Amerigroup RealSolutions®
in healthcare

Provider Manual

Georgia

800-454-3730

https://provider.amerigroup.com/GA

Georgia Families
Choices for a Healthy Life

Georgia Families 360°SM

GAAGP-CD-PM-073031-24

December 2024 Amerigroup Community Care

Updates and changes
This provider manual, as part of your provider agreement and related addendums, may be updated at any time and is subject to change. The most updated version is available online at **provider.amerigroup.com/GA**. To request a free, printed copy of this manual, call Provider Services at **800-454-3730**.

If there is an inconsistency between information contained in this manual and the agreement between you or your facility and Amerigroup Community Care, the agreement governs. In the event of a material change to the information contained in this manual, we will make all reasonable efforts to notify you through web posted newsletters, provider bulletins and other communications. In such cases, the most recently published information supersedes all previous information and is considered the current directive.

This manual is not intended to be a complete statement of all policies and procedures. We may publish other policies and procedures not included in this manual on our website or in specially targeted communications, including but not limited to bulletins, emails and newsletters.

How to apply for participation
If you are interested in participating in the Amerigroup provider network, please visit our website at **provider.amerigroup.com/GA** and select the **Join Our Network** link under the *Our Network* drop-down menu to complete the provider application request online.

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1 Introduction

Welcome to the Amerigroup Community Care network provider family. Amerigroup is pleased that you have joined the network, which represents some of the finest health care providers in the state. Amerigroup offers several programs to best serve our members.

Georgia Families is a program that delivers health care services to members of Medicaid and PeachCare for Kids® through a partnership with the Georgia Department of Community Health (DCH) and care management organizations (CMOs).

Georgia Families 360°SM is a program that delivers care to children, youth and young adults in foster care; children and youth receiving adoption assistance; and certain youth in the juvenile justice system. Amerigroup began managing the Georgia Families 360°SM program in March 2014 to improve access to and coordination of care.

We believe that hospitals, physicians, and all providers play a pivotal role in managed care. We can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, high-quality provider network. All network providers are contracted with Amerigroup via a *Participating Provider Agreement*.

If you are interested in participating in our Medical Advisory Committee or learning more about specific policies, please contact us. Most committee meetings are prescheduled at times and locations intended to be convenient for you. Please call Provider Services at **800-454-3730** with any suggestions, comments, or questions. Together, we can provide an integrated system of coordinated, quality and efficient care for our members — your patients.

2 Overview

Who is Amerigroup Community Care?

Amerigroup is a wholly owned subsidiary of Amerigroup Corporation. We are focused solely on meeting the health care needs of financially vulnerable Americans. Amerigroup is dedicated to offering real solutions that improve health care access and quality for our members, while proactively working to reduce the overall cost of care to taxpayers. We serve approximately 4.5 million beneficiaries of state-sponsored health plans in 20 states, making us the nation's leading provider of health care solutions for public programs. We accept all who are eligible, regardless of age, sex, race or disability.

The implementation of Georgia Families, a managed-care arrangement for Georgia's low income Medicaid and PeachCare for Kids populations, began for Amerigroup in the Atlanta service region in June of 2006 with operations expanding to the East, North, Southeast and Southwest regions in the years following. On March 3, 2014, Amerigroup began to manage both the physical and behavioral health care needs for children who are in foster care or receive adoption assistance, as well as select youth committed into juvenile justice and placed in community residences by the Department of Juvenile Justice (DJJ). This program is known as Georgia Families 360°SM.

Within this document, the populations that make up Georgia Families 360°SM are separated into three groups: Foster Care (FC), Adoption Assistance (AA) and selected members of the DJJ population.

The goals of this program are to:

- Enhance coordination of care and access to services.
- Improve health outcomes.
- Develop and use meaningful and complete electronic medical records.
- Comply fully with regulatory reporting for the program as required by the *Kenny A. v. Sonny Perdue Consent Decree of 2005*.

The processes and information within the provider manual apply to providers who serve Georgia Families and Georgia Families 360°SM members (including FC, AA and DJJ). Be sure to review this manual in its entirety.

Mission

Amerigroup is a community-focused managed care company committed to providing access to cost-effective, high-quality health care to the members we serve throughout the state of Georgia.

Strategy

Our strategies are committed to:

- Improving access to preventive primary care services and early prenatal care by ensuring the selection of a PCP who will serve as provider, care manager and coordinator for all basic medical services.

- Improving the health status and outcomes of the members.
- Educating members about their benefits, responsibilities and the appropriate use of health care services.
- Encouraging stable, long-term relationships between providers and members.
- Discouraging the medically inappropriate use of specialists and emergency rooms.
- Committing to community-based enterprises and community outreach.
- Facilitating the integration of physical and behavioral health care.
- Fostering quality improvement mechanisms that actively involve providers in re-engineering health care delivery.
- Encouraging a customer service orientation with regular measurements of member and provider satisfaction.

Summary

Escalating health care costs are driven in part by a pattern of fragmented episodic care and, quite often, unmanaged health problems of members. Amerigroup strives to educate members to improve the appropriate use of the managed care system and become involved in all aspects of their health care.

3 Quick reference information

Call Provider Services **800-454-3730** (TTY **711**) for preauthorization/notification, health plan network information, member eligibility, claims information, inquiries, and recommendations that you may have about improving our processes and managed care program.

Ongoing provider communications

In order to ensure that providers are up-to-date with the information needed to work effectively with Amerigroup and our members, we provide frequent communications to providers in the form of broadcast faxes, email, provider manual updates, newsletters and information posted to our website.

Amerigroup website

Amerigroup provides a website that includes a robust list of online provider resources. The website features our online provider inquiry tool for real-time eligibility, claims status and referral preauthorization status. In addition, the website also provides general information that is helpful for the provider such as forms, the *Preferred Drug List (PDL)*, provider manuals, updates and other information to assist providers in working with Amerigroup. The website may be accessed at **provider.amerigroup.com/GA**.

Need to know who your local Provider Relations representative is? Visit **provider.amerigroup.com/GA**, select the **Contact Us** link at the bottom of the webpage and open the PDF entitled *Your Local Provider Relations Representative*.

Amerigroup numbers

- Provider Services phone: **800-454-3730** (TTY **711**)
- 24-hour Nurse HelpLine: **800-600-4441**
- Georgia Families Member Services: **800-600-4441**
- Georgia Families 360°SM Member Services: **855-661-2021**
- Behavioral Health Services: **800-454-3730**
- Behavioral Health Georgia Families 360°SM fax: **888-375-5070**
- Pharmacy Services: **800-454-3730**
- Pharmacy Member Services: **833-205-6006**
- Electronic Data Interchange Availity Essentials: **800-282-4548**
- Interpreter Services: **800-454-3730**
- Carelon Medical Benefits Management, Inc. **844-423-0877**
- OrthoNet Medical Services department: **844-276-4258**

The following chart contains additional information that will help you in your day-to-day interaction with Amerigroup.

Useful links	• National Committee for Quality Assurance (NCQA): **ncqa.org** • Joint Commission: **jointcommission.org** • Credentialing Verification Organization: **mmis.georgia.gov** • Georgia Department of Community Health: **dch.georgia.gov**
Enrollment/ disenrollment	Contact Provider Services at **800-454-3730**.
Notification/ preauthorization	May be submitted via telephone or through the Alliant Georgia Medical Care Foundation (GMCF) portal: • Phone: **800-454-3730** • Electronically at **https://Availity.com** and **mmis.georgia.gov** Data required for complete notification/preauthorization: • Member ID number • Legible name of referring provider • Legible name of individual referred to provider • Number of visits/services • Date(s) of service • Diagnosis In addition, clinical information is required for preauthorization and notification. The authorization forms and tools, located on our website at **provider.amerigroup.com/GA**, provide the information required to initiate the authorization process. Amerigroup utilization reviewers use these criteria as part of the preauthorization process for scheduled admissions. Criteria are also used for the concurrent review and discharge planning process to determine clinical appropriateness and medical necessity for coverage of continued hospitalization. Copies of the criteria used to make a clinical determination may be obtained by calling Amerigroup at **800-454-3730** or the local health plan at **678-587-4840**. Providers may also submit their requests in writing to: Medical Management Amerigroup Community Care 740 W Peachtree St NW Atlanta, GA 30308
Claims information	**Submit paper claims to:** Amerigroup Community Care P.O. Box 61010 Virginia Beach, VA 23466-1010 **Availity Electronic claims Payer ID:** 26375 **Claims timely filing guidelines (paper and electronic):** All claims must be submitted within six months after the month in which service was rendered. Claims received after this time period will deny for untimely filing.

