintains user accounts and organization information, and who performs other administrative tasks.

Your organization's PAA is responsible for assigning access to features in Availity.
Contact your PAA if you believe you should have access to a specific feature but do not.

My PAA is: _____

Top Navigation, Detail View



Free Training — Access a variety of free learning options, including live and recorded webinars, interactive online demonstrations and in-person conferences.

Payer Resources — View payer-specific resources, such as payer companion guides, user manuals, directories, forms and links to payer-specific tools.

Knowledge Base — Access Availity's online community for the most current information about Availity products and services, including Web Portal and EDI updates and guidelines, known issues, newsletters, tips and other guidance.

Help — View Help topics about the Web Portal's services.



We're always working to improve your Web Portal experience. Some of the features you see here may look different in the actual Web interface. **Contact your PAA** if you believe you should have access to a featured service.

Left Navigation, Detail View

Eligibility and Benefits
Auths and Referrals
Claims Management
Availity Payer List
EDI File Management
Enrollments
Patient Care Summary
Patient Payments
My Account
Administrative Reporting

Eligibility and Benefits
Eligibility and Benefits Inquiry
Online Batch Management

Eligibility and Benefits Inquiry — Verify eligibility for patients and confirm the benefits covered under their member contracts.

Auths and Referrals
Referrals
Authorizations
Auth/Referral Inquiry
Current Admissions Report
Claims Missing Referrals
Referral Report
Radiology Referral Submission
Online Batch Management

Referrals — Submit referral requests.

Authorizations — Submit authorization requests.

Auth/Referral Inquiry — View the results or status of authorization and referral requests.

Claims Management
Claim Status Inquiry
Professional Claim
Facility Claim
Claim Reconciliation Tool
Remittance Viewer
Remittance Review
Research Procedure Code Edits
Fee Schedules
Online Batch Management
Medical Records Management

Claim Status Inquiry — Check the status of a submitted claim.

Professional Claim — Submit an electronic claim for a professional encounter.

Facility Claim — Submit an electronic claim for a facility encounter.

Remittance Viewer — View, search, and reconcile 835 electronic remittance advice (ERA) files. Your organization must enroll with participating payers to receive ERAs through remittance viewer. Navigate to **Enrollments | ERA Enrollment** to get started.

Availity Payer List
Payer List

Payer List — View a comprehensive list of Availity's health plan partners—including payer IDs—and the Availity products and services each payer supports through the Web Portal.

EDI File Management
EDI Reporting Preferences
Send and Receive EDI Files

Send and Receive EDI Files — Submit EDI batch files and review response files for EDI batch files submitted. Also, view payer responses to claims submitted using the Availity Web-based claim forms.

My Account
My Profile
Manage Providers
Manage My Code List
View My Code List
My Favorite Codes
Availity Knowledge Base

My Profile — Maintain your own user account after login, including user password, security questions and answers, and contact information.

Manage Providers — Associate providers with your organization and pre-populate the Express Entry fields for quick data entry.

My Favorite Codes — Manage frequently used procedure and diagnosis codes for use in Express Entry fields.

WELCOME

YOUR FIRST LOGIN

When you log in for the first time as a new user, Availity prompts you to:

- (a) accept an Availity Privacy and Security statement,
- (b) accept a Confidentiality Agreement,
- (c) choose three security questions and provide a response to each,
- (d) create a new password, and
- (e) verify your e-mail address.

It is important you do not share your user ID or password with others.

After you enter this information, Availity will send you an e-mail verification message. Within 24 hours of receiving the message, click the link in the message to complete your registration with Availity.

HELP LOGGING IN

If you forget your user ID or password, you can retrieve them from the login screen. Click **Help! I can't log in!** and answer your security questions to validate your identity.

To take advantage of this self-service feature, you must have verified your e-mail address the first time you logged in to the Web Portal or know the answers to your security questions.

If you call Availity Client Services for login assistance, an Availity representative will ask you your security questions to validate your identity.

To change your security questions at any time after initial setup, click **My Account | My Profile** in the left navigation menu.

CONFIGURE YOUR PC

SET UP POP-UP BLOCKERS

Pop-up blockers in your Internet browser (such as Windows® Internet Explorer®) can prevent some Web Portal windows and features from displaying properly. To ensure your browser is configured to allow full display of the Web Portal, follow these steps:

In Windows Internet Explorer, click **Tools | Pop-up Blocker | Pop-up Blocker Settings**. This menu item is only available if you have pop-up blockers turned on.

