Medicaid

Amerigroup
District of Columbia

Provider orientation

Amerigroup District of Columbia, Inc.

Services provided by Amerigroup District of Columbia, Inc.

Agenda

- Welcome to Amerigroup
- Introduction to Amerigroup & provider resources
- Claims and billing
- Pre-service processing, rejected & denied claims
- Grievances and appeals
- Population health, enrollee benefits, and services
- Health homes
- Additional resources

Additional resources at the conclusion of the presentation.

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Department of Health Care Finance

The Department of Health Care Finance is the state agency with responsibility for implementation and administration of the Medicaid program: District of Columbia Healthy Families Program (DCHFP) and the Children's Health Insurance Program (CHIP).

The Department of Health Care Finance is also responsible for administering:

- Alliance.
- The Immigrant Children's Program (ICP).
- The District's Child and Adolescent Supplemental Security Income Program (CASSIP).

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Single system of care

The District of Columbia Department of Healthcare Finance (DHCF) contracted Amerigroup to provide comprehensive healthcare services, including physical and behavioral health.

This initiative creates a single system of care to promote the delivery of efficient, coordinated, and high-quality healthcare and establishes accountability in healthcare coordination.

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Provider communications and education

- Provider websites
- Provider manuals
- Monthly provider newsletters
- Fax blasts about program and process changes
- Access to specialized education and training:
  - ICD codes
  - Cultural competency
  - *HIPAA*
  - Quality
  - Early and periodic screening, diagnostic and treatment (EPSDT)
  - *Individuals with Disabilities Education Act (IDEA)*
  - HealthCheck
  - Additional courses and learning resources specifically designed to meet the training needs of our providers

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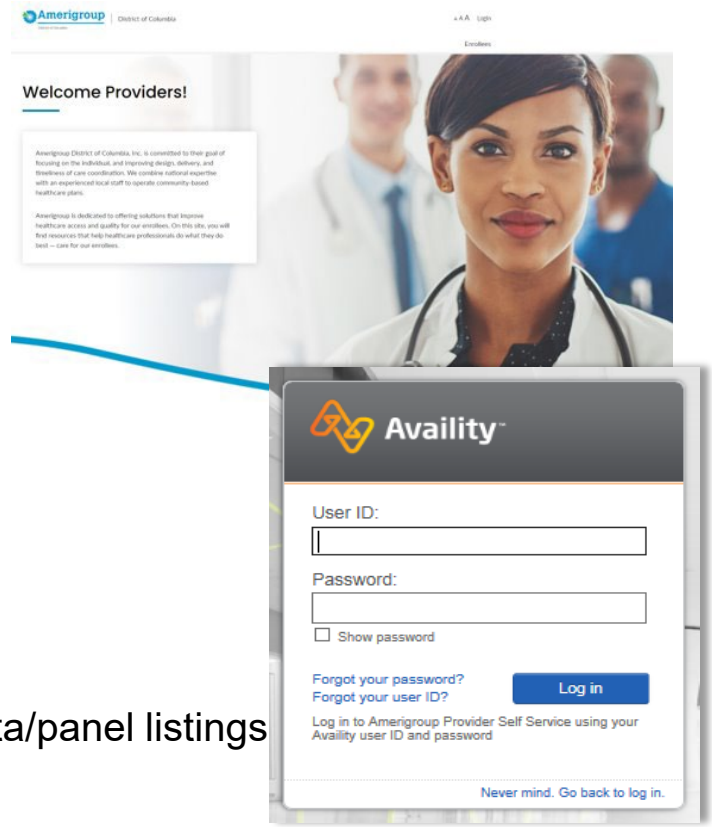
Provider website

- Provider tools & trainings:
  - *Medical Policies*, *UM Guidelines*, and manuals
  - DCHF Enrollment information
  - Health education/case management
  - Digital provider newsletters
  - Referral directory/look-up tool
  - Orientations & CME trainings
  - Cultural & Linguistic Services (CLAS) resources
  - Contact us options
- Availity Essentials * multi-payer secure website:
  - Eligibility & Benefits
  - Provider Online Reporting: Access assigned enrollee data/panel listings
  - Claims submission and Claims Status
  - Provider Enrollment: Network participation requests
  - Authorization Request & Inquiry
  - Provider Data Maintenance: Provider data updates



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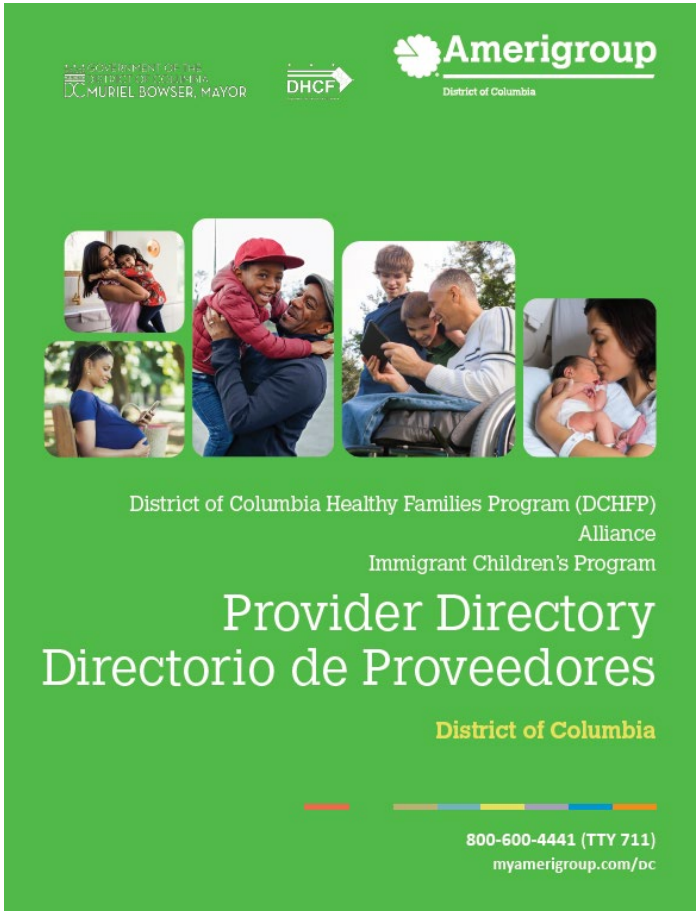
Provider manual



The provider manual is a key support resource for:

- Preauthorization requirements.
- An overview of covered services.
- Enrollee eligibility verification process.
- Enrollee benefits.
- Access and availability standards.
- The grievances and appeals process.