	Corrected claim guidelines (paper and electronic): Corrected claims must be submitted within 90 days from the date of the original claim submission. Corrected claims can be submitted electronically through our website or by paper. Corrected claims submitted by paper must be clearly marked *corrected claim* and mailed to: Amerigroup Community Care P.O. Box 61010 Virginia Beach, VA 23466-1010 For other claims (for example, dental, vision, pharmacy), refer to the **Amerigroup Health Care Benefits and Copays** chapter of this manual. Amerigroup provides an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status and referral authorization status. Visit our website at **provider.amerigroup.com/GA**. If you are unable to access the internet, you may receive claims, eligibility and referral authorization status over the phone anytime by calling our automated Provider Inquiry line at **800-454-3730**.
National Provider Identifier	**National Provider Identifier (NPI)** — The *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* requires the adoption of a standard unique provider identifier for health care providers. All Amerigroup participating providers must have an NPI number. NPI is a 10-digit, intelligence-free numeric identifier. Intelligence-free means that the numbers do not carry information about health care providers, such as the state in which they practice or their specialty. Providers can apply for an NPI by: • Completing the application online at **nppes.cms.hhs.gov** (estimated completion time is 20 minutes). • Completing a paper copy by downloading it at **nppes.cms.hhs.gov**. • Calling **800-465-3203** and requesting an application.
Medical and pharmacy appeals information	• For standard pre-service medical and pharmacy appeals, a member, a person acting on behalf of a member, or the provider (with written member consent) may file an appeal within 60 calendar days from the date of the *Adverse Benefit Determination Letter*. • For post-service/retrospective medical appeals, the member, the member's authorized representative or a provider may file a post-service appeal request (no consent required) within 60 calendar days of the date of the *Adverse Benefit Determination Letter*. • All medical and pharmacy appeal requests should be sent to: Medical Appeals Amerigroup Community Care P.O. Box 62429 Virginia Beach, VA 23466-2429

Provider payment dispute and grievance / complaint process	• If a provider is dissatisfied with the outcome of a claim payment, the provider may begin the claim payment dispute process by requesting an investigation into the claim payment decision, called a Reconsideration, within 90 calendar days from the paid date on the Explanation of Payment (EOP). • Amerigroup will send a determination letter within 30 calendar days of receiving all necessary information. • The most efficient way to begin the claim payment dispute process is to use the secure Provider Availity Payment Appeal Tool at **https://Availity.com**. Through Availity Claim Status tool, the provider can initiate a dispute, upload supporting documentation, receive immediate acknowledgement of the submission, track progress, and receive determination letters and other important information. • A grievance / complaint is defined as a disagreement or objection with an Amerigroup policy, operating procedure, or other issue not related to claim payment or medical necessity appeals. Provider grievances / complaints should be mailed to: Provider Relations Amerigroup Community Care 740 W Peachtree St NW Atlanta, GA 30308
Georgia Health Information Network (GaHIN)	In order to participate in GaHIN, providers must visit **gahin.org/join-gahin**
Demographic updates	All demographic changes for Georgia Medicaid providers must be made through Georgia Medicaid Management Information System (GAMMIS). Providers with a delegated credentialing arrangement with Amerigroup will continue to submit demographic changes to the health plan.
Provider Medicaid ID requirements	The Georgia Department of Community Health (DCH) requires that every provider / y have a valid/active Medicaid ID number for each service location. If you do not have a valid and active Medicaid ID for the service location that you are billing from the claim will be rejected for no Medicaid ID, per DCH policy. If you do not have a valid ID for a service , please contact the DCH Provider Enrollment Unit as indicated below: • Local number: **770-325-9600** • Toll-free number: 8**00-766-4456** • Mail: Provider Enrollment and EDI Services DXC Technology P.O. Box 105201 Tucker, GA 30085 • DCH website: **mmis.georgia.gov**
Care Coordination team/case managers at Georgia Families 360°SM	• The Care Coordination team can be reached at **855-661-2021** from 8:30 a.m.-5:30 p.m. Eastern time, as well as after hours for urgent/emergent issues. • Members can also get help through the 24-hour Nurse HelpLine at **800-600-4441**.

Provider Services representatives	For more information, call Provider Services at **800-454-3730** from 8:30 a.m. to 5:30 p.m.
Georgia Families 360°$_{SM}$ case managers	To speak with a Care Coordination team representative, call **855-661-2021** Monday-Friday, from 8:30 a.m.-5:30 p.m. Eastern time.

4 Primary care providers

Amerigroup is one of the health plans that delivers care management services for the Georgia Families and Planning for Healthy Babies® (P4HB), and Georgia Pathways to Coverage™ programs, and is the only health plan that delivers management services for the Georgia Families 360°℠ program.

Amerigroup encourages enrollees to select a PCP who provides preventive and primary medical care and coordinates all medically necessary specialty services. Members are encouraged to make an appointment with their PCP within 90 calendar days of their effective date of enrollment.

Federally qualified health center (FQHC) and rural health clinic (RHC) providers may function as a PCP. Providers must arrange for coverage of services to assigned members 24 hours a day, 7 days a week in person or by an on-call physician. They must answer emergency telephone calls from members within 20 minutes, and each PCP within the FQHC and/or RHC must be available a minimum of 20 office hours per week.

Provider specialties

Physicians with the following specialties can apply for enrollment with Amerigroup as a PCP:

- Family medicine
- General practitioner
- Pediatrics
- Internal medicine
- Nurse practitioners certified as specialists in family practice or pediatrics
- Physicians who provide medical services at FQHCs and RHCs
- OB/GYN
- Psychiatrists (for members who have a primary diagnosis of a severe, persistent mental illness)

The physician/provider must be enrolled in the Medicaid program at all service locations where he or she wishes to practice as a PCP before contracting with Amerigroup. Independent, advanced practice nurses interested in participating with Amerigroup cannot enroll as a PCP, but can participate using a *Memorandum of Collaboration* with a participating PCP.

PCP on-site accessibility

Amerigroup is dedicated to ensuring access to care for our members, and this depends upon the accessibility of network providers. Amerigroup network providers are required to abide by the following standards:

- PCPs must offer telephone access for members 24 hours a day, 7 days a week. The service may be answered by a designee such as an on-call physician or nurse practitioner with physician backup, an answering service, or a pager system. An answering machine is not acceptable. If an answering service or pager system is used, urgent calls must be returned within 20 minutes. All other calls must be returned within one hour.

- The PCP or another physician/nurse practitioner must be available to provide preventive care and teach healthy lifestyle choices, identify and treat common medical conditions, assess the urgency of the member's medical problems, and direct them to the most appropriate place for care.
- Covering physicians are required to follow the referral/preauthorization guidelines.
- It is **not** acceptable to automatically direct the member to the emergency room when the PCP is **not** available.
- Georgia providers must offer hours of operation that are no less than the hours of operation offered to commercial and fee-for-service patients.
- We encourage our PCPs to offer after-hours office care in the evenings and on weekends.

Provider disenrollment process

Providers may disenroll from participating with the Georgia Families and Georgia Families 360°SM programs for either mandatory or voluntary reasons.

Mandatory disenrollment occurs when a provider becomes unavailable due to immediate unforeseen reasons. Examples of this include but are not limited to death and/or loss of medical license. Members are auto-assigned to another PCP to ensure continued access to the Georgia Families and Georgia Families 360°SM programs.

Providers disenrolling for voluntary reasons, such as retirement, should provide notice to affected members. Providers are required to give written notice to Amerigroup within the time frames specified in the provider's contractual agreement with Amerigroup. Members linked to a PCP who has disenrolled for voluntary reasons are notified to select a new PCP.

Member enrollment process

Georgia Families enrollment process

Mandatory enrollment in a care management organization (CMO) is required for all eligible recipients. During the initial 90 days following the member's effective date of enrollment, the enrollee may disenroll from one CMO to move to another without cause. The 90-day time period applies to the enrollee's initial period of enrollment and to any subsequent enrollment periods when the enrollee enrolls in a new CMO. A member may request disenrollment from a CMO for cause at any time. The following situations constitute cause for disenrollment by the member:

- The CMO does not provide the covered services that the member seeks because of moral or religious objections.
- The member needs related services to be performed at the same time and not all related services are available within the network; the member's provider or another provider has determined that receiving services separately would subject the member to unnecessary risk.
- The member requests to be assigned to the same CMO as family members.
- The member's Medicaid eligibility category changes to a category ineligible for the Georgia Families or Georgia Families 360°SM program, and/or the member otherwise becomes ineligible to participate in the program.

- DCH or its agents shall determine, per 42 CFR 438.56(d)(2), that poor quality of care, lack of access to covered services or lack of provider experience in dealing with the member's health care needs warrant disenrollment.

Members are excluded from the program if they are:

- Receiving Medicare.
- Part of a federally recognized Indian tribe.
- Receiving Supplemental Security Income (SSI).
- Medicaid children enrolled in the Children's Medical Services program administered by the Georgia Department of Public Health.
- Enrolled in the Georgia Pediatric Program (GAPP).
- Enrolled under group health plans in which the DCH provides payment of premiums, deductibles, coinsurance and other cost sharing pursuant to section 1906 of the *Social Security Act*.
- Enrolled in a hospice category of aid.
- Enrolled in a nursing home category aid.
- Enrolled in a Community-Based Alternative for Youth (CBAY) program.

