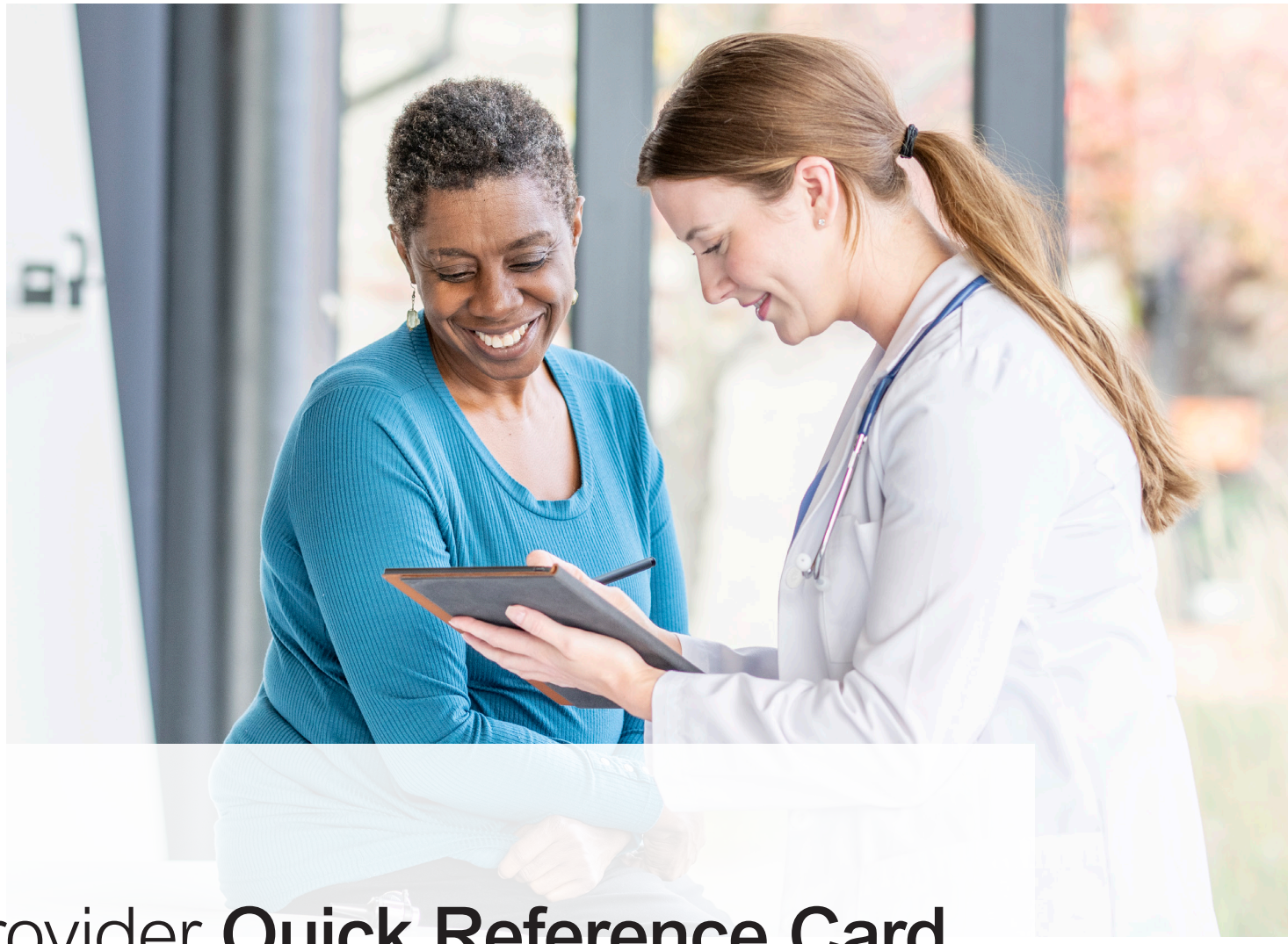
Amerigroup
District of Columbia

Medicaid



Provider **Quick Reference Card**

Precertification/notification requirements | Important phone numbers | Revenue codes

Easy access to precertification/notification requirements and other important information

For more information about requirements, benefits, and services, visit our provider self-service website to get the most recent full version of our provider manual. If you have questions about this Amerigroup District of Columbia, Inc. Quick Reference Card (QRC) or recommendations to improve it, call your local provider relationship management representative. We want to hear from you and improve our service so you can focus on serving your enrollees!