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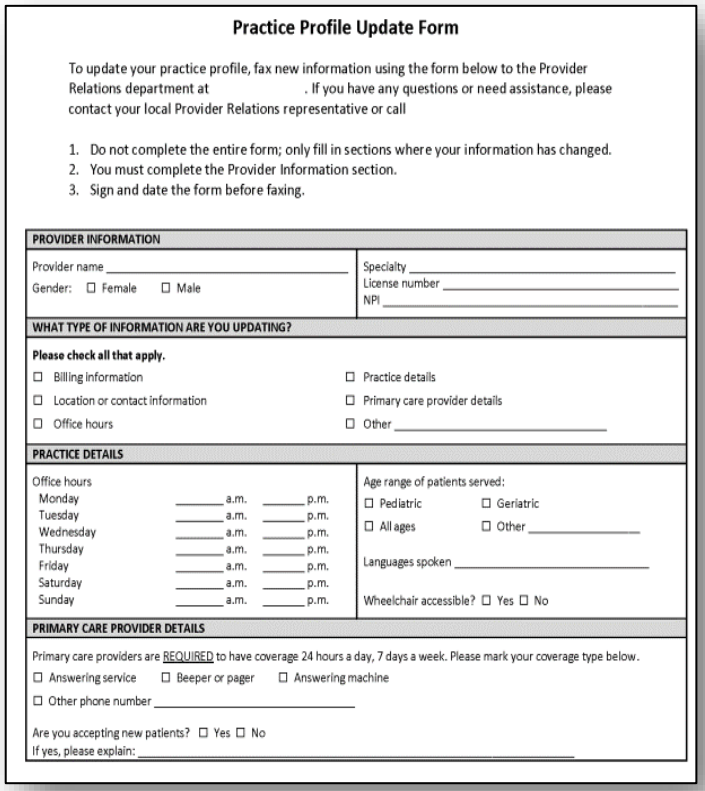
Practice update



Practice Profile Update Form

To update your practice profile, fax new information using the form below to the Provider Relations department at . If you have any questions or need assistance, please contact your local Provider Relations representative or call

1. Do not complete the entire form; only fill in sections where your information has changed.
2. You must complete the Provider Information section.
3. Sign and date the form before faxing.

PROVIDER INFORMATION

Provider name _____
Gender: ☐ Female ☐ Male
Specialty _____
License number _____
NPI _____

WHAT TYPE OF INFORMATION ARE YOU UPDATING?

Please check all that apply.

☐ Billing information
☐ Location or contact information
☐ Office hours
☐ Practice details
☐ Primary care provider details
☐ Other _____

PRACTICE DETAILS

Office hours

Monday	_____ a.m.	_____ p.m.
Tuesday	_____ a.m.	_____ p.m.
Wednesday	_____ a.m.	_____ p.m.
Thursday	_____ a.m.	_____ p.m.
Friday	_____ a.m.	_____ p.m.
Saturday	_____ a.m.	_____ p.m.
Sunday	_____ a.m.	_____ p.m.

Age range of patients served:
☐ Pediatric ☐ Geriatric
☐ All ages ☐ Other _____

Languages spoken _____

Wheelchair accessible? ☐ Yes ☐ No

PRIMARY CARE PROVIDER DETAILS

Primary care providers are REQUIRED to have coverage 24 hours a day, 7 days a week. Please mark your coverage type below.
☐ Answering service ☐ Beeper or pager ☐ Answering machine
☐ Other phone number _____

Are you accepting new patients? ☐ Yes ☐ No
If yes, please explain: _____

Paper: Submit information changes to us at https://providers.amerigroup.com/DC.

Digital resource through Availity-(coming soon)

Applicable changes include the following:

- Change in practice name
- Adding or updating site, billing/remit, email address, phone, or fax number
- Change to tax ID (new signed contract required)
- Change to provider name
- Adding or terminating a provider
- Adding NPI, Medicare, or Medicaid numbers
- Initiating the Council for Affordable Quality Healthcare (CAQH) numbers for new providers

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Cultural competency

Amerigroup is dedicated to providing high-quality, effective and compassionate care to all patients. There are many challenges in delivering health care to a diverse patient population. We're here to help.

Amerigroup offers:

- Translation of Enrollee materials in multiple languages
- Telephonic and onsite interpreter services through our Amerigroup enrollee services line and local vendors
- Cultural competency training tips and CME trainings on our provider website through the Amerigroup Training Academy
- Guides and resources based on the Culturally and Linguistically Appropriate Service (CLAS) Standards, including the My Diverse Patients training platform and local vendors.