In the **Address of website to allow** field, type the following URLs and click **Add** after typing each one.



apps.availity.com
mc.availity.com
www.availity.com

SET YOUR SCREEN RESOLUTION

While a low resolution, like 800 x 600 pixels, makes everything on your screen large and easier to see, some objects might not fit the screen. The Web Portal is best viewed at higher resolutions, such as those between 1024 x 768 pixels and 1280 x 1024 pixels.

To change your screen resolution, see the Web Portal Help topic **Can't See Everything on the Screen**.

Help!

Get help when you need it

View **Help** topics, explore live and on-demand **Free Training** opportunities, or check out articles in the **Knowledge Base** — all located in the top navigation menu in the Web Portal.

Contact Availity Client Services

E-mail support@availity.com

Call 1.800.AVAILITY (282.4548) toll free
M–F, 8 a.m. – 7 p.m. E.T. (excluding holidays)

PRIMARY ACCESS ADMINISTRATORS (PAAs)

YOUR ADMINISTRATIVE TOOLS

Your Web Portal Home Page and Admin Dashboard

The screenshot shows the Admin Dashboard interface. On the left is a vertical navigation menu with the following items: Eligibility and Benefits, Auths and Referrals, Claims Management, Availity Payer List, EDI File Management (highlighted), Enrollments, Patient Care Summary, Patient Payments, My Payer Portals, My Account, Administrative Reporting (highlighted), and Account Administration. The main dashboard area is titled 'Admin Dashboard' and contains three primary action buttons: 'My Users' (with 'Add User' and 'Manage Users' sub-buttons), 'My Providers' (with 'Manage Providers' sub-button), and 'My Organization' (with 'Manage My Organization' and 'PCA/PAA Change Form' sub-buttons). Below these are two sections: 'Additional Enrollments' with links for Medicare E&B Registration, Empire Services Registration, and ERA Enrollment; and 'Helpful Links' with links for View Announcements / Enhancements, Availity Health Plan Partners List, Known Issues / Resolutions, and Free Training/Webinars.

Add User — Add new or existing Availity users to your organization(s)*. Before you begin, see the Availity Help topic **Understanding Availity Roles and Permissions** for guidance.

**Availity assigns a temporary password to each new user account. The user must log in to Availity with his or her user ID and temporary password within 90 days. During login, Availity will prompt the user to create a new password.*

Manage Users — Maintain existing user accounts, including:

- Unlock user accounts and reset passwords
- Assign or remove roles for existing users
- Revoke or reactivate user accounts

Manage Providers — Associate providers with your organization and pre-populate the Express Entry fields for quick data entry. You can add providers one-at-a-time or use a spreadsheet to upload multiple providers.

Manage My Organization — Change demographic information such as address, phone, fax and e-mail. Access forms to change the PAA, Primary Controlling Authority (PCA), tax ID, NPI and organization type.

Other PAA tools

This screenshot shows the 'EDI File Management' section with two sub-links: 'EDI Reporting Preferences' and 'Send and Receive EDI Files'.

EDI Reporting Preferences — Specify the EDI reports you want users at your organization to receive, along with associated file formats and other reporting preferences.

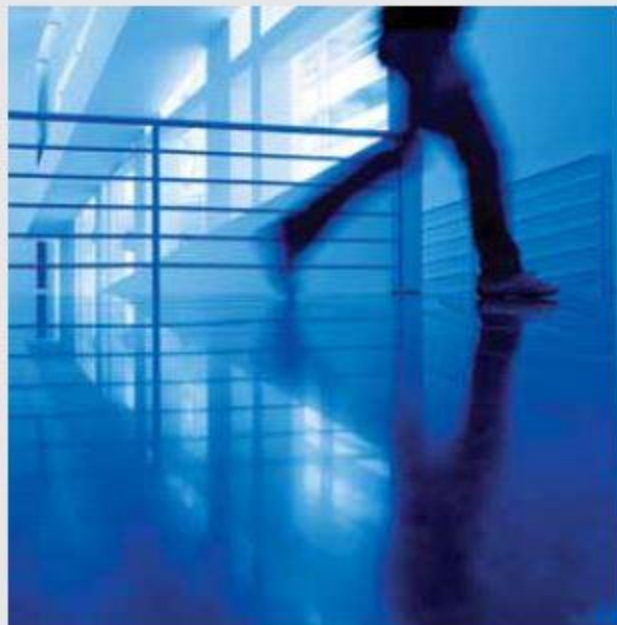
This screenshot shows the 'Administrative Reporting' section with four sub-links: 'PAA Reports', 'My Organization Reports', 'Transaction Log', and 'Web Transaction Report'.

