Amerigroup

District of Columbia

Provider Manual

Amerigroup District of Columbia, Inc.

800-454-3730

https://providers.amerigroup.com/DC

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This manual is not wholly inclusive of all Amerigroup policies and procedures. For more information on Amerigroup policies and procedures, visit the provider self-service website at **https://providers.amerigroup.com/DC** or contact your Provider Relations representative.

Please note: Material in this Provider Manual is subject to change. Please go to **https://providers.amerigroup.com/DC** for the most up-to-date information.

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GENERAL INFORMATION ABOUT THE DISTRICT OF COLUMBIA HEALTHY FAMILIES PROGRAM, ALLIANCE AND THE IMMIGRANT CHILDREN'S PROGRAM

Introduction

Amerigroup District of Columbia, Inc. is one of the managed care organizations (MCOs) serving the eligible population enrolled in the District of Columbia Healthy Families Program (DCHFP) and individuals not eligible for Medicaid who receive health care services through the Alliance and the Immigrant Children's Program (ICP).

Amerigroup District of Columbia, Inc., doing business as Amerigroup, is a wholly owned subsidiary of Amerigroup Partnership Holding Company, LLC.

The purpose of this provider manual is to highlight and explain the program's elements and to serve as a useful reference for providers who participate in the DCHFP, Alliance and ICP programs.

DCHFP, Alliance and ICP Eligibility

Eligibility for coverage through DCHFP, Alliance and ICP is determined through the District of Columbia Economic Security Agency (ESA).

PRIMARY AND SPECIALTY CARE PROVIDERS

Role of the PCP

The primary care provider (PCP) is a board-certified or board-eligible network provider who is responsible for providing primary care or arranging for the complete care of his or her enrollees. A PCP may be any of the following:

- Family Practice Physician
- General Practice Physician
- Internal Medicine Physician
- OB/GYN
- Pediatric Physician (when appropriate to the enrollee)
- Osteopath
- Clinic or FQHC
- Nurse practitioner
- Subspecialty Physician when appropriate in light of an Enrollee's Special Health Care Needs (with the approval of Amerigroup)
- Clinic may be chosen as an enrollee's PCP

Services Provided by the PCP

The PCP manages or arranges for all the health care needs of Amerigroup enrollees who select him or her as their PCP. Each PCP must regularly provide a minimum of 20 hours per week of personal availability. In this capacity as a designated PCP, all baseline physical, emergency, urgent, routine and follow-up care within the PCP's scope of medical training and practice are provided. In addition to managing all services for office care, coordination of hospital admissions and maintenance of the enrollee's complete medical record, PCPs are responsible for providing a wide range of services generally accepted in the community as primary care, including screening and referral as needed for behavioral health and substance abuse services. This also includes the responsibility to educate enrollees about the appropriate use of emergency services.

PCPs must make their best effort to contact each new enrollee to schedule an appointment for a baseline physical that is age- and gender-specific.

PCPs are also required to provide enrollees with telephone access 24 hours a day, 7 days a week. The telephone service may be answered by a designee such as an on-call physician or a nurse practitioner with physician backup. All automated after-hours messages must offer the option to either speak to a live party or respond to enrollee inquiries within 30 minutes.

Arrangements for coverage while off-duty or on vacation are to be made with other network PCPs. Covering PCPs must be able to provide medically necessary services and follow Amerigroup precertification guidelines. It is not acceptable to automatically direct the enrollee to the emergency room when the PCP is not available.

Assignment and Reassignment of an Enrollee

In-network PCPs receive a monthly panel listing identifying all Amerigroup enrollees assigned to them.

The Provider Inquiry Line is available 24 hours a day, 7 days a week at 1-800-454-3730. This is an automated telephone tool that enables providers to verify enrollee eligibility, precertification and claims status. Providers can also log in to the self-service website at https://providers.amerigroup.com/DC to verify enrollee eligibility or call a Provider Services representative at 1-800-454-3730 to answer eligibility questions.

Procedure for Selecting a PCP

Enrollees have the right to select their PCP as well as a primary dental provider. Upon enrollment, the enrollee may select a PCP from the directory or call Enrollee Services at 1-800-600-4441 for help to select a new provider. The enrollee may consider the provider's specialty, accessibility, gender, ethnic background and languages spoken in the selection process. The enrollee handbook includes a description of how to choose a PCP.

Amerigroup issues an enrollee ID card printed with the PCP's name and telephone number.

Default Assignment of a PCP

The Amerigroup provider network will be submitted to the Enrollee Services department to assist new enrollees in selecting a PCP. Enrollees who do not select a PCP will be assigned to one using the enrollment information provided (e.g., geographic proximity to the provider, age and language).

Procedure for Changing PCPs and Other Providers

Enrollees have the right to change their PCPs at any time. The enrollee may select a PCP from the directory or call Enrollee Services at 1-800-600-4441 for help to change his or her PCP. The enrollee handbook includes a description of how to change a PCP. PCP change requests will be processed generally on the same day or by the next business day. Within 10 days, the enrollee will receive a new ID card that displays the new PCP name and phone number.

Anti-Gag Provisions

If the provider is acting within the lawful scope of practice, Amerigroup will not prohibit a provider from advising an enrollee about his or her health status, medical care, or treatment for the enrollee's condition or disease regardless of whether benefits for such care or treatment options are provided by Amerigroup. Amerigroup will not retaliate or take action against a provider for advising the enrollee under these circumstances.

Procedures for Becoming a PCP

See the Provider Credentialing section for more information.

Additional Roles and Responsibilities of the Provider

Obligations of the specialist include the following:
Complying with all applicable statutory and regulatory requirements of the Medicaid program
Meeting eligibility requirements to participate in the Medicaid program
Accepting all enrollees within the scope of the specialist's practice
Submitting required claims information
Arranging for coverage with other network providers while off-duty or on vacation
Verifying enrollee eligibility and precertification of services (when required) at each visit
Providing consultation summaries or appropriate periodic progress notes on a timely basis following a routinely scheduled consultative visit
Specialists to notify both the PCP and Amerigroup, as well as requesting precertification from Amerigroup as appropriate, when scheduling a hospital admission or any other procedure requiring Amerigroup approval

Provider Credentialing

Amerigroup Discretion

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit Amerigroup's discretion in any way to amend, change or suspend any aspect of Amerigroup's credentialing program ("Credentialing Program") nor is it intended to create rights on the part of practitioners or HDOs who seek to provide healthcare services to Enrollees. Amerigroup further retains the right to approve, suspend, or terminate individual physicians and health care professionals, and sites in those instances where it has delegated credentialing decision making.

Credentialing Scope

Credentialing requirements apply to the following:

1. Practitioners who are licensed, certified or registered by the state to practice independently (without direction or supervision);
2. Practitioners who have an independent relationship with Amerigroup
   - An independent relationship exists when Amerigroup directs its Enrollees to see a specific practitioner or group of practitioners, including all practitioners whom a Enrollee can select as primary care practitioners; and
3. Practitioners who provide care to Enrollees under Amerigroup's medical benefits.

The criteria listed above apply to practitioners in the following settings:

1. Individual or group practices;

2. Facilities;
3. Rental networks:
   - That are part of Amerigroup's primary Network and include Amerigroup Enrollees who reside in the rental network area.
   - That are specifically for out-of-area care and Enrollees may see only those practitioners or are given an incentive to see rental network practitioners; and
4. Telemedicine.

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

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

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

- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Use Disorder Practitioners

Amerigroup credentials the following Health Delivery Organizations (HDOs):

- Hospitals
- Home Health agencies
- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health Facilities providing mental health and/or substance use disorder treatment in inpatient, residential or ambulatory settings, including:
    - Adult Family Care/Foster Care Homes
    - Ambulatory Detox
    - Community Mental Health Centers (CMHC)
    - Crisis Stabilization Units
    - Intensive Family Intervention Services
    - Intensive Outpatient – Mental Health and/or Substance Use Disorder Methadone Maintenance Clinics
    - Outpatient Mental Health Clinics
    - Outpatient Substance Use DisorderClinics
    - Partial Hospitalization – Mental Health and/or Substance Use Disorder
- Residential Treatment Centers (RTC) – Psychiatric and/or Substance Use Disorder
- Birthing Centers
- Home Infusion Therapy when not associated with another currently credentialed HDO

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

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

CREDENTIALS COMMITTEE

The decision to accept, retain, deny, or terminate a practitioner's or HDO's participation in on one or more of Amerigroup's networks or plan programs is conducted by a peer review body, known as Amerigroup's Credentials Committee (the "CC").

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC

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

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

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

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

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

NONDISCRIMINATION POLICY

Amerigroup will not discriminate against any applicant for participation in its Plan programs or provider Networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Amerigroup will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the Enrollees to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence. The CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Amerigroup will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. In the event discriminatory practices are identified through an audit or through other means, Amerigroup will take appropriate action to track and eliminate those practices.

INITIAL CREDENTIALING

Each practitioner or HDO must complete a standard application form deemed acceptable by Amerigroup when applying for initial participation in one or more of Amerigroup's networks or plan programs. For practitioners, the Council for Affordable Quality Healthcare (CAQH) ProView system is utilized. To learn more about CAQH, visit their web site at www.CAQH.org.

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

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

Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Enrollees.
Hospital admitting privileges at a TJC, NIAHO or AOA accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state controlled substance registrations • The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating Enrollees. Practitioners who see Enrollees in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

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

RE-CREDENTIALING

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

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

HEALTH DELIVERY ORGANIZATIONS

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

ONGOING SANCTION MONITORING

To support certain Credentialing Standards between the re-credentialing cycles, Amerigroup has established an ongoing monitoring program. The Credentialing Department performs ongoing monitoring to help ensure continued compliance with Credentialing Standards and to

assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the Credentialing Department will review periodic listings/reports within 30 calendar days of the time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General ("OIG")
- Federal Medicare/Medicaid Reports
- Office of Personnel Management ("OPM")
- State licensing Boards/Agencies
- Enrollee/Customer services departments
- Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal Amerigroup departments
- Any other information received from sources deemed reliable by Amerigroup.

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

CREDENTIALING APPEALS PROCESS

Amerigroup has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Amerigroup's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Amerigroup may wish to terminate practitioners or HDOs. Amerigroup also seeks to treat network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Amerigroup's Networks for professional conduct and competence reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB).

Additionally, Amerigroup will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is Amerigroup's intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of Amerigroup's Networks or Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional conduct and competence considerations.

Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, has a criminal conviction, or Amerigroup's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Enrollees. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal

conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

REPORTING REQUIREMENTS

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

AMERIGROUP CREDENTIALING PROGRAM STANDARDS

Eligibility Criteria

A. Health care practitioners:

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

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

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

- For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.
- If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of

their residency or fellowship training program to meet the board certification requirement.

- If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
- Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:

i. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice;

ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or

iii. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Amerigroup's network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

Practitioners meeting one of these three alternative criteria (i., ii., iii.) will be viewed as meeting all Amerigroup education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Amerigroup review and approval. Reports submitted by delegates to Amerigroup must contain sufficient documentation to support the above alternatives, as determined by Amerigroup.

For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO), Center for Improvement in Healthcare Quality (CIHQ), a Healthcare Facilities Accreditation Program (HFAP) accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.

For Genetic Counselors, the applicant must be licensed by the state to practice independently. If the state where the applicant practices does not license Genetic Counselors, the applicant

must be certified by the American Board of Genetic Counseling or the American Board of Genetics and Genomics.

Criteria for Selecting Practitioners

New Applicants (Credentialing):

- Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
- Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
- Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.
- No evidence of potential material omission(s) on application.
- Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Enrollees.
- No current license action.
- No history of licensing board action in any state.
- No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
- Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Enrollees. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Enrollees. Practitioners who treat Enrollees in more than one state must have a valid DEA/CDS registration for each applicable state.
- Initial applicants who have no DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:
- It can be verified that this application is pending.
- The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber;
- The applicant agrees to notify Amerigroup upon receipt of the required DEA/CDS registration.
- Amerigroup will verify the appropriate DEA/CDS registration via standard sources.
- The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90 calendar day timeframe will result in termination from the Network.

Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Amerigroup's Enrollees will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine

environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:

a. It can be verified that the applicant's application is pending; and
b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
c. The applicant agrees to notify Amerigroup upon receipt of the required DEA registration; and
d. Amerigroup will verify the appropriate DEA/CDS registration via standard sources; and
e. The applicant agrees that failure to provide the appropriate DEA registration within a 90 day timeframe will result in termination from the network.

Practitioners who voluntarily choose to not have a DEA/CDS registration if that practitioner certifies the following:

a. controlled substances are not prescribed within his/her scope of practice; or in their professional judgement, the enrollees receiving their care do not require controlled substances and
b. he or she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances should it be clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber; and
c. DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.

- No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions; or for Practitioners in specialties defined as requiring hospital privileges who practice solely in the outpatient setting, there exists a defined referral arrangement with a participating Practitioner of similar specialty at a participating hospital who provides inpatient care to enrollees requiring hospitalization.
- No history of or current use of illegal drugs or history of or current alcohol use disorder.
- No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
- No gap in work history greater than six months in the past five years; however, gaps up to 12 months related to parental leave or immigration will be acceptable and viewed as Level I. All gaps in work history exceeding six months will require additional information and review by the Credentialing Department. A verbal explanation will be accepted for gaps of six to 12 months. Gaps in excess of 12 months will require written explanations. All work history gaps exceeding six (months may be presented to the geographic CC if the gap raises concerns of future substandard Professional Conduct and Competence.
- No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil

litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.

- A minimum of the past 10 years of malpractice claims history is reviewed.
- Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Amerigroup's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
- No involuntary terminations from an HMO or PPO.
- No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
- Investment or business interest in ancillary services, equipment or supplies;
- Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
- Voluntary surrender of state license related to relocation or nonuse of said license;
- An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
- Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
- Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five year post residency training window.
- Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
- History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

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

Participation Criteria and Exceptions for Non-Physician Credentialing

The following participation criteria and exceptions are for non-MD practitioners. They are not additional or more stringent requirements, but instead the criteria and exceptions that apply for these specific provider types to permit a review of education and training.

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
   a. Master or doctoral degree in social work.
   b. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. In addition, a doctor of social work will be viewed as acceptable.
   c. Licensure to practice independently.

2. Licensed professional counselor ("LPC"), marriage and family therapist ("MFT"), licensed mental health counselor (LMHC) or other master level license type:
   Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
   b. Master or doctoral degrees in divinity, masters in biblical counseling, or other primarily theological field of study do not meet criteria as a related field of study.
   c. Practitioners with PhD training as a clinical psychologist can be reviewed.
   d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
   e. Licensure to practice independently or in states without licensure or certification:
      i. Marriage & Family Therapists with a master's degree or higher: Certified as a full clinical enrollee of the American Association for Marriage and Family Therapy (AAMFT), OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).

3. Pastoral Counselors:
   a. Master's or doctoral degree in a mental health discipline.
   b. Licensed as another recognized behavioral health provider type (e.g. MD/DO, PsyD, SW,RNCS, ARNP, and MFT, OR LPC) at the highest level of independent practice in the state where the practice is to occur, OR must be licensed or certified as a pastoral counselor in the state where the practice is to occur.
   c. A fellow or diplomat enrollee of the Association for Clinical Pastoral Education (ACPE) OR meet all requirements to become a fellow or diplomat enrollee of the ACPE [documentation of eligibility of ACPE required].

4. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
   a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.
   b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
   c. Certification by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA) in psychiatric nursing, or the Pediatric Nursing Certification Board. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner; and
   d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in

which the practitioner will be treating Enrollees.

4. Clinical Psychologists:
   a. Valid state clinical psychologist license.
   b. Doctoral degree in clinical or counseling, psychology or other applicable field of study.
   c. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

5. Clinical Neuropsychologist:
   a. Must meet all the criteria for a clinical psychologist listed in Section 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN);
   b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered; and
   c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
      i. Transcript of applicable pre-doctoral training;
      ii. Documentation of applicable formal one-year post-doctoral training (participation in CEU training alone would not be considered adequate);
      iii. Letters from supervisors in clinical neuropsychology (including number of hours per week); or
      iv. Minimum of five years' experience practicing neuropsychology at least ten hours per week.

6. Licensed Psychoanalysts:
   a. Applies only to practitioners in states that license psychoanalysts.
   b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Amerigroup Credentialing Policy (e.g. psychiatrist, clinical psychologist, licensed clinical social worker).
   c. Practitioner must possess a valid psychoanalysis state license.
      (a) Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
      (b) Meet examination requirements for licensure as determined by the licensing state.

7. Process, requirements and Verification – Nurse Practitioners:

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

f. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any

hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.

g. The NP applicant will undergo the standard credentialing processes outlined in Amerigroup's Credentialing Policies. NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
h. Upon completion of the credentialing process, the NP may be listed in Amerigroup's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. NPs will be clearly identified:
    1. On the credentialing file;
    2. At presentation to the CC; and
    3. Upon notification to network services and to the provider database.

2. Process, Requirements and Verifications – Certified Nurse Midwives:
    a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.
    b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
    d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Amerigroup procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
    e. All CNM applicants will be certified by either:
        1. The National Certification Corporation for Ob/Gyn and neonatal nursing; or

2. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.

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

h. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.

i. The CNM applicant will undergo the standard credentialing process outlined in Amerigroup's Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the Network.

j. Upon completion of the credentialing process, the CNM may be listed in Amerigroup's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.

k. CNMs will be clearly identified:
   1. On the credentialing file;
   2. At presentation to the CC; and
   3. Upon notification to network services and to the provider database.

3. Process, Requirements and Verifications – Physician's Assistants (PA):
   a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
   b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
   c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force

adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.

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

Currently Participating Applicants (Re-credentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date 180 calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in Amerigroup's Plan programs or provider Networks, federal sanction,

debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Amerigroup's other credentialed provider Networks.

4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Enrollees;
5. No new history of licensing board reprimand since prior credentialing review;
6. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Enrollees needing hospitalization;
9. No new (since previous credentialing review) history of or current use of illegal drugs or alcohol use disorder;
10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    b. Voluntary surrender of state license related to relocation or nonuse of said license;
    c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five year post residency training window;
    f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    g. History of a licensing board, hospital or other professional entity investigation that

was closed without any action or sanction.

15. No quality improvement data or other performance data including complaints above the set threshold.
16. Re-credentialed at least every three years to assess the practitioner's continued compliance with Amerigroup standards.

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

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

B. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Amerigroup may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If a HDO has satellite facilities that follow the same policy and procedures, Amerigroup may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for Enrollee access need only when the CC review indicates compliance with Amerigroup standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or enrollee safety. HDOs are re-credentialed at least every three years to assess the HDO's continued compliance with Amerigroup standards.

General Criteria for HDOs:

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

Additional Participation Criteria for HDO by Provider Type:

HDO TYPE AND AMERIGROUP APPROVED ACCREDITING AGENT(S)

Medical Facilities

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

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	CTEAM, DNV/NIAHO, HFAP, TJC
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Use Disorder	ACHC, CARF, COA, DNV/NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, HFAP, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Use Disorder	CARF, DNV/NIAHO, HFAP, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Use Disorder	CARF, COA, DNV/NIAHO, HFAP, TJC

Rehabilitation

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

Provider Notification to Amerigroup

The provider must notify Amerigroup in writing within five days, unless otherwise stated below, following the occurrence of any of the following events:

- The provider's license to practice in any state/District is suspended, surrendered, revoked, terminated, or subject to terms of probation or other restrictions. Notification of any such action must be furnished in writing to Amerigroup immediately.
- The provider (i) learns that he or she has become a defendant in any malpractice action relating to an enrollee who also names Amerigroup as a defendant or receives any pleading, notice or demand of claim or service of process relating to such a suit or (ii) is required to pay damages in any such action by way of judgment or settlement. Notification must be furnished in writing to Amerigroup immediately.
- The provider is disciplined by a District board of medicine or a similar agency.
- The provider is sanctioned by or debarred from participation with Medicare or Medicaid.
- The provider is convicted of a felony relating directly or indirectly to the practice of medicine. Notification must be furnished in writing to Amerigroup immediately.
- There is a change in the provider's business address or telephone number.
- The provider becomes incapacitated in such a way that the incapacity may interfere with enrollee care for 21 consecutive days or more.
- There is any change in the nature or extent of services rendered by the provider.
- There is any material change or addition to the information and disclosures submitted by the provider as part of the application for participation with Amerigroup.
- The provider's professional liability insurance coverage is reduced or canceled. Notification must be furnished in writing to Amerigroup no less than five days prior to such a change.
- There is any other act, event, occurrence or the like that materially affects the provider's ability to carry out his or her duties under the *Participating Provider Agreement*.

- The provider's enrollee panel is reaching capacity according to the established capacity standards set in the Standards and Measures for Appropriate Availability to Provider – DC Policy. At least 30 days' advance notice must be given.
- There is any change to hours of operation or staffing levels.
- There is an inability to meet timely access to care and services according to the established appointment access standards set in the Appointment Guidelines – DC Policy.

The occurrence of one or more of the events listed above may result in the termination of the *Participating Provider Agreement* for cause or other remedial action as Amerigroup in its sole discretion deems appropriate.

Peer Review

The peer review process provides a systematic approach for monitoring the quality and appropriateness of care. Peer review responsibilities are:

- To participate in the implementation of the established peer review system.
- To review and make recommendations regarding individual provider peer review cases.
- To work in accordance with the medical director.

Should investigation of an enrollee grievance result in concern regarding a provider's compliance with community standards of care or service, the 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 grievance. Peer review includes investigation of provider actions by or at the discretion of the medical director. The medical director takes action based on the quality issue or the level of severity, invites the cooperation of the provider, and consults with and informs the medical advisory committee and peer review committee as appropriate. The peer review process is a major component of the medical advisory committee's monthly agenda.

The Amerigroup Quality Management Program includes review of quality of care issues identified for all care settings. Enrollee complaints, adverse events and other information are used to evaluate the quality of care and service provided. If a quality issue should result in concern regarding a physician's compliance with standards of care or service, all elements of peer review will be followed. The peer review process provides a systematic approach for monitoring the quality and appropriateness of care. The peer review committee will review cases and recommend disciplinary actions to be taken which may include remedial steps up to and including freeze of panel and/or provider termination. The medical director will inform the provider of the peer review committee's recommendations and follow up. Provider participation is encouraged. Outcomes are reported to the appropriate internal and external entities, Quality Management and the medical advisory committee.

The quality of care and peer review policies are available upon request.

Amerigroup Provider Reimbursement

Reimbursement policies serve as a guide to assist you with accurate claims submissions and to outline the basis for reimbursements when services are covered by the enrollee's Amerigroup plan. Services must meet authorization and medical necessity guidelines appropriate to the procedures and diagnoses, and enrollees' state/District of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines, including using industry standard compliant codes on all claims submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes which indicate the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, Amerigroup policies apply to both participating and nonparticipating providers and facilities.

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

Amerigroup reviews and revises policies when necessary. The most current policies are available on the provider self-service website at https://providers.amerigroup.com.

Review Schedule and Updates

Reimbursement policies undergo review for updates to District contracts, or District, federal or CMS requirements. Updates are also made any time Amerigroup is notified of a mandated change or an Amerigroup business decision requires a change. Updates are posted on the provider self-service website.

Claim Submission

Direct and Clearinghouse Submissions

Providers can submit electronic claims to Amerigroup through Availity* Essentials.

Availity serves as our electronic data interchange (EDI) partner for all electronic data and transactions.

Methods to exchange EDI transmissions with the Availity EDI Gateway:

- **Already exchanging EDI files?** – You can use your existing Clearinghouse or Billing Company for your Healthy Blue transmissions. ***(Please work with them to ensure connectivity to the Availity EDI Gateway)***
- Become a Direct Trading Partner with the Availity EDI Gateway
- Use Direct single claim entry through the Availity Portal

Providers, Billing services and Clearinghouses who are ***not*** currently exchanging EDI transactions can register with Availity.

The Availity Welcome Application is your map to setting up your business for exchanging EDI transactions Availity

Already registered with Availity?

Use your existing login and choose: My Providers > Enrollments Center.
Additionally, the following will guide you through the transition:

- Use the EDI Connectivity Services Startup Guide for detailed instructions.
- Use Availity's EDI Companion Guide

Your organization can exchange the following transactions through the Availity EDI Gateway**:**

- 837 — Institutional Claims
- 837 — Professional Claims
- 837 — Dental Claims
- 835 — Electronic Remittance Advice
- 276/277 — Claim Status: **Batch**
- 270/271 — Eligibility Request: **Batch**

Electronic Funds Transfer (EFT) Registration

To register or manage account changes for EFT only, use the EnrollHub™, a CAQH Solutions™ enrollment tool (link to: https://solutions.caqh.org/bpas/Default.aspx?ReturnUrl=/bpas/default.aspx/%22), a secure electronic EFT registration platform. This tool eliminates the need for paper registration, reduces administrative time and costs, and allows you to register with multiple payers at one time.

If you were previously registered to receive EFT only, you must register using EnrollHub to manage account changes.

Electronic Remittance Advice (ERA) Registration

You can also use Availity link below to register and manage ERA accounts.

Link**:** https://apps.availity.com/availity/web/public.elegant.login

Navigate to My Providers > Enrollments Center > ERA Enrollment

Note: If you were previously registered to receive ERA, you **must** register using Availity to manage ERA account changes.

Contacting Availity

If you have any questions please contact Availity Client Services at 1-800-Availity (1-800-282-4548) Monday-Friday 8:00 a.m.-7:30 p.m. (ET).

Web-Based Claims Submissions

Participating providers have the option to use HIPAA-compliant web claim submission capabilities by registering at https://www.availity.com.

For any questions, please contact Availity Client Services at 1-800-AVAILITY (1-800-282-4548).

Paper Claims Submission

Submit claims on original claim forms (*CMS-1500* or *CMS-1450*) printed with dropout red ink or typed (not handwritten) in large, dark font. AMA- and CMS-approved modifiers must be used appropriately based on the type of service and procedure code. Mail forms to:

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

CMS-1500 and *CMS-1450/UB-04* forms are available at www.cms.hhs.gov.

Encounter Data

Providers must submit encounter data within the timely filing periods outlined in the Claims Adjudication section of this manual through EDI submission methods or *CMS-1500 (08-05)* or *1450/UB-04* claim forms. Include the following information in submissions:

- Enrollee name (first and last name)
- Enrollee ID
- Enrollee date of birth
- Provider name according to contract
- Amerigroup provider number
- Coordination of benefit information
- Date of encounter
- Diagnosis code
- Types of services provided (using current procedure codes and modifiers if applicable)

- Provider tax ID number
- NPI/API number
- CLIA Identification number when applicable (CMS-1500 only)

Amerigroup will not reimburse providers for items received free of charge or items given to enrollees free of charge.

Providers must use HIPAA-compliant billing codes when billing or submitting encounter data. This applies to both electronic and paper claims. When billing codes are updated, providers are required to use appropriate replacement codes for submitted claims or covered services.

Providing after-hours care in an office setting helps reduce inappropriate emergency room use and encourages enrollees to receive appropriate follow-up care. To promote greater access for enrollees, Amerigroup provides additional reimbursement to PCPs who provide after-hours care. Additionally, Amerigroup encourages PCPs to provide efficient quality care in an office setting and will reimburse wellness visits and sick visits billed on the same day. For more information, visit the provider self-service website at https://providers.amerigroup.com/DC.

Claims Adjudication

Amerigroup is dedicated to providing timely adjudication of claims. Amerigroup processes all claims according to generally accepted claims coding and payment guidelines defined by the CPT-4 and ICD-10 manuals. Providers must use HIPAA-compliant billing codes when billing by paper or electronically. When billing codes are updated, providers are required to use appropriate replacement codes for submitted claims. Amerigroup will reject claims submitted with noncompliant billing codes. Amerigroup uses code-editing software to determine which services are considered part of, incidental to, or inclusive of the primary procedure.

Timely Filing

Paper and electronic claims must be filed within 365 calendar days. Timely filing periods begin from the date of discharge for inpatient services and from date of service for outpatient/physician services. Secondary and tertiary claims submitted for payment must be submitted within 180 days from the payment date from Medicare or the third party payer. Timely filing requirements are defined in the provider agreement. Amerigroup will deny claims submitted after the filing deadline.

Documentation of Timely Claim Receipt

Claims will be considered timely if submitted:

- By United States mail first class, return receipt requested or by overnight delivery service; you must provide a copy of the claim log that identifies each claim included in the submission
- Electronically; you must provide the clearinghouse-assigned receipt date from the reconciliation reports
- By hand delivery; you must provide a claim log identifying each claim included in the delivery and a copy of the signed receipt acknowledging the hand delivery

The claims log maintained by providers must include the following information:

- Name of claimant
- Address of claimant
- Telephone number of claimant
- Claimant's federal tax identification number
- Name of addressee
- Name of carrier
- Designated address
- Date of mailing or hand delivery
- Subscriber name
- Subscriber ID number
- Enrollee name
- Date(s) of service/occurrence
- Total charge
- Delivery method

Good Cause

If a claim or claim dispute was filed untimely, you have the right to include an explanation and/or evidence explaining the reason for delayed submission. Amerigroup will contact you for clarification or additional information necessary to make a good cause determination.

Good cause may be found when a physician or supplier claim filing is delayed due to:

- Administrative error due to incorrect or incomplete information furnished by official sources (e.g., carrier, intermediary, CMS) to the physician or supplier.
- Incorrect information furnished by the enrollee to the physician or supplier resulting in erroneous filing with another care management organization plan or with the District.
- Unavoidable delay in securing required supporting claim documentation or evidence from one or more third parties despite reasonable efforts by the physician/supplier to secure such documentation or evidence.
- Unusual, unavoidable or other circumstances beyond the service provider's control that demonstrate the physician or supplier could not reasonably be expected to file timely.

- Destruction or other damage of the physician's or supplier's records, unless such destruction or other damage was caused by the physician's or supplier's willful act of negligence.

Coordination of Benefits

Amerigroup follows District-specific guidelines and all federal regulations when coordination of benefits is necessary with other health insurance (OHI), third party liability (TPL), medical subrogation or estate recovery. Amerigroup uses covered medical and hospital services whenever available or other public or private sources of payment for services rendered to enrollees.

OHI and TPL refer to any individual, entity or program that may be liable for all or part of an enrollee's health coverage. The District is required to take all reasonable measures to identify legally liable third parties and treat verified OHI and TPL as a resource of each plan enrollee.

Amerigroup takes responsibility for identifying and pursuing OHI and TPL for enrollees and puts forth best efforts to identify and coordinate with all third parties against whom enrollees may have claims for payments or reimbursements for services. These third parties may include Medicare or any other group insurance, trustee, union, welfare, employer organization or employee benefit organization, including preferred provider organizations or similar type organizations, any coverage under governmental programs, and any coverage required to be provided for by District law.

When OHI or TPL resources are available to cover the costs of trauma-related claims and medical services provided to Medicaid enrollees, Amerigroup will reject the claim and redirect providers to bill the appropriate insurance carrier (unless certain pay-and-chase circumstances apply — see below). Or, if Amerigroup does not become aware of the resource until after payment for the service was rendered, Amerigroup will pursue post-payment recovery of the expenditure. Providers must not seek recovery in excess of the Medicaid payable amount.

Pay-and-chase circumstances include:

- When the services are for preventive pediatric care (EPSDT)

The Amerigroup subrogation vendor handles the filing of liens and settlement negotiations both internally and externally.

For questions regarding paid, denied or pended claims, call Provider Services at 800-454-3730.

Claims Overpayment Recovery Procedure

Amerigroup's Payment Integrity Division reviews claims for accuracy and requests refunds if claims are overpaid or paid in error. Some common reasons for overpayments are:

- Paid wrong provider / Member
- Coordination of Benefits
- Allowance overpayments
- Late credits
- Billed in error
- Duplicate
- Non-covered services
- Claims editing
- Terminated Members
- Total charge overpaid
- Paid wrong Member/provider number

Overpayments may be identified by two entities — either Amerigroup/our contracted vendors or by the providers.

Amerigroup Identified Overpayment (aka "Solicited")

Once an overpayment has been identified by Amerigroup, Amerigroup will notify the provider of the overpayment. The overpayment notification letter will include instructions on how to refund the overpayment. When refunding on a claim overpayment that Amerigroup has requested, use the payment coupon included on the request letter and the following information with the check:

- The payment coupon
- Member ID number
- Member's name
- Claim number
- Date of service
- Reason for the refund as indicated in the refund request letter

As indicated in the Amerigroup refund request letter, provider overpayment refunds not received and applied within the timeframe indicated will result in claim recoupment from any claim the provider submits to Amerigroup.

Providers wishing to submit an overpayment dispute for a solicitated overpayment recoupment request, can submit their request via Availity, by mail or Fax.

The mailing address and fax number are:

Cost Containment - Disputes
PO Box 62427
Virginia Beach, VA. 23466-2437
Fax - 866-920-1874

The processing time once these documents are received is 30 days.