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Key contact information

Provider services:	**800-454-3730**	**Member services:**	**800-600-4441**
Website:	https://providers.Amerigroup.com/DC		
Physical health prior authorization (PA):	Web: Availity www.availity.com	**Pharmacy PA**	Phone: **800-454-3730** Fax: **844-487-9292** Medical injectable: **844-487-9294**
	Phone: **800-454-3730**	**Behavioral health PA:**	Should be submitted electronically using our preferred method via www.Availity.com
Medical authorization fax numbers	Inpatient requests: **844-495-4419** Outpatient requests: **844-495-4421**	**Behavioral health authorization request fax numbers**	Inpatient requests: **844-445-6647** Outpatient requests: **844-451-2829**
Paper claim submission:	Claims Amerigroup District of Columbia, Inc. P.O. Box 61010 Virginia Beach, VA 23466-1010		
Electronic claim submission:	Availity EDI gateway: • 837 — Institutional claims • 837 — Professional claims • 837 — Dental claims • 835 — Electronic remittance advice • 276/277 — Claims status: Batch • 270/271 — Eligibility request: Batch		Payer IDs Change Healthcare (formerly Emdeon): 27514 Availity: 26375

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Required Medicaid ID number

- To get reimbursed for Medicaid, providers are required to have a Medicaid number.
- If a potential provider does not have a Medicaid number assigned, we'll work with the provider and the District to complete the necessary paperwork and assist the provider with obtaining a Medicaid number.
- You may register for a Medicaid number at

www.dc-Medicaid.com

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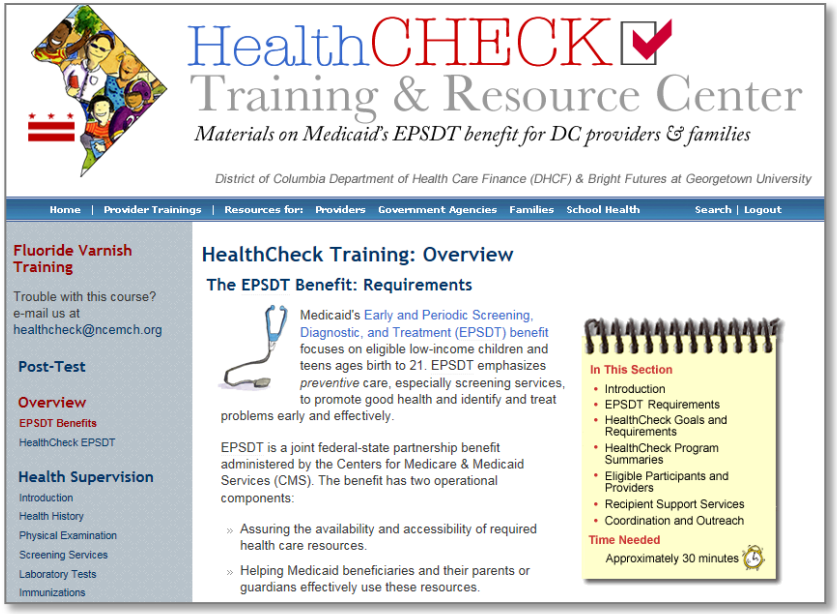
HealthCheck/EPSDT training

- HealthCheck providers must complete the web-based HealthCheck training within 30 days of joining our network and at least every two years thereafter.
- Compliance with HealthCheck training is also a requirement for recredentialing.
- The HealthCheck *Training and Resource Center* is located at https://www.dchealthcheck.net. The HealthCheck provider training module satisfies the EPSDT and IDEA provider training requirements for HealthCheck providers.



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Verifying enrollee eligibility

Always confirm an enrollee's eligibility and PCP of record before providing services:

- Amerigroup resources for determining the enrollee's specific benefit plan and coverage include the following:
  - Availity Essentials – Eligibility & Benefits: https://www.availity.com
  - Enrollee Services: **800-600-4441**, Monday to Friday, 8:30 a.m. to 7 p.m. ET
- Real-time enrollee enrollment and eligibility verification for all District of Columbia Medicaid programs is available 24 hours a day, 7 days a week:
  - IVR system: **202-906-8319**
  - Website: https://www.dc-medicaid.com/dcwebportal

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Claim submission (ERA & EFT)

Amerigroup encourages the use of the Availity EDI:

- Acknowledges receipt of claims electronically
- Improves claims tracking
- Improves claims status reporting
- Reduces adjudication turnaround
- Eliminates paper
- Improves cost-effectiveness
- Allows for auto adjudication of claims –which mean faster claims payment

Use EnrollSafe to register and manage EFT account changes.
https://enrollsafe.payeehub.org/.

Availity

https://www.availity.com

Paper submission

Claims
Amerigroup District of Columbia, Inc.
P.O. Box 61010
Virginia Beach, VA 23466-1010

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Laboratory services

Testing sites *must* have a *Clinical Laboratory Improvement Act/ Amendments* (*CLIA*) certificate or a waiver.

Notification or precertification is not required if lab work is performed:

- In a physician's office.
- In a participating hospital outpatient department (for stat services).
- By one of our preferred lab vendors (LabCorp and Quest).

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Pharmacy program

The *Preferred Drug List* (*PDL*) and formulary are available on our website.

Prior authorization is required for:

- Nonformulary drug requests.
- Brand name medications when generics are available.
- High-cost injectables and specialty drugs.
- Any other drugs identified in the formulary as needing prior authorization.

Note: This list is not all-inclusive and is subject to change.

Balance billing

You must:

- **Not** balance bill enrollees.
- Submit notification and authorization prior to providing non-covered services.

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Medically necessary

Federal and District law as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy, and must be considered first when determining eligibility for coverage.

- Amerigroup uses *Amerigroup Medical Policies* or *Clinical Utilization Management (UM) Guidelines* to determine whether services are considered to be:
  a) investigational/experimental.
  b) medically necessary.
  c) cosmetic or reconstructive.
- A list of the specific *Amerigroup Medical Policies* and *Clinical UM Guidelines* used is posted and maintained on the Amerigroup website at https://providers.amerigroup.com/DC.
- Amerigroup utilizes evidence-based guidelines (McKesson InterQual criteria) to determine medical necessity for acute inpatient care and for skilled nursing care.