Georgia Families 360°SM enrollment process

Foster care and juvenile justice members are enrolled in Amerigroup within 48 hours of DCH's receipt of an eligibility file from the Department of Family and Children Services (DFCS) or Department of Juvenile Justice (DJJ). If a member leaves foster care or DJJ and remains eligible for Medicaid, the member will remain enrolled with Amerigroup as a non-foster care or non-DJJ member until his or her next enrollment period. Youth with an SSI category of eligibility will return to Medicaid fee-for-service (FFS) and will no longer be enrolled in Georgia Families 360°SM.

A member receiving adoption assistance (AA) can elect to opt out without cause during the AA, during the first 90 calendar days following the date of the member's initial enrollment with Amerigroup, or the date DCH sends the member notice of enrollment, whichever is later. An AA member may request to disenroll without cause every 12 months thereafter.

AA members can elect to disenroll for cause at any time and will return to the Medicaid FFS program. AA members can elect to opt-in again at any time, subject to eligibility. The following constitutes cause for AA members to disenroll:

- Amerigroup does not, because of moral or religious objections, provide the covered service the member seeks.
- The member needs related services to be performed at the same time, and not all related services are available within the network; the member's provider or another provider has determined that receiving services separately would subject the member to unnecessary risk.
- Other reasons, including poor quality of care, lack of access to services or lack of providers in dealing with the member's health care needs.

Newborn enrollment process
A baby born to a Georgia Families or Georgia Families 360°SM member will be automatically enrolled with Amerigroup.

Amerigroup will try to work with expectant mothers to encourage them to choose a PCP for their newborn before delivery. All newborns will be automatically assigned to the mother's CMO plan. Upon notification of birth, Amerigroup enters the newborn into the core claims processing system. If the mother has made a PCP selection, this information is included in the newborn notification form. If the mother has not made a PCP selection, Amerigroup will automatically assign the newborn to a PCP within two business days of the birth notification.

Georgia Families 360°SM selection of a primary care provider

If a PCP is not voluntarily selected by the member's adoptive parent, residential placement provider, DFCS case manager, caregiver, foster parent or foster care member upon enrollment, Amerigroup will automatically assign the Georgia Families 360°SM member to a PCP within two business days of receipt of notification of the Georgia Families 360°SM member's enrollment.

Following notification of a change in placement, Amerigroup will assess the member's access to the assigned PCP within one business day. If the PCP no longer meets the documented geographical standards of the state's contract with Amerigroup, a new PCP must be selected by the case manager, caregiver, foster parent or foster care member, or residential or placement provider within two business days of relocation, or Amerigroup will reassign a PCP within three business days of receipt of notification of member relocation.

An eligibility file or written notification from DCH, DFCS or DJJ will serve as notification of the member's relocation.

Member eligibility listing

The PCP will receive a listing of his or her panel of assigned members monthly. If a member, parent, legal guardian or surrogate calls to change his or her PCP within the first 90 days of enrollment, the change will be effective the next business day. The PCP should verify that each Amerigroup member receiving treatment in his or her office is on these membership listings. If a PCP does not receive the lists promptly, they should contact a Provider Relations representative. For questions regarding a member's eligibility, providers may access the Amerigroup website at **provider.amerigroup.com/GA** or call Provider Services at **800-454-3730**.

Eligibility
In accordance with the *Georgia Medicaid Care Management Organizations Act (House Bill 1234)* and the Georgia Families 360°SM contract, if a provider submits a claim to Amerigroup for services rendered within 72 hours after verifying patient eligibility, that claim will be reimbursed. The reimbursement amount is equal to the amount the provider would have been entitled to if the patient had been enrolled as shown in the eligibility verification process.

We will accept either the Amerigroup or the MMIS eligibility web portal screen shot as proof of eligibility when appealing a denial. The screen shot must include a date stamp to demonstrate that the eligibility was verified within 72 hours of the service rendered.

Amerigroup will not apply a penalty for the following:

- Failure to file claims within six months of the month of service
- Failure to obtain preauthorization (unless services required an authorization within 72 hours from the date of service) from the CMO
- Nonparticipating provider status (if proof of 72-hour eligibility verification is submitted with your appeal)

Providers may submit a claim payment dispute to Amerigroup through the secure Provider Availity Payment Appeal Tool at **https://Availity.com** . Please include a screenshot demonstrating the member's eligibility was verified.

Georgia Families 360°SM eligibility

The following Medicaid eligibility categories are required to enroll in Georgia Families 360°SM:

- Children and young adults less than 26 years of age who receive foster care under *Title IV-B* or *Title IV-E* of the *Social Security Act*, including children or youth who are in joint custody of DFCS and DJJ
- Children less than 21 years of age who receive other adoption assistance under *Title IV-B* or *Title IV-E* of the *Social Security Act*
- Children and young adults less than 26 years of age who receive foster care under *Title IV-B* or *Title IV-E* of the *Social Security Act* and are eligible for Supplemental Security Income
- Children and young adults less than 26 years of age who receive foster care under *Title IV-B* or *Title IV-E* of the *Social Security Act* and are enrolled in the State Children's Health Insurance Program (SCHIP), PeachCare for Kids
- Children less than 21 years of age who receive adoption assistance under *Title IV-B* or *Title IV-E* of the *Social Security Act* and are enrolled in the State Children's Health Insurance Program (SCHIP), PeachCare for Kids
- Children and young adults less than 26 years of age who are in foster care or receive adoption assistance under *Title IV-B* or *Title IV-E* of the *Social Security Act* and are enrolled in one of the following home- and community-based services (HCBS) 1915(c) waiver programs:
    - Elderly and Disabled Waiver Program
    - New Options Waiver Program (NOW)
    - Community-Based Alternatives for Youth (CBAY)
    - Independent Care Waiver Program (ICWP)
- Children 18 years of age and under who are eligible for Georgia Families as part of the FCAAP, pursuant to the Interstate Compact for the Placement of Children (ICPC)
- Children and youth who are eligible for Georgia Families as part of the FCAAP, pursuant to the Interstate Compact Adoption and Medical Assistance (ICAMA)
    - The age limitations for these children are based on DFCS eligibility requirements for adoption assistance members.

- In ICAMA cases where Georgia is the receiving state and the child receives adoption assistance from another state, Georgia can provide Medicaid coverage under ICAMA for the period of time the sending state continues to provide such assistance under the adoption assistance agreement.
- Age limitation and eligibility criteria vary by state and are based on the sending state's criteria instead of DFCS eligibility requirements.

The following youth in the Department of Juvenile Justice Population (DJJP) are eligible for enrollment:

- Children and youth less than 19 years of age who are eligible for Right from the Start Medicaid and are placed in community (nonsecure) residential care because of their involvement with the juvenile justice system
- Children and youth less than 19 years of age who are eligible for Right from the Start Medicaid *and Supplemental Security Income*, and are placed in community (nonsecure) residential care as a result of their involvement in the juvenile justice system

Member identification cards

Each Medicaid-eligible member will have an Amerigroup ID card. The ID card will include:

- Member's name
- The member identification number
- Amerigroup address and toll-free telephone number available 24 hours a day, 7 days a week
- PCP's name, address and telephone number
- PCP's after-hours nonemergency number and instructions on what to do in an emergency.
- Effective date of Amerigroup membership
- Dental home name, address and telephone number (if the member is eligible to receive a dental home)
- Provider claims submission information

Americans with Disabilities Act

Amerigroup policies and procedures are designed to promote compliance with the *Americans with Disabilities Act of 1990*. Providers are required to take actions to remove an existing barrier and/or to accommodate the needs of members who are qualified individuals with a disability. This includes the following:

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

Medically necessary services

Based upon generally accepted medical practices in light of conditions at the time of treatment, medically necessary services (including concepts of medically necessary and medical necessity) are those that are:

- For Medicaid children under 21 years of age and PeachCare for Kids members under 19 years of age: to correct, or ameliorate, physical and behavioral health disorders.
- Appropriate and consistent with the diagnosis, and the omission of which could adversely affect the member's medical condition.
- Compatible with the standards of acceptable medical practice.
- Provided in a safe, appropriate, and cost-effective setting, given the nature of the diagnosis and the severity of the symptoms.
- Not provided solely for the convenience of the member or the provider.
- Not primarily custodial care unless custodial care is a covered service or benefit under the member's evidence of coverage.
- Provided when there is no other effective, more conservative or substantially less costly treatment, service and setting available.

Georgia Families 360°SM covered program benefits and services

All medically necessary services and benefits available through the state's Medicaid plan are also available to FC, AA and DJJ beneficiaries enrolled with Amerigroup. Such medically necessary services will be furnished in an amount, duration and scope that are no less than the amount, duration and scope for the same services furnished to recipients under fee-for-service Medicaid. Amerigroup will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness or condition. All benefits and services are provided in the most appropriate service location for the service rendered based on the member's individual needs at a specific point in time.