PAA Reports — Generate administrative reports for your organization, including User Status, User Login, User History, Roles and Permissions, and Organization History.

My Organization Reports — View detailed information about Web and EDI transactions submitted for the entire organization.

PRIMARY ACCESS ADMINISTRATORS (PAAs)

YOUR ROLE AND RESPONSIBILITIES



PAA RESPONSIBILITIES

As the PAA for your organization, you should log in to the portal regularly to:

- Check for important notices and service updates
- Set up and manage user accounts
- Maintain your organization's information
- Perform other administrative tasks

Browse through the **PAA Tasks** collection of topics in Help, in the top navigation menu of the Web Portal, for more information.

STAY INFORMED

It is important to ensure your contact information is always current so Availity may reach you with important information for your organization. The PAA is the primary contact person for Availity and relays timely information to the rest of their organization.

PAAs must provide their e-mail address, phone and fax numbers. To update your e-mail address, click **My Account | My Profile** in the left menu and then click **Change User Information**.

To update your name, phone, or fax—or to replace the PAA on record—submit a change request form to Availity. To access the form, click **PCA/PAA Change Request Form** on the Administrator Dashboard.

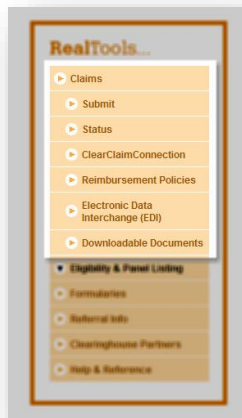
VALUE-ADDED SERVICES

Enroll or set up your organization with value-added services from Availity such as patient payments, electronic remittance advice (ERA) and more. View these in **My Account** in the left navigation menu.

Who's my PAA?

If you are not the PAA for your organization and want to find out who is, click **Who controls my access?** at the top of any page on the Availity portal.

APPENDIX C – AVAILITY PORTAL USER GUIDE



The claims transaction tools on the Amerigroup provider website allow you to:

- Verify the status of one or several claims.
- Use ClearClaimConnection™ to verify code combinations.
- View Amerigroup reimbursement policies.
- Obtain instructions to submit claims using Electronic Data Interchange (EDI).
- Download documents.

This guide will give you steps to:

- View claim status.
- Use ClearClaimConnection.

View Claim Status

1. Select **Claims** on the *Tools...* menu then select **Status**. The *Claim Status Tool* page displays, and the user's provider ID will display in the Provider ID drop-down menu.

Please note: If there are several providers under the same TIN and you want to view claim status for each of them, make sure that all providers are activated under your user name. Otherwise, you will only be able to see claims for the one provider.

To view the status of an individual claim:

1. Enter the start date or date of service.
2. Select the member ID number type from the drop-down menu.
3. Enter the member ID number and select the **Search** button. All claim(s) for the selected date and member will display.

To view the status of several claims:

1. Enter the start date of the dates of service then enter the desired end date. The date range cannot exceed 30 days.
2. Select the **Search** button. Multiple claims will display for the selected date range.

Select the status of any claim line to view more details about that claim.

Claim Details

Claim Number	10349
Member Number	7121
Date of Service	1/7/2009
Amount Charged	\$15.00
Amount Paid	\$6.88
Check Amount	\$6.88
Check Number	101
Process Date	1/24/2009
Insurance Type	MEDICAID
Claim Status	PAID

[RETURN TO RESULTS](#)

[RESUBMIT CMS-1500](#)
[DISPUTE CLAIM](#)
[NEW SEARCH](#)

Search Results

To view more details on an individual claim, click the corresponding link in the status column below.

Results (21) <<< Page 1 of 3 >>> Results per page 10

STATUS	MEMBER #	CLAIM #	DATE OF SERVICE	AMOUNT CHARGED	AMOUNT PAID
PAID	7128	10349	1/7/2009	\$15.00	\$6.88
DENIED	7128	10349	1/7/2009	\$15.00	\$0.00
PAID	7122	10349	1/7/2009	\$15.00	\$6.88
PAID	7128	10353	1/7/2009	\$281.88	\$155.83
PAID	7128	10355	1/11/2009	\$425.38	\$264.78
DENIED	7128	10357	1/11/2009	\$172.00	\$0.00
PAID	7133	10353	1/15/2009	\$15.00	\$6.88
DENIED	7136	10440	1/15/2009	\$15.00	\$0.00
PAID	7138	10429	1/15/2009	\$15.00	\$6.88
PAID	7128	10356	1/15/2009	\$92.25	\$50.89

Results (21) <<< Page 1 of 3 >>> Results per page 10

Use the buttons at the bottom of the window to take further action on the claim, including submitting a dispute.