Services requiring prior authorization*

- Cardiac rehabilitation
- Chemotherapy
- Chiropractic services
- Diagnostic testing
- Durable medical equipment (all rentals; see your provider manual)
- Home health
- Utilization management:
- Hospital admission
- Physical therapy, occupational therapy, and speech therapy treatment
- Sleep studies
- BH services

* Not an exhaustive list. Check Amerigroup website for more info.

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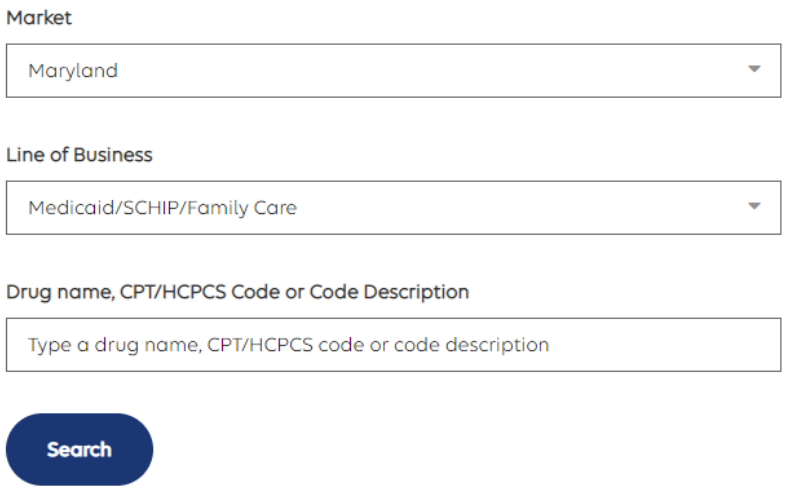
Prior authorization lookup tool

Look-up precertification requests via provider website:

Search by *Market, Line of Business or Drug name, CPT/HCPCS code,* or *Code Description.*

Please note:

- This tool is for outpatient services only.
- This tool does not reflect benefits coverage*, nor does it include an exhaustive listing of all non-covered services (i.e., experimental procedures, cosmetic surgery, etc.). Refer to your **Provider Manual** for coverage or limitations.



Check the status of your request on the website or by calling Provider Services.

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Rejected vs denied claims

There are two notices types you may get in response to your claim submission:

Rejected	Denied
Does not enter the adjudication system due to missing or incorrect information. Please review electronic response reports for rejections.	Goes through the adjudication process but is denied for payment.

Remember:

- You can find claims status information at https://www.availity.com or by calling Provider Services at **800-454-3730**.

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Preservice authorization denials/appeals

- If an authorization is denied prior to the service being rendered to the enrollee, either the enrollee or the provider on behalf of an enrollee can submit an appeal. This appeal type requires the enrollees written consent when submitted by a provider.
- Appeals must be filed within 60 calendar days of the notice of denial/adverse benefit determination.
- Appeals are reviewed and resolved within 30 calendar days. If additional time is needed, a 14 day extension maybe approved.
- Appeals requiring expedited review will be reviewed and resolved within 72 hours of receipt. Expedited appeals are allowed if it is determined that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.
- Appeals that require and expedited review should only be submitted by electronic methods outlined below. **Do not mail expedited appeal request**.
- There is one level of appeal for a denied authorization. If the enrollee or provider filing on behalf of the enrollee disagree with the appeal decision, they may file request for a hearing with the District of Columbia. Instructions on how to file a request will be included in the appeal denial notification letter and is also available in enrollee and provider handbooks.

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Submitting pre-service appeals

- Providers can submit appeals on the enrollee's behalf by logging into Availity Essentials and accessing Interactive Care Reviewer (ICR). Locate the case on your dashboard or through Check Case Status. Select the Appeal button from the Case Overview screen. The enrollee's consent can be attached to the request for appeal.
- Appeal forms can also be downloaded from https://providers.amerigroup.com/DC and submitted the in following ways:
  - By fax to **866-516-4806**
  - By email to MedicaidDCGA@amerigroup.com
  - By calling Provider Services **800-454-3730** requesting an appeal be created
  - Non-expedited appeals can be mailed to:
    Amerigroup District of Columbia Inc.
    Member Appeals
    P.O. Box 62429
    Virginia Beach, VA 23466-2429
- Enrollees can also submit an appeal online via new enrollee secure website or mobile application.

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Provider post service/retrospective appeals

- If services have been rendered to the enrollee, providers should file the claim along with Medical records and explanation of any extenuating circumstances for not submitting the prior authorization, and a medical necessity review will be completed:
  - If a provider is dissatisfied with the outcome of an initial *Medical Necessity* review done as part of the claim submission, they can file an appeal.
- Claims denied because medical necessity review previously denied the preauthorization request can also be appealed to request another review of the medical rational for providing the service.
- If the appeal decision results in a claim adjustment, the payment and *Explanation of Payment* will be sent separately from the appeal decision.
- Provider authorization/UM appeals can be submitted the following ways:
- Digitally: Using Interactive Care Reviewer accessed through Availity Essentials at Availity.com
- Fax: Directly to the Appeals department at **866-587-3316**
- Appeals must be submitted within 60 calendar days from initial denial. Amerigroup will send written acknowledgment of the appeal to the provider within two business days of receipt.
- Amerigroup will respond to appeals associated with a claim denial within 30 days.