Additionally, Georgia Families 360°SM-specific services are covered as follows (for members who are continuously enrolled in the Medicaid program):

Benefit/service description	Specific service coverage
Children First and Babies Can't Wait	Federal laws on child health care (for example, *20 U.S.C. §1435 (a)(5); 34 C.F.R. §303.321(d)*) require network providers to identify and refer to the designated Children First program for assessment and evaluation of any FCAA member ages birth to 35 months (about 3 years) of age who is: • Suspected of having a developmental delay or disability. • At risk of delay.
Initial screenings and follow-up treatment	
Screening	**Provider requirements**
Physical health	Each child shall receive: • An EPSDT medical screening within 10 calendar days of receipt of eligibility. • All treatment as directed by the child's assessing physician.
Dental health	Each child shall receive: • A dental visit within 10 calendar days of receipt of eligibility.

Benefit/service description	Specific service coverage
	• All treatment directed by the child's assessing dentist.
Mental health	Each child under 4 years of age shall receive: • A developmental assessment within 30 days of placement. • All treatment as directed by the child's assessing professional. Each child 4 years of age and older may receive, if indicated: • A mental health screening conducted by a licensed mental health professional, completed within 30 days of receipt of eligibility. • All treatment as directed by the child's assessing professional. Each newly enrolling foster care child 5 years of age and older shall receive: • A trauma assessment conducted by a licensed mental health professional, completed within 15 calendar days of receipt of eligibility. • All treatment as directed by the child's assessing professional.
Periodic health screenings and treatment requirements by age	
Age	**Requirements***
Newborn to 6 months	Each child from newborn to 6 months of age shall receive EPSDT preventive health screenings per Bright Futures guidelines (in other words, newborn, 3 to 5 days, by 1 month, 2 months, 4 months and 6 months).
7 to 18 months	Each child between 7 to 18 months of age shall receive periodic EPSDT/preventive health screenings per Bright Futures guidelines (in other words, 9 months, 12 months, 15 months and 18 months).
19 months to 5 years	Each child between 19 months to5 years of age shall receive EPSDT/preventive health screenings per Bright Futures guidelines (in other words, 24 months, 30 months, 3 years, 4 years and 5 years).
6 years and over	Each child 6 years of age and older shall receive at least one periodic EPSDT/preventive health screening every year.
Every child age 1 and older	Each child shall receive: • At least an annual dental exam in compliance with EPSDT standards (including, at a minimum, the components identified in the EPSDT program manual). • All treatment directed by the child's assessing dentist.
Every child regardless of age	Each child shall receive: • Any follow-up treatment or care as directed by the physician who administered the periodic EPSDT/preventive health screening. • For members in foster care: an EPSDT/preventive health screening within 10 days of receiving a final discharge from placement.

* These requirements are dependent upon continuous enrollment.

Georgia Families 360°SM health information technology and exchange

Electronic health records

Amerigroup promotes the use of the Georgia Health Information Network to close the patient information gap across care settings. This network allows providers to electronically connect disparate systems and data sources to support improved quality of care, better health outcomes and reductions in cost.

Providers have access to a free email messaging service to securely send patient health information to other authorized health care professionals and patients. This service:

- Allows up to 40 document attachments (400 pages).
- Is an entry-level product for health information exchange.
- Is simple to implement.

Georgia Health Information Network (GaHIN)
The electronic health record is structured to provide data in a summarized, user-friendly printable format and employs hierarchical security measures to limit access to designated persons. It is available 24 hours a day, 7 days a week, except during limited scheduled system downtime. Amerigroup encourages all providers to enroll and participate in the GaHIN.
Records will include:

- Member-specific information, including name, address on record, date of birth, race/ethnicity, gender and other demographic information as appropriate.
- Name and address of each member's PCP and caregiver.
- Name and contact information of each member's case manager, community case manager (CCM) or residential placement provider, and nonmedical personnel, such as the Amerigroup care coordinator, as appropriate.
- Retention of the member's Medicaid ID and DFCS personal identification number (person ID) to identify and link each member to a unique Medicaid ID after it has been assigned.
- Description and quarterly update of each member's individual health care service plan, including the plan of treatment to address the member's physical, psychological and emotional health care problems and needs.

For more information, please email **info@gahin.org**.

How to access electronic health records

A provider must submit notes at more frequent intervals, if necessary, to document significant changes in a Georgia Families 360°SM member's treatment or progress. Notes should include the following:

- Primary and secondary (if present) diagnosis
- Assessment information, including results of a mental status exam, history or assessments used for residential placement purposes
- Brief narrative summary of a Georgia Families 360°SM member's progress or status
- Scores on each outcome rating form(s)
- Referrals to other providers or community resources
- Any other relevant care information

Utilization Management decisions

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

- UM decision-making is based only on appropriateness of care and service, and existence of coverage.

- Amerigroup does not reward practitioners or other individuals for issuing denials of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on their agreement or disagreement with the denial process.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.

The Amerigroup medical director and participating doctors review and evaluate new medical advances to determine their appropriateness for covered benefits. Scientific literature and government approval is reviewed for determining if the treatment is safe and effective. The new medical advance or treatment must provide equal or better outcomes than the existing covered benefit treatment or therapy.

5 Amerigroup health care benefits and copays

The following list shows the health care services and benefits that Amerigroup covers. Some services may require prior authorization.

Covered services	Additional information
Abortions	• Abortions are covered services if a provider certifies that the abortion is medically necessary to save the life of the mother or if the pregnancy is the result of rape or incest. • Amerigroup covers treatment of medical complications from an elective abortion or treatments for spontaneous, incomplete or threatened abortions and for ectopic pregnancies. • Please note: Abortions or abortion-related services performed for family planning purposes are not a covered benefit.
Clinic services	FQHCs and RHCs will provide covered services including preventive, diagnostic, therapeutic, rehabilitative or palliative services in the service region.
Court-ordered services	Medically necessary court-ordered services are a covered benefit if an evaluation is ordered by a state or federal court.
Dental care	Coverage of dental services for Medicaid and Georgia Families 360°$_{SM}$ members younger than age 21, PeachCare for Kids members younger than age 19, and pregnant women include:* • Preventive, diagnostic and treatment services. • Exam and cleaning every six months. • X-rays every 12 months. • Fillings, extractions, and other services as medically necessary. • Emergency dental services. All Georgia Families and Georgia Families 360°$_{SM}$ members are assigned to dental homes. * PeachCare for Kids members are eligible for these services through the end of the month of their 19th birthday. Value-added benefit for adults 21 and over includes (with no copay): • Annual exam. • Cleanings every six months.
Durable medical equipment (DME)	Medically necessary DME is a covered benefit.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services	• A covered benefit for PeachCare for Kids members from birth through the end of the month of their 19th birthday • A covered benefit for Medicaid and Georgia Families 360°$_{SM}$ members from birth up to 21 years of age • A covered benefit for Georgia Pathways to Coverage members ages 19 and 20. • EPSDT services include outreach and informing, screening, tracking, diagnostic and treatment services

Covered services	Additional information
Emergency and post-stabilization services	Emergency and medically necessary post-stabilization services do not require a referral. An emergency medical condition is a medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could result in the following: • Serious jeopardy to the physical or mental health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) • Serious impairment to bodily functions • Serious dysfunction of any bodily organ or part • Serious harm to self or others due to an alcohol or drug abuse emergency • Injury to self or bodily harm to others
Family planning services and supplies	Coverage of family planning services and supplies includes: • Education and counseling necessary to make informed choices and understand contraceptive methods • Initial and annual complete physical examinations, including pelvic and breast exams • Lab and pharmacy • Follow-up, brief and comprehensive visits • Contraceptive supplies and follow-up care • Diagnosis and treatment of sexually transmitted diseases • Infertility assessment
Home Health services	The following services are not covered: • Social services • Chore services • Meals On Wheels • Audiology services
Hospice	Medically necessary hospice care is covered for members certified as being terminally ill and having a life expectancy of six months or less.

Covered services	Additional information
Hysterectomies/ sterilizations	**Hysterectomy** is a covered benefit for members age 21 and older at the time of consent only if: • The member is mentally competent. • The member is not institutionalized in a correctional facility/mental hospital or rehabilitative facility. • The member is informed verbally and in writing that the hysterectomy will render the member permanently incapable of reproducing. This is not applicable if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy. • The member has signed and dated the Georgia Families *Sterilization Request Consent* form (located in **Appendix A — Forms**) prior to the procedure. Hysterectomy is not a covered benefit if: • It is performed solely to render the member permanently incapable of reproducing and if performed for cancer prophylaxis. • There is more than one purpose for performing the hysterectomy, but the primary purpose was to render the member permanently incapable of reproducing. • The member is a Planning for Healthy Babies participant. **Sterilizations** are a covered service for members age 21 and older at time of consent only if: • The member is mentally competent. • The member is not institutionalized in a correctional facility/mental hospital or rehabilitative facility. • The member voluntarily gives informed consent, including executing an *Informed Consent for Voluntarily Sterilization* form (located in **Appendix A — Forms**). • The consent is executed at least 30 days prior to the sterilization, but not more than 180 days between the date of informed consent and the date of sterilization, except at the time of a premature delivery or emergency abdominal surgery. A member may consent to be sterilized at the time of premature delivery or emergency abdominal surgery if: o At least 72 hours have passed since the informed consent for sterilization was signed. o In the case of premature delivery, the informed consent is given at least 30 calendar days before the expected date of delivery. (The expected date of delivery must be on the consent form.) Interpreter services are available if needed. Call Amerigroup Provider Services at **800-454-3730**.
Inpatient hospital services	Inpatient hospital services are a covered benefit in general acute care and rehabilitation hospitals.
Inpatient mental health/substance abuse services	Inpatient mental health and substance abuse services are covered in general acute care hospitals with psychiatric units and free-standing psychiatric facilities.