Clear Claim Connection

Amerigroup offers a web-based code auditing reference tool called Clear Claim Connection (C3). C3 mirrors how our current code auditing software evaluates code combinations during the adjudication of a claim. This tool allows you to access our claim auditing rules and clinical rationale built into the code auditing software.

1. Select **Claims** on the *Tools...* menu then select **ClearClaimConnection**.
2. Choose your market and select the check box for *I agree to the Terms & Conditions* to proceed. If you do not agree to the terms, you cannot use this tool.
3. Enter the member's information, the procedure codes, modifiers (if any) and the date of service.
4. Select the **Review Claim Audit Results** button.

Clear Claim Connection™

McKesson Edit Development Glossary About Help Logoff

Gender: ☐ Male ☐ Female

Date of Birth: / / (mm/dd/yyyy)

Click Grid to enter information:

Procedure	Mod 1	Mod 2	Mod 3	Mod 4	Date of Service

[Add More Procedures>>](#)

[Review Claim Audit Results](#) [Clear](#)

Remember: This tool does not guarantee payment. It explains our code edit logic on claims.

How to Submit Corrected Claims Electronically

Definitions

Rejected claim: A claim that was received by Amerigroup and deemed unclear. The claim is never loaded to the adjudication system. The claim is returned along with the reason for rejection back to the provider.

Accepted claim: A claim that was received by Amerigroup and passed all front-end edits. The claim was successfully loaded to the adjudication system where a final determination of paid or denied is achieved.

Corrected claim: A claim that was accepted and finalized by Amerigroup. The claim is updated with additional information that will potentially impact the payment of the claim. *Example: Initial claim submission is accepted and contains a single service line. The provider realizes the lab charges were left off of the original claim and submits a corrected claim, which contains the original services that were billed plus the new service lines containing the lab charges.*

Resubmission claim: Represents a claim that was initially rejected by Amerigroup due to invalid or missing data. Once the appropriate changes are made to the claim in order to make the claim clean, the claim is resubmitted to Amerigroup for consideration. Note: A claim that is resubmitted is always considered and treated as a new claim.

Process Steps

1. EDI Professional Claim (837P): Providers should use one of the following frequency codes to indicate a correction was made to a previously submitted and adjudicated claim:
 - 7 – Replacement of prior claim
 - 8 – Void/cancel prior claim

Note: A full definition of each code and confirmation of the use of these codes on a professional claim can be found on the NUBC website at www.nubc.org/FL4forWeb2_RO.pdf.

2. Indicator Placement:

- Loop: 2300 (Claim information)
- Segment: CLM 05-03 (Claim frequency type code)
- Value: 7, 8
-

3. EDI Claim Institutional (837I): Providers should use one of the following Bill Type frequency codes in order to indicate a correction was made to a previous submitted and adjudicated claim.

- OXX5 – Late charges only claim
- OXX7 – Replacement of prior claim
- OXX8 – Void/cancel prior claim

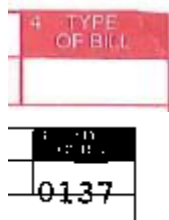
Note: A full definition of each code can be referenced on pages II-111 through II-114 of the Ingenix UB04 Billing Manual.

4. Indicator Placement:

- Loop: 2300 (Claim information)
- Segment: CLM 05-03 (Claim frequency type code)
- Value: 5, 7, 8

5. Indicator Placement:

Field Number 4 (Type of Bill)



4 TYPE OF BILL

4 TYPE OF BILL
0137

Internal Handling Procedure:

Electronic and web claims that contain the appropriate frequency codes are suspended for manual adjudication. Web-corrected claims submitted using the resubmit button on the portal will open either a blank claim form if the original claim was submitted via EDI. A previously submitted claim will open with the claim fields prepopulated with the original data. Once the claim is submitted through the portal, the claim is suspended and is worked manually.

In all cases stated above, if a corrected claim is determined to be a new claim and a pre-existing claim does not exist in the adjudication system, the claim is manually entered and adjudicated. If the claim is truly a corrected claim, the analyst will reopen the original claim, adjust it and make any necessary changes to the claim based on the latest claim submission and adjudicate as necessary.