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Submitting post service appeals

- Providers can submit a claims (no authorization requested) reconsideration though Availity Essentials by selecting claim payment appeal and the initial medical necessity review will be completed.
  - Select the dispute button in Claim Status to initiate & Navigate to appeals tool to add documents and complete
- Providers who do not agree with a medical necessity decision can file an appeal for a second review of the case.
- Providers can request a medical necessity appeal by logging into the Availity and accessing the Authorization in *ICR- select appeal decision.*
- Appeal forms can also be downloaded from https://providers.amerigroup.com/DC and submitted the in following ways:
  - By fax to **866-516-4806**
  - By email to MedicaidDCGA@amerigroup.com
  - By calling Provider Services **800-454-3730** requesting an appeal be created
  - Mail:

    Amerigroup District of Columbia Inc.
    Member Appeals
    P.O. Box 62429
    Virginia Beach, VA 23466-2429

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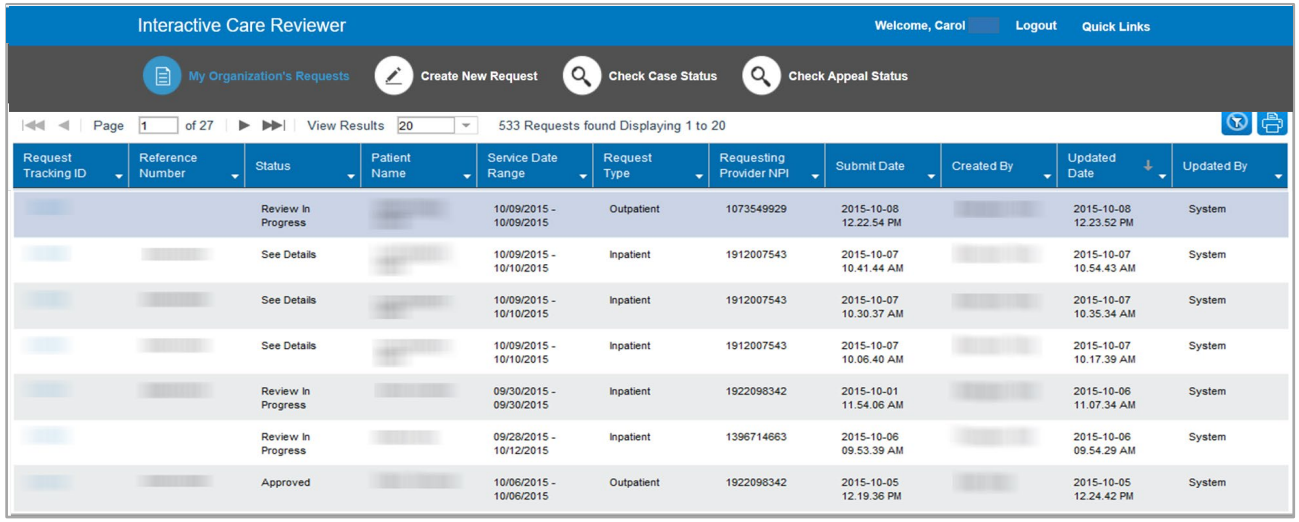
Grievances and appeals

Interactive Care Reviewer

- Submit requests and inquire on medical and behavioral health pre-authorizations using Interactive Care Reviewer (ICR) accessed on Availity Essentials.
- Submit appeals of denied authorizations by locating the case on your dashboard or selecting Check Case **Status.** Then select the **Appeal** button from the Case Overview screen. Add additional documents needed for appeal including an enrollee consent form.
- Status of your appeal can be found in ICR. Select the appeal case number provided on the appeal acknowledgement letter.



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Provider claims payment/dispute process

Providers may access a timely claims/payment dispute resolution process.

- A claims/payment dispute is a claim or any portion of a claim that is denied for any reason or underpaid. Amerigroup must receive payment disputes within 90 business days of the paid date of the *Explanation of Payment* (*EOP*).
- The provider must submit a written request including:
  - An explanation of the issue in dispute.
  - The reason for dispute and all supporting documentation (for example, medical records).
  - *EOP.*
  - A copy of the claim.

To submit a payment dispute, complete the *Payment Dispute Form* located online at https://providers.amerigroup.com/DC and mail to:

- Payment Dispute Unit
  Amerigroup District of Columbia, Inc.
  P.O. Box 61599
  Virginia Beach, VA 23466-1599
- These should all be done through Availity.

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Population management

Health promotions services
800-964-2112 ext. 44120

Case management enrollee referrals
800-454-3730

Disease management enrollee referrals
888-830-4300

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Patient and family-centered care

Patient- and family-centered care is an innovative approach to the planning, delivery, and evaluation of healthcare grounded in a mutually beneficial partnership among patients, families, and providers.

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Enrollee benefits and services

- Coordination of care where applicable
- Initial health assessments
- Physician office visits – inpatient and outpatient services
- Durable medical equipment and supplies
- Emergency services
- Case management and utilization management where applicable
- Pharmacy benefits through CarelonRx.*

New enrollees also receive a welcome letter, enrollee handbook, and provider directory.

Detailed benefits and services information is available in the provider manual at https://www.providers.amerigroup.com/DC.

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Primary care provider (PCP) selection

Enrollees:

- Must select an in-network PCP.
- Can change their PCP at any time (must call enrollee services or complete PCP change form).
- Can see an in-network specialist without a referral.

Note: A PCP is not paid unless he or she is the PCP of record.