Precertification/notification instructions and definitions

Request precertification and give us notifications:

- Online: Log in to Availity Essentials at **Availity.com** or reference the provider website at **providers.amerigroup.com/DC** > Quick Tools > Precertification Lookup Tool.
- By phone: **800-454-3730**.
- By fax: **800-964-3627** — Fax pharmacy requests to **844-487-9292** for retail and **844-487-9294** for medical injectables.

Precertification/prior authorization (PA) — the act of authorizing specific services or activities before they are rendered or occur. This is also known as PA.

Notification — telephonic, fax, or electronic communication received from a provider to inform us of your intent to render covered medical services to an enrollee:

- Prior to rendering services outlined in this document, give us notification.
- For emergency or urgent services, give us notifications within 24 hours or the next business day.
- Although there is no review against medical necessity criteria, enrollee eligibility and provider status (network and non-network) are verified.

For code-specific requirements for all services, log in to Availity at **Availity.com** or visit **providers.amerigroup.com/DC** and select Precertification Lookup from our *Quick Tools* menu.

Requirements listed are for network providers. In many cases, out-of-network providers are required to request precertification for services when network providers do not.

Audiology services

Audiology services are only covered when part of an inpatient hospital stay. Benefits are in accordance with the DC Medicaid Health Check Periodicity Schedule.

Behavioral health/substance use:

- Coordination of physical and behavioral health care is essential.

Cardiac rehabilitation:

- Precertification is required for all services.

Chemotherapy:

- Precertification is required for inpatient chemotherapy services.
- No precertification is required for chemotherapy procedures when performed in outpatient settings by a participating facility, provider office, outpatient hospital, or ambulatory surgery center.

For information on coverage of and precertification requirements for chemotherapy drugs, see the **pharmacy** section of this QRC.

Chiropractic services:

- Precertification is required.
- Spinal manipulation is covered under services related to early and periodic screening, diagnostic testing, and treatment for enrollees under age 21. Spinal manipulation is not a covered benefit for enrollees aged 21 and older.

Dental services for Medicaid enrollees:

- Pediatric enrollees under 21 benefits are in accordance with the DC Medicaid Health Check Dental Periodicity Schedule.
- Enrollees may self-refer for these services.
- Enrollees are covered and allowed one dental exam, one cleaning, and one oral prophylaxis every six months. Also covered are complete radiographic survey and full services of X-rays every three years. A limit of two reline or rebase of a removable denture is covered every five years unless prior authorization is submitted. Additional services are covered when medically necessary.
- Enrollees under 21 are covered and allowed four applications of fluoride varnish per year.
- See the provider manual for additional dental benefit coverages.

Dental services for District of Columbia Healthcare Alliance Program enrollees:

- Enrollees receive a benefit limit of $1000 towards:
  - One dental exam and one cleaning and fluoride treatment every six months.
  - Simple and complex surgical extractions, fillings, X-rays, oral surgeries,

Enrollees should contact Avesis at **833-554-1013** for a listing of participating dentists or additional information.

Diagnostic testing:

- Precertification through CarelonRx, Inc. is required for coverage of high-tech radiology and radiation oncology. Contact CarelonRx online at **carelon.com**. CarelonRx will locate a preferred imaging facility from the network of radiology service providers with Amerigroup.
- Precertification of most outpatient diagnostic radiology services is required when provided at a hospital. Please call Amerigroup for precertification.
- Hospital precertification requirements, excluding outpatient radiology, may be provided at a hospital without precertification. The hospital precertification requirement includes radiation oncology services, services provided in association with an emergency room visit, services provided in association with hospital observation, and services associated with and on the same day as an outpatient surgery performed at a hospital.