Providers submitting a refund check, should mail the refund to the address below and include a copy of the overpayment letter received, a list of claims are being refunded and the refund amount to be applied to each claim to:

Cost Containment
PO Box 933657
Atlanta, GA. 31193-3657

Provider Self-Identified Overpayments (aka "voluntary" or "unsolicited")

To ensure compliance with contractual requirement C.5.33.1.4 and 42 CFR 438.608(d)(2), Amerigroup outlines below our documented mechanism for a Network Provider to report to the Contractor when it has received an overpayment, return the overpayment to the Contractor within sixty (60) calendar days after the date on which the overpayment was identified, and notify the Contractor in writing of the reason for the overpayment.

If a provider identifies an overpayment and submits a refund, a completed Refund Notification Form specifying the reason for the return must be included. This form can be found on the provider website at https://providers.amerigroup.com/dc. The submission of the Refund Notification Form will allow Cost Containment to process and reconcile the overpayment in a timely manner. The provider can also complete a Recoupment Notification Form, which gives Amerigroup the authorization to adjust claims and create claim offsets. This form can also be found on the provider website at https://providers.amerigroup.com/dc.

All provider self-identified overpayment requests must be submitted in writing via US mail, fax, or web submission.

Submission options:

USPS Mail:	Cost Containment – Recoupments P.O. Box 62427 Virginia Beach, VA 23466
Fax:	1-866-920-1874
Web submission:	Availity - https://www.availity.com.

All requests should include the following information:

- Name of Provider
- Tax ID
- NPI
- Member's full name

- Member's ID
- List of claims
- Reason for the recoupment
- Amount of the recoupment
- Include any supporting documentation to validate the reason for the recoupment.
- Signature authorizing the recoupment.

Provider Self-Identified overpayment request turnaround time: Within 30 business days of receipt.

**Incomplete requests will cause a delay in processing or the closure of the request with no further action.*

Changes addressing the topic of overpayments have taken place with the passage of the Patient Protection and Affordable Care Act (PPACA), commonly known as the Healthcare Reform Act. The provision directly links the retention of overpayments to false claim liability.

The language of 42 U.S.C.A. § 1320a-7k makes explicit that overpayments must now be reported and returned to states or respective MCOs within 60 days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the False Claims Act including treble damages. In order to avoid such liability, health care providers and other entities receiving reimbursement under Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the PPACA.

Provision 42 U.S.C.A. § 1320a-7k, entitled "Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments," clarifies the uncertainty left by the 2009 Fraud Enforcement and Recovery Act. This provision of the Healthcare Reform Act applies to providers of services, suppliers, and Medicaid MCOs.

Emergency Services and Self-Referrals

Emergency Room Medical Record Review

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 enrollee is part of the PCP's panel must be noted in the emergency room medical records.

Amerigroup is not responsible for the payment of any remaining days of a hospital admission that began prior to a Medicaid participant's enrollment in Amerigroup. However, Amerigroup is responsible for reimbursement to providers for professional services rendered during the remaining days of the admission.

In addition, providers must verify that enrollees are assigned to Amerigroup. To validate enrollee eligibility, call the Amerigroup Interactive Voice Response (IVR) system at 1-800-454-3730 or visit the provider self-service website at https://providers.amerigroup.com/DC.

Self-Referred and Emergency Services

Amerigroup will reimburse out-of-plan providers for the following services:

- Emergency services
- Family planning services (except for sterilizations)
- Immunizations (shots)
- Receive services for sexually transmitted infections (STIs)
- Receive mental health or services for problems with alcohol or drugs
- Renal dialysis provided at a Medicare-certified facility

Alliance Coverage Exclusions

The following services are excluded for Alliance enrollees:

- Screening and stabilization services for emergency medical conditions provided outside the District

If Amerigroup denies, reduces or terminates services, enrollees have an appeal right regardless of whether they are a new or established enrollee. Pending the outcome of an appeal, Amerigroup may reimburse for services provided.

Specialty Referrals

Amerigroup will maintain a complete network of adult and pediatric providers adequate to deliver the full scope of benefits covered by DCHFP, Alliance and ICP. If a specialty provider cannot be identified, please contact Amerigroup for assistance by calling 1-800-454-3730.

PCP Contract Terminations

If you are a PCP and your contract is terminated, enrollees may follow you to another MCO because of, but not limited to, the following reasons:

- Available PCPs no longer accept new enrollees
- Enrollee's desire to access a location comparable to terminated PCP
- Disruption in continuity of care

Enrollees may contact Amerigroup Enrollee Services to request an MCO change. Amerigroup will notify DHCF within five business days.

Continuity of Care

Amerigroup is responsible for providing ongoing treatment and enrollee care to new enrollees until an initial evaluation is performed and until a new plan of care is developed.

The following steps are taken to ensure enrollees continue to receive necessary health services at the time of enrollment into Amerigroup:

- Appropriate service referrals to specialty care providers will be provided in a timely manner.
- Authorization for ongoing specialty services will not be delayed while enrollees await their initial PCP visit and comprehensive assessment. Services comparable to those the enrollee was receiving upon enrollment into Amerigroup are to be continued during this transition period.
- If, after the enrollee receives a comprehensive assessment, Amerigroup determines a reduction in or termination of services is warranted, Amerigroup will notify the enrollee of this change at least 10 days before it is implemented. This notification will tell the enrollee that he or she has the right to formally appeal to Amerigroup or to DCHFP by calling the District's Enrollee Help Line at 1-800-620-7802 or Amerigroup. In addition, the notice will explain that if the enrollee files an appeal within 10 days of notification and requests to continue receiving services, Amerigroup will continue to provide these services until the appeal is resolved. You will also receive a copy of this notification.

PROVIDER RESPONSIBILITIES

Submitting provider demographic data requests and roster submissions through roster automation

Use the Provider Data Management (PDM) application on Availity Essentials to verify and initiate care provider demographic change requests for all professional and facility care providers*. **Going forward, the PDM application is now the preferred intake tool for care providers to submit demographic change requests, including submitting roster uploads.** If preferred, Providers may continue to utilize the Provider Enrollment application in Availity Essentials to submit requests to add new practitioners under existing groups for available provider types. Once implemented, we will no longer accept demographic change requests via email, fax, or other forms of communication outside Availity.

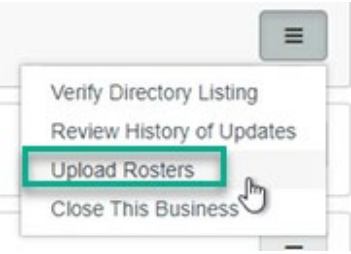
Within the PDM application, Providers have the choice and flexibility to request data updates via the standard PDM experience or by submitting a spreadsheet via a roster upload.

Roster Automation is our new technology solution designed to streamline and automate provider data additions, changes, and terminations that are submitted using a standardized Microsoft Excel document. Any provider, whether an individual provider/practitioner, group, or facility, can use Roster Automation today:**

The resources for this process are listed below and available on our website. Visit **https://providers.amerigroup.com/DC**, then under For Providers, select Forms and Guides. The **Roster Automation Rules of Engagement** and **Roster Automation Standard Template** appear under the Digital Tools category.

- **Roster Automation Rules of Engagement**: Is a reference document, available to ensure error-free submissions, driving accurate and more timely updates through automation.
- **Roster Automation Standard Template:** Use this template to submit your information. More detailed instructions on formatting and submission requirements can also be found on the first tab of the Roster Automation Standard Template (*User Reference Guide*).
- Upload your completed roster via the Availity PDM application.

Accessing PDM Application:
Log onto **availity.com** and select **My Providers > Provider Data Management** to begin the attestation process. If submitting a roster, find the TIN/business name for which you want to verify and update information. Before you select the TIN/business name, select the three-bar menu option on the right side of the window, and select **Upload Rosters** (see screen shot below) and follow the prompts.



Availity Administrators will automatically be granted access to PDM. Additional staff may be given access to **Provider Data Management** by an administrator. To find your administrator, go to **My Account Dashboard > My Account > Organization(s) > Administrator Information**.

***** Exclusions:

- Behavioral Health providers contracted with Carelon Behavioral Health who will continue to follow the process for demographic requests and/or roster submissions, as outlined by Carelon Behavioral Health.
- Any specific state mandates or requirements for provider demographic updates

****** If any roster data updates require credentialing, your submission will be routed appropriately for further action.

Reporting Communicable Disease

Amerigroup providers must comply with the District's Communicable Disease Reporting requirements in accordance with the D.C. Code § 7-131, 132 (2006), Title 22 of the D.C. Code of Municipal Regulations, the District's Childhood Lead Poisoning Screening and Reporting Legislative Review Act (2002) and D.C. Code § 7-871.3 (2006). Specific reporting requirements include but are not limited to:

- Children or adult enrollees with vaccine-preventable diseases.
- Infants, toddlers and school-age children experiencing developmental delays, as evidenced by development assessments or interperiodic exams.
- Enrollees with sexually transmitted and other communicable diseases including HIV.
- Enrollees diagnosed with or suspected of being infected with tuberculosis (report must be made within 24 hours).
- Laboratories and/or provider must report results of all blood lead screening tests to the District of Columbia Department of Health Care Finance, District Department of Environment Division of Childhood Lead Prevention Program and Amerigroup within 72 hours.

Amerigroup providers must also comply with District requirements for reporting to registries and programs, include the Cancer Control Registry.

Health Promotion Programs

Amerigroup provides health promotion programs to encourage enrollees to use health services appropriately and lead healthier lives. These programs include education about prenatal care, prevalent chronic conditions and preventive screenings. To assist your Amerigroup patients in accessing these programs, contact your Provider Relations representative or call Provider Services at 1-800-454-3730.

Appointment Scheduling and Outreach Requirements

To ensure Amerigroup enrollees have every opportunity to access needed health-related services, PCPs must develop collaborative relationships with Amerigroup and community resources.

Contact your Provider Relations representative or call Provider Services at 1-800-454-3730 for information on how Amerigroup can help you bring your enrollees into care.

Prior to any appointment for an Amerigroup enrollee, providers must verify enrollee eligibility and Amerigroup enrollment. This procedure will assist in ensuring payment for services. Eligibility can be verified through Amerigroup's provider portal or by calling 1-800-454-3730.

Providers are required to establish and/or maintain a reasonable schedule of operating hours during which its delivery sites are open to Amerigroup enrollees. These hours must be no less than the operating hours offered to commercially insured individuals or comparable to the hours offer to Medicaid Fee-for-Service enrollees, if the provider serves only the Medicaid population. Providers must report their office hours to Amerigroup twice a year, when hours of operation or staffing levels change, or upon DHCF request.

The Centers for Medicare and Medicaid Services (CMS) prohibits providers from billing Medicaid participants whatsoever including for missed appointments.

Initial Health Appointment for Amerigroup Enrollees

Amerigroup enrollees 21 and over must be offered an initial appointment within 45 days of their date of enrollment with the PCP or within 30 days of request, whichever is sooner, unless one of the following exceptions applies:

- Appointments for initial EPSDT screens shall be offered to new enrollees within 60 days of the enrollee's enrollment date with Amerigroup or at an earlier time if an earlier exam is needed to comply with the periodicity schedule or if the child's case indicates a more rapid assessment or a request results from an emergency medical condition. The initial screen shall be completed within three months of the enrollee's enrollment date with Amerigroup, unless Amerigroup determines that the new enrollee is up-to-date with the EPSDT periodicity schedule. To be considered timely, all EPSDT screens, laboratory tests and immunizations shall take place within 30 days of their scheduled

due dates for children under the age of two and within 60 days of their due dates for children age two and older. Periodic EPSDT screening examinations shall take place within 30 days of a request.

- For pregnant and postpartum women who have not started to receive care, or individuals requesting family planning services, the initial health visit must be scheduled and occur within 10 calendar days of the date the enrollee requests the appointment.

During the initial health visit, the PCP is responsible for documenting a complete medical history and performing and documenting results of an age-appropriate physical exam.

In addition, at the initial health visit, initial prenatal visit, or when physical status, behavior of the enrollee or laboratory findings indicate substance use disorder, refer the enrollee to the Department of Behavioral Health.

Routine and Urgent Appointments for Amerigroup Enrollees

To ensure enrollees receive care in a timely manner, PCPs, Specialists, and Behavioral Health providers must maintain the following appointment availability standards:

Primary care practitioners/Specialists

Type of visit	Availability standard
Emergency care (life threatening)	Immediately at the nearest facility
Urgent care visits	Within 24 hours of request
Routine and preventive care visits (PCP, Specialist, and OB/GYN provider types)	Within 30 days of request
Initial appointments for pregnant women or persons needing family planning (OB/GYN provider types only)	Within 10 calendar days of request

Behavioral health practitioners

Type of visit	Availability standard
Emergency care (life threatening)	Immediately at nearest facility
Care for non-life threatening emergencies	Within 6 hours
Phone based assessments provided	Within 15 minutes of request
Intervention or face to face assessment	Within 90 minutes of completion of phone assessment
Urgent care/outpatient	Within 48 hours of request
Initial visit for routine care	Within 10 business days of request
Follow-up routine care	Within 30 days of request

Cultural Competency

Cultural competency is the integration of congruent behaviors, attitudes, structures, policies and procedures that come together in a system, agency or among professionals to enable effective work in cross-cultural situations. It is an awareness and appreciation of customs, values and beliefs and the ability to incorporate them into the assessment, treatment and interaction with any individual. Cultural competency assists you to:

- 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 enrollee-provider interaction has a profound impact on the ability of a enrollee to communicate symptoms to you as his/her provider and to adhere to recommended treatment. Some of the reasons that justify your need for cultural competency include but are not limited to:

- The perception that illness and disease, and their causes, vary by culture
- The diversity of belief systems related to health, healing and wellness are very diverse
- The fact that culture influences help-seeking behaviors and attitudes toward health care providers

- The fact that individual preferences affect traditional and nontraditional approaches to health care

The fact that health care providers from culturally and linguistically diverse groups are underrepresented in the current service delivery system

Culture is the integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. Culture defines the preferred ways for meeting needs and may be influenced by factors such as geographic location, lifestyle and age. Cultural barriers between you and the enrollee can impact the enrollee-provider relationship in many ways, including but not limited to:

- The enrollee's level of comfort with you and the enrollee'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 enrollee's expectation of you and of the treatment

The Amerigroup Cultural Competency training program is available to all providers, regardless of participation status. This resource offers free tools designed to help promote health and health equity, and develop a more culturally competent practice. The online training also provides a link directly to the *Think Cultural Health* website, provided through the U.S. Department of Health and Human Services.

To be culturally competent, we expect you and all providers serving enrollees within this geographic location to demonstrate the following:

Cultural Awareness:

- The ability to recognize the cultural factors (norms, values, communication patterns, economic disparities and world views), which 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:

- 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.
- Economic disparities shape an enrollee's response to medical advice and attitudes about seeking help.

- Resources, such as formally trained interpreters fluent in communicating in the enrollee's primary non-English language, should be offered to and utilized by enrollees with various cultural and ethnic differences; enrollees/providers should call Amerigroup Enrollee Services at 1-800-600-4441 at least 24 hours before their scheduled appointment and tell us they have a need for an interpreter.
- Interpreters who provide communication for deaf or hard-of-hearing enrollees should be offered to and used by 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 the enrollee to have a person who knows sign language help during the office visit.

Skills:

- The ability to understand the basic similarities and differences between and among the cultures of the persons served
- The ability to recognize the values and strengths of different cultures
- The ability to interpret diverse cultural and nonverbal behavior
- The ability to develop perceptions and understanding of others' 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 family enrollees or friends as interpreters
- The ability to treat each person uniquely
- The ability to recognize racial, ethnic and economic 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
- Acceptance of ethnic differences among people and an understanding of how these differences affect the treatment process
- A willingness to work with clients of various ethnic groups

Affirmative Statement

Amerigroup ensures utilization management decisions are fair, independent, and according to approved criteria and available benefits. Utilization management decisions are based only upon appropriateness of care and service and the existence of coverage. Amerigroup does not

specifically reward providers or other individuals for issuing denials of coverage of care, and financial incentives for utilization management decision-makers do not encourage decisions that result in under-utilization.

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 enrollees on a nondiscriminatory basis, according to District and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, physical or mental disability, or type of illness or condition.

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

Enrollees 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. Amerigroup also provides a free language service 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 customer service number on their enrollee ID card.

If you or your enrollee believes that 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 the grievance coordinator via:

- Mail: 4433 Corporation Lane, Virginia Beach, VA 23462
- Phone: 757-473-2737, ext. 31028

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 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, an enrollee 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.

Medical Records Documentation Standards

Enrollee Records

Amerigroup requires medical records to be maintained in a manner that is current, detailed and organized and permits effective and confidential enrollee care and quality review.

Providers are required to maintain medical records that conform to good professional medical practice and appropriate health management. A permanent medical record must be maintained at the primary care site for every enrollee and be available to the PCP and other providers. Medical records must be kept in accordance with Amerigroup and District standards as outlined below.

Medical Record Standards

The records reflect all aspects of enrollee care, including ancillary services. Documentation of each visit must include:

- Date of service
- Purpose of visit
- Diagnosis or medical impression
- Objective finding
- Assessment of enrollee’s findings
- Plan of treatment, diagnostic tests, therapies and other prescribed regimens
- Medications prescribed
- Health education provided
- Signature and title or initials of the provider rendering the service

If more than one person documents in the medical record, there must be a record on file as to what signature is represented by which initials.

These standards shall, at a minimum, meet the following medical record requirements:

- Enrollee identification information: Each page or electronic file in the record must contain the enrollee's name or ID number.
- Personal/biographical data: The record must include the enrollee's age, gender, address, employer, home and work telephone numbers and marital status.
- All entries must be dated and the author identified.
- Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one provider reviewer.
- Allergies: Medication allergies and adverse reactions must be prominently noted on the record. When clinically appropriate, the note of *No Known Allergies* (i.e., the absence of allergies) must be documented in an easily recognizable location.
- Past medical history (for enrollees seen three or more times): Past medical history must be easily identified, including serious accidents, operations and illnesses. For children, past medical history relates to prenatal care and birth.
- Immunizations: For pediatric records of children age 13 and under, a completed immunization record or a notation of prior immunization must be recorded, including vaccines and dates given when possible.
- Diagnostic information: Information used to arrive at a diagnosis, such as in-office examinations, laboratory and radiology reports, or specialist consultation, must be documented.
- Medication information: Medication information and/or instructions to enrollee are included.
- Identification of current problems: Significant illnesses, medical and behavioral health conditions, and health maintenance concerns must be identified in the medical record.
- Condition Specific Education: The enrollee must be provided with basic teaching and instruction regarding physical and/or behavioral health conditions.
- Smoking/alcohol/substance abuse: A notation concerning cigarette and/or alcohol use or substance abuse must be stated if present for enrollees age 12 and older. Abbreviations and symbols may be appropriate.
- Consultations, referrals and specialist reports: Notes from referrals and consultations must be included in the record. Consultation, laboratory and X-ray reports filed in the chart must have the ordering provider's initials or other documentation signifying review. Consultation and any abnormal laboratory and imaging study results must have an explicit notation in the record of follow-up plans.
- Emergency Care: 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 enrollee is enrolled.
- Hospital discharge summaries: Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the enrollee is enrolled with the provider's panel and for prior admissions as necessary. Prior admissions pertain to

admissions which may have occurred prior to the enrollee being enrolled and are pertinent to the enrollee's current medical condition.

- Advance directive: For medical records of adult enrollees, the medical record must document whether the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.
- Documentation of evidence and results of medical, preventive and behavioral health screenings must be included.
- The record must include documentation of all treatment provided and the results of such treatment.
- The record must include documentation of the team of providers involved in the multidisciplinary team of an enrollee needing specialty care.
- The record must include documentation in both the physical and behavioral health records of integration of clinical care. Documentation should include:
    - Screening for behavioral health conditions, including those which may affect physical health care and vice versa, and referral to behavioral health providers when problems are indicated
    - Screening and referral by behavioral health providers to PCPs when appropriate
    - Receipt of behavioral health referrals from physical medicine providers and the disposition and/or outcome of those referrals
    - A summary of the status and/or progress from the behavioral health provider to the PCP at least quarterly or more often if clinically indicated
    - A written release of information permitting specific information sharing between providers
    - Documentation that behavioral health professionals are included in the primary and specialty care service teams described in this contract when an enrollee with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder

Enrollee Visit Data

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

- History and physical exam: Appropriate subjective and objective information must be obtained for the presenting complaints.
- For enrollees receiving behavioral health treatment, documentation must include at-risk factors (e.g., danger to self and/or others, ability to care for self, affect, perceptual disorders, cognitive functioning, and significant social health) and efforts to coordinate care with all behavioral health providers after obtaining the appropriate release(s) of information.
- Admission or initial assessment must include current support systems or lack of support systems.
- For enrollees receiving behavioral health treatment, an assessment must be completed for each visit relating to client status and/or symptoms of the treatment process.

- Documentation may indicate initial symptoms of the behavioral health condition as decreased, increased or unchanged during the treatment period.
- Plan of treatment must include the activities, therapies and goals to be carried out.
- Diagnostic tests
- Therapies and other prescribed regimens: For enrollees who receive behavioral health treatment, documentation must include evidence of family involvement as applicable and include evidence that family was included in therapy sessions when appropriate.
- Follow-up: Encounter forms or notes must have a notation when indicated concerning follow-up care, calls or visits. The specific time to return must be noted in weeks, months or as needed. Unresolved problems from previous visits are addressed in subsequent visits.
- Referrals, results thereof and all other aspects of enrollee care, including ancillary services.

Amerigroup will systematically review medical records to ensure compliance with standards and will institute actions, as appropriate, for improvement when standards are not met. Access to or copies of medical records must be provided, free of charge, within five days of Amerigroup's request.

Amerigroup policies are designed to maintain an appropriate record-keeping system for services to enrollees. This system will collect all pertinent information related to the medical management of each enrollee and make that information readily available to appropriate health professionals and District agencies. All records will be retained in accordance with the record retention requirements of 45 CFR 74.164 (i.e., records must be retained for ten years from the date of service). Records will be made accessible upon request to agencies of the District of Columbia and the federal government.

Advance Directive

Amerigroup respects the right of the enrollee to control decisions relating to his or her own medical care, including the decision to have the medical or surgical means or procedures calculated to prolong life provided, withheld or withdrawn. This right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession.

Amerigroup adheres to the Enrollee Self-Determination Act and maintains 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 (i.e., durable power) allows the enrollee to name a enrollee advocate to act on his or her behalf. A living will allows the enrollee to state his or her wishes in writing but does not name a enrollee advocate.

Enrollee Services and Outreach associates encourage enrollees to request an advance directive form and education from their PCP at their first appointment. The PCP must offer an advance directive form to all enrollees over age 18 and document each enrollee's response to an offer to execute the advance directive in the enrollee's medical record.

Enrollees over age 18 are able to execute an advance directive by requesting it from their PCP. Their response regarding the decision on an advanced directive must be documented in the medical record. Amerigroup and/or its providers will not discriminate or retaliate based on whether an enrollee has or has not executed an advance directive.

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

Enrollee Services and Outreach associates will assist enrollees with general questions about advance directives. However, no associate of Amerigroup may provide legal advice regarding advance directives. Additionally, no associate may serve as witness to an advance directive or as an enrollee's designated agent or representative.

Amerigroup notes the presence of advance directives and the enrollee's response to whether he or she wants to establish an advance directive in the medical records when conducting medical chart audits. A living will and durable power of attorney are located in Appendix A - Forms.

Services for Children

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) was originally established in 1967 for Medicaid enrollees from birth to age 21. In D.C., these services are called HealthCheck and ensure that enrollees under the age of 21 receive comprehensive screening, diagnostic and treatment services as early as possible in order to identify physical or behavioral health conditions. These services are based on the District of Columbia's Medicaid Health Check Periodicity Schedule and District of Columbia's Medicaid Dental Periodicity Schedule. The most recent D.C. Medicaid periodicity schedules can be found at www.dchealthcheck.net.

A web-based EPSDT Provider Training was developed by Georgetown University's National Center for Education in Maternal and Child Health in collaboration with the DHCF and maintained by Georgetown University. The training module is based on the Bright Futures guidelines and has been tailored to the needs of the DC Provider community. This training module satisfies the EPSDT and IDEA Provider training requirements of DC Health Check Providers. Successful completion of the Training Module is expected of all providers providing EPSDT services within 30 days of joining the Amerigroup network and every two years thereafter. This training will provide five hours of category one credits toward the AMA Physician's Recognition Award, and is paid for by Amerigroup.

For children under age 21, Amerigroup shall assign the enrollee to a PCP certified by the DC HealthCheck program unless the enrollee or enrollee's parent, guardian or caretaker specifically requests assignment to a PCP who is not EPSDT-certified. In this case, the non-EPSDT-certified provider is responsible for ensuring the child receives well-child care according to the EPSDT schedule. If enrollee refuses services, the PCP must document refusal in enrollee's health record. During the initial examination and assessment, the provider must perform applicable HealthCheck screenings and services, based on the periodicity schedule and any additional assessments needed, with the appropriate tools. If a child is identified to have special health care needs or at risk of a developmental delay by the developmental screen required by EPSDT, the provider shall refer the child to specialty care and must make a referral to Amerigroup's Case Management Department.

The HealthCheck assessment must include the following:

- Comprehensive health and developmental history assessment including physical, oral and mental health
- Unclothed comprehensive physical exam
- Immunizations* (based off of D.C. Medicaid Health Check Periodicity Schedule and in accordance with ACIP recommendations)
- Laboratory tests including lead toxicity screenings (if lead level is greater than or equal to 5ug/dL, provider must make a referral to Amerigroup's Case Management Department)
- Health education and explanation of EPSDT services
- Vision services (based off of D.C. Medicaid Health Check Periodicity Schedule and as needed)
- Hearing services (based off of D.C. Medicaid Health Check Periodicity Schedule and as needed)
- Dental services (based off of District of Columbia's Medicaid Dental Periodicity Schedule and as needed)
- Mental health and substance use screening, including a maternal depression screening at the 1 month, 2 month, 4 month, and 6 month well-child visits. If a mental health issue or substance use is determined, provider must make a referral to Amerigroup's Case Management Department.
- Provider must also include any needed diagnostic services for further evaluation and treatment or referrals, as needed to support improving health conditions

* All applicable providers must be enrolled in the Vaccines for Children (VFC) Program. Amerigroup will not reimburse providers for vaccines provided through the VFC Program unless the vaccine was unavailable through the VFC Program and can be proven through written documentation to Amerigroup.

For the EPSDT population, enrollees must be offered an initial appointment within 45 days of their date of enrollment with the PCP or within 30 days of request, whichever is sooner, unless the following exception applies:

Appointments for initial EPSDT screens shall be offered to new enrollees within 60 days of the enrollee's enrollment date with Amerigroup or at an earlier time if an earlier exam is needed to comply with the periodicity schedule or if the child's case indicates a more rapid assessment or a request results from an emergency medical condition. The initial screen shall be completed within three months of the enrollee's enrollment date with Amerigroup, unless Amerigroup determines that the new enrollee is up-to-date with the EPSDT periodicity schedule. To be considered timely, all EPSDT screens, laboratory tests and immunizations shall take place within 30 days of their scheduled due dates for children under the age of two and within 60 days of their due dates for children age two and older. Periodic EPSDT screening examinations shall take place within 30 days of a request.

Americans with Disabilities Act

Providers must comply with all applicable federal and state laws in assuring accessibility to all services for enrollees with disabilities, pursuant to the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973, maintaining the capacity to deliver services in a manner that accommodates the needs of its enrollees. Providers contracted with Amerigroup are required by law to provide disabled persons full and equal access to medical services. Although a review of the requirements of the law and implementing regulations can be daunting, providing full and equal access to persons with disabilities can be achieved by:

- Removing physical barriers.
- Providing means for effective communication with people who have vision, hearing or speech disabilities, including providing auxiliary aids as needed.
- Providing flexibility in scheduling to accommodate people with disabilities.
- Allowing extra time for enrollees with disabilities to dress and undress, transfer to examination tables, and extra time with the provider in order to ensure the individual is fully participating and understands the information.
- Making reasonable modifications to policies, practices and procedures.

For more information on making changes to a practice to ensure ADA compliance, refer to these additional resources:

- https://www.ada.gov
- https://www.ada.gov/medcare_mobility_ta/medcare_ta.htm

Enrollees with Special Health Care Needs

In general, to provide care to enrollees with special health care needs, it is important for the PCP and specialist to:

- Demonstrate their credentials and experience to Amerigroup for treatment of special populations.
- Collaborate with Case Management staff on issues pertaining to the care of a special needs enrollee.
- Document the plan of care and care modalities and update the plan annually.

Individuals in one or more of these special needs populations must receive services in the following manner from Amerigroup and/or Amerigroup providers:

- Upon request of the enrollee or the PCP, a case manager trained as a nurse or social worker will be assigned to the enrollee. The case manager will work with the enrollee, the Health Home if the enrollee is enrolled and the PCP to plan the treatment and services needed. The case manager will not only help plan for the care but will also help keep track of the health care services the enrollee receives during the year and serve as the coordinator of care with the PCP across a continuum of inpatient and outpatient care.
- The PCP and case manager, when required, will coordinate referrals for needed specialty care, including specialists for disposable medical supplies (DMS), durable medical equipment (DME) and assistive technology devices based on medical necessity. PCPs should follow the referral protocols established by Amerigroup for sending enrollees to specialty care networks.
- All providers are required to treat individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990 (P.L.101-336 42 U.S.C. §12101 et. seq.) and regulations disseminated under it.

Services for Pregnant and Postpartum Women

Amerigroup and network providers are responsible for providing pregnancy-related services including:

- Completion of the *DC Collaborative Perinatal Risk Screening Tool*; the completed tool must be submitted with the authorization for obstetric services
- Comprehensive prenatal, perinatal and postpartum care (including high-risk specialty care)
- Development of an individualized plan of care that is based upon the risk assessment and modified during the course of care if needed
- Case management services
- Prenatal and postpartum counseling and education
- Basic nutritional education
- Special substance abuse treatment, including access to treatment within 24 hours of request and intensive outpatient programs that allow for children to accompany their mothers
- Nutrition counseling by a licensed nutritionist or dietician for nutritionally high-risk pregnant women
- Appropriate levels of inpatient care, including emergency transfer of pregnant women and newborns to tertiary care centers
- Postpartum home visits

The PCP, OB/GYN and Amerigroup are responsible for making appropriate referrals of pregnant enrollees to community resources that may improve pregnancy outcomes. In connection with

such referrals, necessary medical information will be supplied to the program for the purpose of making eligibility determinations.

Pregnancy-related service providers will follow, at a minimum, the applicable American College of Obstetricians and Gynecologists (ACOG) clinical practice guidelines. For each scheduled appointment, you must provide written and telephonic (if possible) notice to enrollees of the prenatal appointment dates and times.

Providers must:

- Schedule prenatal appointments in a manner consistent with the ACOG guidelines.
- Provide an initial appointment within 10 days of the request.
- Complete the DC Collaborative Perinatal Risk Screening Tool.
- Refer pregnant enrollees under age 21 to their PCP to receive EPSDT screening services.
- Keep track of missed appointments, making three attempts to contact enrollees regarding missed appointment.
- Notify Amerigroup of pregnant women not completing needed appointments.
- Refer to the WIC program.
- Refer pregnant and postpartum enrollees who are in need of treatment for substance use disorder for appropriate substance abuse assessments and treatment services.
- Offer HIV counseling and testing and provide information on HIV infection and its effects on the unborn child.
- Instruct the pregnant enrollee to notify Amerigroup of her pregnancy and expected date of delivery after her initial prenatal visit.
- Instruct the pregnant enrollee to contact Amerigroup for assistance in choosing a PCP for the newborn prior to her eighth month of pregnancy.
- Document the pregnant enrollee's choice of pediatric provider in the medical record.

Taking Care of Baby and Me

Taking Care of Baby and Me® is a proactive case-management program for all expectant mothers and their newborns. It identifies pregnant women as early in their pregnancies as possible through review of District enrollment files, claims data, hospital census reports, and provider notification of pregnancy and delivery notification forms and self-referrals. Once pregnant enrollees are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care and case management services to mitigate risk.

Experienced case managers work with enrollees and providers to establish a care plan for our highest risk pregnant enrollees. Case managers collaborate with community agencies to ensure mothers have access to necessary services.

When it comes to our pregnant enrollees, we are committed to keeping both mom and baby healthy. That's why we encourage all of our moms-to-be to take part in our Taking Care of Baby and Me program — a comprehensive case management and care coordination program offering:

- Individualized, one-on-one case management support for women at the highest risk
- Care coordination for moms who may need a little extra support
- Educational materials and information on community resources
- Rewards to keep up with prenatal and postpartum checkups

As part of the Taking Care of Baby and Me program, eligible enrollees are offered the My Advocate® program. This program provides pregnant women proactive, culturally appropriate outreach and education through Interactive Voice Response (IVR). Eligible enrollees receive regular phone calls with tailored content from a voice personality (Mary Beth), or they may choose to access the program via a smartphone application or website. This program does not replace the high- touch case management approach for high-risk pregnant women. However, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high-risk, to facilitate connections between them and our case managers and improve enrollee and baby outcomes. Eligible enrollees receive regular calls with tailored content from a voice personality (Mary Beth). For more information on My Advocate visit www.myadvocatehelps.com.