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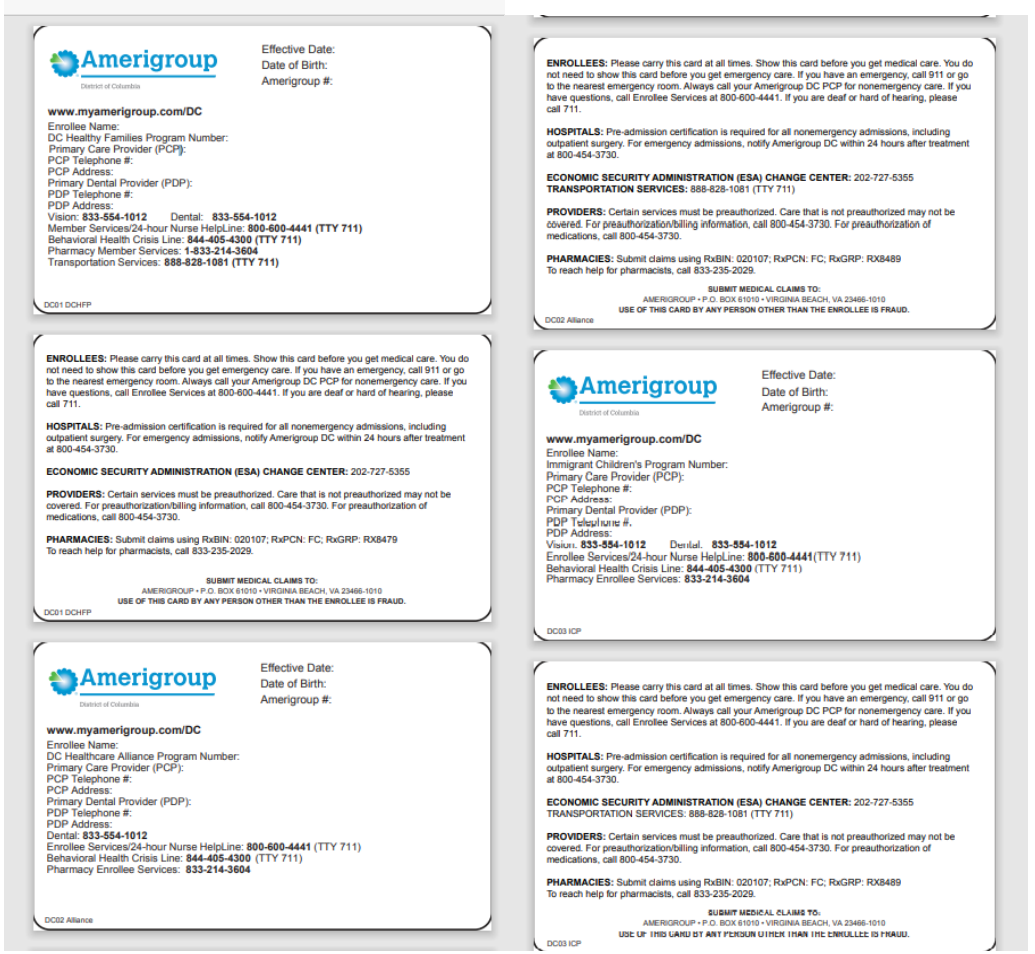
Enrollee card template guidelines

- DCHFP
- Immigrant Children's Program (ICP)
- Alliance



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Access and availability

Measure	Standard
Behavioral health access standards	
Appointment times	• Services for the assessment and stabilization of psychiatric crises must be available 24/7. • Phone-based assessment must be provided within 15 minutes of request. • When medically necessary, intervention or face-to-face assessment must be provided within 90 minutes of completion of the phone assessment.
Dental access standards	
Ratios	At least one full-time equivalent (FTE) dentist for every 750 child enrollees
EPSDT – enrollees under 21 years of age	
Appointment times	• Initial EPSDT screens must be offered within 60 days of the enrollee's enrollment with Amerigroup or at an earlier time if needed (in other words, to comply with the periodicity schedule, if the child's case indicates a more rapid assessment, if a request results from an emergency medical condition). • All initial EPSDT screens must be completed with three months of the enrollee's enrollment with Amerigroup unless the enrollee is up-to-date with the periodicity schedule. • All EPSDT screens, tests and immunizations must be completed within 30 days of their due dates for children under two years of age and within 60 days of their due dates for children two years and older. • Periodic EPSDT screening exams must take place within 30 days of request. • IDEA multidisciplinary assessments must be completed within 30 days of request. Needed treatments shall begin within 25 days of receipt of a completed and signed *Individualized Family Service Plan Assessment.*
Hospital access standards	
Distance	Within 30 minutes travel time by public transportation

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Access and availability (cont.)

Measure	Standard
Laboratory access standards	
Distance	Within five miles or no more than 30 minutes travel time
PCP and OB/GYN access standards	
Distance	• At least two age-appropriate PCPs within five miles or no more than 30 minutes travel time • At least one OB/GYN within five miles or no more than 30 minutes travel time
Ratios	At least one FTE PCP for every 500 enrollees and one FTE PCP with pediatric training for every 500 children (20 years of age and younger)
Appointment times	• Adults: initial appointment within 45 days of enrollment or within 30 days of request, whichever is sooner • Routine: within 30 days • Urgent and emergent: available 24/7 • Initial pregnancy or family-planning services: within 10 days of request
Pharmacy access standards	
Distance	• There must be at least two pharmacies within two miles of each enrollee's residence. • The network must include at least one 24/7 pharmacy, one pharmacy providing home delivery within four hours and one pharmacy offering mail-order service.
Specialty access standards	
Appointment times	Routine: within 30 days

24-Hour Nurse HelpLine

- Enrollees can speak to a registered nurse who can answer their questions and help decide how to take care of any health problems.
- If medical care is needed, our nurses can help an enrollee decide where to go.
- The phone number is located on the back of our enrollee ID cards.

Enrollees can call Nurse HelpLine for health advice seven days a week, 365 days a year. When an enrollee uses this service, a report is faxed to the Amerigroup office within 24 hours of receipt of the call.

Nurse HelpLine

866-864-2544 (TTY **711**)

866-864-2545 (Spanish)

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Benefit partners

Contact name	Contact information
AVESIS (vision & dental services)	Provider Services: **833-554-1013** Enrollee Services: **833-554-1012** Claims Department: P.O. Box 38300 Phoenix, AZ 85069
CarelonRx (pharmacy services)	General phone: **833-235-2029** Prior authorization (PA) phone: **800-454-3730** Retail PA fax: **844-487-9292** Medical injectable PA fax: **844-487-9294**

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Interpreter and translation services

- We offer interpreter services, telephonic translations, and in-person translations in over 170 languages. Our interpreters are formally trained and fluent in communicating in the enrollee's primary, non-English language.
- Enrollees and providers should call at least 24 hours before the scheduled appointment.
- Interpreters who provide communication for deaf or hard-of-hearing enrollees should be offered to enrollees who need these services.
- Enrollees should call the toll-free AT&T Relay Service at TTY 711 at least five days before the scheduled appointment, and we will set up and pay for a person who knows sign language to help during the office visit.