APPENDIX E – STAR+PLUS NURSING FACILITY CARVED IN/CARVED OUT SERVICES

Carved-In Services for the NF Transition to STAR+PLUS

The Bill code crosswalk is a cross-referenced code set used to match the Texas Long-term Care (LTC) Local Codes (i.e., bill codes) to the National Standard Procedure Codes. See <https://hhs.texas.gov/laws-regulations/legal-information/long-term-care-bill-code-crosswalks>.

This version 1.7 is based on the last update of Bill Code crosswalk of July 1, 2014. Services in **red/bold text** will be updated in the next published version of the HHSC Bill Code crosswalk. Services with a yellow highlight are added since version 1.4

Texas LTC Local Codes				National Codes																
SERVICE GROUP	BILL CODE	DESCRIPTION	SERVICE CODE	LEVEL TYPE	LEVEL VALUE	PROC CD	QUAL	HCPCS CODE	CPT CODE 1	REVENUE CODE	POS	MODIFIER 1	MODIFIER 2	MODIFIER 3	MODIFIER 4	CLAIM FIL IND	Claim Type to File I=837I; P=837P; D=837D; E=Expdtd; N=NAT	ACTIVE	BEGIN DATE	END DATE
AUTHORIZATIONS FOR SERVICES BELOW <u>WILL</u> BE AVAILABLE IN HHSCSERVICE AUTHORIZATION DATA SENT TO MCOS (DAILY CARE, MEDICARE COINSURANCE, VENTILATOR & TRACHEOSTOMY CARE)																				
1	RG001	NF - RAD	1	RG	RAD					0100							I	A	09/01/2008	12/31/2199
1	RG002	NF - RAC	1	RG	RAC					0100							I	A	09/01/2008	12/31/2199
1	RG003	NF - RAB	1	RG	RAB					0100							I	A	09/01/2008	12/31/2199
1	RG004	NF - RAA	1	RG	RAA					0100							I	A	09/01/2008	12/31/2199
1	RG005	NF - SE3	1	RG	SE3					0100							I	A	09/01/2008	12/31/2199
1	RG006	NF - SE2	1	RG	SE2					0100							I	A	09/01/2008	12/31/2199
1	RG007	NF - SE1	1	RG	SE1					0100							I	A	09/01/2008	12/31/2199
1	RG008	NF - SSC	1	RG	SSC					0100							I	A	09/01/2008	12/31/2199
1	RG009	NF - SSB	1	RG	SSB					0100							I	A	09/01/2008	12/31/2199
1	RG010	NF - SSA	1	RG	SSA					0100							I	A	09/01/2008	12/31/2199
1	RG011	NF - CC2	1	RG	CC2					0100							I	A	09/01/2008	12/31/2199
1	RG012	NF - CC1	1	RG	CC1					0100							I	A	09/01/2008	12/31/2199
1	RG013	NF - CB2	1	RG	CB2					0100							I	A	09/01/2008	12/31/2199
1	RG014	NF - CB1	1	RG	CB1					0100							I	A	09/01/2008	12/31/2199
1	RG015	NF - CA2	1	RG	CA2					0100							I	A	09/01/2008	12/31/2199
1	RG016	NF - CA1	1	RG	CA1					0100							I	A	09/01/2008	12/31/2199
1	RG017	NF - IB2	1	RG	IB2					0100							I	A	09/01/2008	12/31/2199
1	RG018	NF - IB1	1	RG	IB1					0100							I	A	09/01/2008	12/31/2199
1	RG019	NF - IA2	1	RG	IA2					0100							I	A	09/01/2008	12/31/2199