We encourage notification of pregnancy at the first prenatal visit and notification of delivery following birth. You may fax the forms to Amerigroup at 1-800-964-3627.

We also encourage providers to complete the Maternity form in Availity Essentials:

- Perform an Eligibility and Benefits (E&B) request on the desired enrollee.
- Choose one of the following benefit service types: maternity, obstetrical, gynecological, or obstetrical/gynecological.
- Before the benefit results screen, you will be asked if the enrollee is pregnant. Choose “Yes”, if applicable. If you indicate “Yes” you may provide the estimated due date, if it is known, or leave it blank if the due date is unknown.
- After submitting your answer, the E&B will display. If the enrollee was identified as pregnant, a Maternity form will be generated. You may access the form by navigating to the “Applications” tab and selecting the “Maternity” link.

Dental Care

Dental services are provided by Avesis. Contact Avesis at 1- 855-214-6777 with questions about dental benefits. See Dental Benefits section for more information.

Childbirth-Related Provisions

There are special rules to determine the length of hospital stay following childbirth:

- An enrollee’s length of hospital stay after childbirth is determined in accordance with the ACOG and American Academy of Pediatrics (AAP) guidelines for prenatal care, unless the 48-hour (for uncomplicated vaginal delivery) or 96-hour (for uncomplicated cesarean section) length of stay guaranteed by District law is longer than that required under the guidelines.

- If an enrollee must remain in the hospital after childbirth for medical reasons, and she requests her newborn remain in the hospital while she is hospitalized, additional hospitalization of up to four days must be provided for the newborn and is covered.
- If an enrollee elects to be discharged earlier than the conclusion of the length of stay guaranteed by District law, a home visit must be provided.
- When an enrollee opts for early discharge from the hospital following childbirth (before 48 hours for vaginal delivery or before 96 hours for cesarean section), one home nursing visit within 24 hours after discharge and an additional home visit, if prescribed by the attending provider, are covered.
- The hospital is responsible for notifying Amerigroup of the birth of a child within 24 hours or by the next business day. The hospital must also notify Amerigroup within 24 hours or by the next business day if a newborn is transferred from the nursery to the NICU, transferred to another level of care or is detained beyond the OB global period. These changes would be documented as a separate, new admission and not part of the mother's admission.

Postnatal home visits are to be performed by a registered nurse in accordance with generally accepted standards of nursing practice for home care of a mother and newborn and must include:

- An evaluation to detect immediate problems of dehydration, sepsis, infection, jaundice, respiratory distress, cardiac distress or other adverse symptoms of the newborn.
- An evaluation to detect immediate problems of dehydration, sepsis, infection, bleeding, pain or other adverse symptoms of the mother.
- Blood collection from the newborn for screening (unless previously completed).
- Appropriate referrals.
- Any other nursing services ordered by the referring provider.

If an enrollee remains in the hospital for the standard length of stay following childbirth, a home visit, if prescribed by the provider, is covered.

When a service is not provided prior to discharge, a newborn's initial evaluation by an out-of-network on-call hospital provider before the newborn's hospital discharge is covered as a self-referred service.

It is required to schedule newborns for a follow-up visit within two weeks after discharge if a home visit has not been scheduled to occur within 30 days post-discharge.

Home visits are also performed for high risk newborns within 48 hours of discharge from the birthing hospital or center. This visit includes an assessment of the home environment; facilitation parent-child attachment; ascertaining family resources and parent risk factors; assessing the diagnostic and treatment needs of the mother and newborn; coordination of follow-up care, coordination related to early interventions from other social and educational support agencies.

Children with Special Health Care Needs

Amerigroup will:

- Provide the full range of medical services for children, including services intended to improve or preserve the continuing health and quality of life, regardless of the ability of services to affect a permanent cure.
- Provide case management services to children with special health care needs, as appropriate. For complex cases involving multiple medical interventions, social services or both, a multidisciplinary team must be used to review and develop the plan of care for children with special health care needs.
- Refer special needs children to specialists as needed, including specialty referrals for children found to be functioning at one-third or more below chronological age in any developmental area as identified by the developmental screen required by the EPSDT periodicity schedule.
- Allow children with special health care needs to access out-of-network specialty providers as specified in the special provisions and guidelines detailed in Section 1 titled *Self-Referred Services for Children with Special Health Care Needs*.
- Log any complaints made to the District or to Amerigroup about a child who is denied services. Amerigroup will inform the District about all denials of service to children. All denial letters sent to children or their representatives must state that enrollees can appeal by calling the District's Enrollee Help Line at 1-800-620-7802.
- Work closely with the schools that provide education and family services programs to children with special needs.
- Ensure coordination of care for children in District-supervised care. If a child in District-supervised care moves out of the area and must transfer to another MCO, the District and Amerigroup will work together to find another MCO as quickly as possible.

Individuals with HIV/AIDS

Individuals with HIV/AIDS are enrolled in one of the District's MCOs. Children with HIV/AIDS who are enrolled in My Health GPS Health Home benefit will be managed by the assigned health home. See the Health Home section of this manual for more information.

The following service requirements apply for persons with HIV/AIDS:

- An HIV/AIDS specialist for treatment and coordination of primary and specialty care must be involved in the enrollee's care.
- A Diagnostic Evaluation Service (DES) assessment can be performed once every year at the enrollee's request. The DES includes a physical, behavioral and social evaluation. The enrollee may choose the DES provider from a list of approved locations or can self-refer to a certified DES provider for the evaluation.
- Substance abuse treatment within 24 hours of request.

- The right to ask Amerigroup to send him or herself to a site that performs HIV/AIDS-related clinical trials. Amerigroup may refer enrollees with HIV/AIDS to facilities or organizations that can provide enrollees access to clinical trials.
- The LHD will designate a single staff enrollee to serve as a contact. In all instances, providers will maintain the confidentiality of enrollee records and eligibility information in accordance with all federal, District and local laws and regulations and use this information only to assist the enrollee to receive needed health care services.
- Enrollees enrolled in the My Health GPS benefit will be case managed by the assigned health home. Amerigroup case management services are covered for any enrollee diagnosed with HIV. These services must be provided with the enrollee's consent to facilitate timely and coordinated access to appropriate levels of care and to support continuity of care across the continuum of qualified service providers. Case management will link HIV-infected enrollees with the full range of benefits (e.g., primary behavioral health care and somatic health care services) and referral for any additional needed services including specialty behavioral health services, social services, financial services, educational services, housing services, counseling and other required support services. HIV case management services include:
    - Initial and ongoing assessment of the enrollee's needs and personal support systems, including using a multidisciplinary approach to develop a comprehensive, individualized service plan. This includes periodic re-evaluation and adaptation of the plan.
    - Coordination of services needed to implement the plan.
    - Outreach for the enrollee and the enrollee's family by which the case manager and the PCP track services received, clinical outcomes and the need for additional follow-up care.

The enrollee's case manager will serve as the enrollee's advocate to resolve differences between the enrollee and providers of care pertaining to the course or content of therapeutic interventions.

If an enrollee initially refuses HIV case management services, the services are to be available at any later time if requested by the enrollee.

Individuals with Physical or Developmental Disabilities

Before placement of an individual with a physical disability into an intermediate or long-term care facility, Amerigroup will assess the needs of the individual and the community as supplemented by other Medicaid services. The Amerigroup medical director will conduct a second-opinion review of the case before placement. If the medical director determines the transfer to an intermediate or long-term care facility is medically necessary and the expected stay will be greater than 30 days, Amerigroup will obtain approval from DCHFP before making the transfer.

Providers who treat individuals with physical or developmental disabilities must be trained on special communication requirements of individuals with physical disabilities. Amerigroup is responsible for accommodating hearing-impaired enrollees who require and request a qualified interpreter. Amerigroup can delegate the financial risk and responsibility to providers, and is ultimately responsible for ensuring enrollees have access to these services.

Amerigroup providers must be clinically qualified to provide DME and assistive technology services for both adults and children.

Amerigroup informational materials are approved by persons with experience in the needs of enrollees with disabilities, thereby ensuring the information is presented in a manner in which enrollees understand the material, whether on paper or by voice translation.
Amerigroup provides training to its triage, Enrollee Services and Case Management staff on the special communications requirements of enrollees with physical disabilities. Amerigroup will clearly indicate to its providers how this provision is to be implemented (See Optional Services Provided by Amerigroup on how to access these services).

Individuals who are Homeless

If an individual is identified as homeless, Amerigroup will provide a case manager to coordinate health care services.

Adult Enrollees with Impaired Cognitive Ability/Psychosocial Problems

Support and outreach services are available for adult enrollees needing follow-up care who have impaired cognitive ability or psychosocial problems and who can be expected to have difficulty understanding the importance of care instructions or difficulty navigating the health care system.

MCO Support Services (Outreach)

Amerigroup enacts a variety of outreach campaigns to support our enrollees in getting the care they need. These campaigns are focused on topics including, but not limited to, completion of EPSDT services, preventive care, condition self-management, and medication adherence. Outreach methods include phone, texts, mailings, community events and in person.

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.

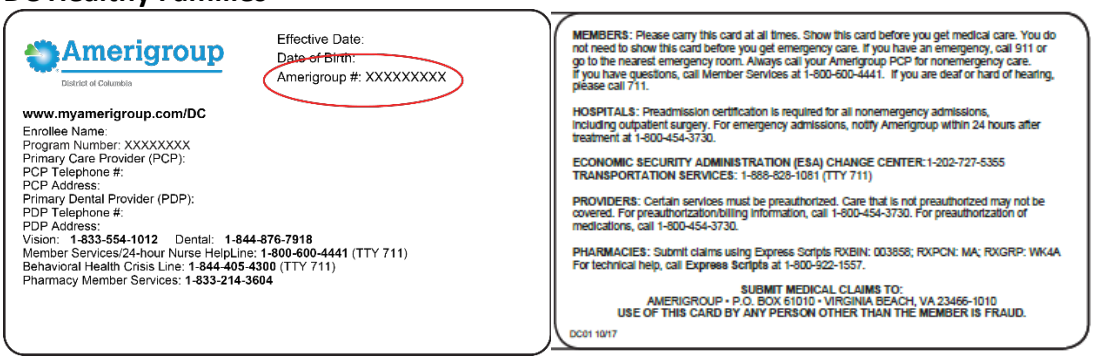
To help prevent fraud, waste or abuse, providers can educate enrollees. For example, spending time with enrollees and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent enrollee fraud is as simple as reviewing the Amerigroup enrollee identification card. It is the first line of defense against fraud. Amerigroup may not accept responsibility for the costs incurred by providers supplying services to a person who is not an enrollee, even if that person presents an Amerigroup enrollee identification card. Providers should take measures to ensure the cardholder is the person named on the card.

Every Amerigroup enrollee identification card lists the following:

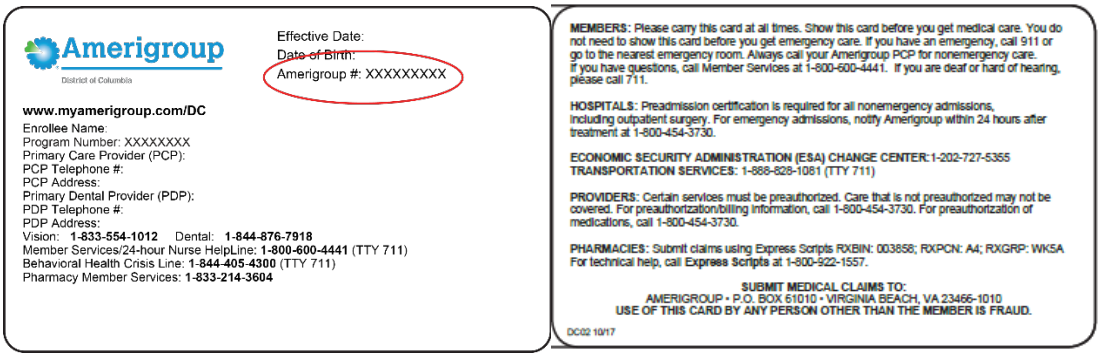
- Effective date of Amerigroup membership
- Enrollee date of birth
- Subscriber number (Amerigroup identification number)
- Carrier and group number (RXGRP number) for injectables
- PCP name, telephone number and address
- Copayments for office visits, emergency room visits and pharmacy services (if applicable)
- Behavioral health benefit
- Vision service plan telephone number and dental service plan telephone number
- Enrollee Services and Nurse HelpLine telephone numbers

Amerigroup enrollee identification card samples:

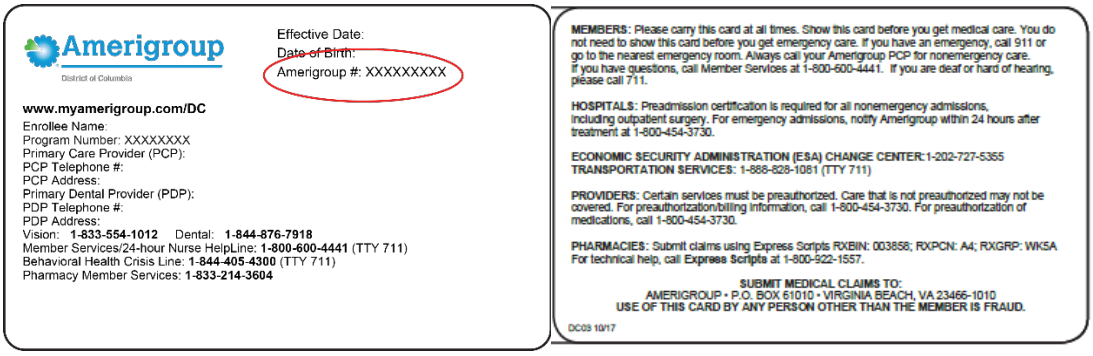
DC Healthy Families



DC Healthcare Alliance



Immigrant Children's Program



Presentation of an enrollee identification (ID) card does not guarantee eligibility; providers should verify an enrollee's status by inquiring online or via telephone. Online support is available for provider inquiries on the website, and telephonic verification may be obtained through the automated Provider Inquiry Line at 1-800-454-3730.

Providers should encourage enrollees to protect their ID cards as they would a credit card, to carry their Amerigroup 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 enrollees to protect their health benefit ID card can help prevent fraudulent activities. If you or a enrollee suspect ID theft, call our Compliance Hotline at 1-877-660-7890. Providers should instruct their enrollees who suspect ID theft to watch the explanation of benefits (EOBs) for any errors and then contact Enrollee Services if something is incorrect.

Reporting Fraud, Waste and Abuse

If you suspect a provider (e.g., provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any enrollee (a person who receives benefits) has committed fraud, waste or abuse, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators.

You can report your concerns by:

- Visiting our website and completing the *Report Waste, Fraud and Abuse* form
- For enrollees, call the Enrollee Services number on your ID card
- For providers, call Provider Services
- Calling our Special Investigations Unit fraud hotline at 1-866-847-8247
- Contact DHCF at:

Department of Health Care Finance
Division of Program Integrity
442 4th Street NW
Washington, DC 20001

Phone: (202) 698-2000
Fraud Hotline: (877) 632-2873

Any incident of fraud, waste or abuse may be reported to us anonymously. If you prefer to remain anonymous, please use one of the hotline numbers instead of completing the form. When using the hotline, leave as much information as you can about the issue, the person(s) involved and the relevant dates. Our ability to investigate an anonymously reported matter may be handicapped without enough information. While there is no need to identify yourself on the hotline, providing your name and contact information allows us to contact you if there are any questions about your referral. We appreciate your time in referring suspected fraud, but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

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

When reporting concerns involving a ***provider*** (a doctor, dentist, counselor, medical supply company, 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

Examples of Enrollee Fraud, Waste and Abuse:

- Forging, altering or selling prescriptions
- Letting someone else use the enrollee's ID (identification) card
- Relocating to out-of-service plan area and not letting us know
- Using someone else's ID card

When reporting concerns involving an ***enrollee***, include:

- The enrollee's name
- The enrollee's date of birth, enrollee ID number, if you have it, or case number if you have it
- The city where the enrollee resides
- Specific details describing the fraud, waste or abuse

Investigation Process

We investigate all reports of fraud, abuse and waste for all services provided under the contract, including those that are subcontracted to outside entities. If appropriate, allegations and the investigative findings are reported to all appropriate District, 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 coding review explanations, requests for recoveries, or may advise of further action.
- *Medical record review:* 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 within 30 days. Failure of the provider to return the overpayment after 30 days may result in reduced payment of future claims or further legal action.

If you are working with the SIU all checks and correspondence should be sent to:
Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Paper medical records and/or claims are a different address, which is supplied in correspondence from the SIU. If you have questions, contact your investigator. An opportunity to submit claims and/or supporting medical records electronically is an option if you register for an Availity account. Contact Availity Client Services at 800-AVAILITY (282-4548) for more information.

Acting on Investigative Findings

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

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

- Will be reviewed by the health plan's 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 contract, may result in termination from our plan.

If an enrollee appears to have committed fraud, waste or abuse, the enrollee may be involuntarily dis-enrolled from our health care plan, with District approval.

Relevant Legislation

Federal False Claims Act (FCA)

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-$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.

HIPAA

The Health Insurance Portability and Accountability Act (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 health care fraud and simplifies the administration of health insurance.

Our company strives to ensure both Amerigroup and contracted participating providers conduct business in a manner that safeguards enrollee information in accordance with the privacy regulations enacted pursuant to HIPAA. Contracted providers shall have the following procedures implemented to demonstrate compliance with the HIPAA privacy regulations:

- Our company recognizes its responsibility under HIPAA privacy regulations to only request the minimum necessary enrollee information from providers to accomplish the intended purpose; conversely, network providers should only request the minimum necessary enrollee information required to accomplish the intended purpose when contacting us; however, privacy regulations allow the transfer or sharing of enrollee information. Our company may request information to conduct business and make decisions about care, such as an enrollee's medical record, authorization determinations or payment appeal resolutions. 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 enrollee information to perform their jobs. When faxing information to us, verify the receiving

fax number is correct, notify the appropriate staff at our company and verify the fax was received.

- Internet email (unless encrypted and/or transferred by another secure service) should not be used to transfer files containing enrollee information, 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 our company.
- Our company voice mail system is secure and password protected. When leaving messages for any of our associates, leave only the minimum amount of enrollee information required to accomplish the intended purpose.

When contacting us, please be prepared to verify the provider’s name, address and tax identification number (TIN) or enrollee’s provider number.

Misrouted Protected Health Information

Providers and facilities are required to review all enrollee information received from Amerigroup to ensure no misrouted Protected Health Information (PHI) is included. Misrouted PHI includes information about enrollees 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 contact Amerigroup, as Amerigroup is required to inform the Information Security and Privacy Officer of the District of Columbia with 10 days of any security incident/breach. Once all required information regarding the misrouted PHI is provided to Amerigroup, providers and facilities are to destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or re-disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please contact Provider Services.

UTILIZATION MANAGEMENT

Overview

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

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Amerigroup does not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support denials of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization, or create barriers to care and service.
- Access to UM Staff is available. Amerigroup associates are available at least eight hours a day from 8 a.m. to 5 p.m., Monday through Friday, for inbound communications regarding UM inquiries. Clinical professionals are available twenty-four hours a day, seven days a week for urgent/emergent admissions. Staff will identify themselves by name, title, and organizational name when initiating or returning calls regarding UM issues.
- Amerigroup offers TDD/TTY services for deaf, hard of hearing or speech-impaired enrollees. For all enrollees who request language services, Amerigroup provides services free of charge through bilingual staff or interpreter to help enrollees with UM issues.

Criteria and Clinical Information for Medical Necessity

Medical Policies and Clinical UM Guidelines, which are publicly accessible from its subsidiary websites, are the primary guidelines used to determine whether services are considered to be a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive.

MCG criteria will be used to determine medical necessity for acute inpatient care. A list of the specific *Medical Policies* and *Clinical UM Guidelines* used will be posted and maintained on the websites and can be obtained in hard copy by written request. To request a copy of the criteria on which a medical decision was based, call Provider Services at 1-800-454-3730.

The policies described above will support precertification requirements, acute inpatient care, and retrospective review.

Federal and District law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over clinical policy and must be considered first when determining eligibility for coverage. As such, in all cases, District Medicaid contracts will supersede MCG, McKesson InterQual, Medical Policy, and Clinical UM Guidelines. Medical technology is constantly evolving, and Amerigroup reserves the right to review and periodically

update medical policy and utilization management criteria. The Amerigroup Utilization Management department reviews the medical necessity of medical services using:

- District guidelines
- Medical Policies
- MCG (inpatient care, behavioral health services)
- McKesson InterQual (acute inpatient rehabilitation, inpatient skilled nursing))
- Clinical Utilization Management Guidelines
- *Carelon Medical Benefits Management, Inc.* Specialty Health Clinical and Diagnostic Appropriateness Guidelines* (high-tech radiology, sleep medicine, radiation oncology)
- *Carelon Medical Benefits Management Diagnostic Musculoskeletal Guidelines (pain management, muscular skeletal surgery)*

Amerigroup follows established procedures for applying medical necessity criteria based on individual enrollee needs and an assessment of the availability of services within the local delivery system. To learn more about these procedures, visit the provider self-service website at https://providers.amerigroup.com/DC or call Provider Services. These procedures apply to:

- Precertification
- Concurrent reviews
- Retrospective reviews

Requests for services/care should include current applicable and appropriate ICD and CPT codes and relevant clinical information. Appropriate clinical information includes:

- Office and/or hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic testing results
- Treatment plans and progress notes
- Psychosocial history
- Consultation notes
- Operative and pathological reports
- Rehabilitation evaluations
- Enrollee characteristics and information
- Estimated/anticipated length and/or frequency of treatment

Services reviewed by Carelon Medical Benefits Management, Inc.

As of November 1, 2023, care providers are required to contact Carelon Medical Benefits Management for prior authorization of services. Providers are always strongly encouraged to verify that a prior authorization has been obtained before scheduling and performing any service. Failure to obtain prior authorization will result in an administrative denial of the claim.

Contact Carelon Medical Benefits Management to obtain pre-service review for the following non-emergency services:

- Durable medical equipment
- Orthotics
- Prosthetics
- Radiology services:
    - Nuclear imaging, including myocardial perfusion imaging, cardiac blood pool imaging, infarct imaging and positron emission tomography (PET) myocardial imaging
    - Computed tomography (CT), including CT angiography, derived fractional flow reserve, structural CT and quantitative evaluation of coronary calcification
    - Magnetic resonance imaging (MRI)
    - Magnetic resonance angiography (MRA)
    - Magnetic resonance spectroscopy (MRS)
    - Functional MRI (fMRI)
- Radiation oncology services:
    - 2D conventional and 3D conformal radiation therapy
    - Brachytherapy
    - Proton beam therapy
    - Intensity-modulated radiation therapy (IMRT)
    - Intraoperative radiation therapy (IORT)
    - Selective internal radiation therapy (SIRT)
    - Stereotactic body radiotherapy (SBRT)
    - Stereotactic radiosurgery (SRS)
    - Fractionation in bone metastases, non-small cell lung cancer, and breast cancer when requesting external beam radiation therapy (EBRT) and intensity-modulated radiation therapy (IMRT)
    - Image-guided radiation therapy (IGRT)
    - Special procedures and consultations associated with treatment planning (CPT® codes 73370 and 77470)
- Supports

PA requests may be submitted to Carelon through the following methods:

- Online via the Availity Portal: https://availity.com
- Online via the Carelon MBM provider portal at https://www.providerportal.com
- By phone via the Carelon call center at **933-419-2141**

Enrollees included in this program:

All enrollees except for the following products/groups:

- For radiology, echocardiography is excluded.
- For radiation oncology, radiopharmaceuticals are excluded.

Amerigroup's Chief Medical Officer will review any denial of care for EPSDT services and services for enrollees with special health care needs. Amerigroup's Chief Psychiatric Medical Officer will review all denials of care for mental health treatment services.

Referral/Precertification Process

Referrals to in-network specialists are not required for payment; however, Amerigroup highly recommends PCPs supply the enrollee with instructions for follow-up care. Visit https://providers.amerigroup.com/DC to download a *Personalized Treatment Plan* form under Provider Documents & Resources > Forms.

Precertification and Notification — General

Some covered services require **precertification** prior to services being rendered, while other covered services require **notification** prior to being rendered.

Notification is a communication received from a provider informing Amerigroup of the intent to render covered medical services to an enrollee. For services that are emergent or urgent, notification must be provided by the next business day. Notifications may be submitted by telephone or fax.

Prospective means the coverage request occurred prior to the service being provided. Precertification is the prospective process whereby licensed clinical associates apply specific criteria sets against the intensity of services and severity of illness to determine the medical necessity and appropriateness of the request.

Services requiring precertification include but are not limited to:

- Elective inpatient admissions
- Select outpatient and specialty care provided outside of the PCP's scope of practice
- High-tech radiology
- Durable medical equipment
- Home health services
- Out-of-network services

The following information should be provided to the Medical Management department for precertification at 1-800-454-3730:

- Enrollee's name
- Enrollee's address
- Enrollee's Amerigroup ID number
- Enrollee's date of birth
- Enrollee's PCP
- Scheduled date of admission and/or surgery
- Name of hospital
- Enrollee's diagnosis
- Attending provider
- Clinical information (if applicable)

All Amerigroup enrollees scheduled for inpatient surgery must be admitted to the hospital on the day of the surgery except in preapproved medically necessary cases. Amerigroup will **not** pay for any costs associated with admissions on the day before surgery unless specific medical justification is provided and approved. Each enrollee's case will be examined individually in this respect.

The following are **not** acceptable reasons for an admission before surgery:

- Enrollee, provider or hospital convenience
- Routine laboratory or X-ray
- NPO (i.e., nothing by mouth)
- Distance or transportation to the hospital
- Most preps

Upon notification, Amerigroup reviews the clinical basis for admission and authorizes benefits for the admission. The medical director reviews any potential denial of coverage after evaluating the enrollee's medical condition, and medical criteria.

To verify whether or not a particular service requires precertification, use the Precertification Look-up Tool under the *Quick Tools* menu at https://providers.amerigroup.com/DC.

Precertification is **not** required for the following services:

- Routine laboratory tests (excluding genetic testing) performed in the PCP's office or contracted laboratory
- Routine X-rays, EKGs, EEGs or mammograms at a network specialist office at a freestanding radiology facility or at some network hospitals
- Routine outpatient behavioral health therapy services (excluding psychological testing) at a network specialist office.
- Sleep studies unattended by a technologist at an enrollee's home

The medical director will periodically review and revise this list with the expectation that additional services will be added as practice patterns of the network warrants.

Interactive Care Reviewer (ICR)*

The Interactive Care Reviewer (ICR), our online authorization tool is the preferred method for the submission of preauthorization requests, offering a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for Amerigroup enrollees. Additionally, providers can use this tool to inquire about previously submitted requests regardless of how they were submitted (phone, fax, ICR or other online tool). Access ICR via Availity Essentials www.availity.com. (Select Patient Registration > Authorizations & Referrals)
Initiate preauthorization requests online, eliminating the need to fax. ICR allows detailed text, photo images and attachments to be submitted along with your request.

Appeal a denied authorization- ICR allows you to appeal a denied authorization by selecting appeal on the denied decision located on the Case Overview.

Review requests previously submitted via phone, fax, ICR or other online tool.
Request and check the status of clinical appeals.
Instant accessibility from almost anywhere, including after business hours.
Utilize the dashboard to provide a complete view of all UM requests with real-time status updates.
Real-time results for some common procedures.

For an optimal experience with Amerigroup ICR, use a browser that supports 128-bit encryption. This includes, Micosoft Edge, Chrome or Firefox.

*Mid to late 2023, ICR will migrate to the Availity Essentials multi-payer authorization application. The features available to you in ICR will be offered through Availity's application.

Amerigroup ICR is not currently available for the following:

- Transplant services
- Services administered by vendors such as Carelon Medical Benefits Management (For these requests, follow the same preauthorization process that you use today.)

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

Precertification Determination Time Frames

For services that require precertification, Amerigroup will make a determination in a timely manner so as not to adversely affect the health of the enrollee. For nonurgent preservice requests, the determination will be made within 14 calendar days of receipt of the request. For urgent preservice requests, the determination will be made with 72 hours of receipt of the requests.

Enrollees or their authorized representative may agree to extend the decision-making timeframe for preservice requests. If the request lacks clinical information, the organization may extend the decision time frame up to an additional 14 calendar days for both routine and urgent preservice requests.

Utilization Management — Inpatient Services

Elective Inpatient Admission Notification Time Frames
All elective admissions must receive prior approval through Provider Services at least 72 hours prior to the admission or scheduled procedure. Failure to comply with notification rules will result in an administrative denial.

The hospital is responsible for notifying Amerigroup of the birth of a child within one business day of the date of birth. For transfer of a newborn from the nursery to the NICU or to another level of care, or to detain a newborn beyond the OB global period, the hospital must notify Amerigroup within one business day. These circumstances are considered separate, new admissions and are not part of the mother's admission.

Emergent admissions require notification to Amerigroup within one business day following the admission. Failure to comply with notification rules will result in an administrative denial.

Administrative Denial
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, lack of precertification or failure by the provider to submit clinical when requested. Appeals for administrative denials must address the reason for the denial (i.e., why precertification was not obtained or why clinical was not submitted).

If Amerigroup overturns its administrative decision, then 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.

Inpatient Specialist Referrals
Referrals to in-network specialists are not required for payment; however, Amerigroup highly recommends PCPs supply the enrollee with instructions for follow-up care. Log in at https://providers.amerigroup.com/DC to download the *Personalized Treatment Plan* form under Provider Documents & Resources > Forms.

Acute Inpatient Admission:

- All medical inpatient hospital admissions will be reviewed for medical necessity within 72 hours of the facility notification to Amerigroup.
- Clinical information for the initial (admission) review will be requested by Amerigroup at the time of the admission notification.
- For medical admissions, the facilities are required to provide the requested clinical information within 24 hours of the request.
- If the information is not received within 24 hours, an administrative adverse determination (i.e., a denial) will be issued.

Inpatient Concurrent Review
Each network hospital will have an assigned concurrent review clinician. The concurrent review clinician will conduct a review of the medical records electronically or by telephone to determine the authorization of coverage for an admission.

When the clinical information is received, a medical necessity review will be conducted using applicable nationally recognized clinical criteria, and a determination will be communicated to the facility.

The Amerigroup concurrent review clinician will conduct a discharge planning review every 7 days, or more often when condition warrants, and help coordinate discharge planning needs with the designated facility staff and the attending provider. The attending provider is expected to coordinate with the enrollee's PCP or outpatient specialty provider regarding follow-up care and services after discharge. The PCP or outpatient specialty provider is responsible for contacting the enrollee to schedule all necessary follow-up care.

If the medical director/physician reviewer denies authorization for an inpatient stay based upon applicable guidelines or criteria, a notice of intent to deny will be provided to the facility and to the attending provider.

Upon notification of the intention to deny, the enrollee's treating physician can request a physician-to-physician review to provide additional information not previously submitted to Amerigroup. The request for this review must be made within two business days of the notification of intent to deny. To initiate this request, the physician or a physician representative may contact Amerigroup at 1-844-421-5656 from 8:30 a.m. to 5:30 p.m. Eastern time.

All notifications of intent to deny will be followed with a written adverse determination. Hospital representatives must follow the provider payment dispute process to appeal inpatient adverse determination decisions. See the Provider Claims/Payment Dispute Process for additional information.

Inpatient Retrospective Review
Inpatient admissions may be retrospectively reviewed after the enrollee is discharged. If Amerigroup is notified of the admission while the enrollee is still in the hospital, the review will be considered concurrent and subject to concurrent time frames and guidelines. For additional questions and a quick reference guide, visit the provider website.

Discharge Planning
Discharge planning is designed to assist the provider with coordination of the enrollee's discharge when acute care (i.e., hospitalization) is no longer necessary.

When a lower level of care is necessary, Amerigroup works with the provider to help plan the enrollee's discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital setting such as:

- Hospice facility
- Skilled nursing facility
- Residential treatment facilities (RTF)
- Partial hospitalization programs (PHP)
- Intensive outpatient programs (IOP)
- Home health care

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

Discharge plan authorizations follow the applicable precertification process and determinations are made using nationally recognized clinical criteria or guidelines. Authorizations include, but are not limited to, home health, durable medical equipment (DME), follow-up visits to providers or outpatient procedures.

Utilization Management — Outpatient Services

Outpatient Precertification
Precertification is required and must be requested at a minimum of 72 hours before the service/procedure/etc. must be provided. Failure to comply with notification rules will result in an administrative denial.

Administrative Denial
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, lack of precertification or failure by the provider to submit clinical when requested.

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

If Amerigroup overturns its administrative decision, then 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.

This applies to the following types of care (the list may be modified periodically):

- Home health care
- Physical and speech therapy beyond the initial evaluation (subsequent visits require clinical documentation and precertification from Amerigroup)
- DME
- Cardiac rehabilitation
- Outpatient diagnostic radiology

In addition, precertification is required for all out-of-network care (certain exclusions apply) and for specialty visits (i.e., services beyond the initial evaluation and management) if performed by a nonparticipating provider.