Enrollee Services
800-600-4441

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MTM* nonemergency transportation services

Enrollees can call the MTM Call Center to schedule trips, change trip details (time/date/additional passengers) and cancel their rides.

MTM Call Center

888-828-1183

Monday to Friday, 7 a.m. to 10 p.m. ET

Saturday, 7 a.m. to 6:30 p.m. ET

tphelpdesk@mtm-inc.net

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Value-added services

We believe expanded programs and services provide opportunities to help care for the whole person and better address the specific needs for each segment of the population.

For staying healthy	• $50 in over-the-counter medicines • Weight Watchers® vouchers to help eligible enrollees lose weight • Baby & Toddler Essentials up to $200 • DCHFP app to find doctors, access enrollee ID cards, and send them to a doctor if needed
For getting better	• Digital mental health toolkit – a mental health and well-being app • Amerigroup on Call to get health advice from a nurse day or night • Disease management programs to help enrollees with special health conditions set goals and manage their health
For living healthy	• Free memberships for children ages 6-18 at Boys & Girls Clubs of Greater Washington (District of Columbia locations) • General Education Development (GED) test vouchers for qualified enrollees 18 and up • Free cellphone with data, talk, and texts and unlimited calls to Enrollee Services

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Behavioral health

- Our mission is to coordinate the physical and behavioral health (BH) care of enrollees, offering a continuum of targeted interventions, education, and enhanced access to care to ensure improved outcomes and quality of life for Amerigroup enrollees.
- BH services for Amerigroup include a robust array of both mental health services and substance use disorder services.
- We work collaboratively with healthcare providers, community mental health centers (CMHCs), the D.C. Department of Behavioral Health (DBH), substance use disorder providers, and a variety of community agencies and resources to successfully meet the needs of enrollees with mental health (MH) and substance use disorders (SUDs).

Integration of behavioral health and physical health

- Integrated physical health/behavioral health case management training for all case managers
- Integrated quality management committee and medical advisory group
- One integrated IT system for both physical and behavioral health - Health Insights Platform (HIP)
- Behavioral case management including enrollees with co-occurring disorders

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My DC Health Home benefit

- A health home is a service delivery model that coordinates an enrollee's health and social service needs — primary and hospital health services, mental healthcare, substance abuse care, and long-term care services and supports. A health home care manager will serve as the central point for coordinating all of an enrollee's clinical and nonclinical needs.
- My DC Health Home services are provided through community-based mental health providers (core service agencies) certified by the District to be a health home. They have hired nurses, primary care doctors, and others with social and health-related backgrounds to create care teams.

Enrollees with a serious mental illness or serious emotional disturbance are eligible for the My DC Health Home benefit.

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My Health GPS health home benefit

Enrollees are eligible for My Health GPS if they have three or more of the following chronic health conditions:

- Mental health conditions (depression, personality disorder)
- Substance use disorder
- Diabetes
- Chronic renal failure (on dialysis)
- Hyperlipidemia
- Heart disease (congestive heart failure)
- Hypertension
- Sickle cell anemia
- Asthma
- Chronic obstructive pulmonary disease
- Cerebrovascular disease
- Morbid obesity
- Hepatitis
- HIV
- Malignancies
- Paralysis
- Peripheral atherosclerosis

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Health home benefits

Core health home services include:

- Comprehensive care management.
- Care coordination.
- Transitions in care.
- Support to individual and family enrollees.
- The facilitation of referrals to community services and supports.
- Health promotion and self-care.

The District identifies eligible enrollees and assigns the enrollee to a health home provider. To refer an enrollee to a health home, call the DC Access HELPLINE at **888-7WE-HELP** (**888-793-4357**).

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District of Columbia

Office of the healthcare ombudsman and *Bill of Rights*

The District of Columbia's Office of the healthcare ombudsman and *Bill of Rights*:

- Tell enrollees about and help to understand healthcare rights and responsibilities.
- Help enrollees solve problems with healthcare coverage, access to healthcare, and issues regarding healthcare bills.
- Advocate for enrollees until their healthcare needs are addressed and fixed.
- Guide enrollees towards the appropriate private and government agencies when needed.
- Help enrollees with appeals processes.
- Track healthcare problems and report patterns to help fix what is causing the problem.

Amerigroup
District of Columbia

Fraud, waste, and abuse

Help us prevent it and tell us if you suspect it!

- Verify a patient's identity
- Ensure services are medically necessary
- Document medical records completely
- Bill accurately

Reporting fraud, waste, and abuse is required.

If you suspect or witness it, please tell us immediately by:

- Visit the provider website and completing the Report Waste, Fraud, and Abuse form.
- Call the SIU Hotline at **866-847-8247**
- Calling the External Anonymous Compliance Hotline at **877-725-2702** or filling out the form at https://www.amerigroup.silentwhistle.com.
- Emailing corpinvest@amerigroup.com or obe@amerigroup.com.
- **Contacting the Department of Health Care Finance**

  Division of Program Integrity

  441 4th Street NW, Washington, DC 20001

  Phone: **202-698-2000**
  Fraud Hotline: **877-632-2873**

Amerigroup
District of Columbia

Provider roles and responsibilities

- Provide preventive health screenings if you're a DCHFP PCP.
- Provide culturally competent care, with no discrimination whatsoever, complying with ADA standards.
- Maintain and support access standards (for example, wheelchair accessibility).
- Notify us of changes, such as billing address, name, full panel, and more.
- Encourage advance directives, educating your patients on their importance.
- Comply with *HIPAA* requirements and recordkeeping standards in all transactions, including medical records.
- Promote preventive care services to all patients.
- Identify behavioral health needs and participate in collaborating care.