Covered services	Additional information
Laboratory and X-ray services	All laboratory and X-ray services ordered, prescribed and directed or performed within the scope of the license of a practitioner. The following services are covered: • Portable X-ray services • Services or procedures referred to another testing facility • Services provided by a state or public laboratory (see list in **Appendix A — Forms**) • Services performed by a facility that is Clinical Laboratory Improvement Amendments (CLIA)-certified or a waiver of a certificate of registration (**cms.gov/medicare/quality/clinical-laboratory-improvement-amendments**)
Nurse midwife	A certified nurse midwife (CNM) is a registered professional nurse legally authorized under state law to practice as a nurse midwife and has completed a program of study and clinical experience for nurse midwives or equivalent.
Nurse practitioner	A nurse practitioner certified (NP-C) is a registered professional nurse who is licensed by the state of Georgia and meets the advanced educational and clinical practice requirements beyond the two or four years of basic nursing education required for all registered nurses.
Oral surgery	Oral surgery services are a covered benefit if medically necessary.
Organ transplants	Medically necessary transplant services that are not experimental or investigational are covered. Heart, lung and heart/lung transplants are not covered benefits for members age 21 and older.
Outpatient hospital services	Outpatient hospital services that are preventive, diagnostic, therapeutic, rehabilitative or palliative are covered benefits.
Outpatient mental health/substance abuse services	• Outpatient mental health and substance abuse services are covered through community service boards (CSBs), community mental health providers designated as CORE or Intensive Family Intervention (IFI), and private practitioners. • Members may self-refer to a network provider for mental health or substance abuse visits. • Partial hospitalization and intensive outpatient treatment — Refer to the **Precertification and Notification Coverage Guidelines** section of this manual for more information. • Psychological testing — Refer to the **Precertification and Notification Coverage Guidelines** section of this manual for more information. • Community mental health rehabilitation services are covered — Refer to the **Precertification and Notification Coverage Guidelines** section of this manual for more information.
Physical/ occupational therapy, speech-language pathology and audiology services	Covered for: • All Medicaid and Georgia Families 360°$_{SM}$ members • PeachCare for Kids members ages 0-18 • All members older than age 21 for restorative care • Children's Intervention Services that are covered include audiology, nursing, nutrition services provided by licensed dietitians, occupational therapy, physical therapy, counseling provided by clinical social workers and speech-language pathology when performed by a participating provider.

Covered services	Additional information
Physician services	All symptomatic visits to physicians or physician extenders within the scope of their licenses — including services while admitted in the hospital, in an outpatient hospital department, in a clinic setting or in a physician's office — are covered benefits.
Podiatric services	Podiatric services are not a covered benefit for flatfoot, subluxation, routine foot care, supportive devices and vitamin B-12 injections.
Pregnancy-related services	Covered services for pregnant women include: • Pregnancy planning, prenatal care and perinatal health promotion and education for reproductive-age women. • Risk assessment of nonpregnant women, pregnant women, postpartum women, and newborns and children up to 5 months old. • Childbirth education classes for all pregnant women and their chosen partner: ○ Through these classes, expectant parents will be encouraged to prepare themselves physically, emotionally and intellectually for the childbirth experience. • Access to appropriate levels of care based on risk assessment (including emergency care). • Transfer and care of pregnant women, newborns and infants at tertiary care facilities when necessary. • Availability and accessibility of OB/GYNs, anesthesiologists and neonatologists, and appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems. • Inpatient care and professional services relating to labor and delivery for pregnant/delivering members, and neonatal care for newborn members at the time of delivery up to 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated cesarean delivery. • In addition to individual parent education and anticipatory guidance to parents and guardians at EPSDT preventive visits: offer, or arrange for, parenting skills education to expectant and new parents at no cost to the member.
Prescription drugs	Prescription drugs must be prescribed by a member's primary care physician, specialist, consultant physician, dental provider, or other lawful prescriber. Excluded drug categories are those permitted under *Section 1927(d)* of the *Social Security Act*. Refer to the *Preferred Drug List* (*PDL*) for mandatory generic requirements, prior authorization (PA), step therapy, medical exception process and quantity limits. The *PDL* may be found at **provider.amerigroup.com/georgia-provider/resources/pharmacy-information**. Over-the-counter (OTC) medications specified in the Georgia Medicaid plan and included in the *PDL* are covered if ordered by a physician with a valid prescription. An in-network pharmacy must be used for prescription and OTC drug coverage.
Private-duty nursing services	Private-duty nursing services are a covered benefit if medically necessary.
Prosthetic and orthotic services	The following orthotic and prosthetic services are covered benefits for members under 21 years of age:

Covered services	Additional information
	• Orthopedic shoes and support devices for the feet that are not an integral part of a leg brace except diabetic shoes • Hearing aids and accessories
Skilled nursing facility services	Long-term nursing facility stays over 30 days are not covered.
Swing-bed services	Swing beds are defined as hospital beds that can be used for either nursing facility or hospital acute levels of care on an as-needed basis. Swing-bed services are a covered benefit if rendered in an inpatient hospital setting for eligible Medicaid recipients as medically necessary.
Transportation	Emergency transportation is a covered benefit. Nonemergency transportation (NEMT) is covered through the DCH for Medicaid, PeachCare for Kids and Georgia Pathways to Coverage (ages 19-20 as part of EPSDT) enrollees. Refer to the **Precertification and Notification Coverage Guidelines** section of this manual for more information on planned air transportation. Please contact the Care Coordination team if assistance is needed to coordinate any transportation services.
Vision services	• Routine eye exams and refractions are a covered benefit for members younger than age 21 only as part of EPSDT services. • The following services are covered benefits: routine eye exams, medically necessary eyeglasses and contact lenses including a polycarbonate or plastic lens upgrade every 365 days. • Amerigroup offers a value-added benefit for members 21 and over for a comprehensive vision exam every 12 months, frames and lenses once per year (contact lenses are included if medically necessary). Adults 21 and over may receive up to $75 toward their choice in glasses, if medically necessary.
Well-baby and well-child care	Routine well-baby and well-child care services include routine office visits with health assessments, physical exams, routine lab work, and age-appropriate immunizations. The required EPSDT screening components for children through 20 years of age include: • A comprehensive health and developmental history (including assessment of both physical and mental health development). • A comprehensive unclothed physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate examination). • Appropriate immunizations (according to the schedule established by the Advisory Committee on Immunization Practices for individuals 18 years of age and younger and individuals 19 years of age and older). • Certain laboratory procedures (including the federally required blood lead level assessment). • Health education (including anticipatory guidance). • Measurements (including head circumference for infants and BMI). • Sensory screening (in other words, vision and hearing tests and oral health assessment).
Women's health specialists	Female members may self-refer to an in-network women's health specialist for annual exams and routine health services (including a Pap smear and a mammogram). Refer to the **Precertification and Notification Coverage Guidelines** section of this manual for more information.

Cost-sharing information

Copays

Copays do not apply to the following members:

- Children enrolled in Medicaid younger than 21 years of age, including PeachCare for Kids recipients younger than 6 years of age (Note: See the **Copayments for PeachCare for Kids** section for exceptions.)
- Actively enrolled Georgia Families 360°SM members
- Pregnant women
- Nursing facility residents
- Hospice care members
- Those who use family planning services
- Those who use emergency services except as defined below
- Georgia Pathways to Coverage members.

The following table lists the copay schedule for Medicaid members. Copays for medical services or prescription drugs are paid to the health care provider at the time of service. Covered services cannot be denied to members based on their inability to pay these copays.

Covered service	Copays
Ambulatory surgical centers	A $3 copay will be deducted from the surgical procedure code billed. In the case of multiple surgical procedures, only one $3 amount will be deducted per date of service.
FQHCs/RHCs	A $2 copay for all FQHC and RHC visits
Inpatient services	A $12.50 copay for hospital inpatient services **Additional exceptions:** Members admitted from an emergency department or after receiving urgent care, or transferred from a different hospital, from a skilled nursing facility or another health facility are exempt from the inpatient copay.
Oral maxillofacial surgery	A $2 copay for management procedure codes (99202, 99499) billed by an oral surgeon
Outpatient services (nonemergency)	A $3 copay is required on all nonemergency outpatient hospital visits.
Physician services	A $2 copay on all evaluation and management procedure codes (99202-99499), including the ophthalmologic services procedure codes (92002-92014) used by physicians or physician assistants
Prescription drugs	**Drug cost** — **Copay** < $10.01 — $0.50 $10.01-$25 — $1 $25.01-$50 — $2 > $50.01 — $3

Subject to payment at fee for service rates, Amerigroup implemented copays for PeachCare for Kids. Copays only apply to services provided to members 6 years of age and older.