For code-specific precertification requirements for dermatology, genetics, otolaryngology, podiatry, plastic surgery and pain management performed in a participating clinic/outpatient facility/ambulatory surgery center, visit https://providers.amerigroup.com and select **Precertification Lookup** from the *Quick Tools* menu.

For precertification requirements for behavioral health services, please refer to the Behavioral Health section in this manual.

Precertification Requirement Review and Updates

Amerigroup will review and revise policies when necessary. The most current policies are available on the provider self-service website.

Specialist as PCP Referral

Under certain circumstances, a specialist may be approved by Amerigroup to serve as an enrollee's PCP when an enrollee requires the regular care of the specialist. The criteria for a specialist to serve as an enrollee's PCP include the existence of a chronic, life-threatening illness or condition of such complexity whereby:

- The need for multiple hospitalizations exists
- The majority of care must be provided by a specialist
- The administrative requirements of arranging for care exceed the capacity of the PCP. This would include enrollees with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis, etc.

The specialist must meet the requirements for PCP participation (including contractual obligations and credentialing), provide access to care 24 hours a day, 7 days a week and coordinate the enrollee's health care including preventive care. When such a need is identified, the enrollee or specialist must contact the Amerigroup Case Management department and complete a *Specialist as PCP Request Form*. An Amerigroup case manager will review the request and submit it to the Amerigroup medical director. Amerigroup will notify the enrollee and the provider of the determination in writing within 30 days of receiving the request. Should Amerigroup deny the request, Amerigroup will provide written notification to the enrollee and provider of the reason(s) for the denial of the request. Specialists serving as PCPs will continue to be paid under fee-for-service while serving as the enrollee's PCP. The designation cannot be retroactive. For further information, see the *Specialist as PCP Request Form* in Appendix A – Forms.

Reporting Changes in Address and/or Practice Status

Please report any status changes either via fax to 1-866-920-1873 or mail to:

Provider Services
Amerigroup District of Columbia, Inc.
609 H Street NE, Suite 200

Washington, DC 20002

Second Opinions

An enrollee or the enrollee's PCP may request a second opinion for serious medical conditions or elective surgical procedures at no cost to the enrollee. Also, an enrollee of the health care team and/or the enrollee's parents or guardians may also request a second opinion. These conditions and/or procedures include but are not limited to the following:

- Treatment of serious medical conditions such as cancer
- Elective surgical procedures such as hernia repair (simple) for adults (age 18 or older), hysterectomy (elective procedure), spinal fusion (except for children under age 18 with a diagnosis of scoliosis) and laminectomy (except for children under age 18 with a diagnosis of scoliosis)
- Other medically necessary conditions as circumstances dictate

The second opinion must be obtained from a network provider (see the *Provider Referral Directory* at https://providers.amerigroup.com/DC). A second opinion can be obtained from 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 enrollee of the date and time of the appointment and will forward copies of all relevant records to the consulting provider. The PCP will notify the enrollee of the outcome of the second opinion.

Amerigroup may also request a second opinion at its own discretion. This includes but is not limited to the following scenarios:

- There is concern about care expressed by the enrollee or the provider.
- Potential risks or outcomes of recommended or requested care are discovered by the plan during its regular course of business.
- Before initiating denial of coverage of service.
- Denied coverage is appealed.
- An experimental or investigational service is requested.

When Amerigroup requests a second opinion, Amerigroup will make the necessary arrangements for the appointment, payment and reporting. Once the second opinion is completed, Amerigroup will inform the enrollee and the PCP of the results and the consulting provider's conclusion and recommendation(s) regarding further action.

Claim Submission

Claims must be submitted in accordance with timely filing guidelines and must include all necessary information as outlined in the following sections. In addition, all codes used in billing must be supported by appropriate medical record documentation.

Paper Claim Submission

Amerigroup encourages electronic claim submission; however, providers have the option to submit paper claims. Amerigroup utilizes optical character recognition (OCR) technology as part of its front-end claims processing procedures. The benefits of this technology include:

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

To use OCR technology, claims must be submitted on original, red claim forms (not black and white or photocopied forms) that are laser-printed or typed (not handwritten) in large, dark font. Providers must submit a properly completed *UB-04* or *CMS-1500 (08-05)* claim form within 365 days from the date of discharge for inpatient services or from the date of service for outpatient services except in cases of coordination of benefits/subrogation or in cases where an enrollee has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date the third party documents resolution of the claim. For cases of retroactive eligibility, the time frames for filing a claim will begin on the date Amerigroup receives notification from DCHFP of the enrollee's eligibility/enrollment.

In accordance with the implementation timelines set by CMS, the National Uniform Claim Committee (NUCC) and the National Uniform Billing Committee (NUBC), Amerigroup requires the use of the new *CMS-1500 (08-05)* form for the purpose of accommodating the National Provider Identifier (NPI).

CMS-1500 (08-05) and *UB-04 CMS-1450* claim forms must include the following information prior to the District of Columbia becoming compliant with the NPI federal rule. Amerigroup has aligned its NPI and taxonomy code requirements with the District of Columbia (HIPAA-compliant where applicable):

- Enrollee's name
- Enrollee's ID number
- Enrollee's date of birth
- Provider name according to contract
- Provider tax ID number and District Medicaid ID number
- Amerigroup provider number
- NPI of billing provider when applicable
- Date of service
- Place of service
- ICD-10 diagnosis code/revenue codes
- Procedures, services or supplies rendered, CPT-4 codes/HCPCS codes/diagnosis-related groups (DRGs) with appropriate modifiers, if necessary
- Itemized charges
- Days or units
- Modifiers as applicable

- Coordination of benefits (COB) and/or other insurance information
- The precertification number or copy of the precertification
- Name of referring provider
- NPI of referring provider when applicable
- Any other District-required data

Amerigroup cannot accept claims with alterations to billing information. Amerigroup does not accept computer-generated or typewritten claims with information that has been marked through, handwritten, or appears to have been covered by correction fluid or tape. Claims that have been altered will be returned to the provider with an explanation of the reason for the return.

Paper claims must be submitted to:

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

Please note: AMA- and CMS-approved modifiers must be used appropriately based on the type of service and procedure code.

Electronic Claim Submission

Amerigroup prefers the submission of claims electronically through Electronic Data Interchange (EDI). Providers must submit claims within 365 days from the date of discharge for inpatient services or from the date of service for outpatient services.

To initiate the electronic claims submission process or obtain additional information, please visit the EDI area of the public provider website which includes registration forms and contact information.

The advantages of electronic claims submission are:

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

Web Portal Submissions — Participating Providers Only

Participating providers have the option to use HIPAA-compliant web claim submission capabilities by registering at https://www.availity.com.

For any questions, please contact Availity Client Services at 1-800-AVAILITY (1-800-282-4548).

Encounter Data Reporting Requirements

Amerigroup maintains a system to collect enrollee encounter data. All capitated providers and/or sites must report all enrollee encounters. This is a key component of the Amerigroup information system, and electronic reporting is encouraged. Failure to submit accurate and timely reports may result in corrective action up to and including termination of the *Participating Provider Agreement*.

If a provider is capitated, the provider will receive a monthly check based on a number of factors (e.g., enrollee's age, gender, number of enrollees in provider's panel) that includes payment for all capitated services rendered.

Due to reporting needs and requirements, Amerigroup network providers reimbursed by capitation must send encounter data to Amerigroup for each enrollee encounter. This is performed through use of the *CMS-1500 (08-05)* claim form. Data must be submitted in a timely manner. Failure to provide information can result in delayed capitation payment.

The encounter data must include:

- Enrollee ID number
- Enrollee's first and last name
- Date of enrollee's birth
- Date of encounter
- Diagnosis code
- Types of services provided (utilizing current procedure codes and modifiers, if applicable)
- Provider's tax ID number and District Medicaid ID number
- NPI

Submit encounter data to:

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

HEDIS® outcomes are also collected through claim and encounter data submissions. This includes but is not limited to:

- Preventive services (e.g., childhood immunization, mammography and Pap smears)
- Prenatal care (e.g., the number and frequency of prenatal visits)
- Acute and chronic illness (e.g., ambulatory follow-up and hospitalization for major disorders)

- Compliance is monitored by the Amerigroup Utilization and Quality Improvement staff, coordinated with the medical director and reported to the quality management committee on an annual basis. The PCP is monitored for compliance with reporting of utilization. Lack of compliance will result in training and follow-up audits and may result in termination.

Claims Adjudication

Amerigroup is dedicated to providing timely adjudication of provider claims for services rendered to enrollees. All network and non-network provider claims submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by the CPT-4 and ICD-10 manuals. Hospital facility claims should be submitted using the *UB-04* form, and provider services claims should be submitted using the *CMS-1500 (08-05)* form.

For claims payment to be considered, providers must adhere to the following time limits:
Submit claims within 365 days of the date of service (for inpatient claims filed by a hospital, within 365 days from the date of discharge)
In the case of other insurance, submit the claim within 180 days of receiving a response from the third-party payer
Claims for enrollees whose eligibility has not been added to the District's eligibility system must be received within 365 days from the date the eligibility is added

Claims submitted after the 365-day filing deadline will be denied.

After filing a claim with Amerigroup, providers should review the weekly explanation of payment (EOP). If the claim does not appear on an EOP within 15 business days as adjudicated, or you have no other written indication the claim has been received, **check the status of your claim using the Provider Inquiry Line at 1-800-454-3730 or the Amerigroup website**. If the claim is not on file with Amerigroup, resubmit your claim within 365 days from the date of service. If filing electronically, check for acceptance of the claim via the confirmation reports you receive from your EDI or practice management vendor.

The Interactive Voice Response System

Amerigroup provides an automated interactive voice response (IVR) system to better serve enrollees and participating providers. This IVR technology allows Amerigroup to provide more detailed enrollment, claims and authorization status information along with self-service features for enrollees. These features allow each enrollee to:

- Update his or her address and telephone number.
- Request a new enrollee ID card.
- Search for and/or change his or her PCP name.

Amerigroup recognizes that in order for you to provide the best service to enrollees, accurate, up-to-date information must be shared. As a result, Amerigroup offers an automated inquiry

line for accessing claims status, enrollee eligibility and precertification determination status 24 hours a day, 365 days a year.

The toll-free automated Provider Inquiry Line (1-800-454-3730) can be used to verify enrollee status, claim status and precertification determination. This tool also offers the ability to be transferred to the appropriate department for other needs such as requesting new precertification, ordering referral forms or directories, seeking advice in case management, or obtaining an enrollee roster. Detailed instructions for use of the Provider Inquiry Line are outlined below.

To access enrollee eligibility information:
Electronic eligibility and benefits are available at https://www.availity.com. For manual calls to the Provider Inquiry Line:

Dial 1-800-454-3730. After saying your NPI or provider ID and TIN for the prompt, you can say, **"enrollee status," "eligibility"** or **"enrollment status."**
Be prepared to say the enrollee's **Amerigroup ID number**, **ZIP code** and **date of service.**
You can search by **Medicaid ID**, **Medicare ID** or **Social Security number.**
Say, "**I don't have it"** when asked to say the enrollee's Amerigroup ID number, then say the ID type you would like to use when prompted.
The system will verify the enrollee's eligibility and PCP name.

To review claim status:
Electronic claim status inquiry including status detail and the ability to dispute the claim decision is available at https://www.availity.com. For manual calls to the Provider Inquiry Line:

Dial 1-800-454-3730 and listen for the prompt.
At the main menu, say, "**claims**."
You can get the status of a **single claim** or the **five most recent claims.**
You can speak to someone about a ***Payment Appeal Form*** or an **EOP.**
Be prepared to say the **claim number.**
If you don't have it, you can hear the **five most recent claims** by saying **recent claims.**

To review referral authorization status:
Status of authorizations including corresponding case letters submitted via phone, fax or ICR are available at www.availity.com.

Provider Inquiry Line:

Dial 1-800-454-3730 and listen for the prompt.
At the main menu, say, "**authorizations**" or "**referrals**."
Say "**authorization status**" to hear up to 10 outpatient or one inpatient authorization determination.
Say "**new authorization**" to be transferred to the correct department based on the authorization type.

Be prepared to say the enrollee's **Amerigroup ID number**, **ZIP code**, **date of birth** and **date of service.**

Say the admission date or the first date for the start of service in MM/DD/YYYY format.

CMS-1500 (08-05) Claim Form

Health care practitioners and other persons entitled to reimbursement must use the *CMS-1500 (08-05)* form and instructions provided by CMS for use of the *CMS-1500 (08-05)* as the sole instrument for filing claims with Amerigroup for professional services. This does not apply to dental services billed by dentists using the *J 512 Form* or its equivalent or pharmacists or pharmacies filing claims for prescription drugs.

Except for parties to a global contract, Amerigroup may not require a health care practitioner or other person entitled to reimbursement to use any code or modifier to file claims for health care services different from, or in addition to, what is required under the applicable standard code set for the professional services provided.

Except as noted, Amerigroup may not use and may not require a health care practitioner or other person entitled to reimbursement to use another descriptor with a code or to furnish additional information with the initial submission of a *CMS-1500 (08-05)* that is different from, or in addition to, the applicable standard code set for the professional services provided.

A health care practitioner or other person entitled to reimbursement whose billing is based on the amount of time involved will indicate the start and stop time or number of minutes in Field 24G, currently titled Day or Units, of the *CMS-1500 (08-05)* if it is not used to specify the number of days of treatment.

This form is available at www.cms.hhs.gov.

UB-04 Claim Form

Hospitals or persons entitled to reimbursement must use the *UB-04*, and instructions provided by CMS for use of the *UB-04*, as the sole instrument for filing claims with Amerigroup for hospital and other health care services.

Except for parties to a global contract, Amerigroup may not use and may not require a hospital or other person entitled to reimbursement to use any code or modifier for the filing of claims for hospital and other health care services that is different from, or in addition to, what is required under the applicable standard code set for hospital or other health care services provided.

Except as noted, Amerigroup may not use and may not require a hospital or other person entitled to reimbursement to furnish additional information with the initial submission of a

UB-04 that is different from, or in addition to, the applicable standard code set for the hospital or other health care services provided.

This form is available at www.cms.hhs.gov.

Claim Form Attachments

Amerigroup requires the following attachments for a claim to qualify as a clean claim:

- Explanation of benefits statement from the primary payer to the secondary payer, unless an electronic remittance notice has been sent by the primary payer to the secondary payer
- Medicare remittance notice if the claim involves Medicare as a primary payer, and Amerigroup provides evidence it does not have a crossover agreement to accept an EFT notice
- Description of the procedure or service which may include the medical record, if a procedure or service rendered has no corresponding CPT or HCPCS code
- Operative notes if the claim is for multiple surgeries or includes modifier 22, 58, 62, 66, 78, 80, 81 or 82
- Anesthesia records documenting time spent on the service if the claim for anesthesia services rendered includes modifiers P4 or P5
- Documents referenced as contractual requirements in a global contract (if applicable)
- Ambulance trip report if the claim is for ambulance services submitted by an ambulance company licensed by the District of Columbia Emergency Medical Services Systems
- Office visit notes if the claim includes modifiers 21 or 22
- Information related to an audit as specified in writing by Amerigroup if the Amerigroup audit demonstrated a pattern of fraud, improper billing or improper coding
- Admitting notes, if the claim is for inpatient services provided outside of the time or scope of the authorization
- Physician notes, if the claim for services provided is outside of the time or scope of the authorization or if the authorization is in dispute
- Itemized bills, if the claim is for services rendered in a hospital, and the hospital claim has no precertification for admission or the claim is for services inconsistent with the Amerigroup concurrent review determination rendered before the delivery of services regarding the medical necessity of the service

Adjunct Claims Documentation

The following are permissible categories of disputed claims for which Amerigroup may request additional information:

- If there is no authorization or there was a precertification and Amerigroup disputes the claim consistent with the Amerigroup basis for denial or because the claim is for services provided outside the time or scope of the authorization and the applicable attachment was not submitted with the claim

- Eligibility for benefits or coverage
- Necessity of a service, procedure or DME rendered or provided by a specialist and not requested by a network PCP on a referral form or consultant treatment plan
- Information necessary to adjudicate the claim consistent with the global contract
- Reasonable belief of incorrect billing
- Additional information not obtained by Amerigroup from the enrollee within 30 days of receipt of the claim
- Legibility of the claim in a material manner
- Reasonable belief of fraudulent or improper coding, consistent with the Amerigroup retroactive denial
- Reasonable belief that a claim for emergency service may not meet the standards for an emergency service
- Category approved by the commissioner by regulation

Amerigroup may not request additional information if an attachment containing the same type of information was submitted with the claim.

Amerigroup may not request additional information for the following categories of disputed claims:

- Except for global contracts, a description of the procedure or service that is inconsistent with the applicable standard code set
- Services that were precertified by Amerigroup

Encounter Data Format

Amerigroup utilizes the *CMS-1500 (08-05)* claim form to obtain encounter data. See the Encounter Data Reporting Requirements section for more information.

Claim Forms

A **clean claim** is defined as a claim for reimbursement submitted to Amerigroup by a health care practitioner, pharmacy or pharmacist, hospital or person entitled to reimbursement that contains the required data elements and any attachments requested by Amerigroup.

An **applicable code set** is defined as the most recent version, as of the date of service, of the following:

- For services rendered by health care practitioners, the Current Procedural Terminology (CPT) maintained and distributed by the American Medical Association, including its codes and modifiers and codes for anesthesia services
- For dental services, the Code on Dental Procedures and Nomenclature (CDT), maintained and distributed by the American Dental Association

- For all professional and hospital services, the International Classification of Diseases, Clinical Modification (ICD-10 CM)
- For all other health-related services, the CMS' HCPCS levels I and II and modifiers, maintained and distributed by the U.S. Department of Health and Human Services
- For prescribed drugs, the National Drug Codes (NDC), maintained and distributed by the U.S. Department of Health and Human Services
- For anesthesia services, the codes maintained and distributed by the American Society of Anesthesiologists
- For psychiatric services, the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-V*) codes, distributed by the American Psychiatric Association
- For hospital and other applicable health care services including home health services, the District *UB-04 Uniform Billing Data Elements Specification Manual*
- For hospital services pursuant to a Maryland contract or insurance policy, a revenue code approved by the Health Services Cost Review Commission for a hospital located in the District or by the National or State Uniform Billing Data Elements Specifications for a hospital not located in the District

An **auto code** is defined as an ICD-10 code designed by Amerigroup as a diagnosis that is an emergency service.

A **modifier** is defined as a code appended to a CPT or HCPCS code to provide more specific information about a medical procedure.

For a paper claim, Amerigroup will date-stamp the claim with the date received or assign a batch number to the electronic claim that includes the date received. Amerigroup will maintain a written or electronic record of the date of the receipt of a claim. If a provider requests verification, Amerigroup will provide verification of the date of claim receipt within five working days. The claim is presumed to have been received by Amerigroup within three working days from the date the provider placed the claim in the U.S. mail if the provider maintains the stamped certificate of mailing for the claim or on the date recorded by the courier, if the claim was delivered by courier.

Amerigroup utilizes auto codes to determine emergency services and provides them to all network practitioners or hospitals rendering emergency services and to all health care practitioners or hospitals rendering emergency services that request the auto codes. If the auto codes are updated, the codes will be distributed 30 days prior to implementation.

International Classification of Diseases, 10th Revision (ICD-10) Description

ICD-10 is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9), which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes. In the United States, the

codes are the foundation for documenting the diagnosis and associated services provided across health care settings.

Although the term ICD-10 is often used alone, there are actually two parts to ICD-10:
Clinical modification (CM): ICD-10-CM is used for diagnosis coding.
Procedure coding system (PCS): ICD-10-PCS is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaces the code sets ICD-9-CM, volumes one and two for diagnosis coding, and ICD-10-PCS replaces ICD-9-CM, volume three for inpatient hospital procedure coding.

Provider Reimbursement

Acute Care Hospital Reimbursement

"Acute care hospital" means an institution providing medical, nursing and surgical treatment for sick or injured enrollees, usually for a short-term illness or condition. Acute care hospital reimbursement is for facility services only.

Inpatient Services
The inpatient facility services reimbursement to the provider will be based on the all patient diagnosis-related group (APR-DRG) relative weights as defined in the District of Columbia Medicaid DRG system.
Amerigroup will update the APR-DRG no more than 60 days from the date of receipt of notice of final changes or on the effective date of such changes, whichever is later. APR-DRG changes will be applied on a prospective basis.
Reimbursement for readmissions, transfers and outliers will be treated in accordance with the District of Columbia Medicaid APR-DRG standards.
Amerigroup will calculate the AP-DRG from the claim submitted by the provider using APR-DRG software. Payment is based on the calculated APR-DRG.

Outpatient Services

The initial District of Columbia Medicaid cost-to-charge ratio (CCR) will be the current CCR in effect as of the effective date of the Agreement.

Changes to the CCR will occur either:
Upon official notification to Amerigroup by the state or the provider of CCR updates.
Upon the mutual written agreement of Amerigroup and the provider.

Amerigroup will update the CCR no more than 60 days from the date of receipt of notice of final changes or on the effective date of such changes, whichever is later. CCR changes will be applied on a prospective basis. The effective date of a change in the CCR is the effective date of the change as published by the state or an effective date mutually agreed upon by the provider

and Amerigroup. Amerigroup will not be responsible for interest payments that are the result of late notification to Amerigroup of CCR changes.

For adjustments based on changes in the provider's charge master: Within 30 days of any adjustment to the charge amounts set forth in the provider's charge master for a covered service set forth above for which the provider's reimbursement hereunder is based on a percentage of eligible charges, the provider must give notice to Amerigroup in writing regarding the increase. Amerigroup is entitled to reduce, as of the date of such charge master increase, the percentage set forth above applicable to such covered service by an offsetting amount so the amount payable by Amerigroup to the provider for the covered service on and after such date will equal the amount payable to Amerigroup to the provider for the covered service prior to the date of the charge master increase.

In addition, outpatient hospital claims will be reimbursed in accordance with the Enhanced Ambulatory Patient Groups (EAPG). EAPGs are a visit-based classification system intended to reflect the utilization and type of resources of outpatient encounters for patients with similar clinical characteristics. The EAPG grouper evaluates CPT/HCPCS and diagnosis codes along with other information readily available on a claim to determine EAPG assignments.

Allied Health Professional Reimbursement

"Allied health professionals" means health care practitioners with formal education and clinical training who are credentialed through certification, registration and/or licensure. They collaborate with physicians and other enrollees of the health care team to deliver high-quality enrollee care services for the identification, prevention and treatment of diseases, disabilities and disorders. Such health care practitioners include but are not limited to nurse practitioners, nurse midwives, chiropractors, audiologists, optometrists, opticians, registered nurse anesthetists, clinical nurse specialists, physician assistants and registered nurse first assistants.

Allied health professionals will be reimbursed in accordance with regulatory requirements for the applicable methodology based on the referenced fee schedule. If the reimbursement is based on an Amerigroup rate, the applicable state methodology on which the fee schedule is based will be used to determine the appropriate level of reimbursement.

Ambulatory Surgical Center (ASC) (Freestanding) Reimbursement

"Ambulatory surgical center" means a distinct entity that operates exclusively for the purpose of furnishing surgical services to enrollees who do not require hospitalization and in which the expected duration of services does not exceed 24 hours following admission. ASC reimbursement is for facility services only.

Reimbursement for multiple outpatient surgical procedures performed during the same admission will be paid in accordance with regulatory requirements. Codes for procedures that are incidental to other procedures performed on the same day will not be eligible for separate reimbursement.

Anesthesiology Services Reimbursement

"Anesthesiology services" refers to the branch of medicine that studies how to suppress the perception of pain and sensation in the brain. An anesthesiologist administers anesthesia for enrollees who undergo surgery and other medical procedures that cause pain.

Reimbursement for anesthesiology services will be in accordance with the *CMS Anesthesia Conversion Factor Fee Schedule* in effect as of the date of service.

When multiple surgical procedures are carried out during the same anesthetic/anesthesia session, Amerigroup will reimburse according to the maximum number of base units carried by the primary procedure. Services should be billed in minute increments. One time unit will be allowed for each 15-minute interval, or fraction thereof, starting from the time the provider begins to prepare the enrollee for induction and ending when the enrollee may safely be placed under postoperative supervision, and the provider is no longer in personal attendance. Anesthesia consultation on the same date as surgery or the day prior to surgery is not payable if part of the preoperative assessment.

Behavioral Health Facility Reimbursement

"Behavioral health facility" means a facility is licensed to provide outpatient, inpatient or community-based mental health and/or substance use services, usually for multiple levels of care with appropriate state licensure and quality accreditation certification. Behavioral health levels of care may include all of the following or a combination thereof: inpatient acute mental health, inpatient acute detoxification, inpatient acute substance abuse rehabilitation, substance abuse residential treatment, psychiatric residential treatment, partial hospital programs (sometimes called day treatment) and intensive outpatient programs. Behavioral health facility reimbursement is for facility services only.

The facility must agree the per diem rate/per visit rate(s) apply to each approved and medically necessary day of substance use/psychiatric service and includes payment for all services rendered, including but not limited to: room and board (which includes all services rendered by facility employees), laboratory, radiology, equipment, pharmaceuticals, and other services incidental to the inpatient or outpatient service.

Per diem payments for all inpatient admissions will account for all services during the stay, plus any observation charges within one day in advance of the admission.

Inpatient Notes

Reimbursement for readmissions and transfers will be treated in accordance with CMS standards.
Medicare severity diagnosis-related group (APR-DRG): Amerigroup reserves the right to validate the accuracy of the APR-DRG code submitted by the provider by utilizing APR-DRG grouper software. APR-DRG codes listed are those designated by CMS.
Per Diem reimbursement is inclusive of all payments to the provider.

Outpatient Notes

For substance use and dual diagnosis services, payments are for facility services. Professional services of physicians are excluded.
Per Diem rates will account for all services during the stay.

Durable Medical Equipment (DME) Reimbursement

Miscellaneous codes A4421, E1399, K0108, L9990 *L9990 is an invalid code* and T5999 may only be used by the provider if no other codes have been assigned by CMS to the product or service to be supplied. For miscellaneous HCPCS codes that don't have an established fee schedule reimbursement rate, the provider must furnish documentation describing the following:

- Service or item
- Manufacturer's name
- Product name and number
- Invoice cost

Note: If it is a customized option or accessory, the statement must clearly describe what options or accessories were customized. The provider must submit this information when billing services.

Amerigroup has a rent-to-purchase policy for DME (e.g., standard or customized wheelchairs or accessories). Original standard accessories are included in the rental or purchase price of the DME item and won't be billed separately by the provider nor reimbursed separately by Amerigroup. For enrollee-owned equipment, replacement standard and/or customized accessories for DME will be billed separately by the provider, following industry-standard guidelines.

For DME items that are not authorized for rental-to-purchase, rental payments for DME will be applied to the purchase of such item in the event Amerigroup authorizes conversion of the rental to purchase. Under no circumstances will the Amerigroup total rental payments exceed the purchase price of the item. Original standard accessories are included in the rental or purchase price of certain DME items and will not be billed or separately reimbursable expenses. These include but are not limited to: hospital beds, oxygen, wheelchairs, power-operated vehicles (POVs), power-mobility devices (PMDs).

Amerigroup does not allow reimbursement for repair or replacement of purchased items while under the warranty period designated by the applicable manufacturer. This charge will not be allowed on regular or rental DME prosthetics, orthotics and supplies (POS) items (the repair of a rental item is included in the rental price and is not separately reimbursable).

The only exception to the Amerigroup rent-to-purchase policy is a custom wheelchair. The Amerigroup definition of a custom wheelchair is a wheelchair that is not readily available from manufacturers, but one that has been uniquely constructed or substantially modified for a

specific enrollee based on medical necessity, according to the description and orders of the enrollee's physician. There must be customization of the base frame of the wheelchair for the wheelchair to meet the definition of a custom-made wheelchair. The addition of customized options or accessories to a standard wheelchair does not result in that wheelchair being considered custom-made. Only custom-made wheelchairs will be considered for outright purchase by Amerigroup.

For custom wheelchairs ordered by the physician, Amerigroup will conduct a medical necessity review. Should the custom wheelchair meet the Amerigroup medical necessity criteria, we will determine if the customizing parts are necessary for the enrollee's particular condition and notify the provider of the subsequent approval or denial of the custom wheelchair and/or customizing parts for the wheelchair.

Mounting hardware is included with the accessory item and should not be billed separately or under a miscellaneous code. If the description, manufacturer name, product name, product number and invoice cost are not provided with the claim, the claims will be denied for lack of adequate documentation.
There is no separate or additional reimbursement for administration charges, measurements, fitting, delivery fees, taxes, etc.

Outlier reimbursement — audit and review process

Requirements and policies

This section includes guidelines on reimbursement to providers and facilities for services on claims paid by a diagnosis-related group (DRG) with an outlier paid at percent of billed charge or where the entire claim is paid at percent of billed charge. Our vendor-partner or our internal team may review these claims as part of our itemized bill review (IBR) program to ensure appropriate reimbursement. Upon completion of the review, documentation, including a summary of adjusted charges, will be provided for each claim. Disputes related to the review may be submitted according to the instructions in the Claims Payment Disputes section of this manual. In addition to any header in this section, please refer to all other service specific sections which may have more stringent guidelines. There may be multiple sections that apply to any given reimbursable service.

Audits/records requests

At any time, a request may be made for on-site, electronic, or hard copy medical records, utilization review documentation, and/or itemized bills related to claims for the purposes of conducting audit or reviews.

Blood and blood products

Administration of blood or blood products are not separately reimbursable on inpatient claims. Administration charges on outpatient claims are separately reimbursable when submitted without observation/treatment room charges.

Charges for blood storage and processing, thawing fees charges, irradiation, and other processing charges are also not separately reimbursable.

Emergency room supplies and services charges

The emergency room level reimbursement includes all monitoring, equipment, supplies, time, and staff charges. Reimbursement for the use of the emergency room includes the use of the room and personnel employed for the examination and treatment of enrollees. This reimbursement does not typically include the cost of physician services.

Facility personnel charges

Charges for inpatient services for facility personnel are not separately reimbursable, and the reimbursement for such is included in the room and board rate. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), professional therapy functions, including physical, occupational, and speech, call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Charges for outpatient services for facility personnel are also not separately reimbursable. The reimbursement is included in the payment for the procedure or observation charge.

Implants

Implants are objects or materials which are implanted such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert placed into a surgically or naturally formed cavity of the human body to continuously assist, restore or replace the function of an organ system or structure of the human body throughout its useful life. Implants include, but are not limited to, stents, artificial joints, shunts, pins, plates, screws, anchors, and radioactive seeds, in addition to non-soluble, or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the enrollee's body upon discharge from the inpatient stay or outpatient procedure.

Staples, sutures, clips, as well as temporary drains, tubes, similar temporary medical devices, and supplies shall not be considered implants. Implants that are deemed contaminated and/or considered waste and/or were not implanted in the enrollee will not be reimbursed.

IV sedation and local anesthesia

Charges for IV sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, is not separately reimbursable and is included as part of the operating room (OR) time/procedure reimbursement. Medications used for IV sedation and local anesthesia are separately reimbursable.

Lab charges

The reimbursement of charges for specimen collection are considered facility personnel charges and the reimbursement is included in the room and board or procedure/observation charges. Examples include venipuncture, urine/sputum specimen collection, draw fees, phlebotomy, heel sticks, and central line draws. Processing fees, handling fees, and referral fees are considered included in the procedure/lab test performed and not separately reimbursable.

Labor care charges

Reimbursement will be made for appropriately billed room and board or labor charges. Payment will not be made on both charges when billed concurrently.

Nursing procedures

Fees associated with nursing procedures or services provided by facility nursing staff or unlicensed facility personnel (technicians) performed during an inpatient (IP) admission or outpatient (OP) visit will not be reimbursed separately. Examples include, but are not limited, to intravenous (IV) injections or IV fluid administration/monitoring, intramuscular (IM) injections, subcutaneous (SQ) injections, IV or PICC line insertion at bedside, nasogastric tube (NGT) insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time, etc.) and inpatient blood transfusion administration/monitoring (with the exception of OP blood administration or OP chemotherapy administration which are submitted without observation/treatment room charges.)

Operating room time and procedure charges

The operating room (OR) charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the enrollee enters the room until the enrollee leaves the room, as documented on the OR nurse's notes. The operating room charge will reflect the cost of:

- The use of the operating room.
- The services of qualified professional and technical personnel.

Personal care items and services

Personal care items used for enrollee convenience are not separately reimbursable. Examples include, but are not limited to, breast pumps, deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste, bedpans, chux, hot water bottles, icepacks, pillows, sitz baths, and urinals.

Pharmacy charges

Reimbursement will be made for the cost of drugs prescribed by the attending physician. Additional separate charges for the administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel will not be reimbursed separately. All other services are included in the drug reimbursement rate. Example of pharmacy charges which are not

separately reimbursable include, but are not limited to, IV mixture fees, IV diluents such as saline and sterile water, IV piggyback (IVPB), heparin and saline flushes to administer IV drugs, and facility staff checking the pharmacy (Rx) cart.

Portable charges

Portable charges are included in the reimbursement for the procedure, test, or x-ray, and are not separately reimbursable.