Key enrollee responsibilities

Amerigroup enrollees have the responsibility to:

- Show their Amerigroup ID card each time they receive medical care.
- Make or change appointments and get to them on time.
- Call their doctor if they cannot make it to their appointment or will not be on time.
- Use the emergency room only for true emergencies.
- Pay for any services they ask for that are not covered by Medicaid.
- Treat their doctor and other healthcare providers with respect.
- Tell us, their doctor and their other healthcare providers what they need to know to treat them.
- Do the things that keep them from getting sick.
- Follow the treatment plans that the enrollee, the doctor, and their other healthcare providers agree on.

Note: This is not a complete list; refer to your provider manual for a full listing and additional details.

Amerigroup
District of Columbia

HIPAA compliance

- *HIPAA* was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of healthcare fraud, and simplifies the administration of health insurance.
- We strive to ensure our organization and our contracted, participating providers conduct business in a manner that safeguards enrollee information in accordance with *HIPAA* privacy regulations.

Individuals with Disability Education Act

- *IDEA* is a law ensuring services to children with disabilities throughout the nation. *IDEA* governs how states and public agencies provide early intervention, special education, and related services to more than 6.5 million eligible infants, toddlers, children, and youth with disabilities.
- Infants and toddlers with disabilities (birth through age two) and their families receive early intervention services under *IDEA* Part C. Children and youth (ages 3 to 21) receive special education and related services under *IDEA* Part B.
- PCPs evaluate the child to determine the need for services.
- If a child needs *IDEA* services, the PCP provides a referral to the District's Early Intervention Program.
- Website: https://osse.dc.gov/service/strong-start-dc-early-intervention-program-dc-eip

Early and periodic screening, diagnostic, and treatment (EPSDT)

PCPs are responsible for providing EPSDT services to enrollees from birth to age 21 in compliance with the *District of Columbia Periodicity Schedule* and *Salazar v. the District of Columbia Et Al.*

DHCF

Department of Health Care Finance

DC Medicaid HealthCheck Periodicity Schedule

Based on Recommendations from Preventive Pediatric Health Care from Bright Futures/American Academy of Pediatrics (AAP)

HealthCHECK

District of Columbia Department of Health Care Finance (DHCF)

The DC HealthCheck Periodicity Schedule follows AAP health recommendations in consultation with the local medical community. The recommendations are for the care of children who have no manifestations of any important health problems. Additional visits or interperiodic screens may become necessary if circumstances suggest the need for more screens, i.e., medical conditions, referral by parent, Head Start, DC Public Schools, early intervention services and programs. Developmental, psychosocial, and chronic disease issues may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal. If a child comes under care for the first time, or if any items are not done at the suggested age, the schedule should be brought up to date as soon as possible. The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

KEY: • = to be performed = risk assessment to be performed with appropriate action to follow, if positive ←—• —→ = range during which a service may be provided

AGE[1]	CPT CODE	INFANCY							EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLSECENCE										
		PRENATAL[2]	NEWBORN[3]	3-6 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	99381-5; or 99391-5	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PHYSICAL EXAMINATION[5]			•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MEASUREMENTS																																	
Length/Height and Weight	Included as part of preventive medicine visit CPT codes		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head Circumference			•	•	•	•	•	•	•	•	•	•	•																				
Weight for Length			•	•	•	•	•	•	•	•	•	•																					
Body Mass Index[6]													•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Blood Pressure[7]															•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
ANTICIPATORY GUIDANCE		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
ORAL HEALTH																																	
Oral Health Assessment[8]	D0191							•[9]	•[9]																								
Fluoride Varnish[10]	99188							←—•	—→	←—•	—→																						
SENSORY SCREENINGS																																	
Vision[11]	99173, 99174														•	•	•	•		•		•		•			•						
Hearing	92551-2, 92587		•[12]	•[13]	←—•	—→										•	•	•		•		•	←—•	—→		•[14]	←—•	—→	←—•	—→	←—•	—→	
DEVELOPMENTAL/BEHAVIORAL HEALTH																																	
Developmental Surveillance	Included as part of History	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Developmental Screening[15]	96110								•			•		•																			
Autism Spectrum Disorder Screening[16]	96110											•	•																				
Psychosocial/Behavioral Surveillance	Included as part of History	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Psychosocial/Behavioral Screening[17]	96127	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Tobacco, Alcohol, or Drug Use Screening[18]	99420																																
Behavioral Health Screening[19]	96127																							•	•	•	•	•	•	•	•	•	•
Maternal Depression Screening[20]	96161				•	•	•	•																									
PROCEDURES[5]																																	
Immunization[22]	90460-1; 90471-4		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Newborn Screening[23]	Bill as applicable depending on provider capacity		•	•	←—•	—→																											
Lead[24]	88655									•or [25]			•or [25]																				
Anemia[26]	Include all applicable CPT codes									•																							
Dyslipidemia[27]																					←—•	—→						←—•	—→			
Tuberculosis[28]																																	
Cervical Dysplasia[29]																																	•
Sexually Transmitted Infections[30]																																	
HIV[31]																											←—•	—→					
Hepatitis C Virus Infection[32]																														•	—→		

Updated October 2021

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* Availity, LLC is an independent company providing administrative support services on behalf of the health plan. CarelonRx, Inc. is a separate company providing utilization review services on behalf of the health plan. MTM is an independent company providing nonemergency transportation services on behalf of the health plan.

https://provider.amerigroup.com/DC