Copays for PeachCare for Kids

Services excluded from copays include:

- Emergency services.
- Preventive care services like routine checkups.
- Immunizations.
- Routine preventive and diagnostic dental services like oral examinations, prophylaxis, topical fluoride applications, sealants and X-rays.

The following table lists the copay schedule for PeachCare for Kids members. Covered services cannot be denied to members based on their inability to pay these copays.

Category of service	Copay amount
Ambulatory surgical centers/birthing	$3
Durable medical equipment	$2
Federally qualified health center	$2
Freestanding rural health clinic	$2
Home health services	$3
Hospital-based rural health center	$2
Inpatient hospital services	$12.50
Oral maxillofacial surgery	Cost-based
Orthotics and prosthetics	$3
Outpatient hospital services	$3
Pharmacy (nonpreferred drugs)	Cost-based
Pharmacy (preferred drugs)	$0.50
Physician program services	$2
Podiatry	$2
Vision care	Cost-based

Cost of service	Proposed copay
$10 or less	$0.50
$10.01 to $25	$1
$25.01 to $50	$2
$50.01 or more	$3

Noncovered services by Amerigroup, Medicaid or Georgia Families 360°SM

The following services are not covered:

- Services not considered to be medically necessary
- Investigational and/or experimental services, such as a new treatment that has not been proven to work
- Cosmetic surgeries and services
- Sterilizations for members younger than age 21
- Audiology services, hearing aids and accessories for members age 21 and older
- Heart, lung and heart/lung transplants for members age 21 and older
- Home health services for social services, chore services and Meals On Wheels
- Hysterectomy if it is performed solely for the purpose of rendering a member permanently incapable of reproducing or if it is performed for the purpose of cancer prophylaxis
- Long-term nursing facility stays over 30 days
- Optometric services for members age 21 and older unless a value-added benefit
- Orthotic and prosthetic services for members age 21 and older; orthopedic shoes and support devices for the feet that are not an integral part of a leg brace except for diabetic shoes
- Podiatric services for flatfoot, subluxation, routine foot care, support devices and vitamin B-12 injections
- Portable X-ray services, services provided by a facility not meeting the definition of an independent laboratory or X-ray facility, services provided by a state public laboratory (see list in **Appendix A**), laboratory facilities not *CLIA*-certified

For more information about noncovered services, please call Provider Services at **800-454-3730**.

Members and practitioners can access staff to discuss UM issues. The organization provides the following communication services for members and practitioners:

- Staff are available at least 8 hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.
- Staff can receive inbound communication regarding UM issues after normal business hours
- Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues
- TDD/TYY services are available for members

Self-referral services

Members have direct access to the following services rendered by an Amerigroup network provider qualified to provide the required service:

- Behavioral health services (mental health and/or substance abuse) from any state approved Medicaid mental health in-network provider
- Dental services
- Vision services
- Emergent/urgent care
- Eye care services (except surgeries)
- EPSDT services
- Annual exams from a network OB/GYN
- Screening and testing for sexually transmitted diseases including HIV by a network physician

Behavioral health services
Precertification and notification

The following details the services that require precertification, which providers must seek prior to approval from Amerigroup. To find out if a service requires precertification:

- Log in to the Amerigroup provider website at **provider.amerigroup.com/GA** and select **Prior Authorization Lookup Tool** from the *Claims* drop down menu. Or you can access the Interactive Care Reviewer, our online authorization tool through Availity (**https://Availity.com**). Select **Patient Registration** from the menu on Availity's homepage, then choose **Authorizations and Referrals** from the menu.
- See the **Precertification** section of this manual.
- Check your Quick Reference Card (also located at **provider.amerigroup.com/GA** > Resources > Provider Manuals, Policies and Guidelines).

For more detailed information, see **Medical Management**.

Out-of-network providers

If Amerigroup does not have a health care provider with appropriate training and credentials in our panel or network meeting geographic access requirements defined by the state of Georgia to meet a Georgia Families or Georgia Families 360°SM member's particular health care needs, Amerigroup will coordinate with an appropriate out-of-network provider. The out-of-network provider services are pursuant to a treatment plan approved by Amerigroup, in consultation with the member's PCP; the noncontracted provider; and, where applicable, the foster or adoptive parent, caregiver, or DFCS staff or DJJ staff member at no additional cost to the Georgia Families or Georgia Families 360°SM member.

Standing referrals

When the member's medical and behavioral health necessitates, standing referrals to specialists are permitted. See the **Specialty Referrals** section of the manual for instructions and details. Authorizations for referrals are not required when utilizing a participating provider for a covered service. All referrals for a nonparticipating provider for a covered service will require prior authorization.

Children First and Babies Can't Wait

As a network provider, you are required to identify and refer to the designated Children 1st or Babies Can't Wait program for assessment and evaluation of any Georgia Families or Georgia Families 360°SM member, age birth through 35 months of age, who is:

- Suspected of having a developmental delay or disability.
- At risk of delay.
- Suspected of exposure to substantiated maltreatment (so a developmental screening as required by the *Child Abuse Prevention and Treatment Act* can be performed).

Dental services

Amerigroup members do not need a referral to use their dental care benefits. Members younger than age 21 and pregnant women have the following covered services as part of their EPSDT services:

- Preventive, diagnostic and treatment services
- Exam and cleaning every six months
- X-rays every six months
- Emergency dental services

Amerigroup members age 21 and older have a value-added benefit for the following services:

- Exam and cleaning every six months
- X-rays every 12 months
- Simple extractions
- Emergency dental services

Dental benefits are administered through our network vendor DentaQuest. You may contact DentaQuest at **800-516-0124**.

The DentaQuest Provider Manual is available at **dentaquest.com/state-plans/regions/georgia/dentist-page**.

Dental homes

Amerigroup offers dental homes to Georgia Families and Georgia Families 360°SM members to further facilitate coordination of care and improve health outcomes related to dental conditions that have downstream affects to overall health and quality of life. Dental homes, or primary dental providers, will serve as the point of reference for coordinating dental care for Georgia Families 360°SM members.

Selection of a primary dental provider
If a dentist is not voluntarily selected by the member, parent, adoptive parent, residential placement provider, DFCS case manager, caregiver, foster parent or foster care member upon enrollment, Amerigroup will automatically assign the member to a primary dental provider (PDP) within five business days of receipt of notification of the member's enrollment.

For Georgia Families 360°SM members
Following notification of a change in placement, Amerigroup will assess the member's access to the assigned dental provider. If the dental provider no longer meets the documented geographical standards within the state's contract with Amerigroup, a new dental provider will be selected by the case manager, caregiver, or residential or placement provider within two business days of relocation or Amerigroup will reassign a PDP within five business days of receipt of notification of member relocation.

An eligibility file or written notification from DCH, DFCS or DJJ will serve as notification of the member's relocation.

Vision services

Amerigroup members have direct access to vision providers.

Amerigroup members under age 21 have the following covered services as part of their EPSDT services (every 12 months):

- Routine refractions
- Routine eye exams
- Medically necessary eyeglasses or contact lenses
- Amerigroup also offers a value added benefit for members 21 years and older
- Comprehensive vision exam every 12 months
- Frames and lenses once per year
- Contact lenses are included (if medically necessary)

All vision services are administered through our network vendor Avesis. You may contact Avesis at **866-522-5923**.

Pharmacy services

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. Members have access to most national pharmacy chains and many independent retail pharmacies.

Amerigroup has contracted with CarelonRx, Inc. as our pharmacy benefits manager (PBM). All members must use a contracted in-network pharmacy when filling prescriptions in order for benefits to be covered. We have a mandatory generic drug program. Brand-name products are covered if a generic substitution is not available or where the prescribing physician indicates that a brand name is medically necessary.

Monthly limits

The majority of prescriptions are limited to a maximum 31-day supply; however, there are a few exceptions:

- Injectable contraceptives may be dispensed for a 90-day supply.
- Extended 60-day supply may be dispensed at the retail pharmacy for certain non-specialty maintenance medications used to treat asthma, depression, and diabetes after two previous 30-day retail fills of the same dose.
- Mail order (also referred to as home delivery) is available for up to a 60-day supply for certain non-specialty maintenance medications after two previous 30-day retail fills of the same dose. Foster Care and Department of Juvenile Justice members are only eligible to receive a 30-day supply through mail order. Once a member enrolls in mail order, the provider can send prescriptions to CarelonRx Pharmacy in the following ways:
    - ePrescribe: Search for CarelonRx Pharmacy in your ePrescribing platform
    - Fax: **800-378-0323**
    - Phone: **833-203-1742**

Outpatient pharmacy refills are allowed when 90 percent of the previous supply has been used while specialty drugs have a 75 percent refill threshold.