Pre-operative care or holding room charges

Charges for a pre-operative care or a holding room used prior to a procedure are included in the reimbursement for the procedure and are not separately reimbursed. In addition, nursing care provided in the pre-operative care areas will not be reimbursed separately.

Preparation (set-up) charges

Charges for set-up, equipment, or materials in preparation for procedures or tests are included in the reimbursement for that procedure or test.

Recovery room charges

Reimbursement for recovery room services (time or flat fee) includes the use of all and/or available services, equipment, monitoring, and nursing care that is necessary for the enrollee's welfare and safety during their confinement. This will include, but is not limited to, cardiac/vital signs monitoring, pulse oximeter, medication administration fees, nursing services, equipment, supplies, (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

Recovery room services related to IV sedation and/or local anesthesia

Separate reimbursement will not be made for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post procedure room or a phase II recovery (step-down). Examples of procedures include arteriograms and cardiac catheterization.

Supplies and services

Items used for the enrollee which are needed as a direct result of a procedure or test are considered part of the room and board or procedure charges and are not separately reimbursable.

Any supplies, items, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately reimbursable in the inpatient and outpatient environments.

Special procedure room charge

Special procedure room charges are included in the reimbursement for the procedure. If the procedure takes place outside of the OR suite, then OR time will not be reimbursed to cover OR personnel/staff being present in the room, such as ICU, GI lab, etc.

Stand-by charges

Standby equipment and consumable items which are on standby, are not reimbursable. Standby charges for facility personnel are included in the reimbursement for the procedure and not separately reimbursable.

Stat charges

Stat charges are included in the reimbursement for the procedure, test, and/or X-ray. These charges are not separately reimbursable.

Supplies and equipment

Charges for medical equipment, including but not limited to, IV pumps, PCA pumps, oxygen, and isolation carts and supplies are not separately reimbursable.

Telemetry

Telemetry charges in ER/ ICU/CCU/NICU or telemetry unit (step-down units) are included in the reimbursement for the place of service. Additional monitoring charges are not reimbursable.

Time calculation

- **Operating room (OR**) — Time should be calculated on the time the enrollee enters the room until the enrollee leaves the room, as documented on the OR nurse's notes.
- **Hospital/technical anesthesia** — Reimbursement of technical anesthesia time will be based on the time the enrollee enters the operating room (OR) until the enrollee leaves the room, as documented on the OR nurse's notes. The time the anesthesiologist spends with the enrollee in pre-op and the recovery room will not be reimbursed as part of the hospital anesthesia time.
- **Recovery room** — The reimbursement of recovery room charges will be based on the time the enrollee enters the recovery room until the enrollee leaves the recovery room as documented on the post anesthesia care unit (PACU) record.
- **Post recovery room** — Reimbursement will be based on the time the enrollee leaves the recovery room until discharge.

Video or digital equipment used in operating room

Charges for video or digital equipment used in a surgery are included in the reimbursement for the procedure and are not separately reimbursable. Charges for batteries, covers, film, anti-fogger solution, tapes etc., are not separately reimbursable.

Additional reimbursement guidelines for disallowed charges

The disallowed charges (charges not eligible for reimbursement) include, but are not limited to, the following, whether billed under the specified revenue code or any other revenue code. These guidelines may be superseded by your specific agreement. Refer to your contractual fee schedule for payment determination.

The tables below illustrate examples of non-reimbursable items/services codes.

Examples of non-reimbursable items/services codes	
Typically billed under this/these revenue codes but not limited to the revenue codes listed below	**Description of excluded items**
0990 – 0999	Personal care items • Courtesy/hospitality room Enrollee convenience items (0990) • Cafeteria, guest tray (0991) • Private linen service (0992) • Telephone, telegraph (0993) • TV, radio (0994) • Non-enrollee room rentals (0995) • Beauty shop, barber (0998) • Other enrollee convenience items (0999)
0220	Special charges
0369	Preoperative care or holding room charges
0760 – 0769	Special procedure room charge
0111 – 0119	Private room* (subject to enrollee's benefit)
0221	Admission charge
0480 – 0489	Percutaneous transluminal coronary angioplasty (PTCA) stand-by charges
0220, 0949	Stat charges

Examples of non-reimbursable items/services codes	
Typically billed under this/these revenue codes but not limited to the revenue codes listed below	**Description of excluded items**
0270 – 0279, 0360	Video equipment used in operating room
0270, 0271, 0272	**Supplies and equipment** • Blood pressure cuffs/stethoscopes • Thermometers, temperature probes, etc. • Pacing cables/wires/probes • Pressure/pump transducers • Transducer kits/packs • SCD sleeves/compression sleeves/ted hose • Oximeter sensors/probes/covers • Electrodes, electrode cables/wires • Oral swabs/toothettes; • Wipes (baby, cleansing, etc.) • Bedpans/urinals • Bed scales/alarms • Specialty beds • Foley/straight catheters, urometers/leg bags/tubing • Specimen traps/containers/kits • Tourniquets • Syringes/needles/lancets/butterflies • Isolation carts/supplies • Dressing change trays/packs/kits • Dressings/gauze/sponges • Kerlix/tegaderm/opsite/telfa

Examples of non-reimbursable items/services codes	
Typically billed under this/these revenue codes but not limited to the revenue codes listed below	**Description of excluded items**
	• Skin cleansers/preps • Cotton balls; band-aids, tape, Q-Tips • Diapers/chucks/pads/briefs • Irrigation solutions • ID/allergy bracelets • Foley stat lock • Gloves/gowns/drapes/covers/blankets • Ice packs/heating pads/water bottles • Kits/packs (gowns, towels and drapes) • Basins/basin sets • Positioning aides/wedges/pillows • Suction canisters/tubing/tips/catheters/liners • Enteral/parenteral feeding supplies (tubing/bags/sets, etc.) • Preps/prep trays • Masks (including CPAP and nasal cannulas/prongs) • Bonnets/hats/hoods • Smoke evacuator tubing • Restraints/posey belts • OR equipment (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.) • IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets,

Examples of non-reimbursable items/services codes	
Typically billed under this/these revenue codes but not limited to the revenue codes listed below	**Description of excluded items**
	transducers, fluid warmers, heparin, and saline flushes, etc.)
0220 – 0222, 0229, 0250	• Pharmacy administrative fee (including mixing meds) • Portable fee (cannot charge portable fee unless equipment is brought in from another Facility) • Enrollee transport fees
0223	Utilization review service charges
263	IV infusion for therapy, prophylaxis (96365, 96366) IV infusion additional for therapy IV infusion concurrent for therapy (96368) IV injection (96374, 96379)
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing procedures
0230	Incremental nursing — general
0231	Nursing charge — nursery
0232	Nursing charge — obstetrics (OB)
0233	Nursing charge — intensive care unit (ICU)
0234	Nursing charge — cardiac care unit (CCU)
0235	Nursing charge — hospice
0239	Nursing charge — emergency room (ER) or post anesthesia care unit (PACU) or operating room (OR)
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) • Medication prep • Nonspecific descriptions

Examples of non-reimbursable items/services codes	
Typically billed under this/these revenue codes but not limited to the revenue codes listed below	**Description of excluded items**
	• Anesthesia gases — billed in conjunction with anesthesia time charges • IV solutions 250 cc or less, except for pediatric claims • Miscellaneous descriptions • Non-FDA approved medications
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	• Specimen collection • Draw fees • Venipuncture • Phlebotomy • Heel stick • Blood storage and processing blood administration (Rev codes 0380, 0390 – 0392; 0399) • Thawing/pooling fees
0270, 0272, 0300 – 0309	• Bedside/point of care/near enrollee testing (such as glucose, blood count, arterial blood gas, clotting time, glucose, etc.)
0222, 0270, 0272, 0410, 0460	Portable charges
0270 – 0279, 0290, 0320, 0410, 0460	Supplies and equipment • Oxygen • Instrument trays and/or surgical packs • Drills/saws (all power equipment used in O.R.) • Drill bits • Blades • IV pumps and PCA (enrollee controlled analgesia) pumps

Examples of non-reimbursable items/services codes	
Typically billed under this/these revenue codes but not limited to the revenue codes listed below	**Description of excluded items**
	• Isolation supplies • Daily floor supply charges • X-ray aprons/shields • Blood pressure monitor • Beds/mattress • Enrollee lifts/slings • Restraints • Transfer belt • Bair hugger machine/blankets • SCD pumps • Heel/elbow protector • Burrs • Cardiac monitor • EKG electrodes • Vent circuit • Suction supplies for vent enrollee • Electrocautery grounding pad • Bovie tips/electrodes • Anesthesia supplies • Case carts • C-Arm/fluoroscopic charge • Wound vacuum pump • Bovie/electro cautery unit • Wall suction

Examples of non-reimbursable items/services codes	
Typically billed under this/these revenue codes but not limited to the revenue codes listed below	**Description of excluded items**
	• Retractors • Single instruments • Oximeter monitor • CPM machines • Lasers • Da Vinci machine/robot
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia • Nursing care • Monitoring • Intervention • Pre- or post-evaluation and education • IV sedation and local anesthesia if provided by RN • Intubation/extubation • CPR
410	Respiratory Functions: • Oximetry reading by nurse or respiratory • Respiratory assessment/vent management • Medication administration via Nebs, metered dose (MDI), etc. • Charges postural drainage • Suctioning procedure • Respiratory care performed by RN
0940 – 0945	Education/training

Contact us

Availity* Chat with Payer is available during normal business hours. Get answers to your questions about eligibility, benefits, authorizations, claims status, and more. To access Availity Essentials, go to **Availity.com** and select the appropriate payer space tile from the drop-down. Then, select **Chat with Payer** and complete the pre-chat form to start your chat.

For additional support, visit the *Contact Us* section at the bottom of our provider website for the appropriate contact.

Home Infusion Therapy (HIT) Reimbursement

"Home infusion therapy provider" means a health care provider that offers enrollees, on an outpatient basis, treatment that involves intravenous or subcutaneous treatments or injections.

HIT providers provide a wide range of services required to safely and effectively administer home infusion, nutritional therapies, specialty drugs, and disease state and care management services in a home setting. Typical therapies include but are not limited to antibiotic therapy, total parenteral nutrition, chemotherapy and pain management. HIT providers offer supplies and clinical services to an enrollee who is under the care of a physician or other health care provider. Such supplies and clinical services are provided in an integrated manner under a plan established and periodically reviewed by the ordering physician or other health care provider. Routine supplies, as defined by CMS, are included in these services.
Multiple discipline visits (e.g., occupational vs. physical vs. speech therapy) may be reimbursed separately on the same day.
Amerigroup has a rent-to-purchase policy for durable medical equipment (DME) (e.g., standard or customized wheelchairs and accessories). Original standard accessories are included in the rental or purchase price of the DME item and will not be billed separately by the provider nor reimbursed separately by Amerigroup. For enrollee-owned equipment, replacement standard and/or customized accessories for DME will be billed separately by the provider, following industry-standard guidelines.
For DME items that are not authorized for rental-to-purchase, rental payments for DME will be applied to the purchase of the item in the event Amerigroup authorizes conversion of the rental to purchase. Under no circumstances will the Amerigroup total rental payments for a DME item exceed the purchase price of the item.
Original standard accessories are included in the rental or purchase price of certain DME items and will not be billed or separately reimbursable expenses. These items include but are not limited to: hospital beds, oxygen, wheelchairs, POVs and PMDs.
Amerigroup does not allow reimbursement for repair or replacement of rented or purchased items while under the warranty period designated by the applicable manufacturer. This charge will not be allowed on regular or rental DMEPOS items (repair of a rental item is included in the rental price and is not separately reimbursable).

The only exception to the Amerigroup rent-to-purchase policy is a custom wheelchair. The Amerigroup definition of a custom wheelchair is a wheelchair that is not readily available from

manufacturers, but one that has been uniquely constructed or substantially modified for a specific enrollee based on medical necessity, according to the description and orders of the enrollee's physician. There must be customization of the base frame of the wheelchair for the wheelchair to meet the definition of a custom-made wheelchair. The addition of customized options or accessories to a standard wheelchair does not result in that wheelchair being considered custom-made. Only custom-made wheelchairs will be considered for outright purchase by Amerigroup.

For a custom wheelchair ordered by the physician, Amerigroup will conduct a medical necessity review. Should the custom wheelchair meet the Amerigroup medical necessity criteria, we will determine if the customizing parts are necessary for the enrollee's particular condition and notify the provider of the subsequent approval or denial of the custom wheelchair and/or customizing parts for the wheelchair.

If it is a customized option/accessory, the statement must clearly describe what options or accessory was customized. The provider must submit this information when billing services. Mounting hardware is included with the accessory item and should not be billed separately or under a miscellaneous code. If the description, manufacturer name, product name, product number and invoice cost are not provided with the claim, the claims will be denied for lack of adequate documentation.

There is no separate or additional reimbursement for administration charges, measurements, fitting, delivery fees, taxes, etc.

Hospice Reimbursement

"Hospice" means covered services designed to give supportive care to enrollees in the final phase of a terminal illness. Services include but are not limited to routine home care day, continuous home care day, inpatient respite care day and general inpatient care day. Reimbursement is inclusive of skilled nursing, home health aide, medical social worker services, dietary, pastoral, bereavement counseling, DME, medical supplies and administration of medication.
"Routine home care day" means covered services for a day on which an enrollee who has elected to receive hospice care at his or her current residence and is not receiving continuous care. Routine home care day is payable at the Amerigroup rate using the appropriate coded service identifier(s). Covered services include but are not limited to any combination of the following services, without regard to volume or intensity occurring in one day: skilled nursing care, certified nurse assistance, homemaker, social worker, family counseling, respite care, therapies and bereavement services.

"Continuous home care day" means covered services for a day on which an enrollee who has elected hospice care is at home and receives hospice care consisting predominantly of nursing care on a continuous basis at home. A continuous home care day is only furnished during brief periods of crisis and only as necessary to maintain the terminally ill enrollee at home, with a minimum of eight hours of care being furnished on a particular day to qualify as a continuous

home care day. Continuous home care day is payable at the Amerigroup rate; however, billing is required at an hourly rate using the appropriate revenue code. Billing for continuous home care day is required at an hourly rate using the appropriate coded service identifier(s), and reimbursement will not exceed the general inpatient care day reimbursement. Claims with less than eight hours of direct enrollee care in one day will be at the routine home care day reimbursement.

“Inpatient respite care day” means covered services for a day on which an enrollee who has elected hospice care receives services in an inpatient facility (skilled nursing facility, hospital or inpatient hospice house) on a short-term basis when necessary to relieve family enrollees or others caring for the enrollee, for respite. The inpatient respite care day is payable as a per diem rate using the appropriate revenue code.
“General inpatient care day” means covered services for a day on which the enrollee who has elected hospice care receives inpatient services for pain control or acute or chronic symptom management that cannot be managed in other settings. The general inpatient care day is payable as a per diem rate using the appropriate revenue code.

The per diem rate includes but is not limited to: 1) provider services performed by the hospice medical director or any other hospice staff provider, including establishing, reviewing and updating plans of care as well as supervision of care and services and establishment of governing policies; 2) nursing care; 3) medical equipment and/or DME related to terminal illness, such as oxygen and hospital appropriate beds; 4) medical supplies related to terminal illness, such as IV fluids/IV antibiotics (including administration); 5) drugs related to the terminal illness for symptom management and pain relief and other special modalities if used for palliative purposes (including pain pumps, infusion therapy and supplies, etc.).

This determination is based on the enrollee’s condition and the caregiving philosophy of the hospice. Amerigroup will make no additional payment regardless of the cost of the services, home health aide and homemaker services, physical and occupational therapy, speech/language pathology services, medical social services/chaplain, counseling services including dietary counseling, all labs/X-ray services related to the terminal illness, ambulance used as transport, nonemergent, bereavement counseling for family enrollees and/or significant others one year after the enrollee’s death. Hospice may not bill for health services while an enrollee is considered an inpatient at a facility other than the same facility.

The Amerigroup rate does not include the following: nonstaff physician consultants and visits, chemotherapy, radiation therapy, or third-party network (TPN) solution. These services must be provided and billed by a network/participating provider under a separate agreement with Amerigroup. The facility must agree that it will neither bill nor seek payment from Amerigroup for any of these items.

Independent Diagnostic Treatment Facility (IDTF) Reimbursement

“Independent diagnostic treatment facility” means a facility that is independent of a physician office or hospital (e.g., not owned by a hospital, individual or physician group practice) where therapeutic and diagnostic services are performed.

If an IDTF and/or a freestanding radiology facility employs the physicians interpreting the radiology procedures, the global payment, including the technical and professional component, will be made to the provider. If the physicians are not employed, the provider will bill for the technical component only.

Independent Laboratory (LAB) Reimbursement

"Independent laboratory” means an entity that provides covered services involving the procurement, transportation, testing (which includes clinical and anatomic/surgical pathology), reporting of specimens and consulting services provided by the lab.

Collection of specimens (including venipuncture), lab handling, and/or stat services are considered as part of the primary laboratory test components and are not separately reimbursable expenses.

Rehabilitation Facility Reimbursement

“Rehabilitation facility” means a facility that is licensed to provide comprehensive rehabilitation services, including but not limited to therapy and training for rehabilitation, occupational therapy, physical therapy, and speech therapy to enrollees for the alleviation of disabling effects of illness or intended to achieve the goal of maximizing the self-sufficiency of the enrollee. Rehabilitation facility reimbursement is for facility services only. Multiple discipline visits (e.g., OT vs. PT vs. ST) may be reimbursed separately on the same day.

Skilled Nursing Facility (SNF) Reimbursement

"Skilled nursing facility" means a facility that mainly provides inpatient skilled nursing and related services to enrollees requiring convalescent and rehabilitation care given by or under the supervision of a qualified/certified practitioner as licensed in the state, following a hospitalization, for a limited period. SNF reimbursement is for facility services only.

The facility must agree the per diem rate includes but is not limited to room and board, nursing care, therapies, oxygen, case management, social services, discharge planning services, family education, special diets, legend pharmaceuticals, medical supplies, wound care, ventilators, laboratory services, DME, specialized beds, prosthetics and orthotics, X-rays, total parenteral nutrition, third-generation antibiotics, prescriptions, and DME purchased during the admission — for use during the admission and/or after the enrollee is discharged. If the enrollee requires excess and/or extraordinary labs, the provider must use the Amerigroup contracted lab vendor for the lab draws and processing.

Urgent Care Center (UCC) Reimbursement

"Urgent care center" means an entity that provides treatment and diagnosis of conditions that require prompt attention to prevent serious deterioration to the enrollee's health but would not generally be considered to require treatment in an emergency room.

The per-visit rate is all inclusive of professional, technical and facility charges, including laboratory and radiology on site. The provider cannot bill as a PCP in the urgent care center when he or she renders services to enrollees assigned to him or her as a PCP.

ENROLLE BENEFITS AND SERVICES

Overview

Amerigroup must provide a complete and comprehensive benefit package equivalent to the benefits available to Medicaid participants through the Medicaid fee-for-service delivery system. Carve-out services, which are not subject to capitation and are not an Amerigroup responsibility, are still available for enrollees. Medicaid will reimburse these services directly on a fee-for-service basis.

An Amerigroup PCP serves as the entry point for access to covered health care services. The PCP is responsible for providing enrollees with medically necessary covered services or for referring an enrollees to a specialty care provider to furnish the needed services. The PCP is also responsible for maintaining medical records and coordinating comprehensive medical care for each assigned enrollee.

An enrollee has the right to access certain services without prior referral or authorization by a PCP. This applies to specified self-referred services and emergency services. Amerigroup is responsible for reimbursing out-of-plan providers who have furnished these services to enrollees (see Self-Referral Services).

Only benefits and services that are medically necessary are covered.

Covered Benefits and Services

The following covered benefits and services are listed alphabetically.

Audiology Services

Audiology services are covered.

Blood and Blood Products

Blood, blood products, derivatives, components, biologics and serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin and albumin are covered.

Case Management Services

Case management services are covered for enrollees who need such services, including but not limited to enrollees with special health care needs.

Case Management focuses on the timely, proactive, collaborative, and enrollee-centric coordination of services for individuals. These individuals can be identified with complex medical conditions, provider or enrollee referral, repeated admissions for the same condition,

or high risk obstetrics. Amerigroup assists enrollees who are found to have potentially preventable emergency department utilization and those who qualify for the Lock-In Program.

The defining features of Amerigroup case management programs are:
A collaborative process that includes contact with the enrollee, family enrollee, caregiver and physician or other health care providers.
A process carried out using communication and available resources with the goal of promoting quality and effective outcomes.
A process that assists in optimizing the enrollees' health care outcomes through plans designed to empower enrollees to use the benefits, services and options available to meet individual health needs.

Case Management Programs

Complex Case Management is the coordination of care and services provided to enrollees who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

Stabilization Case Management is part of the continuum of care provided to Amerigroup enrollees. Stabilization helps Case Managers focus interventions on behaviors that can help prevent readmissions. This program focuses enrollee education which leads to self-management of post discharge needs including completion of a personal health record, medication reconciliation and follow-up appointments, necessary home care and community resources.

High-Risk OB (HROB) Case Management are focused on pregnant enrollees identified by early OB assessment as being at risk for an early delivery or poor birth outcome influenced by a known maternal or fetal condition or risk factor.

The Case Management Process: Amerigroup Case Managers perform the activities of assessment, planning, facilitation and support throughout the continuum of care and provide evidenced-based, enrollee-centric care planning that is consistent with recognized standards of case management practice and accreditation requirements.

Case managers consider Amerigroup enrollees' needs for:

- Social services
- Educational services
- Therapeutic services
- Other nonmedical support services (personal care, WIC, transportation)

The Amerigroup Case Management team will also provide:
Education and counseling with regard to enrollee compliance with prescribed treatment programs and compliance with EPSDT appointments.

A case manager will perform home visits as necessary as part of the Amerigroup Case Management program and will have the ability to respond to an enrollee's urgent care needs during this home visit. Call Provider Services to refer an enrollee to case management.

Enrollees enrolled in the MY DC Health Home or My Health GPS Health Home benefits will be managed by the assigned Health Home Provider. See the Health Home section for referral details.

Amerigroup welcomes provider referrals of enrollees who can benefit from the case management support, as well as enrollee self-referral or caregiver referrals. Please call the Provider Services toll-free number at 1-800-454-3730 and request the Case Management team. All Case Managers are licensed RNs and social workers. Case Managers are available from 8 a.m. to 5 p.m. local time. Confidential voicemail is available 24 hours a day.

Clinical Trials

Clinical trials and experimental treatment are not covered.

Dental Services

DC Medicaid provides a comprehensive dental benefit for children and adults. Adult services are provided through the Fee-For-Service program and two cleanings per year are covered as well as all amalgams or restorative fillings. Please contact the Dental Hotline at 1-866-758-6807 to locate participating dentist or for additional information on the dental program and benefits.

Dental services for enrollees under age 21 are covered and provided through Avesis. Please contact Avesis at 1- 855-214-6777 to locate a participating dentist or for additional information on the dental program and benefits.

Diabetes Care Services

Amerigroup covers all medically necessary diabetes care services. For enrollees who have been discharged from a hospital inpatient stay for a diabetes-related diagnosis, these diabetes care services include:

- Diabetes nutrition counseling
- Diabetes outpatient education
- Diabetes-related DME and disposable medical supplies including:
    - Blood glucose meters for home use
    - Finger-sticking devices for blood sampling
    - Blood glucose monitoring supplies
    - Diagnostic reagent strips and tablets used in testing for ketone, glucose in urine, and glucose in blood
    - Therapeutic footwear and related services to prevent or delay amputation that would be highly probable in the absence of specialized footwear
- Routine foot care

Condition Care

Our Condition Care (CNDC) program is based on a system of coordinated care management interventions and communications designed to help physicians and other health care professionals manage enrollees with chronic conditions. CNDC services include a holistic, focusing on the needs of the enrollee through telephonic and community-based resources. Motivational interviewing techniques used in conjunction with enrollee self-empowerment. This ability to manage more than one condition to meet the changing health care needs of our enrollee population. Our condition care programs include:

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disorder (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder – adult and child/adolescent
- Schizophrenia
- Substance abuse disorder

In addition to our condition-specific condition care programs, our enrollee-centric, holistic approach also allows us to assist enrollees with smoking cessation and weight management education.

Enrollees enrolled the My DC Health Home or My Health GPS Health Home benefits will be managed by the assigned health home provider. See the Health Home section of this manual for referral details.

Program Features

Proactive population identification processes

Program content is based on evidence-based clinical guidelines
Collaborative practice models to include physician and support providers in treatment planning
Continuous self-management education

Ongoing communication with primary and ancillary providers regarding enrollee status
Nine of our Condition Care programs are National Committee for Quality Assurance accredited and incorporate outreach, education, care coordination and follow-up to improve treatment self-care.

Condition Care Clinical Practice Guidelines are located at https://providers.amerigroup.com/DC. Select **Clinical Practice Guidelines** in the *Provider Resources & Documents* section.

Who Is Eligible?

All enrollees diagnosed with one or more of the listed conditions are eligible for Condition Care.

How Can You Use CNDC Services?
As a valued provider, we welcome your referrals of enrollees who can benefit from additional education and case management support. Our case managers will work collaboratively with you to obtain your input in the development of care plans. Enrollees identified for participation in any of the programs are assessed and risk stratified based on the number of gaps in care/case needs. They are provided with continuous education on self-management concepts, which include primary prevention, coaching healthy behaviors and compliance/monitoring as well as case/care management for high-risk enrollees. Providers are given telephonic and/or written updates regarding enrollee status and progress.

Condition Care Provider Rights and Responsibilities
You have the right to:

- Have information about Amerigroup including:
- Provided programs and services
- Our staff
- Our staff's qualifications
- Any contractual relationships
- Decline to participate in or work with any of our programs and services for your enrollees
- Be informed of how we coordinate our interventions with your enrollees' treatment plans
- Know how to contact the person who manages and communicates with your enrollees
- Be supported by our organization when interacting with enrollees to make decisions about their health care
- Receive courteous and respectful treatment from our staff
- Communicate complaints about Condition Care as outlined in the Amerigroup provider complaint and grievance procedure

Hours of Operation
Our CNDC case managers are registered nurses. They are available:
8:30 a.m. to 5:30 p.m. local time
Confidential voicemail is available 24 hours a day. The Nurse Helpline is available for our enrollee 24 hours a day, 7 days a week.

Contact Information
You can call a CNDC team enrollee at 1-888-830-4300. CNDC program content is located at https://providers.amerigroup.com/DC. Printed copies are available upon request. Enrollees can obtain information about CNDC program by visiting www.myamerigroup.com or calling 1-888-830-4300.

Disposable Medical Supplies/Durable Medical Equipment

Authorization

Authorizations for durable medical equipment (DME) and/or disposable medical supplies (DMS) will be provided in a timely manner so as not to adversely affect the enrollee's health. Determinations are made within two business days of receipt of the necessary clinical information but no later than seven calendar days from the date of the initial request.

No precertification is required for coverage of purchased glucometers and nebulizers, dialysis and ESRD equipment, gradient pressure aids, infant photo/light therapy, UV light therapy, sphygmomanometers, walkers, orthotics for arch support, heels, lifts, shoe inserts and wedges ordered by a network provider. Precertification is required for coverage of certain prosthetics, orthotics and DME, including all rentals.

For code-specific precertification requirements for DME, prosthetics and orthotics ordered by network providers or facilities, go to https://providers.amerigroup.com > Quick Tools > Precertification Lookup.

Precertification may be requested by completing a *Certificate of Medical Necessity (CMN)* — available on the Amerigroup website — or by submitting a physician order and an Amerigroup *Referral and Authorization Request* form. A properly completed and physician-signed *CMN* must accompany each claim for the following services: hospital beds, support surfaces, motorized wheelchairs, manual wheelchairs, continuous positive airway pressure devices, lymphedema pumps, osteogenesis stimulators, transcutaneous electrical nerve stimulator units, seat-lift mechanisms, power-operated vehicles, external infusion pumps, parenteral nutrition equipment, enteral nutrition equipment and oxygen. Amerigroup and the provider must agree on HCPCS and/or other codes for billing covered services. All custom wheelchair precertifications require the medical director's review. All DME billed with an RR modifier (i.e., rental) requires precertification.

DMS are covered, including incontinency pants, disposable underpants for medical conditions associated with prolonged urinary or bowel incontinence if necessary to prevent institutionalization or infection, and all supplies used in the administration or monitoring of prescriptions by the enrollee.

DME is covered when medically necessary, including but not limited to all equipment used in the administration or monitoring of prescriptions by the enrollee. Amerigroup pays for any DME authorized for enrollees, even if delivery of the item occurs within 90 days after the enrollee's disenrollment from Amerigroup, as long as the enrollee remains Medicaid-eligible during the 90-day time period.

Early and Periodic Screening, Diagnostic and Treatment Services

For enrollees under age 21, all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services rendered by an EPSDT-certified provider are covered and recorded in accordance with the EPSDT periodicity schedule. Providers rendering EPSDT service receive training on these services through the District's HealthCheck Program. Services include:

Annual comprehensive physical examination, health and developmental history, including an evaluation of both physical and behavioral health development; the implementation of an approved developmental screening tool (e.g., Ages and Stations Questionnaire [ASQ] or Parents Evaluation of Developmental Status [PEDS]) should begin at the 9-month, 18-month, and 24-30 month visit. The results of the developmental surveillance and screening and the screening tool used should be documented in the enrollee's chart. Children identified as being at risk for developmental delays should have documented counseling and referral for additional evaluation services.
Immunizations and review of required documentation.
Laboratory tests for at-risk screening including Tb risk assessment, hematocrit and blood lead level test and assessments.
Health education/anticipatory guidance including a dental referral at 12 months old.

Partial or interperiodic well-child services and health care services necessary to prevent, treat or ameliorate physical, behavioral or developmental problems or conditions with services in sufficient amount, duration and scope to treat the identified condition, and are subject to limitation only on the basis of medical necessity, including:

- Chiropractic services
- Nutrition counseling
- Audiological screening when performed by a PCP
- Private-duty nursing
- Durable medical equipment including assistive devices
- Any other benefit listed in this section

Providers and Amerigroup are responsible for making appropriate referrals for community resources not covered by Medicaid like the Women, Infants and Children (WIC) nutritional program.

Family Planning Services

Comprehensive family planning services are covered including:

- Office visits for family planning services
- Laboratory tests, including Pap smears
- Contraceptive devices such as Mirena, Paraguard and Implanon (Precertification is not required.)
- Voluntary sterilization (including Essure Micro-Insert if done in an obstetrician's office)

Enrollees may see any provider they choose, without referral, for family planning services, including out of network providers.

Home Health Services

Home health services are covered when the enrollee's PCP or attending provider certifies the services are medically necessary on a part-time, intermittent basis by an enrollee who requires home visits. Precertification is required for coverage of procedures and services. Amerigroup

may choose to provide coverage of home health services to a non-homebound enrollee, but this is not a mandatory benefit. Covered home health services are delivered in the enrollee's home and include:

- Skilled nursing services including supervisory visits
- Home health aide services (including biweekly supervisory visits by a registered nurse in the enrollee's home and with observation of aide's delivery of services to enrollee at least every second visit)
- Physical therapy services
- Occupational therapy services
- Speech pathology services
- Medical supplies used in a home health visit

Hospice Care Services

Hospice care services are covered for enrollees who are terminally ill with a life expectancy of six months or less. Hospice services can be provided in a hospice facility, a long-term care facility or at home. Notification is required for coverage of outpatient hospice services. Precertification is required for home health care and most DME.

Inpatient Hospital Services

Inpatient hospital services are covered. Elective admissions require precertification for coverage. Emergency admissions require notification within 24 hours or by the next business day. To be covered, preadmission testing must be performed by an Amerigroup-preferred laboratory vendor or network facility outpatient department. See the *Provider Referral Directory* at https://providers.amerigroup.com/DC for a complete listing of participating vendors. Same-day admission is required for surgery.

For special rules for length of stay for childbirth, see the Childbirth-Related Provisions section.

Laboratory Services

Diagnostic and laboratory services performed by providers who are Clinical Laboratory Improvement Act of 1998 (CLIA)-certified or have a waiver of certificate registration and a CLIA identification number are covered. However, viral-load testing, genotypic, phenotypic or drug resistance testing used in treatment of HIV/AIDS are reimbursed directly by DCHFP and must be rendered by a DCHFP-approved provider and be medically necessary. Precertification is required for genetic testing. All laboratory services furnished by nonparticipating providers require precertification by Amerigroup, except for hospital laboratory services for an emergency medical condition. If a convenient alternative is not available, precertification is required for enrollees to access network hospital outpatient departments for blood drawings and/or specimen collection.