Texas LTC Local Codes				National Codes																
SERVICE GROUP	BILL CODE	DESCRIPTION	SERVICE CODE	LEVEL TYPE	LEVEL VALUE	PROC CD QUAL	HCPCS CODE	CPT CODE 1	REVENUE CODE	POS	MODIFIER 1	MODIFIER 2	MODIFIER 3	MODIFIER 4	CLAIM FIL IND	Claim Type to File I=837I; P=837P; D=837D; E=Expdtd; N=NAT	ACTIVE	BEGIN DATE	END DATE	
1	RG020	NF - IA1	1	RG	IA1				0100							I	A	09/01/2008	12/31/2199	
1	RG021	NF - BB2	1	RG	BB2				0100							I	A	09/01/2008	12/31/2199	
1	RG022	NF - BB1	1	RG	BB1				0100							I	A	09/01/2008	12/31/2199	
1	RG023	NF - BA2	1	RG	BA2				0100							I	A	09/01/2008	12/31/2199	
1	RG024	NF - BA1	1	RG	BA1				0100							I	A	09/01/2008	12/31/2199	
1	RG025	NF - PE2	1	RG	PE2				0100							I	A	09/01/2008	12/31/2199	
1	RG026	NF - PE1	1	RG	PE1				0100							I	A	09/01/2008	12/31/2199	
1	RG027	NF - PD2	1	RG	PD2				0100							I	A	09/01/2008	12/31/2199	
1	RG028	NF - PD1	1	RG	PD1				0100							I	A	09/01/2008	12/31/2199	
1	RG029	NF - PC2	1	RG	PC2				0100							I	A	09/01/2008	12/31/2199	
1	RG030	NF - PC1	1	RG	PC1				0100							I	A	09/01/2008	12/31/2199	
1	RG031	NF - PB2	1	RG	PB2				0100							I	A	09/01/2008	12/31/2199	
1	RG032	NF - PB1	1	RG	PB1				0100							I	A	09/01/2008	12/31/2199	
1	RG033	NF - PA2	1	RG	PA2				0100							I	A	09/01/2008	12/31/2199	
1	RG034	NF - PA1	1	RG	PA1				0100							I	A	09/01/2008	12/31/2199	
1	RG035	NF - BC1	1	RG	BC1				0100							I	A	09/01/2008	12/31/2199	
1	RG036	NF - PCE	1	RG	PCE				0100							I	A	09/01/2008	12/31/2199	
1	N0400	MEDICARE SKILLED	3						0101							I	A	01/01/1900	12/31/2199	
1	N0500	VENTILATOR - FULL	4			HC		94004	0230		U1	UA	U7			I	A	02/01/2008	12/31/2199	
1	N0500	VENTILATOR - FULL	4			HC		94005	0230		U1	UA	U7			I	A	01/01/2010	12/31/2199	
1	N0501	VENTILATOR - PARTIAL	4			HC		94004	0230		U1	UA	U8			I	A	02/01/2008	12/31/2199	
1	N0501	VENTILATOR - PARTIAL	4			HC		94005	0230		U1	UA	U8			I	A	01/01/2010	12/31/2199	
1	N0502	CHILD TRACHEOSTOMY CARE	24			HC		99199	0410							I	A	06/01/2014	12/31/2199	
AUTHORIZATIONS FOR SERVICES BELOW <u>WILL NOT</u> BE AVAILABLE IN HHSC SERVICE AUTHORIZATION DATA SENT TO MCOs (ADD-ON SERVICES)																				
1	N0600	EMERGENCY DENTAL - PULL OF IMPACTED TOOTH - BONY	5			AD	D7240									D	A	05/27/1999	12/31/2199	

Texas LTC Local Codes				National Codes															
SERVICE GROUP	BILL CODE	DESCRIPTION	SERVICE CODE	LEVEL TYPE	LEVEL VALUE	PROC CD QUAL	HCPCS CODE	CPT CODE 1	REVENUE CODE	POS	MODIFIER 1	MODIFIER 2	MODIFIER 3	MODIFIER 4	CLAIM FIL IND	Claim Type to File I=837I; P=837P; D=837D; E=Expdtd; N=NAT	ACTIVE	BEGIN DATE	END DATE
1	N0600	EMERGENCY DENTAL - PALLIATIVE	5			AD	D9110									D	A	05/27/1999	12/31/2199
1	N0600	EMERGENCY DENTAL - SUBSEQUENCE X-RAYS	5			AD	D0230									D	A	05/27/1999	12/31/2199
1	N0600	EMERGENCY DENTAL - INITIAL X-RAY	5			AD	D0220									D	A	05/27/1999	12/31/2199
1	N0600	EMERGENCY DENTAL - ORAL	5			AD	D0140									D	A	05/27/1999	12/31/2199
1	N0600	EMERGENCY DENTAL - GENERAL NUMBING FIRST HALF HOUR	5			AD	D9220									D	A	05/27/1999	12/31/2199
1	N0600	EMERGENCY DENTAL - LOCAL NUMBING	5			AD	D9215									D	A	05/27/1999	12/31/2199
1	N0600	EMERGENCY DENTAL - CUT AND EVACUATE OF ABSCESS - EXTRAORAL	5			AD	D7520									D	A	05/27/1999	12/31/2199
1	N0600	EMERGENCY DENTAL - PULL REMAINING TOOTH ROOTS	5			AD	D7250									D	A	05/27/1999	12/31/2199
1	N0600	EMERGENCY DENTAL - REMOVAL OF IMPACTED TOOTH - PULL BONY COMPLICATIONS	5			AD	D7241									D	A	05/27/1999	12/31/2199
1	N0600	EMERGENCY DENTAL - PULL OF IMPACTED SLIGHTLY TOOTH - BONY	5			AD	D7230									D	A	05/27/1999	12/31/2199