Durable medical equipment (DME):

- Precertification is required for certain DMEs. Log on to Availity at **Availity.com** or refer to our online Precertification Lookup Tool at **providers.amerigroup.com/Pages/PLUTO.aspxDC** > Quick Tools > Precertification Look Up Tool.
- Amerigroup and providers must agree to HCPCS and/or other codes for billing covered services.
- All custom wheelchair pre-certifications require a medical director's review.
- All DME billed with an RR modifier (rental) requires precertification.

For guidelines relating to disposable medical supplies, see the **medical supplies** section of this QRC.

Early and periodic screening, diagnosis, and treatment (EPSDT) visit:

- Enrollees may self-refer for these services.
- Benefits are in accordance with the DC Medicaid Health Check Periodicity Schedule.
- Providers use EPSDT schedule and **document** visits/encounters on *CMS-1500* (08-05) claim form.

Emergency services:

- Emergency care in the emergency room does **not** require prior notification.
- Emergency care resulting in admission requires notification to Amerigroup within 24 hours or the next business day.

For observation precertification requirements, see the **observation** section of this QRC.

Family planning/sexually transmitted disease care:

- Enrollees may self-refer for these services.
- See the benefits limitations in your provider manual.

Gynecology:

- Enrollees may self-refer for these services.
- Precertification is required for elective surgeries.

Hearing aids

Hearing aid services are provided under the Amerigroup fee-for-service program.

Hearing screening:

- Benefits are in accordance with the DC Medicaid Health Check Periodicity Schedule.
- The following services do not require notification or precertification by network providers: diagnostic and screening tests, hearing aid evaluations, or counseling.
- Services are not covered for enrollees aged 21 and older unless medically necessary.

Home healthcare

Precertification is required for procedures and services.

Hospice care:

- Precertification is required for inpatient hospice services.
- Notification is required for outpatient hospice services.

Hospital admission:

- Elective admissions require precertification.
- Emergency admissions require notification within 24 hours or next business day.
- Preadmission lab testing and a complete listing of participating vendors is available in the referral directory.
- Amerigroup must be notified within one business day if same-day admission is required after an outpatient surgery.

Laboratory services — outpatient:

- All laboratory services furnished by non-network providers require precertification by Amerigroup — except for hospital laboratory services provided for an emergency medical condition.

Medical supplies

No precertification is required for **most** disposable medical supplies. Please log on to Availity at **Availity.com** or check our Precertification Tool at **providers.amerigroup.com/DC** > Quick Tools > Precertification Lookup Tool.

Neurology:

- Precertification is required for psychological and neuropsychological testing.

Newborn care:

- We will designate a newborn coordinator 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.
- You can contact Amerigroup directly and ask to speak to the newborn coordinator at **800-454-3730**.

Detained newborns
Hospitals should notify Amerigroup within 24 hours or by the next business day for transfer of a newborn from the nursery to the neonatal intensive care unit, another level of care or to detain a newborn beyond the obstetrical (OB) global period. These circumstances are considered separate and new admissions — They are **not** part of the mother's admission.

Observation (OB and medical)

No precertification or notification is required for in-network observation. If observation occurs in the ER and the principal diagnosis is not on the autopay list, the medical record may be requested for review. If observation results in admission, notification to Amerigroup is required within 24 hours or the next business day.

OB care:

- No precertification is required for OB visits or OB diagnostic testing and laboratory services when performed by a participating OB provider's office, freestanding lab, or freestanding radiology center.
- Notification to Amerigroup is required at the **first** prenatal visit.
- No precertification is required for labor, delivery and circumcision for newborns up to 12 weeks in age. However, notification of delivery is required within 24 hours along with newborn information.

OB case management programs are available. See the **diagnostic testing** section of this QRC.

Out-of-area/out-of-network care:

- Precertification is required except for emergency care (including self-referral) and OB delivery.

Outpatient/ambulatory surgery:

- Precertification requirement is based on the services being performed.