To ensure outpatient diagnostic laboratory services are directed to the most appropriate setting, laboratory services should be sent to an Amerigroup-preferred laboratory vendor (e.g.,

Lab Corp or Quest Diagnostics). Laboratory services provided in a District hospital will be reimbursed under certain circumstances including:

- Services identified by Amerigroup as stat laboratory procedures (for a list of identified stat laboratory procedure codes, refer to the provider website)
- Services rendered in an emergency room setting with an emergent diagnosis
- Services rendered in conjunction with ambulatory surgery services (RV0360-RV0369, RV0481, RV0490-RV0499, RV0720-RV0729, RV0750-RV0759, and RV0790-RV0799)
- Services rendered in conjunction with observation services (RV0760-RV0769)
- Services billed with certain chemotherapy, obstetric and sickle cell diagnosis codes (C00.0-C14.8, C15.3-C26.9, C30.0-C39.9, C40.0-C41.9, C43.0-C44.99, C45.0-C49.9, C50.011-C50.929, C51.0-C58, C60.0-C63.9, C6.1 *C6.1 is not a valid code*-C68.9, C69.00-C72.9, C73-C75.9, C76.0-C80.2, C81.00-C96.9, D00.00-D09.9, D37.01-D48.9, D49.0-D49.9, D57.00-D57.819, O00.00-O00.91, O01.0-O01.9, O02.0-O02.81, O03.0-O03.9, O08.0-O08.9, O09.00-O09.93, O10.011-O10.019, O10.02, O10.111-O10.119, O10.12, O10.211-O10.219, O10.22, O10.311-O10.319, O10.32, O10.411-O10.419, O10.42, O10.911-O10.919, O10.92, O11.1-O15.1, O15.9-O16.9, O20.0-O24.019, O24.02, O24.111-O24.119, O24.12, O24.311-O24.319, O24.32, O24.410-O24.429, O24.811-O24.819, O24.82, O24.911-O24.919, O24.92, O25.10-O25.13, O25.2, O26.00-O26.62, O26.711-O26.719, O26.72, O26.811-O29.93, O30.001-O48.1, O60.00-O77.9, O80-O82, Z33.1, Z34.00-Z34.93, Z39.0-Z39.2, Z51.11-Z51.12)

Physicians may continue to perform laboratory testing in their office but must otherwise direct outpatient diagnostic laboratory tests to an Amerigroup-preferred laboratory vendor (e.g., LabCorp or Quest Diagnostics)*.

Laboratory codes for drug testing or urine drug screening related to a substance use disorder are not the payment responsibility of the MCOs.

Long-Term Care Facility Services/Nursing Facility Services

Long-term care facilities include chronic hospitals, rehabilitation hospitals and nursing facilities. The first 30 days in a long-term care facility are the responsibility of Amerigroup, subject to specific rules. Precertification is required for coverage from Amerigroup.

When an enrollee is transferred to skilled nursing or long-term care facility and the length of the enrollee's stay is expected to exceed 30 days, medical eligibility approval of the Department of Health for long-term institutionalization must be secured as soon as possible.

Amerigroup covers the first 30 days or until medical eligibility approval is obtained, whichever is longer. If required disenrollment procedures are **not** followed, financial responsibility continues until the District's requirements for the enrollee's disenrollment are satisfied. In order for an enrollee to be disenrolled from Amerigroup based on a long-term care facility admission, all of the following must first occur:

- A DCHFP 3871 application for a departmental determination of medical necessity must be filed. If a length of stay of more than 30 days is anticipated at the time of admission, the application should be filed at the time of admission.
- DCHFP must determine the enrollee's long-term care facility admission was medically necessary, in accordance with the District's criteria.
- The enrollee's length of stay must exceed 30 consecutive days.
- Amerigroup must file an application for disenrollment with DCHFP, including documentation of the enrollee's medical and utilization history if requested.

Inpatient acute care services provided within the first 30 days following admission to a long-term care facility are **not** considered an interruption of the Amerigroup-covered 30 continuous days in a long-term care facility, as long as the enrollee is discharged from the hospital back to the long-term care facility.

An enrollee with serious behavioral illness, intellectual disability or a related condition may **not** be admitted to a nursing facility (NF) unless the District determines NF services are appropriate for coverage. For each enrollee seeking NF admission, a preadmission screening and resident review (PASRR) ID screen must be completed.

The first section of the PASRR ID screen exempts an enrollee if both:

NF admission is directly from a hospital for the condition treated in the hospital.
The attending provider certifies, prior to admission to the NF, that the enrollee is likely to require less than 30 days of NF services.

Newborn Coordinator and Provider Responsibilities

Amerigroup will designate a newborn coordinator (NC) to serve as a point of contact for providers who have questions or concerns related to the eligibility of services for newborns during the first 60 days after birth.

Outpatient Hospital Services

Medically necessary outpatient hospital services are covered.

Oxygen and Related Respiratory Equipment

Oxygen and related respiratory equipment are covered.

Personal Care Services

Personal Care Services are covered for those enrollees who meet functional eligibility requirements.

Pharmacy Services

Amerigroup will expand the drug formulary to include new products approved by the Food and Drug Administration (FDA) in addition to maintaining drug formularies that are at least

equivalent to the standard benefits of the District of Columbia Department of Health Care Finance. This requirement pertains to new drugs or equivalent drug therapies, and certain vaccines. . If a generic equivalent drug is not available, a new brand-name drug rated as P (priority) by the FDA will be added to the formulary. Coverage may be subject to precertification to ensure medical necessity for specific therapies. For formulary drugs requiring precertification, a decision will be provided in a timely manner so as not to adversely affect the enrollee's health. For covered outpatient drugs requiring preauthorization, a decision will be provided within 24 hours. For medical injectable drugs that are not included in "outpatient drugs," a decision will be provided within 72 hours after receipt for expedited requests, and 14 calendar days for standard requests. If the service is denied, Amerigroup will notify the prescriber and the enrollee in verbally and in writing of the denial.

When a prescriber believes a nonformulary drug is medically indicated, Amerigroup has procedures in place for nonformulary requests. The District expects a nonformulary drug to be approved if documentation is provided indicating the formulary alternative is not medically appropriate.

The Amerigroup 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. Enrollees have access to most national pharmacy chains and many independent retail pharmacies. Amerigroup contracts with CarelonRx, Inc. as the pharmacy benefits manager. All enrollees must utilize a contracted CarelonRx, Inc. network pharmacy when filling prescriptions in order for benefits to be covered. Several large chains and most independent pharmacies are contracted with CarelonRx, Inc. For specialty drugs, please use the CarelonRx Specialty Pharmacy at 1-833-255-0646. Enrollees may also request an override which would allow them to obtain specialty medications at a local in-network retail pharmacy. To request a specialty pharmacy override, enrollees may contact Pharmacy Member Services at 833-214-3604.

Enrollees are not required to use mail-order pharmacy providers.

Monthly Limits:

- All prescriptions are limited to a maximum 30-day supply per fill at an in-network *retail* pharmacy.
- All specialty prescriptions are limited to a maximum 30-day supply per fill at an in-network *specialty* pharmacy.
- All prescriptions are limited to a maximum 60-day supply per fill at an in-network *mail order* pharmacy.
- An enrollee may receive up to a 12-month supply of a covered prescription contraceptive at one time.

Prescription and Drug Formulary

The Amerigroup Pharmacy program utilizes a preferred drug list (PDL), which has been reviewed and approved by DHCF. This is a list of the preferred drugs within the most commonly

prescribed therapeutic categories. The medications included in the PDL are reviewed and approved by the Pharmacy and Therapeutics (P&T) committee. The P&T committee is comprised of practicing physicians and pharmacists who evaluate safety, efficacy, adverse effects, outcomes and total pharmacoeconomic value for each drug product reviewed. The goal of the PDL is to provide cost-effective pharmacotherapy choices based on prospective, concurrent and retrospective review of medication therapies and utilization. Many over-the-counter (OTC) medications are also included in the PDL and should be considered for first-line therapy when appropriate. To access the PDL, go to https://providers.amerigroup.com/DC > Pharmacy > Medicaid Preferred Drug List.

Check the current Amerigroup formulary at https://providers.amerigroup.com/DC > Pharmacy > Medicaid Formulary, before writing a prescription for either prescription or over-the-counter drugs. Amerigroup enrollees must have their prescriptions filled at an in-network pharmacy.

The following are examples of covered items (this list is not all-inclusive and is subject to change):

- Legend (prescription) drugs
- Insulin
- Disposable insulin needles/syringes
- Disposable blood/urine glucose/acetone testing agents
- Latex condoms
- Lancets and lancet devices
- Compounded medication of which at least one ingredient is a legend drug and listed on the Amerigroup PDL
- Any other drug which under applicable District law may only be dispensed upon the written prescription of a physician or other lawful prescriber and is listed on the Amerigroup PDL
- PDL listed legend contraceptives

Exclusions (subject to change):

- Drugs not approved by the FDA
- Infertility medications
- Drugs used for cosmetic reasons
- Erectile dysfunction drugs to treat impotence
- Weight control products (except Alli, which requires precertification)
- Experimental or investigational medications
- Surgical supplies
- Diagnostic products

Over-the-Counter Drugs

Amerigroup offers an extra benefit for certain over-the-counter (OTC) drugs. Each enrollee can receive up to $50 annually. The provider must write a prescription for these drugs. If the

enrollee reaches his or her maximum within the year, the pharmacy will notify the enrollee. The following drugs are covered as part of this benefit (the brand names listed serve as a reference only). This is not a complete list and is subject to change, but represents some of the most common OTC drugs.

OTC drug type	Brand name
Antidiarrheals	Florastor, and Pedialyte
Antibiotic Ointments	Neosporin
Cough and cold preparations	Dimetapp, Delsym, and Robitussin
Decongestants	Sudafed
Laxatives	Senokot
Miscellaneous, topical	Visine
Nutritionals/Supplements	Preservision, Vita-Min

Carve-Out Drugs

Managed directly by the DHCF:

- For DC Healthy Families Enrollees: HIV/AIDS, PrEP and PEP medications are managed by the DHCF.
- For DC Alliance Enrollees: HIV/AIDS treatment medications are managed by the DC AIDS Drug Assistance Program (DC ADAP). PrEP and PEP medications are managed by Amerigroup.

Injectables and Nonformulary Medications Requiring Prior Authorization

To access the Precertification Lookup Tool, log in at https://providers.amerigroup.com/DC. You must be a registered user to access the tool.

Mail Order Pharmacy

We do not require an enrollee to use mail-order, but we do offer mail-order pharmacy services for certain drugs through CarelonRx's home delivery pharmacy. To obtain mail-order pharmacy services:

- Call: 1-833-203-1737
- Fax: 1-800-378-0323

Pharmacy Restriction (Lock-in)

Amerigroup's pharmacy restriction process limits enrollees to a single pharmacy to obtain their medications. The need for restriction is determined as a result of medication claims review. Enrollees identified with uncoordinated care, excessive utilization or suspected patterns of fraud and abuse may also be referred to the pharmacy department.

Using predefined queries, the Pharmacy department identifies enrollees that meet the criteria for lock-in. These enrollees are notified in advance of the lock-in and provided a period of time to appeal or request additional information. The PCP and the identified prescribers will be notified in writing of the decision to lock-in the enrollee to a pharmacy. The network pharmacy provider will also receive a letter identifying the enrollees that are restricted to their pharmacy.

Pharmacy Prior Authorization Process

Providers are strongly encouraged to write prescriptions for preferred products as listed on the PDL. If for medical reasons an enrollee cannot use a preferred product, providers are required to contact Amerigroup Pharmacy Services to obtain prior authorization in one of the following ways:

- Call 1-800-454-3730, Monday through Friday from 8 a.m. to 8 p.m. Eastern time, or 10 a.m. to 2 p.m. on Saturdays.
- Fax all information required and a *Prior Authorization Form* to 1-844-487-9292 for general pharmacy and 1-844-487-9294 for medical injectable request. The form is located at https://providers.amerigroup.com/DC > Pharmacy > Prior Authorization Form.
- Submit electronically through https://www.availity.com which allows you to:
    - Submit requests for general pharmacy — medications dispensed directly to an enrollee from retail pharmacy or shipped from a specialty pharmacy.
    - Request medical injectables for those medications obtained by your office/facility for onsite infusion or administration.
    - Check precertification status.
    - Appeal denied requests.
    - Upload supporting documents and review appeal status.

Providers can also submit electronic PAs through www.covermymeds.com.*

To access the Precertification Lookup Tool, log in at https://providers.amerigroup.com/DC and go to Availity. From Availity's home page select Payer Spaces, then choose Amerigroup from the Payer Menu. You will find the link to the Precertification Look Up Tool on Payer Spaces Applications. Availity also offers tutorials to guide you through the medication prior authorization process and other helpful functions.

The information will be reviewed by our clinical team for medical necessity and the provider will be notified within 24 hours of receipt of the necessary clinical information for a covered outpatient drug. For medical injectable drugs that are not included in “outpatient drugs,” a decision will be provided within 72 hours after receipt for expedited requests, and 14 calendar days for standard requests.

If the service is denied, the prescriber and the enrollee are notified verbally and in writing of the denial. All decisions are based on medical necessity and are determined according to certain established medical criteria. Amerigroup does not cover brand name medications where there is an FDA-approved therapeutically equivalent generic. Requests for brand name

medications when there is a generic available will follow the precertification process to determine medical necessity. Some drugs have daily quantity and/or dosage limits and are identified as such on the PDL. Request for drugs exceeding the limits will require precertification to determine medical necessity.

Examples of medications that require precertification are listed below (this list is not all-inclusive and is subject to change):

- Drugs not listed on the PDL
- Brand-name products for which there are therapeutically equivalent generic products available
- Self-administered injectable products
- Drugs that exceed certain limits (for information on these limits please contact the Pharmacy department)

Step Therapy and Quantity Limits

Certain prescription medications may have additional requirements or limitations of coverage, which are outlined in the *Preferred Drug List*. Step therapy (ST) requires the use of a clinically recognized first-line drug before Amerigroup will approve the use of a more complex, and often more expensive, medication where the safety, effectiveness and value has not been well established.

Quantity limits are in place per prescription or per month based on the maximum recommended dose or supply, according to the FDA approved package labeling or appropriate use and standards of quality care.

Specialty Drug Program

Amerigroup partners with CarelonRx Specialty Pharmacy Services as a supplier of high-cost, specialty and/or injectable drugs that treat a number of chronic or rare conditions. To obtain one of the listed specialty drugs, fax your prescription to CarelonRx Specialty at 1-833-263-2871 or call 1-833-255-0646.

Physician and Advanced Practice Nurse Specialty Care Services

Specialty care services provided by a physician or an advanced practice nurse (APN) are covered when such services are medically necessary and are outside of the PCP's customary scope of practice.

Specialty care services covered under this section also include:

- Services performed by nonphysicians or non-APN practitioners within their scope of practice, employed by a physician to assist in the provision of specialty care services and working under the physician's direct supervision
- Services provided in a clinic by or under the direction of a physician or dentist

- Services performed by a dentist or dental surgeon when the services are customarily performed by physicians

Amerigroup shall clearly define and specify referral requirements to all providers.

An enrollee's PCP is responsible for making the determination based on Amerigroup referral requirements (i.e., whether a specialty care referral is medically necessary).

PCPs must follow Amerigroup specialty referral protocol for children with special health care needs who suffer from a moderate to severe chronic health condition that:
Has significant potential or actual impact on health and ability to function.
Requires special health care services.
Is expected to last longer than six months.

A child who is functioning one third or more below chronological age in any developmental area must be referred for specialty care services intended to improve or preserve the child's continuing health and quality of life, regardless of the services ability to affect a permanent cure.

Podiatry Services

Amerigroup provides its enrollees medically necessary podiatry services when furnished by a licensed podiatrist within the scope of practice under District of Columbia law.

No precertification is required for network providers for in-office evaluation & management services, testing and procedures.

Primary Care Services

Primary care is generally received through an enrollee's PCP who acts as a coordinator of care and has the responsibility to provide accessible, comprehensive and coordinated health care services covering the full range of benefits for which an enrollee is eligible. In some cases, enrollees will opt to access certain primary care services by self-referral to providers other than their PCPs (e.g., school-based health centers). Primary care services include:

- Addressing the enrollee's general health needs
- Coordination of the enrollee's health care
- Disease prevention and health promotion and maintenance
- Treatment of illness
- Maintenance of the enrollees' health records
- Referral for specialty care

For female enrollees: If the enrollee's PCP is not a woman's health specialist, she may see a participating woman's health specialist, without a referral, for covered services necessary to provide women's routine and preventive health care services.

Primary Behavioral Health Services (Mental Health and Substance Use Disorders)

Primary behavioral health services required by enrollees, including clinical evaluation and assessment, provision of primary behavioral health services, and/or referral for additional services as appropriate are covered. Reference the Behavioral Health Services section for specific services.

The PCP of an enrollee requiring behavioral health services may elect to treat the enrollee if the treatment, including visits for buprenorphine treatment, falls within the scope of the PCP's practice, training and expertise. Neither the PCP nor Amerigroup may bill the Behavioral Health System for the provision of such services because these services are included in the capitation rates.

When, in the PCP's judgment, an enrollee's need for behavioral health treatment cannot be adequately addressed by primary behavioral health services provided by the PCP, the PCP should, after determining the enrollee's eligibility based on probable diagnosis, refer the enrollee to the Behavioral Health at 1-800-600-4441 for specialty behavioral health services.

Rehabilitative Services

Rehabilitative services, including but not limited to medically necessary physical therapy, speech therapy and occupational therapy are covered.

Prior authorization must be obtained from InterQual for physical therapy, speech therapy, and occupational therapy services beyond the initial evaluation. InterQual conducts medical necessity reviews for therapy services and medical necessity criteria must be met. Providers can request authorization from InterQual by calling 1-855-596-7618 or by faxing clinical information to 1-855-596-7626.

Second Opinions

Upon enrollee request, Amerigroup will provide for a second opinion from a qualified health care professional within the network and, if necessary, will arrange for the enrollee to obtain a second opinion outside of the Amerigroup network.

Transplants

Pre- and post-transplant surgery services are covered.

Transportation

Transportation services for enrollees is covered related to the provision of triage and stabilization services for emergency medical conditions and as described in 42 C.F.R. § 440.170(a) for medical examinations and treatment.

For assistance with scheduling transportation, please call Medical Transportation Management, Inc. (MTM) at 1-888-828-1071.*

Vision Care Services

Routine and medically necessary vision care services are covered. Amerigroup is responsible, at a minimum, for providing the following:

Routine Eye Exams

For enrollees under age 21, coverage includes one eye examination every 12 months.
For enrollees under age 21, coverage includes more frequent eye exams as needed in accordance with EPSDT guidelines. Amerigroup arranges for the provision of at least one eye examination every year.

Vision Hardware

Coverage includes standard spectacle lenses with a retail allowance for frames every 24 months (contact lenses are covered in lieu of eyeglasses). EPSDT guidelines allow one pair of lenses and frames once per year and contact lenses if medically necessary. Replacement frames and lenses are covered if they are lost, stolen or broken or if enrollee's prescription has changed more than 0.5 diopters.
For enrollees age 21 and older, coverage includes one pair of eyeglasses every 24 months except when lost or when the prescription has changed by more than 0.5 diopters.

Benefit Limitations

Excluded Medicaid Services

The following items and services are excluded from coverage:

- The service is not included as a covered service in the District plan
- The service is of an amount, duration, and scope in excess of a limit expressly set forth in section C.5.20.2 of the MCO contract between District of Columbia and Amerigroup
- The service is not medically necessary as defined in section C.3.137 of the MCO contract between District of Columbia and Amerigroup
- The service is a prescription drug for which Amerigroup has received prior approval in writing from DHCF to exclude from the Amerigroup Formulary
- The service is an inpatient transplantation surgery: Amerigroup shall cover pre and postoperative costs of the transplant surgery
- The service is cosmetic, except that the following services shall not be considered cosmetic:
    - Surgery required correcting a condition resulting from surgery or disease
    - Surgery required to correct a condition created by an accidental injury
    - Surgery required to correct a congenital deformity
    - Surgery required correcting a condition that impairs the normal function of a part of the body
    - Surgery to address gender dysphoria as identified in DHCF policy
- The service is sterilization for an enrollee under age 21

- The service is an abortion that does not meet the standard of the applicable Appropriations Act for the District of Columbia; the standard applicable for federal Fiscal Year ending September 30, 2016 is that:
    - None of the funds appropriated under this act, and none of the funds in any trust fund to which funds are appropriated under this act, shall be expended for health benefits coverage that includes coverage of abortion
    - The limitations established in the preceding sections shall not apply to an abortion:
        - If the pregnancy is the result of an act of rape or incest
        - In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed
    - Nothing in this section shall be construed as prohibiting the expenditure by a District, locality, entity, or private person of District, local, or private funds (other than a District's or locality's contribution of Medicaid matching funds)
    - Nothing in this section shall be construed as restricting the ability of Amerigroup from offering abortion coverage or the ability of a District or locality to contract separately with such a provider for such coverage with District funds (other than a District's or locality's contribution of Medicaid matching funds)
- The service is described as a non-MCO covered service, which is covered by the Medicaid State Plan for Medical Assistance but not described as an Amerigroup covered service, and therefore not the responsibility of Amerigroup under the contract
- The service is an investigational or experimental treatment if it is a diagnostic or treatment service that, in accordance with relevant evidence, is not considered to fall within the range of professionally accepted clinical practice with respect to illness, disability, or condition that is the focus of a coverage determination
- The services are part of a clinical trial protocol; Amerigroup shall cover all inpatient and outpatient services furnished over the course of a clinical trial but shall not cover the services included in the clinical trial protocol

Alliance Coverage Exclusions

The following services are excluded for Alliance enrollees:

- Screening and stabilization services for emergency medical conditions provided outside the District
- Emergency medical conditions as described in DHCF Policy Number HCPRA-2013-02R
- Services furnished in schools

- Any covered services when furnished by providers that are not in the Amerigroup provider network
- Services and supplies related to surgery and treatment for temporal mandibular joint problems (TMJ)
- Cosmetic surgery
- Open heart surgery
- Sclerotherapy
- Therapeutic abortions
- Routine vision care for adults
- Treatment for obesity
- Infertility treatment
- Experimental treatment and investigational services and items
- Treatment for behavioral health and alcohol or substance abuse services, except services related to medical treatment received in a hospital for life threatening withdrawal or withdrawal symptoms from alcohol or narcotic drugs
- Deliveries
- Nonemergency transportation services

Health Home Benefits

Health Home for Persons with Mental Health Care needs — MY DC Health Home

On January 1, 2016, DHCF launched a new benefit for Medicaid beneficiaries with **mental health care needs, called My DC Health Home**, that will help coordinate a person's full array of health and social service needs — including primary and hospital health services; mental health care, substance abuse care and long-term care services and supports. My DC Health Homes are community-based mental health providers, as known as core services agencies, which have hired nurses, primary care doctors and others with social and health-related backgrounds, to create care teams. Each person that decides to receive services through the My DC Health Home benefit will be linked with a care team who will work with the person's doctors, family and anyone else the person selects.

My DC Health Homes are located across the District. To refer an enrollee to these free services, call the DC Access HELPLINE at 1-888-7WE-HELP or 1-888-793-4357 24 hours a day, 7 days a week to be connected with a My DC Health Home.

Health Home for Persons with Multiple Chronic Conditions — My Health GPS

The District of Columbia Department of Health Care Finance (DHCF) launched a care coordination benefit for Medicaid beneficiaries with multiple chronic conditions, called My Health GPS on July 1, 2017. As part of the District's My Health GPS program, interdisciplinary teams embedded in the primary care setting will serve as the central point for integrating and coordinating the full array of eligible beneficiaries' primary, acute, behavioral health, and long-term services and supports to improve health outcomes and reduce avoidable and preventable

hospital admissions and ER visits. Unlike DHCF's initial Medicaid Health Home benefit (My DC Health Home) where individuals must have a severe mental illness to receive services, the My Health GPS program will deliver care coordination services to beneficiaries who have three or more chronic conditions and are enrolled in either fee-for-service or managed care.

Eligible conditions are:

- Mental health condition (depression, personality disorders)
- Substance use disorder
- Asthma (and chronic obstructive pulmonary disease [COPD])
- Diabetes
- Heart disease (congestive heart failure [CHF])
- Conduction disorders/cardiac dysrhythmias
- Myocardial infarction (pulmonary heart disease)
- Morbid obesity only
- Cerebrovascular disease
- Chronic renal failure (on dialysis)
- Hepatitis
- HIV
- Hyperlipidemia
- Hypertension
- Malignancies
- Paralysis
- Peripheral atherosclerosis
- Sickle cell anemia

What are the My DC and My Health GPS Health Home services?

Comprehensive care management, where information about a person's health and social needs are gathered and a care plan to support the person's health is written

Care coordination, includes the activities that help a person follow his or her care plan — such as scheduling doctor visits and transportation to these visits;

Health promotion, includes helping a person understand what he or she can do to keep good health — such as stopping smoking, joining walking groups, and cooking with fresh foods

Comprehensive transitional care/follow-up, ensures that if a person is admitted to a hospital, the person has access to needed services when he or she leaves the hospital

Enrollee and family support, helps the person and his or her support team (such as family and friends) connect with medical and social service providers, better understand papers on health care, and other activities that ensure that both the person and his or her support team stay healthy

Referral to community and social support services, link the person to neighborhood, church and other helpful activities that can help keep the person healthy

Interpreter Services

Oral interpretive services are available either in-office or telephonically at no cost to you or the enrollee. If you serve an Amerigroup enrollee with whom you cannot communicate, call Enrollee Services at 1-800-600-4441 to access an interpreter. For immediate needs, Amerigroup has Spanish-language interpreters available without delay and can provide access to interpreters of other languages within minutes.

Amerigroup recommends that requests for in-office interpreter services be arranged at least one business day in advance of the appointment. If an enrollee with special needs requires an interpreter to accompany him or her to a clinic appointment, a case manager/care coordinator can make arrangements for the interpreter to be present.

Providers are required to offer interpretive services to enrollees who may require assistance. Providers should document the offer and the enrollees' response and reiterate that interpretive services are available at no cost. Family and friends should not be used to provide interpretation services, except at an enrollee's request.

Guidelines for Working with an Interpreter

Use the following guidelines for better communication when speaking through an interpreter:

- Keep your sentences short and concise — the longer and more complex your sentences, the less accurate the interpretation.
- When possible, avoid using medical terminology, which is unlikely to translate well.
- Ask key questions in several different ways to ensure the questions are fully understood, and you get the information you need.
- Be sensitive to potential enrollee embarrassment, reticence or confusion. It is possible your questions or statements were not understood.
- Ask the enrollee to repeat the instructions you have given as an effective review of how well the enrollee has understood.

Services for the Deaf and Hard of Hearing

Enrollees have the right to receive assistance through a text telephone/telecommunications device for the deaf (TTY/TDD) line. Amerigroup can help you telephonically communicate with enrollees with impaired hearing via a translation device. Call the Enrollee Services using the TTY relay service at 711. In-office sign language assistance is also available. Call Enrollee Services at 1-800-600-4441 to arrange for the service.

Additional Communication Options for Enrollees and Providers

Amerigroup policies are designed to ensure meaningful opportunities for enrollees with limited-English proficiency (LEP) to obtain access to health care services and to help enrollees with LEP overcome language barriers and fully use services or benefits.

The Amerigroup provider directory includes a list of languages spoken by participating primary and specialty care providers. Translation assistance options are available at no cost to the

enrollee or provider. Upon request, written materials are available in large print, on tape and in languages other than English (dependent upon the plan's population). Enrollee materials are written at a fifth-grade reading level per District requirement.

Amerigroup will not prohibit a provider, acting within the scope of his practice, from advising an enrollee about his or her medical care or treatment for the condition or disease regardless of whether benefits are provided by Amerigroup. Amerigroup will not retaliate against a provider for advising the enrollee.

TELEHEALTH

Telemedicine is a service delivery model that delivers healthcare services through a two-way, real-time interactive video-audio communication or audio-only communication for the purpose of evaluation, diagnosis, consultation, or treatment. Eligible services can be delivered via telemedicine when the beneficiary is at the originating site,[1] while the eligible "distant" provider renders services via the audio/video or audio-only connection.

Pursuant to the D.C. Telehealth Reimbursement Act of 2013, the Program will not reimburse for service delivery using e-mail messages or facsimile transmissions.

To find out more about telehealth, or for contracting questions, please call Provider Services at 1-800-454-3730.

SERVICE STANDARDS:

- **Access** —Amerigroup pays for telehealth care services delivered by care providers contracted with the health plan. The telehealth providers must confirm enrollee eligibility every time enrollees access virtual visits, similar to in-person visits.
- **Staffing Credentials** — All professional staff are certified or licensed in their specialty or have a level of certification, licensure, education and/or experience in accordance with state and federal laws.
- **Staff Orientation and Ongoing Training** — The telehealth providers must comply with all applicable state, federal and regulatory requirements relating to their obligations under contract with Amerigroup. Telehealth providers must participate in initial and ongoing training programs including policies and procedures.
- **Service Response Time** — The telehealth provider will comply with the response time requirements outlined in their contract.
- **Compliance & Security** — The telehealth platform should be HIPAA compliant and meets state, federal and 508 compliance requirements. The telehealth providers will conduct all enrollee Virtual Visits via interactive audio and/or video telecommunications systems using a secure technology platform and will maintain enrollee records in a secure medium, which meets state and federal law requirements for security and confidentiality of electronic enrollee information.
- **Enrollee Complaints** — The telehealth providers are not delegated for complaint resolution but will log, by category and type, enrollee complaints and should refer enrollee complaints to National Call Center.
- **Regulatory Assessment Results** — Amerigroup reserves the right to request access to any applicable regulatory audit results.
- **Utilization** — The telehealth provider will comply with the reporting requirements outlined in their contract.
- **Electronic Billing/Encounter Coding** — The telehealth provider will submit Virtual Visit encounters or claims with proper coding as part of its existing encounter submission process.
- **Eligibility Verification** — The telehealth provider will use existing eligibility validation methods to confirm Virtual Visit benefits.

- **Case Communication** — The telehealth provider will support enrollee records management for Virtual Visits using existing EMR systems and standard forms. Its EMR records should contain required medical information including referrals and authorizations.
- **Professional Environment** — The telehealth provider will help ensure that, when conducting Virtual Visits with enrollees, the rendering care provider is in a professional and private location. The telehealth provider (rendering care providers) will not conduct enrollee Virtual Visits in vehicles or public areas.

Provider rendering telehealth services must comply with all credentialing requirements stipulated in their Provider Agreements.

All laws regarding the privacy, security and confidentiality of health care information and a enrollee's rights to his or her medical information and personal information shall apply to Telehealth interactions.

Claims for services provided via telehealth must be billed with the same procedure code as would be used for a face-to-face encounter along with modifier GT.

BEHAVIORAL HEALTH SERVICES

Overview

Behavioral health services are covered services for the treatment of mental, emotional or substance use disorders.

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

- 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 enrollee'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 enrollee or provider.

For more information about behavioral health services, providers should call 1-800-454-3730 and enrollees should call 1-800-600-4441 (TTY 711).

Coordination of Physical and Behavioral Care

We recognize treatment and recovery can be complicated by comorbid conditions. Additionally, we believe essential ambulatory care should continue unabated while an enrollee is hospitalized; therefore, PCPs and behavioral health providers are required to communicate directly to ensure continuity of care.
When an enrollee, who is being treated for a comorbid behavioral health condition is admitted for treatment of a physical health condition, the attending physician will attempt to secure a release of information and review the admission with the PCP. This is necessary to ensure that essential treatment will continue unabated.
When an enrollee who is being treated for a comorbid physical health condition is admitted for treatment of a behavioral health condition, the attending physician will attempt to secure a release of information and review the admission with the behavioral health provider. This is necessary to ensure that essential treatment will continue unabated.

We require that physical and behavioral health providers share relevant case information in a timely, useful and confidential manner. We require that the behavioral health provider be notified of the enrollee's physical examination and laboratory and radiological tests within 24 hours of receipt for urgent cases and within five business days in nonurgent cases. This notification will be made by telephone with follow-up in writing. The provider will obtain a release of information from any enrollee or his or her legal representative (e.g., parent,

guardian or conservator) before releasing confidential health information. The release of information must contain, at a minimum, the following:

- Name and identification number of the enrollee whose health information is being released
- Name of provider releasing the information
- Name of provider receiving the information
- Information to be released
- Period for which the authorization is valid
- Statement informing the signatory that he or she can cancel the authorization at any time
- Printed name of the signatory
- Signature or mark of the signatory
- Date of signature

A physical health provider who recognizes concomitant behavioral health needs requiring treatment by a behavioral health provider will facilitate the enrollee's access to a behavioral health service. A non-network provider who recognizes concomitant physical health needs requiring treatment by a physical health provider is expected to facilitate the enrollee's access to a primary provider by contacting us.

For enrollees who are hospitalized and receive both behavioral and physical health services, primacy (i.e., the form of care that is primary) will be determined by the principle diagnosis, type of attending physician and location of service. Either type of provider may initiate consultation with the other and coordinate further and/or ongoing care. A physical and behavioral health provider should exchange health information at the following junctures:

- When the enrollee first accesses a physical or behavioral health service
- When a change in the enrollee's health or treatment plan requires an alteration of the other provider's treatment plan (e.g., when an enrollee who has been taking lithium becomes pregnant)
- When the enrollee is admitted to or discharged from the hospital
- When the enrollee discontinues care
- When an enrollee is admitted and a consultation is warranted
- Once a quarter if not otherwise required

Information should contain at a minimum:

- Provider's name and contact information
- Enrollee's name, date of birth, gender, ID number and contact information
- Reason for referral (initial contact only)
- Current diagnosis
- History of the presenting illness and other relevant medical and social histories (initial contact only)
- Level of suicide, homicide, physical harm or threat
- Current treatment plan

- Special instructions (e.g., diagnostic questions to be answered, treatment recommendations)

The provider will maintain a copy of the release of information form and document care coordination in the enrollee's medical record. We will coordinate inpatient behavioral health consultations and services, as well as discharge planning and follow-up with the enrollee's behavioral health provider (both network and non-network).