Texas LTC Local Codes				National Codes															
SERVICE GROUP	BILL CODE	DESCRIPTION	SERVICE CODE	LEVEL TYPE	LEVEL VALUE	PROC CD QUAL	HCPCS CODE	CPT CODE 1	REVENUE CODE	POS	MODIFIER 1	MODIFIER 2	MODIFIER 3	MODIFIER 4	CLAIM FIL IND	Claim Type to File I=837I; P=837P; D=837D; E=Expdtd; N=NAT	ACTIVE	BEGIN DATE	END DATE
1	N0600	EMERGENCY DENTAL - PULL IMPACTED TOOTH	5			AD	D7220									D	A	05/27/1999	12/31/2199
1	N0600	EMERGENCY DENTAL - PULL OF TOOTH DAMAGED	5			AD	D7210									D	A	05/27/1999	12/31/2199
1	N0600	EMERGENCY DENTAL - GENERAL NUMBING AND EACH SUBSEQUENT 15 MINUTES	5			AD	D9221									D	A	05/27/1999	12/31/2199
1	N0600	EMERGENCY DENTAL - CUT AND EVACUATE ABSCESS - INTRAORAL	5			AD	D7510									D	A	05/27/1999	12/31/2199
1	N0600	EXTRACTION ERUPTED TOOTH/EXR	5			AD	D7140									D	A	01/01/2006	12/31/2199
1	G0452	OT-REHABILITATIVE SERV	7			HC		97039	0431		U1	UA				I	A	01/01/1900	12/31/2199
1	G0453	OT ASSESSMENT-REHABILITATIVE SERV	7			HC		97003	0434		U1	UA				I	A	01/01/1900	12/31/2199
1	G0467	OT-REHABILITATIVE SERVICE CONTRACTED	7			HC		97039	0431		U1	UA	GO			I	A	10/01/2008	12/31/2199
1	G0468	OT-ASSESSMENT-REHABILITATIVE SERVICE CONTRACTED	7			HC		97003	0434		U1	UA	GO			I	A	10/01/2008	12/31/2199
1	G0479	CPWC ASSESSEMENTS BY PT SERVICE CONTRACTED.	7B			HC		97542	0434		U1	UA	GO			I	A	10/01/2008	12/31/2199

Texas LTC Local Codes				National Codes															
SERVICE GROUP	BILL CODE	DESCRIPTION	SERVICE CODE	LEVEL TYPE	LEVEL VALUE	PROC CD QUAL	HCPCS CODE	CPT CODE 1	REVENUE CODE	POS	MODIFIER 1	MODIFIER 2	MODIFIER 3	MODIFIER 4	CLAIM FIL IND	Claim Type to File I=837I; P=837P; D=837D; E=Expdtd; N=NAT	ACTIVE	BEGIN DATE	END DATE
1	G0956	CPWC ASSESSMENTS BY OT	7B			HC		97542	0434							I	A	01/01/2008	12/31/2199
1	G0454	PT-REHABILITATIVE SERV	8			HC		97039	0421		U1	UA				I	A	01/01/1900	12/31/2199
1	G0455	PT ASSESSMENT-REHABILITATIVE SERV	8			HC		97001	0424		U1	UA				I	A	01/01/1900	12/31/2199
1	G0469	PT-REHABILITATIVE SERVICE CONTRACTED	8			HC		97039	0421		U1	UA	GP			I	A	10/01/2008	12/31/2199
1	G0470	PT-ASSESSMENT-REHABILITATIVE SERVICE CONTRACTED	8			HC		97001	0424		U1	UA	GP			I	A	10/01/2008	12/31/2199
1	G0480	CPWC ASSESSEMENTS BY OT SERVICE CONTRACTED.	8B			HC		97542	0424		U1	UA	GP			I	A	10/01/2008	12/31/2199
1	G0957	CPWC ASSESSMENTS BY PT	8B			HC		97542	0424							I	A	01/01/2008	12/31/2199
1	G0456	ST-REHABILITATIVE SERV	9			HC		92507	0441		U1	UA				I	A	01/01/1900	12/31/2199
1	G0457	ST ASSESSMENT-REHABILITATIVE SERV	9			HC	V5364		0444		U1	UA				I	A	01/01/1900	12/31/2199
1	G0457	ST ASSESSMENT-REHABILITATIVE SERV	9			HC		92523	0444		U1	UA				I	A	06/01/2014	12/31/2199
1	G0457	ST ASSESSMENT-REHABILITATIVE SERV	9			HC		92521	0444		U1	UA				I	A	06/01/2014	12/31/2199
1	G0457	ST ASSESSMENT-REHABILITATIVE SERV	9			HC		92524	0444		U1	UA				I	A	06/01/2014	12/31/2199