Pain management/physiatry/ physical medicine and rehabilitation:

- Non-E/M-level testing and procedures require precertification for coverage.

Pharmacy:

- **Pharmacy benefit information:** The pharmacy benefit covers medically necessary prescription and over-the-counter medications prescribed by a licensed provider. Exceptions and restrictions exist as the benefit is provided under a closed formulary/*Preferred Drug List* (*PDL*). Please refer to the appropriate *PDL* and/or the *Medicaid Medication Formulary* on our website at **providers.amerigroup.com/DC** for the preferred products within therapeutic categories, requirements around generics, PA, step therapy, and quantity limit edits.
- **Medical injectable drugs:** Many self-injectable medications and self-administered oral specialty medications are available through CarelonRx, Inc. Specialty and require PA. For a complete list of covered injectables, please visit the *Pharmacy* section of our website at **providers.amerigroup.com/DC**. Call CarelonRx at **833-255-0646** to schedule delivery once you receive PA approval. Office-administered injectable medications are available through CVS Caremark®. To determine if a medical injectable requires PA, please go to the *Quick Tools* section of our website and use the Precertification Lookup tool. Call Caremark at **800-378-5697** to schedule delivery once you receive a PA approval. Providers may also choose to buy and bill office-based injectables.
- **Pharmacy PA requests:** Submit PA requests online using the electronic PA Request Tool at **covermymeds.com** or call **800-454-3730.**
- **Pharmacy online PA tool allows you to**:
  - Verify enrollee eligibility.
  - Attach clinical documentation.
  - Use drug lookup.
  - Enter multiple requests for multiple drugs at one time.
  - Appeal denied requests.
  - Upload supporting documents and review the appeal status.
  - Request medical injectables for those medications obtained by your office/facility for onsite infusion or administration.

Plastic/cosmetic/reconstructive surgery — including oral maxillofacial services:

- Precertification required — including treatment of trauma to the teeth and oral maxillofacial medical and surgical conditions such as temporomandibular joint.

See the **diagnostic testing** section of this QRC.

Podiatry:

- No precertification is required for E/M, testing, and most procedures when provided by a participating podiatrist.

Radiology

See the **diagnostic testing** section of this QRC.

Rehabilitation therapy (short term): occupational therapy (OT), physical therapy (PT), radiation therapy (RT), and speech therapy (ST):

- Precertification is required for PT and OT services beyond the initial assessment for adults ages 21 and older. OrthoNet® conducts medical necessity reviews for adult PT and OT services. Medical necessity criteria must be met. Request precertification by calling OrthoNet at **855-596-7618** or faxing clinical information to **855-596-7626**.

Skilled nursing facility:

- Precertification is required.
- Sleep study:
- Precertification is required.

Sterilization:

- Sterilization services are a covered benefit for enrollees ages 21 and older.
- No precertification or notification is required for sterilization procedures — including tubal ligation and vasectomy.
- **A *Sterilization Consent Form* is required for claims submission.**
- Sterilization reversal is not a covered benefit.

Termination of pregnancy

We are not responsible for coverage of abortion procedures, related services provided at a hospital on the day of the procedure or during an inpatient stay, or an abortion package as may be provided at a freestanding clinic — however, we are responsible for coverage of any related services not indicated above that may be performed as part of a medical evaluation prior to the actual performance of an abortion. Additionally, we are responsible for referring enrollees who require or express a need for an abortion to a participating service provider.

Non-emergency transportation:

- Medicaid enrollees should contact Medical Transportation Management, Inc. for arranging transportation accommodations for medical appointments. Enrollees can call MTM at **888-828-1071**. Providers can call MTM at **888-828-1081**.
- Non-emergency transportation services are an excluded benefit for District of Columbia Healthcare Alliance Program enrollees.

Urgent care center:

- No notification or precertification is required for participating facilities.