Behavioral Health Covered Services

Service*	Benefit Limit
Physician and mid-level visits including: Diagnostic and assessment services Individual counseling Group counseling Family counseling FQHC services Medication/somatic treatment	As medically necessary
Crisis services provided in a higher level of care (this may not be necessary to differentiate to this degree)	As medically necessary
Inpatient hospitalization and emergency department services	As medically necessary
Day services and intensive day treatment for mental health conditions	As medically necessary
Case management services	As medically necessary
Inpatient psychiatric facility services	Individuals under age of 21 for the duration of a medically necessary stay and covered over the age of 21 for up to 15 days when medical necessity is met.
Pregnancy-related services	Treatment for any mental condition that could complicate the pregnancy
Psychiatric residential treatment facility (PRTF)	Individuals under age of 22
Access to mental health services	Education regarding how to access mental health services provided by Amerigroup and Department of Behavioral Health (DBH)
Pediatric mental health service	All mental health services for children that are included in an IEP or IFSP during holidays, school vacations or sick days from school
Inpatient detoxification	As medically necessary

Service*	Benefit Limit
Routine outpatient alcohol and drug abuse treatment	Referrals to Department of Behavioral Health (DBH) as medically necessary
Behavioral health service to students in school setting	Provider must meet the following conditions: Meet fee schedule requirements for children and youth without an IEP Must be credentialed as an in-network provider Must have office in the school and provided services in that office Provider bills Amerigroup for the services using the codes provided by DHCF

Behavioral Health Covered Services Chart

The following services are covered by the D.C. Department of Behavioral Health (DBH)

Service*	Benefit Limit
Community-based interventions	As medically necessary
Multi-systemic therapy (MST)	As medically necessary
Assertive community treatment (ACT)	As medically necessary
Community support	As medically necessary
Day treatment services for alcohol and drug abuse treatment	As medically necessary
Outpatient crisis stabilization services	As medically necessary
Methadone treatment	As medically necessary
Ambulatory detoxification	As medically necessary

Behavioral Health Access Standards

Service Type	Geographic Access Requirement	Maximum Time for Admission/Appointment
Psychiatric Inpatient Hospital Services	Travel distance does not exceed 30 minutes by public transportation for at least 98 percent of enrollees.	24 hours (involuntary)/24 hours (voluntary)
24-hour Psychiatric Residential Treatment	Not subject to geographic access standards.	Within 14 calendar days of receipt of the request for service; if urgent, no later than 72 hours of receipt of the request for service

Service Type	Geographic Access Requirement	Maximum Time for Admission/Appointment
Outpatient	Not subject to geographic access standards.	Within 14 calendar days; if urgent, within 72 hours of receipt of the request for service
Intensive Outpatient (may include day treatment (adult), intensive day treatment (children and adolescent) or partial hospitalization)	Not subject to geographic access standards.	Within 14 calendar days; if urgent, within 72 hours of receipt of the request for service
Inpatient Facility Services (substance abuse)	Not subject to geographic access standards.	24 hours (involuntary)/24 hours (voluntary)
24-hour Residential Treatment Services (substance abuse)	Not subject to geographic access standards.	Within 14 calendar days; if urgent, within 72 hours of receipt of the request for service
Outpatient Treatment Services (substance abuse)	Not subject to geographic access standards.	Within 14 calendar days;
Crisis Stabilization	Not subject to geographic access standards.	Within four hours of referral

Behavioral Health Precertification

We require precertification for all elective behavioral health inpatient admissions and certain outpatient services. We use Amerigroup's Behavioral Health Medical Policies and Clinical UM Guidelines. The following all-inclusive list of services that must be precertified:

- Inpatient admission
- Non-routine outpatient BH services (i.e., intensive outpatient)
- Routine outpatient BH services for out-of-network providers only
- Partial hospital programs
- Psychological and neuropsychological testing

Coordination of Behavioral Health and Physical Health Treatment

Amerigroup emphasizes the coordination and integration of physical and behavioral health services, wherever possible. Key elements of the Amerigroup model of coordinated care include:

- Ongoing communication and coordination between PCPs and specialty providers, including behavioral health (mental health and substance use) providers
- The expectation that providers screen for co-occurring disorders including:
- Behavioral health screening by PCPs
- Medical screening by behavioral health providers
- Screening of mental health enrollees for co-occurring substance use disorders
- Screening of consumers in substance use disorder treatment for co-occurring mental health and/or medical disorders
- Screening tools for PCPs and behavioral health providers can be located at https://providers.amerigroup.com/DC
- Referrals to PCPs or specialty providers, including behavioral health providers, for assessment and/or treatment for consumers with co-occurring disorders
- Involving enrollees, as well as caregivers and family enrollees, as appropriate, in the development of enrollee-centered treatment plans. Case management and disease management programs to support the coordination and integration of care between providers

As an Amerigroup network provider, you are required to notify an enrollee's PCP when an enrollee first enters behavioral health care and anytime there is a significant change in care, treatment or need for medical services, provided that you have secured the necessary release of information. The minimum elements to be included in such correspondence are:

- Enrollee demographics
- Date of initial or most recent behavioral health evaluation
- Recommendation to see PCP, if medical condition identified or need for evaluation by a medical practitioner has been determined for the enrollee (e.g., EPSDT screen, complaint of physical ailments)
- Diagnosis and/or presenting behavioral health problem(s)
- Prescribed medication(s)
- Vital signs
- Allergy/drug sensitivity
- Pregnancy status
- Behavioral health clinician's name and contact information

Recovery and Resiliency

Amerigroup believes physical and behavioral health services should be rendered in a manner that supports the recovery of persons experiencing mental illness and enhances the development of resiliency of those who are impacted by mental illness, serious emotional

disturbance and/or substance use disorder issues. Recovery is a consumer-driven process in which consumers find their paths to work, learn and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life despite the continued presence of a disability.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has released a consensus statement on mental health recovery. The components listed in this consensus statement are reflective of our desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency. The ten fundamental components of recovery as elucidated by SAMHSA include:

The 10 fundamental components of recovery include:

1. **Self-direction:** Consumers lead, control, exercise choice over and determine their own path of recovery by optimizing autonomy, independence and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
2. **Individualized and person-centered:** There are multiple pathways to recovery based on an individual's unique strengths and resiliency, as well as his or her needs, preferences, experiences (including past trauma) and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result, as well as an overall paradigm for achieving wellness and optimal mental health.
3. **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions — including the allocation of resources — that will affect their lives and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
4. **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and health care treatment and services, complementary and naturalistic services (e.g., recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation and family supports as determined by the person. Families, providers, organizations, systems, communities and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
5. **Nonlinear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

6. **Strengths-based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, and employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
7. **Peer support:** Mutual support including the sharing of experiential knowledge and skills and social learning plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles and community.
8. **Respect:** Community, systems and societal acceptance and appreciation of consumers including protecting their rights and eliminating discrimination and stigma are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
9. **Responsibility:** Enrollees have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Enrollees must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
10. **Hope:** Recovery provides the essential and motivating message of a better future- that people can and do overcome the barriers and obstacles that confront them. Hope is internalized but can be fostered by peers, families, friends, providers and others. Hope is the catalyst of the recovery process.

Resiliency is a dynamic developmental process for children and youth that encompasses positive adaptation and is manifested by traits of self-efficacy, high self-esteem, maintenance of hope and optimism within the context of significant adversity.

Services that are provided to children and youth with serious emotional disturbances and their families should be delivered based on the System of Care Values and Principles that are endorsed by the SAMHSA and the Center for Mental Health Services (CMHS). Services should be:

- Child centered and family focused with the needs of the child and family dictating the types and mix of services provided
- Community based with the focus of services as well as management and decision making responsibility resting at the community level
- Culturally competent with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve
- The guiding principles of a system of care include:
- Children should have access to a comprehensive array of services that address the child's physical, emotional, social, educational and cultural needs.

- Children should receive individualized services in accordance with their unique needs and potential, which is guided by an individualized service plan.
- Children should receive services within the least restrictive, most normative environment that is clinically appropriate.
- Children should receive services that are integrated, with linkages between child serving agencies and programs and mechanisms for planning, developing and coordinating services.
- Children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated, therapeutic manner and adapted in accordance with the changing needs of the child and family.
- Children should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics.

Enrollee Records and Treatment Planning

Enrollee records must meet the following standards and contain the following elements, if applicable, to permit effective service provision and quality reviews:

- Information related to the provision of appropriate services to an enrollee must be included in his or her record to include documentation in a prominent place whether there is an executed declaration for mental health treatment.
- For enrollees in the priority population, a comprehensive assessment that provides a description of the consumer's physical and mental health status at the time of admission to services. This comprehensive assessment covers:
    - A psychiatric assessment that includes:
    - Description of the presenting problem.
    - Psychiatric history and history of the enrollee's response to crisis situations.
    - Psychiatric symptoms.
    - Diagnosis using the most current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM).
    - Mental status exam.
    - History of alcohol and drug abuse.
- A medical assessment that includes:
    - Screening for medical problems.
    - Medical history.
    - Present medications.
    - Medication history.
- A substance use assessment that includes:
    - Frequently used over-the-counter medications.
    - Alcohol and other drugs and history of prior alcohol and drug treatment episodes.
    - History reflecting the impact of substance use in the domains of the community functioning assessment.

- A community functioning assessment or an assessment of the enrollee's functioning in the following domains:
    - Living arrangements, daily activities (vocational/educational)
    - Social support
    - Financial
    - Leisure/recreational
    - Physical health
    - Emotional/behavioral health
- An assessment of the enrollee's strengths, current life status, personal goals and needs
- An enrollee-centered, wellness-oriented care plan, which is based on the psychiatric, medical, substance use and community functioning assessments listed above, must be completed for any enrollee who receives behavioral health services.

The enrollee-centered care plan must be completed within the first 14 days of admission to behavioral health services and updated every 90 days, or more frequently as necessary based on the enrollee's progress towards goals or a significant change in psychiatric symptoms, medical condition and/or community functioning.

There must be documentation in every case that the enrollee and, as appropriate, his or her family enrollees, caregivers, or legal guardian, participated in the development and subsequent reviews of the treatment plan.

For providers of multiple services, one comprehensive treatment/care/support plan is acceptable as long as at least one goal is written, and updated as appropriate, for each of the different services that are being provided to the enrollee.

The treatment/support/care plan must contain the following elements:

- Identified problem(s) for which the enrollee is seeking treatment
- Enrollee goals related to problem(s) identified, written in enrollee-friendly language
- Measurable objectives to address the goals identified
- Target dates for completion of objectives
- Responsible parties for each objective
- Specific measurable action steps to accomplish each objective
- Individualized steps for prevention and/or resolution of crisis, which includes identification of crisis triggers (situations, signs and increased symptoms); active steps or self-help methods to prevent, de-escalate or defuse crisis situations; names and phone numbers of contacts that can assist the enrollee in resolving crisis; and the enrollee's preferred treatment options, to include psychopharmacology, in the event of a mental health crisis
- Signatures of the enrollee as well as family enrollees, caregivers, or legal guardian as appropriate
- Clinical progress notes written to document status related to goals and objectives indicated on the treatment plans

- Correspondence concerning the enrollee's treatment and signed and dated notations of telephone calls concerning the enrollee's treatment

A brief discharge summary must be completed within 15 calendar days following discharge from services or death.
Discharge summaries for psychiatric hospital and residential treatment facility admissions that occur while the enrollee is receiving behavioral health services should also be included.
Amerigroup will monitor provider compliance with treatment plan requirements through medical record reviews or other measures. Providers who do not meet the goal of 100-percent compliance with treatment plan requirements may be subject to corrective action and may be asked to submit a plan for meeting the 100-percent requirement.

Provider Roles and Responsibilities

We believe the success of providers is necessary to achieve our goals. We are committed to supporting and working with qualified providers to ensure that we jointly meet quality and recovery goals. Our commitment includes:

- Improving communication of the clinical aspects of behavioral health care to improve outcomes and recovery
- Supporting providers in delivering integrated, coordinated physical and behavioral health services to meet the needs of the whole person
- Simplifying precertification rules, referrals, claims and payment processes to help providers reduce administrative time and focus on the needs of enrollees
- Monitoring the quality of the behavioral health provider network in accordance with the standards and expectations outlined in the Amerigroup provider manual
- A team of clinical care managers, case managers and support staff providing high-quality care management and care coordination services to our enrollees, and striving to work collaboratively with all providers
- Amerigroup case management and care coordination teams acting as a liaison between the physical and behavioral health providers to ensure communication occurs between providers in a timely manner, and facilitating coordinated discussions (when indicated) to meet the health outcome goals of the enrollee's care plan

Our experienced behavioral health care staff is available by phone to help identify the closest and most appropriate behavioral health service provider. Providers can call Provider Services at 1-800-454-3730, and enrollees can call Enrollee Services at 1-800-600-4441 for help with finding a provider.

At Amerigroup, our behavioral health care benefit is fully integrated with the rest of our health care programs. This coordination of health care resources requires certain roles and responsibilities for behavioral health providers, including:

- Participating in the care management and coordination process for each Amerigroup enrollee under their care

- Seeking prior authorization for all services that require it.

For more information on prior authorization, visit our provider website at https://providers.amerigroup.com/DC and use our Precertification Lookup Tool to search for services by code.

Behavioral Health Emergency Services

Behavioral health emergency services are those services that are required to meet the needs of an individual who is experiencing an acute crisis resulting from a mental illness, which is at a level of severity that would meet the requirements for involuntary examination and who, in the absence of a suitable alternative or psychiatric medication, would require hospitalization.

Examples of behavioral health and alcohol and drug abuse emergency medical conditions are when:

- The enrollee is suicidal
- The enrollee is homicidal
- The enrollee is violent with objects
- The enrollee has suffered a precipitous decline in functional impairment and is unable to take care of his or her activities of daily living
- The enrollee is alcohol- or drug-dependent and there are signs of severe withdrawal

In the event of a behavioral health and/or alcohol and drug abuse emergency, the safety of the enrollee and others is paramount. The enrollee should be instructed to seek immediate attention at an emergency room or behavioral health and alcohol and drug abuse crisis service facility. An emergency dispatch service or 911 should be contacted in the event that the enrollee is a danger to self or others and is unable to go to an emergency setting.

Behavioral Health Medically Necessary Services

Amerigroup defines medically necessary behavioral health services as those that are:
Reasonably expected to prevent the onset of an illness, condition or disability; reduce or ameliorate the physical, behavioral or developmental effects of an illness, condition, injury or disability; and assist the enrollee to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the enrollee and those functional capacities appropriate for enrollees of the same age
Reasonably expected to provide an accessible and effective course of treatment or site of service that is equally effective in comparison to other available, appropriate and substantial alternatives and is no more intrusive or restrictive than necessary
Sufficient in amount, duration and scope to reasonably achieve their purpose as defined in federal law
Of a quality that meet standards of medical practice and/or health care generally accepted at the time services are rendered

QUALITY ASSURANCE AND PROCESS IMPROVEMENT (QAPI) PROGRAM

Amerigroup is committed to excellence in the quality of care and services provided to our enrollees and our network of providers. Because we are dedicated to improving provider satisfaction, enrollee health status, quality of care and, enrollee satisfaction, we have embedded our Quality Assurance Performance and Process Improvement (QAPI) Program across all aspects of health plan operations.

The purpose of the QAPI Program is to:

- Objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical and behavioral healthcare
- Identify, implement, and evaluate improvement strategies including a Whole Health management approach
- Facilitate organization-wide integration of Quality Assessment and Performance Improvement principles

The QAPI Program's goal is to improve the quality and safety of clinical care and services provided to enrollees through the Amerigroup District of Columbia, Inc. network of providers and its programs and services. Specific goals are established to support the QAPI Program's purpose. The goals are reviewed annually and revised as needed. In addition, Amerigroup works with the District's External Quality Review Organization (EQRO). External Quality Review (EQR) plays an important part in Medicaid and Children's Health Insurance Program (CHIP) managed care quality and accountability. The EQRO, under contract with the District, conducts the annual EQR activities and produces the annual EQR technical report. EQR-related activities are the mandatory and optional activities, as set forth in 42 CFR §438.358, which produce the data and information that the EQRO analyzes when performing the EQR.

As providers, you play a vital role in achieving quality improvement. For more information about the Amerigroup QAPI program or EQRO activites call Provider Services at 1-800-454-3730.

Medical Record Reviews

As part of its Quality Assurance activities, Amerigroup may conduct random sampling of provider medical records to assess documentation in accordance with established standards. Amerigroup may also review quality metrics by provider and communicate specific opportunities for improvement.

Reportable Diseases and Conditions

Amerigroup providers must comply with the reporting of specific conditions and diseases in accordance with the D.C. Code § 7-131, 132 (2006), Title 22 of the D.C. Code of Municipal

Regulations, the District's Childhood Lead Poisoning, Screening and Reporting Legislative Review Emergency Act (2002) and D.C. Code § 7-871.3 (2006).

Providers are also responsible for complying with all reporting requirements related to District registries and programs, including the Cancer Control Registry.

A complete list of reportable communicable diseases is available at https://doh.dc.gov/publication/communicable-and-reportable-diseases.

Examples of reporting requirements, include, but are not limited to reporting of:

- Individuals with vaccine preventable diseases.
- Infants, toddlers, and school-age children experiencing developmental delays
- Individuals with sexually transmitted and other communicable diseases, including HIV
- Individuals diagnosed or suspected of being diagnosed with tuberculosis must be reported within 24 hours.
- Results of all blood lead screening tests to the District of Columbia Department of Health Care Finance (DHCF), District Department of the Environment Division of Childhood Lead Prevention Program and Amerigroup within 72 hours of result.

Enrollee Safety

Amerigroup provides information and resources for providers regarding health care safety and standards. An example of a resource is www.hospitalcompare.hhs.gov, a CMS website providing specific information on hospitals. This user-friendly site compiles quality indicators for all Medicare-certified hospitals and provides a comparison of quality indicators for services rendered by the selected hospital.

CRITICAL INCIDENTS, SENTINEL EVENTS AND NEVER EVENTS

Amerigroup monitors the quality and appropriateness of care provided to its enrollees by hospitals, clinics, physicians, home health care agencies and other providers of health care services. The purpose of monitoring care is to identify those unusual and unexpected occurrences involving death or serious physical or psychological injury, or the possibility of an unexpected event, or which otherwise adversely affects the quality of care and service, operations, assets, or the reputation of Amerigroup. This includes critical incidents, sentinel events and never events, as defined below. The phrase "possibility of" includes any process variation for which an occurrence (as in a 'near miss') or recurrence would carry a significant chance of a serious adverse outcome.

Important definitions include:

- **Sentinel Event** – Real-time identification of an unexpected occurrence that causes an enrollee death or serious physical or psychological injury, or risk thereof, that includes permanent loss of function. This includes medical equipment failures that could have

caused a death and all attempted suicides. These events are referred to as "sentinel" because they signal the need for immediate investigation and response. Please note, the terms "sentinel event" and "medical error" as not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events.

- **Critical Incident** – Retrospective identification of an unexpected occurrence that causes an enrollee death or serious physical or psychological injury, or risk thereof, that includes permanent loss of function. Critical incidents differ from sentinel events only in terms of the timeframe in which they are identified.
- **Never Event** – Reportable adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability. These events are clearly identifiable and measurable. Never events are also considered sentinel events, as defined above.

Providers are expected to report unusual occurrences, including all instances as described above and including near misses, events that require the intervention of law enforcement or security, and/or any event during which an Amerigroup enrollee displays behavior or symptoms leading to the reasonable belief that additional engagement by Amerigroup is necessary to improve the enrollee's wellbeing. All such events must be reported to Amerigroup within 24 hours of occurrence.

Amerigroup will not take punitive action or retaliate against any person for reporting an event or near miss. The practitioners involved will be offered the opportunity to present factors leading to the event and to respond to any questions arising from the review of the event.

Amerigroup Enrollee Hotline

The Enrollee Hotline can be reached at 1-800-600-4441, Monday through Friday from 8 a.m. to 6 p.m. Eastern time. This unit handles, resolves and/or properly refers enrollees' inquiries and complaints to other departments. Additionally, Amerigroup provides enrollees with information about how to access the Enrollee Services department and Consumer Services Hotline to obtain information and assistance.

Enrollee Complaint Policies and Procedures

Amerigroup has written complaint policies and procedures whereby an enrollee dissatisfied with Amerigroup or its network may seek recourse verbally or in writing from the National Call Center Help Line staff. Amerigroup must submit its written internal complaint policies and procedures to the District of Columbia Healthy Families Program for approval.

Enrollee Complaint/Grievance Procedure

A grievance is an oral or written expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a

provider or employee or failure to respect the enrollee's right regardless of whether remedial action is requested.

An enrollee or authorized representative may file a grievance with Amerigroup, either orally, or in writing, at any time.

If enrollees have a question or grievance about their health care, such as not being able to schedule an appointment, the way in which they were treated or having to travel too far to get health care services, they should call Enrollee Services toll-free at 1-800-600-4441 Monday-Friday between 8:00a.m. and 6:00 p.m. The enrollee service representative will:

1. Take the grievance.
2. Answer any questions.
3. Tell the enrollee when he/she will have an answer.
4. Amerigroup has up to 90 days to provide a response to the grievance. Amerigroup may ask for additional time (up to an additional 14 days) to resolve the grievance if requested by the enrollee, provider or if Amerigroup can show that additional time would be beneficial to the enrollee.
5. Amerigroup will provide written acknowledgement of the receipt of the grievance within two business days of receipt.
6. Forward the grievance to the appropriate person, who will:
    a. Investigate the grievance.
    b. Decide what steps will be taken.
    c. Respond to the grievance.

Amerigroup internal complaint materials are developed in a culturally sensitive manner, at a suitable reading comprehension level and in the enrollee's native tongue if the Amerigroup enrollee is also an enrollee of a substantial minority. Amerigroup delivers a copy of its complaint policies and procedures to each new enrollee at the time of initial enrollment and at any time upon request.

The Amerigroup written internal complaint process includes the procedures for registering and responding and grievances in a timely fashion. These procedures include resolving emergency medically related grievances within 72 hours. Amerigroup will respond to standard grievances in writing within ninety (90) calendar days from the time the grievance was received.

In addition, the written procedures:

- Require documentation of the substance of the complaints and steps taken to resolve them.
- Include participation by the provider, if appropriate.
- Allow participation by the ombudsman, if appropriate.
- Ensure the participation of individuals within Amerigroup who have the authority to require corrective action.
- Include a documented procedure for written notification on the outcome of the determination.

- Include a procedure for immediate notice to DCHFP of all disputed denials of benefits or services in emergency medical situations.
- Include a documented procedure for reporting of all complaints received by Amerigroup to appropriate parties.
- Include a protocol for the aggregation and analysis of complaints and grievance data and use of the data for quality improvement.

No punitive action will be taken against the enrollee for making a complaint against Amerigroup or DCHFP.

No punitive action will be taken against a provider for utilizing the provider complaint process, requesting an expedited resolution or supporting an enrollee's appeal.

Appeals

If Amerigroup decides to deny, reduce, limit, suspend, or terminate a service the enrollee is receiving, the enrollee will receive a written Notice of Action.

If the enrollee does not agree with Amerigroup determination as outlined in the Notice of Action, he/she may file an appeal. The enrollee may ask an authorized representative (i.e., his/her doctor, a family enrollee or friend) to file the appeal for them. Or, the provider may file the appeal, with the enrollee's written consent.

The enrollee may also ask for a fair hearing once the Amerigroup appeal process has been exhausted.

If the enrollee wants to file an appeal with Amerigroup, he or she has to file it orally or in writing within 60 calendar days from the date of the adverse determination letter. Providers can also file an appeal for the enrollee if he or she signs a form giving permission to do so. Other people, such as a family enrollee or lawyer, can also help the enrollee file an appeal.

For Pre-Service Authorization denials, a provider can file an appeal on behalf of the enrollee consent utilizing the ICR application and attaching the enrollees consent. Locate the Appeal button for an eligible denied authorization on the ICR Case Overview screen.

An enrollee or provider can also send appeal request or additional information to:
Fax: **866-516-4806**
Email: MedicaidDCGA@amerigroup.com
Mail: Enrollee Appeals
Amerigroup
P.O. Box 62429
Virginia Beach, VA 23466-2429

When reviewing the enrollee's appeal, Amerigroup will:

- Use providers with appropriate clinical expertise in treating the enrollee's condition or disease.
- Not use the same Amerigroup staff to review the appeal that denied the original request for service.
- The provider making the appeal decision will not be subordinate to the previous reviewer or decision maker.
- Make a decision about appeals within 30 calendar days after receipt of the appeal
- The appeal process may take up to 44 days if the enrollee asks for more time to submit information or if Amerigroup needs to obtain additional information from other sources. A notice will be sent to the enrollee if additional information is needed

Expedited Resolution of an Appeal

If the enrollee, enrollee's provider or Amerigroup feels the enrollee's appeal should be reviewed quickly due to the seriousness of the enrollee's condition, the enrollee will receive a decision about the appeal within 72 hours from the date that Amerigroup received the appeal.

If the enrollee's appeal is about a service already authorized and already being received, the enrollee is entitled to have benefits continued as long as the following occur:

- The enrollee files the appeal within 60 days
- 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

Once Amerigroup completes the review, a notice will be sent to the enrollee to advise him or her of the decision. If Amerigroup decided the enrollee should not receive the denied service, that letter will tell the enrollee how to file another appeal through Amerigroup or how to ask for a District Fair Hearing.

District Fair Hearings

Once the Amerigroup process has been exhausted, the enrollee, or their provider with written consent who is the subject of an action may request a District Fair Hearing. Amerigroup will provide each enrollee with information about their right to request a fair hearing, the method by which they may obtain a fair hearing, and their right to represent themselves or to be represented by their family caregiver, legal counsel or other representative. Within five days of receiving notice from DHCF that a fair hearing request has been filed, Amerigroup will submit all documents regarding the action and the enrollee's dispute to DHCF. The District Office of Administrative Hearings will issue a decision within 90 days of the date the enrollee filed the appeal for standard resolution or within three working days for expedited resolution. The District's decision will be final and cannot be appealed by Amerigroup.

While the appeal or District fair hearing is pending, the enrollee is entitled to have his/her benefits continued if the following requirements are met:

- The enrollee requested a fair hearing on or before 10 days of the date on the Notice of Action or on the intended effective date of the proposed action.
- The appeal or fair hearing involves the termination, suspension or reduction of a course of treatment previously authorized by an authorized provider.
- The authorization period has not expired.

If an appeal or fair hearing results in a reversal of a decision to deny, limit or delay services that were not furnished while the appeal was pending, Amerigroup will authorize or provide the disputed services as expeditiously as the enrollee's health condition requires and no later than two business days after the reversal of the decision for standard appeals and services shall begin within 24 hours of the reversal for expedited appeals.

To request a fair hearing:

Write to:
District of Columbia, Office Administrative Hearings
Clerk of the Court
One Judiciary Square
441 Fourth Street, NW
Suite 4150 North
Washington, DC 20001

Telephone to:
202-442-9094

Provider Claim Payment Dispute Process

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

Please be aware there are three 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 an enrollee may have
- Medical necessity appeals: a pre-service appeal for a denied service; for these, a claim has not yet been submitted

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

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

Claim payment reconsideration: This is the first step in the Amerigroup provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.

Claim payment appeal: This is the second step in the Amerigroup provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.

District of Fair Hearing: The District of Columbia supports an external review process if you have exhausted both steps in the Amerigroup payment dispute process but still disagree with the outcome.

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

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

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

We accept reconsideration requests in writing, verbally and through our secure provider website within 90 calendar days from the date on the *EOP* (see below for further details on how to submit). Reconsiderations filed more than 90 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. If a reconsideration requires clinical expertise, the appropriate clinical Amerigroup professionals will review it.

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

We will send you our 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.
- An address to submit the claim payment appeal.
- A statement that the completion of the Amerigroup claim payment appeal process is a necessary requirement before requesting a District of Fair Hearing.

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

Claim Payment Appeal

If you are dissatisfied with the outcome of a reconsideration determination, you may submit a claim payment appeal. Please note, we cannot process a claim payment appeal without a reconsideration on file.

We accept claim payment appeals through our provider website or in writing within 30 calendar days of the date on the reconsideration determination letter.

Claim payment appeals received more than 30 calendar days after the *EOP* or the claims reconsideration determination letter 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 reconsideration determination was in error. If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical Amerigroup professionals.

Amerigroup will make every effort to resolve the claim payment appeal within 30 calendar days of receipt. If additional information is required to make a determination, the determination

date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

We will send you our 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.
- A statement about how to submit a state fair hearing.

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

How to Submit a Claim Payment Dispute

We have several options to file a claim payment dispute:

1. **Verbally** (for reconsiderations only): Call Provider Services at 1-800-454-3730.
2. **Online** (for reconsiderations and claim payment appeals): Use the secure Provider Availity Payment Appeal Tool at https://www.availity.com. Through Availity, you can upload supporting documentation and will receive immediate acknowledgement of your submission.
3. **Written** (for reconsiderations and claim payment appeals): Mail all required documentation (see below for more details), including the *Payment Dispute Form* located in Appendix A – Forms to:
   Payment Dispute Unit
   Amerigroup District of Columbia, Inc.
   P.O. Box 61599
   Virginia Beach, VA 23466-1599

Required Documentation for Claims Payment Disputes

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

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

Claim 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

the claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

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

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact, issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.
- The PSU is available to assist providers in determining the appropriate process to follow for resolving a claim issue. Refer to the Amerigroup quick reference card (QRC) at https://providers.amerigroup.con/DC > Provider Resources & Documents > Manuals and QRCs for guidance on issues considered claim correspondence, which should not go through the payment appeal process.

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 finalize the claim.

Medical Necessity Appeals

A medical necessity appeal is the request for a review of an adverse decision. An appeal encompasses requests to review adverse decisions of care denied (after services are rendered (post service), such as medical necessity decisions, benefit determination related to coverage, rescission of coverage or the provision of care or service.

Amerigroup offers a medical necessity appeal process that provides enrollees, enrollee representatives and providers the opportunity to request and participate in the re-evaluation of adverse actions. The enrollee, enrollee representatives and providers will be given the opportunity to submit written comments, medical records, documents or any other information relating to the appeal. Amerigroup will investigate each appeal request, gathering all relevant facts for the case before making a decision. Appeal letters and other related clinical information should be sent to within 60 calendar days from the date of the denial or EOP.

Appeals can be submitted through the ICR application. Locate the Appeal button for an eligible denied authorization on the ICR Case Overview screen
Fax: **866-516-4806**
Email: MedicaidDCGA@amerigroup.com
Mail: Provider Appeals

Amerigroup
P.O. Box 61599
Virginia Beach, VA 23466-2429

District of Columbia Fair Hearings

The District shall grant an opportunity for a fair hearing to any enrollee who is the subject of an adverse benefit determination once the enrollee has exhausted the Amerigroup appeal process.

Amerigroup shall notify the enrollee or the enrollee's designee of the right to a fair hearing with a District Administrative Hearing Officer at the time of any adverse benefit determination affecting an enrollee's claim.

For appeals not resolved wholly in favor of the enrollee, Amerigroup will inform the enrollee of:

- The enrollee's right to request a district fair hearing and how to do so
- The enrollee's right to receive benefits while the Fair Hearing is pending and how to assure continuation of benefits

The parties to a District fair hearing include Amerigroup as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

Amerigroup will designate an individual responsible for the Amerigroup defense of the adverse benefit determination at issue.

CONTACT INFORMATION

Important Telephone Numbers

Department of Health Care Finance

Enrollee Enrollment:	1-202-727-5355
Office of Program Operations:	1-202-698-2000
Provider Inquiry:	1-202-906-8319

Amerigroup Phone Numbers

Provider Services (telephone):	1-800-454-3730
Provider Services (fax):	1-800-964-3627
Interpretive Services:	1-800-454-3730
Provider Inquiry Line:	1-800-454-3730
Nurse HelpLine:	1-866-864-2544
Enrollee Services:	1-800-600-4441
TTY Relay Line:	711

Call **Amerigroup Provider Services** for:
Precertification
Health plan network information
Enrollee eligibility
Claims information
Inquiries or enrollee issues
Suggestions you may have to improve Amerigroup processes

Other Services

Transportation: Medical Transportation Management, Inc. (MTM)
Provider Services: 1-888-828-1071
Enrollee Services: 1-888-828-1081

Vision: Avesis
Provider Services: 1-833-554-1013
Enrollee Services: 1-833-554-1012

Dental: Avesis
Provider and Enrollee Services: 1- 855-214-6777

The Amerigroup website (https://providers.amerigroup.com) has general information for providers such as forms, the preferred drug list (PDL) and credentialing and recredentialing information.