Texas LTC Local Codes				National Codes															
SERVICE GROUP	BILL CODE	DESCRIPTION	SERVICE CODE	LEVEL TYPE	LEVEL VALUE	PROC CD QUAL	HCPCS CODE	CPT CODE 1	REVENUE CODE	POS	MODIFIER 1	MODIFIER 2	MODIFIER 3	MODIFIER 4	CLAIM FIL IND	Claim Type to File I=837I; P=837P; D=837D; E=Expdtd; N=NAT	ACTIVE	BEGIN DATE	END DATE
1	G0457	ST ASSESSMENT-REHABILITATIVE SERV	9			HC		92522	0444		U1	UA				I	A	06/01/2014	12/31/2199
1	G0471	ST-REHABILITATIVE SERVICE CONTRACTED	9			HC		92507	0441		U1	UA	GN			I	A	10/01/2008	12/31/2199
1	G0472	ST-ASSESSMENT-REHABILITATIVE SERVICE CONTRACTED	9			HC	V5364		0444		U1	UA	GN			I	A	10/01/2008	12/31/2199
1	G0472	ST-ASSESSMENT-REHABILITATIVE SERVICE CONTRACTED	9			HC		92522	0444		U1	UA	GN			I	A	06/01/2014	12/31/2199
1	G0472	ST-ASSESSMENT-REHABILITATIVE SERVICE CONTRACTED	9			HC		92524	0444		U1	UA	GN			I	A	06/01/2014	12/31/2199
1	G0472	ST-ASSESSMENT-REHABILITATIVE SERVICE CONTRACTED	9			HC		92521	0444		U1	UA	GN			I	A	06/01/2014	12/31/2199
1	G0472	ST-ASSESSMENT-REHABILITATIVE SERVICE CONTRACTED	9			HC		92523	0444		U1	UA	GN			I	A	06/01/2014	12/31/2199
1	G0500	DME - ROLLABOUT CHAIR	15			HC	E1031		0290							I	A	05/19/1998	12/31/2199
1	G0500	DME/ADAPTIVE AIDS - COMMUNICATION OTHER	15			HC	E1902		0290							I	A	05/19/1998	12/31/2199
1	G0500	DME/ADAPTIVE AIDS - OTHER (IN HOME/NON-VEHICLE LIFT)	15			HC	E0636		0290							I	A	05/19/1998	12/31/2199
1	G0500	DME/ADAPTIVE AIDS -	15			HC	E2510		0290							I	A	01/01/2010	12/31/2199

Texas LTC Local Codes				National Codes															
SERVICE GROUP	BILL CODE	DESCRIPTION	SERVICE CODE	LEVEL TYPE	LEVEL VALUE	PROC CD QUAL	HCPCS CODE	CPT CODE 1	REVENUE CODE	POS	MODIFIER 1	MODIFIER 2	MODIFIER 3	MODIFIER 4	CLAIM FIL IND	Claim Type to File I=837I; P=837P; D=837D; E=Expdtd; N=NAT	ACTIVE	BEGIN DATE	END DATE
		COMMUNICATIO N DEVICE																	
1	G0500	DME - MISCELLANEOUS (HOSPITAL BEDS VENTILATOR)	15			HC	E1399		0290							I	A	05/19/1998	12/31/2199
1	G0500	DME - STANDARD WHEELCHAIR	15			HC	E1130		0290							I	A	05/19/1998	12/31/2199
1	G0955	CUSTOMIZED POWER WHEELCHAIR	15A			HC	K0898		0290							I	A	01/01/2008	12/31/2199
1	G0970	CUSTOM MANUAL WHEELCHAIR	15D			HC	K0009		0290							I	A	06/01/2012	12/31/2199