Automatic refills are not allowed. All prescription refills shall be initiated by a request from the physician, member, or other person acting as an agent of the member (in other words, family member).

Co-pays
Co-pays are on a sliding scale using the drug's calculated ingredient cost (CIC). Co-pays range from $0.50 to $3.00.

Exclusions to co-pays include:

- Prescriptions for diabetic supplies (lancets, test strips, needles, and syringes), naloxone, and emergency prescriptions
- Certain over-the-counter (OTC) medications are offered as a value-added service by Amerigroup at no cost to eligible members.

A pharmacy may not deny services to any eligible Amerigroup member because of the member's inability to pay the co-payment.

Covered drugs

The Amerigroup Pharmacy Program uses a *Preferred Drug List* (*PDL*). This is a list of the preferred drugs within the most commonly prescribed therapeutic categories. The *PDL* is comprised of drug products reviewed and approved by the Amerigroup Pharmacy and Therapeutics (P&T) Committee. The P&T Committee is an independent committee comprised of external practicing physicians, pharmacists, and clinicians from leading academic medical centers with expertise in evidence-based medicine. All major clinical specialties are represented. The P&T Committee meets four times per year to review evidence related to the safety and efficacy of drugs, biologics, and devices. Their decisions create drug lists that are evidence-based and reflect clinically appropriate therapy.

Over the counter (OTC) medications specified in the Georgia State Medicaid plan and included in the *PDL* are covered with a valid prescription from a physician.

To prescribe medications that are nonformulary or do not appear on the *PDL*, please refer to the section on *Pharmacy Prior Authorization (PA) Process*. The *PDL*, including current updates and information on additional requirements and limitations, such as prior authorization, quantity limits, age limits or step-therapy, can be found at **provider.amerigroup.com/georgia-provider/resources/pharmacy-information.** Providers can also use real-time prescription benefit functionality which is a tool supported by Surescripts® integrated within the e-prescribing process to check member specific formulary status, alternatives, members cost share and PA or step edit requirements.

The following are examples of covered items:

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

Diabetic supplies

Diabetic supplies are covered under the outpatient Pharmacy benefit.

The preferred blood glucose meter and test strips are the True Metrix products.

Pharmacy prior authorization (PA) process
Providers are strongly encouraged to write prescriptions for preferred products as listed on the *PDL*. If a member cannot use a preferred product because of failure, contraindication or intolerance, providers are required to contact Amerigroup pharmacy services to obtain a PA before sending the prescription to the retail or specialty pharmacy. PA requests may be submitted in three ways:

1. Electronically (referred to as ePA) through **covermymeds.com**
2. Faxing the completed PA form to **844-490-4736** (for drugs under pharmacy benefit) or to **844-490-4870** (for drugs under medical benefit)
3. Calling Provider Services at **800-454-3730** (Monday-Friday 7 a.m.-7 p.m.)

The two standard PA forms are located on the website.

- Outpatient pharmacy PA form (for pharmacy benefit) **provider.amerigroup.com/docs/gpp/GA_CAID_PharmacyPriorAuthorizationForm.pdf?v=202101262004**
- Medical injectables PA form (for medical benefit) **provider.amerigroup.com/docs/gpp/GA_CAID_MedicalInjectablePriorAuthorizationForm.pdf?v=202111171437**

Providers must be prepared to provide relevant clinical information regarding the member's need for a nonpreferred product or medication requiring PA. Decisions are based on medical necessity for the following circumstances:

- Drugs not listed on the *PDL* (for example, non-preferred, non-formulary, or plan exclusion drugs)
- Brand-name products for which there are therapeutically equivalent generic products available
- Drugs that require specific clinical criteria
- Drugs that exceed certain limits (for information on these limits, please refer to the *PDL* on the provider website or contact the Pharmacy department)

Medically necessary drug therapy will be reviewed and provided to all members under age 21 when supported by evidence-based clinical data and clinical history provided by the prescriber for the intended use.

Pharmacy PA requests are processed within 24 hours of receipt, or up to 72 hours if additional information is needed. Medical injectable PA requests are processed within three business days for standard requests and 24 hours for urgent requests.

Prior authorization renewals can only be completed 30 days prior to the existing prior authorization expiring. Medical injectable and pharmacy PAs are approved for up to 52 weeks (1 year) unless limited by the prescriber's request or the drug criteria.

Amerigroup recognizes that it is sometimes necessary for members to begin therapy before a prior authorization is reviewed. In an emergency situation, Amerigroup allows coverage for a three-day (72-hour) supply of certain eligible outpatient prescription drugs before a PA decision is rendered. Each member is allowed one emergency fill per medication and dosage strength per

30 days. Controlled substances (for example, narcotics, ADHD agents) are covered, however, a new prescription must be written to fill the remaining days needed. This policy also applies to covered outpatient prescription drugs that are part of an *unbreakable package*, such as asthma inhalers or insulin vials. This policy **does not** cover:

- Compounded drugs.
- Specialty drugs.
- Over-the-counter (OTC) products.
- Cough and cold products (OTC and prescription).
- Blood glucose meters.
- Vaccines.

Our in-network pharmacies are authorized to follow this policy and, at their discretion, will dispense a three-day (72-hour) emergency supply when an eligible prescription drug is ordered.

Pharmacy peer to peer consults

When a prior authorization (PA) has been denied, providers may request a pharmacy peer-to-peer (PTP) consult to review the decision with a pharmacist and provide additional clinical information to support overturning the denial. Providers have the ability to contact Provider Services at **800-454-3730** to speak to a PTP technician who will gather all information needed to initiate the request and schedule a call with the reviewer or leave a voicemail with this information to request a PTP. **A pharmacy PTP request cannot be submitted by email.**

The PTP request must occur within 30 days of the PA denial. Once the PTP request has been left on the voicemail or taken by the PTP technician and cannot be overturned, the provider will be contacted within 24-72 business hours by the pharmacist or Medical Director for review. If the denial is overturned, the provider will be sent a new approval letter via fax. If the denial is upheld for the same reason, no additional notification will be sent to the provider.

The PTP process cannot be initiated once a PA denial has been appealed (in other words, filed or completed).

Over-the-counter drugs

Amerigroup has an over-the-counter (OTC) medication benefit. The member must obtain a valid prescription from a physician for certain OTC or non-legend drugs to receive this benefit. Some examples of covered OTC medication classes can be found at **provider.amerigroup.com/docs/gpp/GA_CAID_ProviderOTCList.pdf?v=202012230000**

Feminine hygiene products (pads and tampons) are also covered as an OTC benefit with a prescription required. Providers are encouraged to prescribe these products with eleven (11) refills to provide coverage for a full year. The list of available products can be found on the website at: **provider.amerigroup.com**

Excluded drugs

Below are examples of medications that are excluded from the pharmacy benefit:

- Erectile Dysfunction Drugs or sexual enhancement

- Cosmetic Applications (Anti-wrinkle, Hair removal, Hair growth)
- Weight Loss Drugs directly related to the treatment of obesity (except OTC Alli, which requires a prior authorization)
- Fertility or infertility products
- Claims for brand drugs where there is a generic available will reject, regardless of DAW code submission. We have a mandatory generic program.
- DESI drugs and Identical, Related and Similar (IRS) drugs that are classified as ineffective
- Legend drugs that are not included in a rebate agreement with the Secretary of the U.S. Department of Health and Human Services or otherwise approved for coverage by the Agency
- Experimental or investigational drugs
- Non-FDA approved drugs
- Outpatient drugs when the manufacturer requires as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Drugs administered to recipients who are hospitalized or receiving emergency room treatment
- Drugs given by an outpatient hospital or ambulatory surgery center in conjunction with laboratory, X-ray and other medical procedures
- Drugs dispensed to recipients in a skilled nursing facility who are covered by Medicare Part A
- Drugs dispensed to a dually eligible Medicaid and Medicare recipient whose nursing home or hospice stay is reimbursed by Medicare
- Oxygen, blood, and blood plasma
- Durable Medical Equipment (DME) and medical supplies unless listed on the Plan's Preferred Drug List

Transition of Care
Members who are in ongoing treatment or who are receiving medication that has been covered by fee-for-service (FFS) or another care management organization (CMO) prior to the effective date at Amerigroup will be covered for at least 30 days to allow time for a clinical review (in other words, PA) if needed. Amerigroup is not obligated to cover services beyond 30 days, even if the previous authorization was for a period greater than 30 days.

Specialty drug program
Specialty drugs may be covered as a pharmacy benefit or an outpatient medical benefit. Providers should refer to our searchable formulary for pharmacy benefit drugs **(provider.amerigroup.com/georgia-provider/resources/pharmacy-information)** and the searchable Prior Authorization Lookup Tool for medical benefit drugs **(provider.amerigroup.com/georgia-provider/claims/prior-authorization-lookup-tool)** to

determine if a prior authorization is needed. Once the PA has been submitted and approved, providers should send the prescription to one of the following in-network specialty pharmacies.