Claims processing information

Dental	Avesis Third Party Administrators, Inc. Attn: Dental Claims P.O. Box 7777 Phoenix, Arizona 85011-7777 12121 N. Corporate Parkway Mequon, WI 53092 1-800-341-8478
Pharmacy	CarelonRx P.O. Box 52065 Phoenix, AZ 85072-2065 1-800-600-4441 (Amerigroup Enrollee Services)
Vision	Avesis Claims Department P.O. Box 38300 Phoenix AZ 85069-8300

ENROLLEE RIGHTS AND RESPONSIBILITIES

Amerigroup is committed to ensuring enrollees are treated in a manner that acknowledges their rights and responsibilities.

Amerigroup enrollees have the right to:

- Be treated with respect and dignity.
- Know that when they speak with providers, it's private.
- Have an illness or treatment explained to them in a language they can understand.
- Participate in decisions about their care.
- Receive a full, clear and understandable explanation of treatment options and risks of each option so they can make an informed decision, regardless of cost or whether it is part of covered benefits.
- Refuse treatment or care.
- Be free of physical and chemical restraints except for emergency situations.
- Be free of restraint or seclusion used as coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraint and seclusion.
- See their medical records and request a change if incorrect.
- Choose an eligible primary care provider/primary dental provider (PCP/PDP) from within the Amerigroup network and to change their PCP/PDP.
- Make a grievance about the organization or care provided to them and receive an answer.
- Request an appeal or a fair hearing if they believe Amerigroup was wrong in denying, reducing or stopping a service or item.
- Receive family planning services and supplies from the provider of their choice.
- Obtain medical care without unnecessary delay.
- Receive information on advance directives and choose not to have or continue any life-sustaining treatment.
- Receive a copy of the Amerigroup enrollee handbook and/or provider directory.
- Receive information about our practitioners and other providers.
- Continue treatment they are currently receiving until they have a new treatment plan.
- Receive interpretation and translation services free of charge.
- Refuse oral interpretation services.
- Receive transportation services free of charge.
- Get an explanation of prior authorization procedures.
- Receive information about the Amerigroup organization, its services, its practitioners and providers, financial condition, and any special ways we pay providers.
- Receive information on their rights and responsibilities.
- Obtain summaries of customer satisfaction surveys.
- Receive the Amerigroup "Dispense as Written" policy for prescription drugs.
- Receive a list of all covered drugs.
- Make suggestions to Amerigroup about the rights and responsibilities policy.

- Furnished health care services that are available and accessible in a timely manner; coordinated; sufficient in amount, duration, or scope; and provided in a culturally competent manner, in order to meet the enrollee's specific needs.
- Be free to exercise his or her rights and that the exercise of those rights does not adversely affect the way Amerigroup or its network provider, sub-contractors, or the District of Columbia treat the enrollee.
- Obtain services from an out of network provider when the provider network is unable to provide the necessary services, for as long as the provider network is unable to provide them.
- Obtain a second opinion from a qualified health professional within the network or, if necessary, arrange for the enrollee to obtain one outside the network at no cost to the enrollee.

Amerigroup enrollees have the responsibility to:

- Treat those providing care with respect and dignity.
- Follow the rules of the DC Medicaid Managed Care Program and Amerigroup.
- Follow plans and instructions they have agreed to with their providers.
- Tell providers about their health conditions.
- Work as a team with providers in deciding what health care is best for them and developing mutually agreed-upon treatment goals.
- Go to scheduled appointments.
- Tell providers at least 24 hours before the appointment if they must cancel appointments.
- Ask for more explanation if they do not understand a provider's instructions.
- Go to the emergency room only if they have a medical emergency.
- Tell their PCP/PDP about medical and personal problems that may affect their health.
- Report to Economic Security Administration (ESA) and Amerigroup if they or a family member have other health insurance or if they have a change in address or phone number.
- Report to ESA and Amerigroup if there is a change in family (i.e., deaths, births, etc.).
- Try to understand their health problems, supply this information and participate in developing treatment goals.
- Help providers in getting medical records from providers who have treated them in the past.
- Tell Amerigroup if they were injured as the result of an accident or at work.

Amerigroup will provide enrollees notice of any change that the Department of Healthcare Finance defines as significant at least 30 days before the intended effective date of the change.

DISCLAIMERS

* Availity, LLC is an independent company that administers the secure provider portal on behalf of the health plan.

* Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan.

* CoverMyMeds is an independent company providing electronic prior authorization services on behalf of the health plan.

* Avesis is an independent company providing dental and vision services on behalf of the health plan.

* LabCorp and Quest Diagnostics are independent companies providing laboratory and radiology services on behalf of the health plan.

* MTM is an independent company providing nonemergency transportation services on behalf of the health plan.

GLOSSARY OF TERMS

Abuse: Provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to the Medicaid program or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care; abuse also includes enrollee practices that result in unnecessary cost to the Medicaid program.

Action: Denial or limited authorization of a requested service, including the type or level of service; reduction, suspension or termination of a previously authorized service; a denial, in whole or part, of payment for a service; failure to provide services in a timely manner; failure of Amerigroup to act within the required time frames.

ACIP: Advisory Committee in Immunization Practices. A federal advisory committee convened by the Center for Disease Control, Public Health Service, Health and Human Services to make recommendations on the appropriate use and scheduling of vaccines and immunizations for the general public.

Adjudicate: Payment or denial of a clean claim

Administrative denial: 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, lack of precertification or failure by the provider to submit clinical when requested.

Adverse benefit determination: The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirement for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction,

suspension, or termination of a previously authorized service; or the denial, in whole or in part, of payment for a service.

Advance directive: a written instruction, such as a living shall or durable power of attorney for health care, recognized under District of Columbia law (whether statutory or as recognized by the courts of the District), relating to the provision of health care when the individual is incapacitated.

Alternative birthing center: A facility offering a nontraditional setting for giving birth; while alternative birthing centers can range from freestanding centers to special areas within hospitals, birthing centers are generally known for a more comfortable, home-like atmosphere, allowing more participation by the other parent and more procedural flexibility than commonly found in hospital births.

Ambulatory care: A general term for care that does not involve admission to an inpatient hospital bed. Visits to a doctor's office are a type of ambulatory care.

Ancillary care: Diagnostic and/or support services (e.g., radiology, physical therapy, pharmacy or laboratory work)

Appeal: A request to review an adverse benefit determination

Assertive community treatment (ACT): Intensive, integrated rehabilitative, crisis, treatment and mental health rehabilitative community support provided by an interdisciplinary team to children and youth with serious emotional disturbance and to adults with serious and persistent mental illness by an interdisciplinary team. ACT is provided with dedicated staff time and specific staff to consumer ratios. Service coverage by the ACT team is required twenty- four (24) hours per day, seven (7) days per week. ACT is a specialty service. More information: 29 DCMR § 3499

Behavioral care services: Assessment and therapeutic services used in the treatment of mental health and substance use disorders

Benefits: List of health and related services provided in a health plan

Business day: Any day other than a Saturday, Sunday, or holiday recognized by the federal government or the District

Brand-name drug: Drug manufactured by a pharmaceutical company that has chosen to patent the drug's formula and register its brand name

Capitation: A method of payment in which a provider receives a fixed per enrollee per month (PMPM) amount of reimbursement, regardless of the services used by the enrolled enrollee

Care coordination: Services that ensure all Medicaid, Alliance and ICP Enrollees gain access to necessary medical, social and other health-related services (including education-related health services)

Care plan: A multidisciplinary care plan for each enrollee in case management. It includes specific services to be delivered, the frequency of services, expected duration, community resources, all funding options, treatment goals, and assessment of the Enrollee environment. The plan is updated at least annually and when the Enrollee condition changes significantly. The plans are developed in collaboration with the attending physician and Enrollee and/or Guardian/personal representative.

Case management plan: Comprehensive plan that must include: an assessment of an eligible individual, development of a specific care plan, referral to services including the coordination of such services, and monitoring the activities of the individual and effectiveness of services rendered. More information found in 42 C.F.R. § 440.169.

Centers for Medicare & Medicaid Services (CMS): Federal agency responsible for administering Medicare and federal participation in Medicaid

Certified nurse midwife: A registered professional nurse who is licensed under District of Columbia Health Occupations Regulatory Act and acting within the scope of his/her practice and complies with the requirements set forth in 42 C.F.R. §440.165.

Children with special health care needs: A child under 21 who has a chronic, physical, developmental or behavioral condition and requires health and related services of a type or amount beyond that which is required by children generally, including a child who receives Supplemental Security Income (SSI), a child whose disabilities meets the SSI definition, a child in foster care and a child with developmental delays or disabilities who needs special education and related services under the individuals with Disabilities Education Act.

Claim: A bill for services, a line item of service, or all services for one beneficiary within a bill.

Clean claim: a claim that can be processed without obtaining additional information from the Provider of the service or from a third party. It includes a claim with errors originating in the District's claims system. It does not include a claim from a Provider who is under investigation for Fraud or abuse, or a claim under review for Medical Necessity.

Clinical Laboratories Improvement Act (CLIA): Federal legislation found in Section 353 of the federal Public Health Services Act, including regulations adopted to implement the Act

Community-based intervention (CBI) services: Time limited, intensive mental health services delivered to children and youth ages 6 through 20 and intended to prevent the utilization of an out-of-home therapeutic resource or a detention of the consumer, as defined in 29DCMR § 3499. CBI is primarily focused on the development of consumer skills to promote behavior

change in the child or youth's natural environment and empower the child or youth to cope with his or her emotional disturbance.

Community support services: Rehabilitation and environmental support considered essential to assist a consumer in achieving rehabilitation and recovery goals. Community support services focus on building and maintaining a therapeutic relationship with the consumer. More information in 29 DCMR § 3499.

Complaint: Expression of dissatisfaction that results in either an appeal or a grievance

Concurrent review: A review to determine extending a previously approved, ongoing course of treatment or number of treatments. Concurrent reviews are typically associated with inpatient care, residential Behavioral Health care, intensive outpatient Behavioral Health care and ongoing ambulatory care.

Condition Care and Condition Care programs: A multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions. Condition care supports the practitioner-enrollee relationship and plan of care, and emphasizes prevention of complications using cost-effective, evidence-based practice guidelines and enrollee empowerment strategies such as self-management. The organization's condition-specific package of ongoing services and assistance that includes education and interventions.

Consultation: Discussion with another health care professional when additional feedback is needed during diagnosis or treatment; consultation is usually by PCP referral

Coordination of Benefits (COB): Contract provision that applies when a person is covered under more than one group's health benefits program. COB requires payment of benefits be coordinated by all programs to eliminate duplication of benefits.

Copayment (copay): Amount an enrollee pays at the time of service (i.e., predetermined fees for provider office visits, prescriptions or hospital services)

Core Services Agency: Provider that contracts with the Department of Behavioral Health to provide mental health rehabilitation services.

Covered services: The items and services, transportation, and case management services described herein that, taken together, constitute the services that Amerigroup must provide to enrollees under District and federal law.

D.C. Health Care Alliance: A public program designed to provide medical assistance to needy District residents who are not eligible for federally-financed Medicaid benefits. The Alliance provides comprehensive coverage of health care services for eligible residents of the District.

Department of Health Care Finance (DHCF): The Agency within the District of Columbia Government responsible for administering all Medicaid services under Title XIX (Medicaid) and Title XXI (CHIP) of the Social Security Act, for eligible beneficiaries, including the DC Medicaid Managed Care Program and oversight of its managed care contractors, as well as the Alliance and including all agents and Contractors of DHCF. For purposes of the contract, the CA shall be authorized to act on behalf of DHCF unless other individuals are specifically otherwise noted.

Department of Behavioral Health (DBH): The Department of Behavioral Health provides prevention, intervention and treatment services and supports for children, youth and adults with mental and/or substance use disorders including emergency psychiatric care and community-based outpatient and residential services. DBH serves eligible adults, children and youth and their families through a network of community based Providers and unique government delivered services. It operates Saint Elizabeth's Hospital—the District's inpatient psychiatric facility.

Developmental delay: When a child does not reach their developmental milestones at the expected times. It is an ongoing major or minor delay in the process of development. This includes delays with intellectual disability, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities.

Discharge planning: Identifying an enrollee's health care needs after discharge from inpatient care

District of Columbia Healthy Families Program (DCHFP): District of Columbia Healthy Families Program is the District's combination of the Medicaid program and the Children's Health Insurance Program (CHIP).

Disenrollment: Terminating enrollee participation in a health plan

Durable medical equipment: Medical equipment that can withstand repeated use, is primarily and customarily used to serve a purpose consistent with the amelioration of physical, mental, or developmental conditions that affect healthy development and functioning, is generally not useful in the absence of a physical, mental, or developmental health condition, and is appropriate for use in a home or community setting.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services: The health benefit for individuals under age 21, combined with informational, scheduling and transportation services required under federal law. The EPSDT benefit is defined in 42 U.S.C. §§1396a (a)(43), 1396d(a)(4)(B), and 1396d(r). The EPSDT benefit encompasses regularly scheduled assessments beginning at birth and continuing through age 20 inter-periodic (as needed) assessments when

a physical, developmental, or mental condition is suspected, comprehensive vision care (including regularly scheduled and as needed eye exams and eyeglasses), hearing care (including regularly scheduled and as-needed exams and hearing aids and batteries), dental care needed to treat emergencies, restore the teeth and maintain dental health and the items and services set forth in 42 U.S.C. § 1396d(a) that are needed to meliorate or correct any physical or mental condition identified through a periodic or inter-periodic assessment, whether or not included in the District's State Medicaid Plan.

Eligible: Qualifying for coverage under a health plan

Emergency medical condition: A medical condition characterized by sudden onset and symptoms of sufficient severity, including severe pain, where the absence of immediate medical attention could reasonably be expected by a prudent layperson possessing an average knowledge of health and medicine to result in placing the enrollee's health, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy

Emergency services: Health care services provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, where the absence of immediate medical attention could reasonably be expected by a prudent layperson possessing an average knowledge of health and medicine to result in placing the enrollee's health or with respect to a pregnant enrollee, the health of the enrollee, or her unborn child, in serious jeopardy.

Experimental treatment: Diagnostic or treatment services that, in accordance with relevant evidence, are not considered to fall within the range of professionally accepted clinical practice with respect to illness, disability, or condition that is the focus of a coverage determination.

Extended care facility (ECF): Medical care institution for enrollees who require long-term custodial or medical care, especially for chronic disease or a condition requiring prolonged rehabilitation therapy

Fair hearing: An administrative process run by the District of Columbia that gives applicants and Enrollees the opportunity to contest adverse benefit determinations regarding eligibility and benefits.

Federally qualified health center (FQHC): CMS-certified medical facility that meets the requirements of §1861 (aa) (3) of the Social Security Act as a federally qualified health center and is enrolled as a provider in the Medicaid program

Fee-for-service (FFS): Payment to Providers on a per-service basis for health care services provided to Medicaid beneficiaries not enrolled in a Medicaid Managed Care Program.

Formulary: List of preferred, commonly prescribed prescription covered drugs chosen by a team of doctors and pharmacists because of their clinical superiority, safety, ease of use and cost

Fraud: As defined in 42 C.F.R. § 455.2, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes Fraud under applicable federal, State, or District law.

Generic drug: Prescription drug with the same active ingredient formula as a brand name drug; known only by its formula name, and its formula is available to any pharmaceutical company; rated by the Food and Drug Administration (FDA) to be as safe and effective as brand name drugs and are typically less costly

Grievance: An oral or written expression of dissatisfaction about any matter other than as adverse benefit determination.

Health maintenance organization (HMO): Organization that arranges a wide spectrum of health care services (e.g., hospital care, providers' services and many other kinds of health care services with an emphasis on preventive care)

Health maintenance services: Health care service or program that helps maintain an enrollee's good health; include all standard preventive medical practices (e.g., immunizations and periodic examinations, health education and special self-help programs)

Health education: Consciously constructed opportunities for learning, involving some form of communication designed to improve health literacy, including improving knowledge and developing life skills, which are conducive to individual and community health. Health education as not limited to the dissemination of health-related information but also "fostering the motivation, skills and confidence (self-efficacy) necessary to take action to improve health", as well as "the communication of information concerning the underlying social, economic and environmental conditions impacting on health, as well as individual risk factors and risk behaviors and use of the health care system.

Health Check Provider Training Module: A web-based EPSDT Provider training used for the EPSDT and IDEA Provider training requirements of Health Check Providers. See EPSDT Services for a review of topic content.

Health home:

Programs: A service delivery model that focuses on providing individualized, person-centered recovery oriented case management and care coordination.
Provider: Core Services Agency that has been certified as a DC Medicaid health home provider by the DC Department of Behavioral Health (DBH).

Services: Addresses the full spectrum of individuals' health needs (i.e., primary care, behavioral health, specialty services, long-term care services and supports). There are six types of core health home services that DC Medicaid health home providers must deliver at a minimum.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Federal legislation establishing health insurance portability and coverage protections for qualified individuals and authorizing the promulgation of federal regulations related to health information privacy, health information security, information simplification, and the transfer of electronic health information among health care payers, plans, and Providers and certain third parties. HIPAA also refers to the federal regulations promulgated in at 45 C.F.R. § 160-164.

Identification (ID) card: Provided to all enrollees for proper identification under Amerigroup; ID card information helps providers verify enrollee eligibility for coverage

Immigrant child: As defined in 29 DCR §7399, any child who is ineligible for Medicaid by virtue of the child's immigration status.

Immigrant Children's Program (ICP): In accordance with 29 DCR § 57A00, a health coverage program that is offered to children under age twenty-one (21), who are not eligible for Medicaid due to citizenship or immigration status who meet the income guidelines as determined by the Economic Security Administration. The beneficiaries enrolled in the ICP are only eligible for medical services when enrolled in a managed care organization.

Individuals with Disabilities Education Act (IDEA): Federal law governing the rights of infants and toddlers to receive Early Intervention and the educational rights of school-age children and youth with education-related disabilities.

Individualized education program (IEP): A legally binding document that describes the educational program that has been designed to meet that child's unique needs in accordance with the IDEA that is developed, reviewed, and revised in a meeting in accordance with 34 C.F.R. §300.320 through 300.324.

Individualized Family Service Plan (IFSP): A legally binding document that guides the Early Intervention process for children with disabilities and their families in accordance with the IDEA.

Inpatient care: Care given to an enrollee who is admitted to a hospital, extended care facility, nursing home or other facility.

Inpatient mental health service: Residence and treatment provided in a psychiatric hospital or unit licensed or operated by the District of Columbia.

Intensive day treatment: Facility-based, structured, intensive mental health, and coordinated acute treatment program which serves as an alternative to acute inpatient treatment or as a

step-down service from inpatient care. Its duration is time-limited. Intensive Day Treatment is provided in an ambulatory setting.

Intensive outpatient program services (IOP): A structured, intensive, mental health outpatient treatment program which serves as a step up from outpatient services or a step down service from inpatient hospital care, intensive day services, or Partial Hospitalization. Services are rendered by an interdisciplinary team to provide stabilization of psychiatric impairments to enrollees that typically cannot be stabilized with outpatient therapy.

Interpreter: An individual who is proficient in both English and another language who has had orientation or training in the ethics of interpreting, the ability to interpret accurately and impartially, and has the ability to interpret for medical Encounters using medical terminology in English and his/her other non-English language.

Limited or no English proficiency individual: An individual whose primary language is other than English and as a result, does not speak, read, write, or understand the English language at a level that permits effective interaction with Contractor or its Provider network.

Long-term care: Services typically provided at skilled nursing, intermediate care, personal care or elder care facilities

Managed care organization (MCO): Managed care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs).

Medicaid: Federal program that provides payment of medical expenses for eligible persons who meet income and/or other criteria.

Medical record: Documents, whether created or stored in paper or electronic form, which correspond to and contain information about the medical health care, or allied care, goods, or services furnished in any place of service. The records may be on paper or electronic. Medical records must be dated, signed, or otherwise attested to (as appropriate to the media) and be legible.

Medically necessary: Services for individuals that promote normal growth and development and prevent, diagnose, detect, treat, ameliorate the effects or a physical, mental, behavioral, genetic, or congenital condition, injury, or disability and in accordance with generally accepted standards of medical practice including clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the enrollee’s illness, injury, disease, or physical or mental health condition.

Medicare: Title XVIII of the Social Security Act that provides payment for medical and health services to individuals age 65 and older, regardless of income, as well as certain disabled persons and persons with end-stage renal disease (ESRD)

Mental health and substance use disorder services: Services for the treatment of mental or emotional disorders and treatment of chemical dependency disorders.

Mileage and travel time standards: A source of treatment within five (5) miles of an enrollee Enrollee's residence or no more than thirty (30) minutes Travel Time.

National Committee for Quality Assurance (NCQA): Independent, nonprofit organization that assesses the quality of managed care plans, managed behavioral health care organizations and credential verification organizations

Network: Group of contracted or employed health care providers by the health plan to provide covered services to enrollees.

Out-of-area benefits: Benefits the health plan provides to enrollees for covered services obtained outside of the network service area

Outpatient care: Health care service provided to an enrollee not admitted to a facility; may be provided in a provider's office, clinic, enrollee's home or hospital outpatient department

Physical therapy: Rehabilitation concerned with the restoration of function and prevention of physical disability following disease, injury or loss of a body part

Post-stabilization care services: Covered services related to an emergency medical condition provided after an enrollee is stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 CFR 438.114(e) as amended, to improve or resolve the enrollee's conditions

Preadmission certification: Assessment conducted prior to elective inpatient hospital care to determine whether the proposed health care services meet the medical necessity criteria under a health plan

Prescription drug: FDA-approved drug that can only be dispensed according to a provider's prescription order

Preventive care: Medical and dental services aimed at early detection and intervention

Primary care: Basic, comprehensive, routine level of health care typically provided by an enrollee's general or family practitioner, internist, or pediatrician

Primary care provider (PCP): Family or general practitioner, internist, pediatrician, OB/GYN (for pregnant women only), nurse practitioner or specialists designated as PCPs (with the approval of an Amerigroup medical director) who provides a broad range of routine medical services and refers enrollees to specialists, hospitals and other providers as necessary

Primary dental provider: A dental professional who provides comprehensive oral health by treating dental concerns and diseases and promotes prevention and oral health literacy.

Prior approval: Permission needed from a PCP or the health plan before a service can be delivered or paid

Provider directory: Listings of providers who have contracted with a managed care network to provide care to its enrollees; enrollees use to select network providers

Psychiatric residential treatment facility (PRTF): In accordance with 42 C.F.R.§483.352, a facility other than a hospital that provides inpatient psychiatric services to individuals under age 21.

Referral: When a PCP determines an enrollee has a condition that requires the attention of a specialist

Residential treatment facility: 24-hour treatment facility primarily for children with significant behavioral problems that need long-term treatment.

School-based health center: A health care site located on school building premises which provides, at a minimum, on-site, age-appropriate primary and preventive health services with parental consent, to children in need of primary health care.

Service area: Geographical area covered by a network of health care providers

Severe mental illness (SMI): Diagnosable mental, behavioral, or emotional disorder (including those of biological etiology) which substantially impairs the mental health of the person or is of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) or its international Statistical Classification of Diseases and Related Health Problems, 9th Revision (ICD-9-CM) equivalent (and subsequent revisions) with the exception of DSM-IV “V” codes, substance abuse disorders, intellectual disabilities and other developmental disorders, or seizure disorders, unless those exceptions co-occur with another diagnosable mental illness.

Somatic: Physical

Specialists: Providers whose practices are limited to treating a specific disease (e.g., oncologists), specific parts of the body (e.g., ear, nose and throat specialists), a specific age group (e.g., pediatrician) or specific procedures (e.g., oral surgery)

Substance abuse treatment services: Management and care of an enrollee suffering from alcohol or drug abuse, a condition which is identified as having been caused by that abuse, or both, in order to reduce or eliminate the adverse effects upon the enrollee.

Transportation services (non-emergency): Mode of transportation that is appropriate to an Enrollee's medical needs. Acceptable forms of transportation include, but are not limited to bus, subway, or taxi vouchers, wheel chair vans, and ambulances.

Travel time: The time required in transit to travel to a source of treatment from the enrollee's residence. Travel Time does not include the time that is spent waiting for the arrival of regularly scheduled public transportation vehicles (i.e., bus or metro) but does include waiting times for specially arranged modes of transportation including wheelchair vans, ambulances, and taxis.

Urgent medical care: The diagnosis and treatment of a medical condition, including mental health and/or substance use disorder which is severe and/or painful enough to cause a prudent layperson possessing an average knowledge of medicine to believe that his or her condition requires medical evaluation or treatment within 24 hours in order to prevent serious deterioration of the individual's condition or health. Contractors shall provide urgent medical care within 24 hours of an enrollee's request.

APPENDIX A – FORMS

The rest of this page is intentionally left blank.

Specialist as PCP Request Form

Date: _____

Enrollee name: _____

Enrollee ID number: _____

PCP name (if applicable): _____

Specialist/specialty: _____

Enrollee diagnosis: _____

Describe the medical justification for selecting a specialist as the PCP for this enrollee.

_____

_____

_____

_____

_____

The signatures below indicate agreement by the specialist, Amerigroup and the enrollee that the specialist will function as this enrollee's PCP, including providing to the enrollee 24 hours a day, 7 days a week access.

Specialist signature: _____ Date: _____

Medical director signature: _____ Date: _____

Enrollee signature: _____ Date: _____

Living Will

You can make a living will by completing this form. You can choose another form or use the one your doctor gives you. If you make a living will, give it to your Amerigroup network provider. If you need help to understand or complete this form, call Enrollee Services at 1-800-600-4441.

I, (*Print your name here*) _____, am of sound mind. I want to have what I indicate here followed. I am writing this in the event something happens to me and I cannot make decisions about my medical care. These instructions are to be used if I am not able to make decisions. I want my family and doctors to honor what I say here. These instructions will tell what I want to have done if 1) I am in a terminal condition (going to die), or 2) I am permanently unconscious and have brain damage that is not going to get better. If I am pregnant and my doctor knows it, then my instructions here will not be followed during the time I am still pregnant and the baby is living.

TREATMENT I DO **NOT** WANT
I do not want (put your initials by the services you do not want):
_____Cardiac resuscitation (start my heart pumping after it has stopped)
_____Mechanical respiration (machine breathing for me if my lungs have stopped)
_____Tube feeding (a tube in my nose or stomach that will feed me)
_____Antibiotics (drugs that kill germs)
_____Hydration (water and other fluids)
_____Other (indicate what it is here)

TREATMENT I **DO** WANT
I want (put your initial by the services you do want):
_____Medical services
_____Pain relief
_____All treatment to keep me alive as long as possible
_____Other (indicate what it is here)
_____

What I indicate here will happen, unless I decide to change it or decide not to have a living will at all. I can change my living will anytime I wish. I just have to let my doctor know I want to change it or forgo a living will entirely.
Signature: _____
Date: _____
Address: _____

Statement of witness
I am not related to this person by blood or marriage. I know that I would not get any part of the person's estate when he or she dies. I am not an enrollee in the health care facility where this person is an enrollee. I am not a person who has a claim against any part of this person's estate when he or she dies. Furthermore, if I am an employee of a health facility in which this person is an enrollee, I am not involved in providing direct enrollee care to him or her. I am not directly involved in the financial affairs of the health facility.

Witness: _____
Date: _____
Address: _____

Durable Power of Attorney

You can name a durable power of attorney by filling out this form. You can use another form or use the one your doctor gives you. If you name a durable power of attorney, give it to your Amerigroup network provider. If you need help to understand or complete this form, call Enrollee Services at 1-800-600-4441.

I, (*Name*) **_____, want**
_____ _____,
(*Name of person I want to carry out my wishes*) (*Person's address*)

to make treatment decisions for me if I cannot. This person can make decisions when I am in a coma, not mentally able to or so sick I just cannot tell anyone. If the person I named is not able to do this for me, then I name another person to do it for me. This person is
_____ _____.
(*Name of second person I want to carry out my wishes*) (*Second person's address*)

TREATMENT I DO **NOT** WANT
I do not want (put your initials by the services you do not want):
_____Cardiac resuscitation (start my heart pumping after it has stopped)
_____Mechanical respiration (machine breathing for me if my lungs have stopped)
_____Tube feeding (a tube in my nose or stomach that will feed me)
_____Antibiotics (drugs that kill germs)
_____Hydration (water and other fluids)
_____Other (indicate what it is here)
_____

TREATMENT I **DO** WANT
I want (put your initial by the services you do want):
_____Medical services
_____Pain relief
_____All treatment to keep me alive as long as possible
_____Other (indicate what it is here)

What I indicate here will happen, unless I decide to change it or decide not to have a durable power of attorney at all. I can change my durable power of attorney anytime I wish. I just have to let my doctor know I want to change it or not have it at all.
Signature: _____
Date: _____
Address: _____

Statement of witness
I am not related to this person by blood or marriage. I know that I would not get any part of the person's estate when he or she dies. I am not an enrollee in the health care facility where this person is an enrollee. I am not a person who has a claim against any part of this person's estate when he or she dies. Furthermore, if I am an employee of a health facility in which this person is an enrollee, I am not involved in providing direct enrollee care to him or her. I am not directly involved in the financial affairs of the health facility.

Witness: _____ Date: _____
Address: _____

Provider Payment Dispute and Correspondence Submission Form

This form should be completed by providers for payment disputes and claim correspondence only.

Enrollee first/last name _____ Date of birth _____

Enrollee Amerigroup, Medicaid or Medicare ID (circle one) _____

Provider first/last name_____ NPI #_____
☐ Participating ☐ Nonparticipating*

* If filing for a Medicare enrollee and the enrollee has potential financial liability, you must include a completed CMS Waiver of Liability form.

Provider contact first/last name_____ Contact phone (____) _____

Provider street address_____

City_____ State_____ ZIP_____ Phone (_____) _____

Claim #_____ Billed amount $_____ Amount received $_____

Start date of service _____ End date of service _____ Auth #_____

To ensure timely and accurate processing of your request, please complete the payment dispute or claim correspondence section below by checking (✓) the applicable determination or request reason provided on the Amerigroup determination letter or Explanation of Payment (EOP).

PAYMENT DISPUTE: Check (✓) One → ☐ **First-level dispute** ☐ **Second-level dispute**
A payment dispute is defined as a dispute between the provider and Amerigroup in reference to a claim determination where the enrollee cannot be held financially liable. All disputes with enrollee liability must follow the applicable appeals process. Please refer to the EOP to ensure you are following the correct process.

Clearly and completely indicate the payment dispute reason(s). You may attach an additional sheet if necessary. **Please include appropriate medical records**.

CLAIM CORRESPONDENCE: Check (✓) appropriate box below.
Claim correspondence is defined as a request for additional and/or needed information for a claim to be considered clean, to be processed correctly or for a payment determination to be made.

☐ **Itemized bill/medical records** (In response to an Amerigroup claim denial or request)

☐ **Corrected claim** ☐ **Other insurance/third-party liability information** ☐ **Other correspondence**

Clearly and completely indicate the reason(s) for your correspondence. You may attach an additional sheet, if necessary. Mail this form and supporting documentation to:

Payment Disputes
Amerigroup District of Columbia, Inc.
P.O. Box 61599
Virginia Beach, VA 23466-1599

APPENDIX B – CLINICAL GUIDELINES

As part of its quality improvement process, Amerigroup adopts nonpreventive and preventive clinical practice guidelines for acute and chronic medical and behavioral health conditions that are scientific and evidenced-based. This is determined by scientific evidence, review of government research sources, review of clinical or technical literature, involvement of board-certified practitioners from appropriate specialties or professional standards. Recognized sources of the evidenced-based guidelines include national organizations such as the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH), professional medical-specialty organizations such as the American Academy of Pediatrics (AAP), American College of Obstetrics and Gynecologists (ACOG), American Academy of Family Practice (AAFP) and voluntary health organizations as the American Diabetes Association (ADA) and American Cancer Society (ACS). The American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), Texas Implementation of Medication Algorithm (TIMA) and Texas Medicaid Algorithm Project (TMAP) are currently more specific sources recognized for behavioral health guidelines. Other sources that may be referenced in developing or updating behavioral health guidelines include organizations such as the Substance and Mental Health Services Administration (SMHSA) and National Institute of Mental Health (NIMH). The guidelines are based on valid and reliable clinical evidence, a consensus of health care professionals in a particular field and the needs of the enrollees. The guidelines are adopted and approved in consultation with network health care professionals. They are reviewed and updated periodically as appropriate, but at a minimum of every two years. Amerigroup will disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. The Amerigroup decisions regarding disease management, case management, utilization management, enrollee education, coverage of services and other areas included in the guidelines, will be consistent with Amerigroup guidelines. Data is gathered and monitored using HEDIS, ad hoc medical records review and other sources to measure performance against the guidelines and improve the clinical care process.

Visit https://providers.amerigroup.com/DC and log in to the secure site by entering your login name and password. On the homepage, go to *Clinical Policy & Guidelines* and select **Clinical Practice Guidelines**. A copy of the guidelines can be printed from the website or you can contact Provider Services at 1-800-454-3730 to receive a copy.