Vision care — routine:

- Enrollees may self-refer for services and should call Avesis Vision at **833-554-1012** for more information. Providers can call **833-554-1013**.
- Benefits are in accordance with the DC Medicaid Health Check Periodicity Schedule.
- Eye Exams: Enrollees are covered and allowed one eye examination every 12 months.
- Eyeglasses: Enrollees are covered and allowed one complete pair in a 24-month period except when lost or prescription has changed more than one-half (0.5) diopter.
- For enrollees aged 21 and older, Medicaid coverage includes one eye exam every 24 months. Amerigroup covers one eye examination every 12 months as an added benefit.

Well-woman exam

Enrollees may self-refer for services. See the benefit limitations in the provider manual.

Important Contact Information

Our service partners

Avesis (vision and dental services):	Provider: **833-554-1013** Enrollee: **833-554-1012**
CarelonRx (for specialty drugs)	**833-255-0646**
Carelon Medical Benefits Management, Inc. (radiology precertification)	**800-714-0040**
MTM (transportation)	**888-828-1071**

Provider Services Program

Our Provider Services team offers assistance with precertification, case and disease management, automated enrollee eligibility, claims status, health education materials, outreach services, and more. Call **800-454-3730** Monday through Friday from 8 a.m. to 6 p.m. ET.

Amerigroup provider website

Access provider communications, newsletters, manuals, policies, and trainings. Go to **provider.amerigroup.com/DC**.

Availity sign-in

Amerigroup offers a one-stop multi-function sign-in website for all of your provider servicing needs. Sign in to the Availity platform at **Availity.com** for:

- Eligibility and benefit inquiries.
- Claim status inquiries.
- Claim submissions.
- A direct link to the Amerigroup provider self-service website for all other functionality — including panel listings, precertification requests and appeals. You can access the link located under the *My Payer Portal* in the left-hand navigation bar on the Availity website.

Whom should I call if I have questions about the Availity website?

Contact Availity Client Services at **800-Availity** (**800-282-4548**) or email questions to support@availity.com. Availity Client Services is available Monday through Friday from 5 a.m. to 4 p.m. PT (excluding holidays).

National Provider Call Center for self-service available Monday through Friday, 8:30 a.m. to 5 p.m.

To verify eligibility, check claims and referral authorization status, and look up precertification/notification requirements, call **800-454-3730**. The recording guides you through our menu of options — Just select the information or materials you need when you hear it.

Claims services

Timely filing is within 365 calendar days of the date of service.

Electronic data interchange (EDI)

For information about registering to submit electronic transactions, companion documents, and contact information for E-Solutions, visit EDI at **providers.amerigroup.com/DC** > Claims Submission and Reimbursement Policy.

Paper claims

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

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

Payment disputes

Claims payment disputes or grievances must be filed within 90 business days of the adjudication date of the *Explanation of Payment*. Forms for provider appeals are available on our website. Mail to:

Payment Dispute Unit
Amerigroup District of Columbia, Inc.
P.O. Box 61599
Virginia Beach, VA 23466-1599

Medical appeals

Medical appeals, or medical administrative reviews, can be initiated by enrollees or providers on behalf of enrollees and must be submitted within 60 calendar days from receipt of an adverse determination. Submit appeals in writing to:

Medical Appeals
Amerigroup District of Columbia, Inc.
7550 Teague Road
Hanover, MD 21076

When submitting an appeal on behalf of an enrollee, write a letter or use the *Provider Appeals* form on our website. You **must** have written authorization from the enrollee to act as the designated representative.

Health services

Care management services — 800-454-3730

We offer care management services to enrollees who are likely to have extensive healthcare needs. Our nurse case managers work with you to develop individualized care plans — including identifying community resources, providing health education, monitoring compliance, assisting with transportation.

Disease Management Centralized Care Unit (DMCCU) services — 888-830-4300

DMCCU services include educational information such as local community support agencies and events in the health plan's service area. Services are available for enrollees with the following medical conditions: asthma, bipolar disorder, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, diabetes, HIV/AIDS, hypertension, major depressive disorder, schizophrenia, and substance use disorder.

Nurse HelpLine — 800-600-4441 (TTY 711)

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

Enrollee services — 800-600-4441 (TTY 711)

Learn more about Amerigroup programs
provider.amerigroup.com/DC

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