- For specialty drugs given as a pharmacy benefit:
  - CarelonRx Specialty Pharmacy
    - Phone: **833-255-0646**
    - Fax: **833-263-2871**
  - Twelvestone Pharmacy
    - Phone: **844-893-0012**
    - Fax: **800-223-4063**
- For specialty drugs given as a medical benefit:
  - CVS CareMark Specialty Pharmacy
    - Phone: **877-254-0015**
    - Fax: **866-336-8479**

Amerigroup contracts with these specialty pharmacies and other in-network specialty pharmacies as our suppliers of high-cost, specialty/injectable drugs that treat a number of chronic or rare conditions including:

- Anemia
- Crohn's disease
- Cystic fibrosis
- Gaucher disease
- Growth hormone deficiency
- Hemophilia
- Hepatitis C
- Immunologic disorders
- Multiple sclerosis
- Neutropenia
- Primary pulmonary hypertension
- Rheumatoid arthritis
- Respiratory syncytial virus (RSV) disease

New specialty drugs continually become available, so check with our searchable drug tools or call Provider Services before ordering any specialty/injectable drugs.

Clinical pharmacy programs

The purpose and goal of medication management programs are to improve quality of care, member experience and HEDIS® quality scores while reducing inappropriate utilization and meeting state contract requirements. In order to achieve these goals, clinical pharmacy programs are offered as a service or group of services to optimize drug therapy and improve therapeutic outcomes for patients.

The Clinical Pharmacy Programs are offered through retrospective Drug Utilization Reviews (DUR) that is defined as an authorized, structured, ongoing review of prescribing, dispensing, and use of medications. They are delivered via mailings, faxes, or phone calls. These programs change as the needs of members change and as industry best practices evolve. The following programs are offered at this time:

- Diabetes Polypharmacy Program
- Opioid Medication Management and Outlier Prescriber Program
- Asthma Medication Management: letter/fax campaign
- Asthma Adherence: call campaigns
- Behavioral Health (BH) Polypharmacy and Child Age-Appropriate Programs

- Antidepressant New Start
- ADHD New Start/Follow-up Care

ZipDrug is another clinical pharmacy program that partners with local independent community pharmacies to provide telephonic and face-to-face interactions for adherence support and education, medication synchronization, compliance packaging, and convenient hand delivery to eligible members. Based on targeted disease states, ZipDrug focuses on members in high-risk clinical categories and/or those with HEDIS gaps.

Psychotropic Medication Management Program for Georgia Families 360°SM

As a component of the Georgia Families 360°SM program, Amerigroup utilizes a psychotropic drug prescription management program. The use of psychotropic medications is an integral part of treatment for persons receiving care for behavioral health conditions. As such, the use of psychotropic medications must be monitored closely to help ensure that persons are treated safely and effectively. The goal of the program is to work collaboratively with prescribers to improve the quality and efficacy of psychotropic drug prescribing patterns and to improve the health outcomes of Georgia Families 360°SM members. The program is designed to ensure the safety of persons taking psychotropic medications, reduce or prevent the occurrence of adverse side effects, and help the child, adolescent, or young adult taking psychotropic medications receive optimal functioning and achieve positive clinical outcomes.

The program specifically assesses prescribing patterns and treatment plans for psychotropic medications and medications at risk of abuse. The program also intervenes and seeks to improve decision-making, medication adherence, detect and reduce adverse drug events, monitor and reduce patterns of overuse, and provides frequent and routine outreach for high-risk children involved in the child welfare system.

The program ultimately ensures members are only prescribed medications when in their best interest and that is consistent with evidence-based prescribing practices. Claims data is used to identify members and their prescribing physicians, with respect to the following clinical and safety issues:

- Lack of or poor adherence to prescribed medications and dosages
- Prescriptions for psychotropic medications from multiple prescribers
- Prescriptions for more than two psychotropic medications
- Prescriptions for psychotropic medications that exceed the maximum recommended dosage
- Use of psychotropic medications in children under age 6 years
- Therapeutic duplication
- Drug-to-drug interactions
- Children prescribed psychotropic medications but are not provided appropriate non-pharmacologic treatments (in other words, psychotherapy)

The program seeks to improve care for Georgia Families 360°SM members by educating prescribing clinicians about evidence-based best practices for mental health medications and reducing inefficient and ineffective prescribing patterns.

Medication management programs have been shown to be effective at improving health care quality while reducing medical and pharmacy costs.

Visit our searchable formulary at **provider.amerigroup.com/georgia-provider/resources/pharmacy-information** for clinical criteria related to a particular psychotropic drug.

Pharmacy-Prescriber Restriction (Lock-In) Program
The Lock-In Program identifies Georgia members who have shown a consistent pattern of overutilization of pharmacy benefits and assigns them to a Pharmacy-Prescriber Lock-In to manage these benefits. This program is based on overutilization of providers, medications, and pharmacies, particularly for obtaining narcotics and controlled drugs. Members may be enrolled if they meet overutilization criteria based on pharmacy claims reports, when requested by a provider, outside agency, or health plan associate, or in cases of suspected waste, fraud, or abuse.

In the Lock-In Program, members will be assigned to one retail pharmacy for all medications and to one or two prescribers for certain classes of controlled medications (for example, opiates, ADHD stimulants, barbiturates, benzodiazepines, sedative-hypnotics, and Carisoprodol in DEA controlled drug schedules II-IV).

a. Prescription claims will only be reimbursed when filled at the assigned Lock-In pharmacy. This program does not pertain to specialty medications as designated by the Amerigroup formulary. Restricted members who are receiving specialty medications will have these medications supplied by a pharmacy within our specialty pharmacy network.
b. Lock-In prescribers must be enrolled in GA Medicaid and agree to care for the member under the program guidelines. Assigned controlled drug prescribers may include the member's Primary Care Provider (PCP) or primary prescriber, and may also include contracted specialists (for example, Pain Management Specialist, Psychiatrist, Orthopedic Surgeon). Claims will only be reimbursed when filled at the assigned Lock-In Pharmacy and written by the assigned Medicaid Lock-In prescriber(s).

The Lock-In criteria include the use of three or more providers and three or more pharmacies and either three or more opiates or five or more controlled substances in the last ninety days.

After the determination is made that the member fits the criteria for the Lock-In program, the member is notified in writing via certified mail of the decision to restrict the member to a single pharmacy for all medicines, and to one or two designated prescriber(s) for controlled medicines only prior to the restriction taking place. The member will have 10 days from the date of the letter to request a different pharmacy/prescriber(s).

Lock-In prescriber(s) will be notified in writing 10 days prior to the restriction start date of the decision to assign the member to a single pharmacy for all medicines, and to one or two designated controlled drug prescriber(s) for controlled medicines only. The letter will contain, at a minimum, the following information:

a. General information on the pharmacy restriction and review process;
b. Identification of the Lock-In pharmacy;

c. A 6-month prescription profile; and
d. Educational materials to review with the member

Once the member has been restricted to a pharmacy and prescriber(s), a request to change pharmacies/prescribers will be considered only for good cause. Good cause acceptable reasons are as follows:

a. Pharmacy Changes
    1) The member has moved out of the designated pharmacy area 30 miles or 30 minutes for rural, 15 miles or 15 minutes for urban
    2) The designated pharmacy is consistently unable to provide the needed medication at the time of fill
    3) The designated pharmacy has closed, is no longer an in-network pharmacy or participates with Medicaid, or refuses to provide services to the member
    4) The member's PCP or specialist office has relocated, or the member has been re-assigned to a different PCP or specialist office
b. Prescriber Changes
    1) The member relocates outside of the prescriber's zip code radius
    2) The prescriber closes or relocates outside of the member's zip code radius
    3) The prescriber cannot provide the needed medications or services on a regular basis
    4) The prescriber requests the member be transferred
    5) The prescriber stops participating in GA Medicaid

The Lock-In program includes members aged 18 and older. Members with active cancer, sickle cell, or in hospice are not considered eligible for this program. A member's Lock-In status is reviewed on an annual basis to determine if further coordination of care is needed.

All members enrolled in the Pharmacy-Prescriber Lock-In Program will be offered Case Management services. When deemed necessary, the case manager (CM) will educate members regarding appropriate pharmacy utilization including the risks of usage patterns for current medications, coordination of care with multiple providers, and the importance of medical adherence and timely prescription renewal. The CM will also inform the member of the availability and process for accessing mental health and substance abuse services.

6 Member rights and responsibilities

Members have rights and responsibilities when participating with a managed care organization. Our Member Services representatives serve as advocates for Amerigroup members. The following lists include rights and responsibilities identified for members. Member rights and responsibilities can be found at **provider.amerigroup.com/GA** or you may request a copy by calling Provider Services at **800-454-3730**, Monday-Friday from 7 a.m.-7 p.m. Eastern time.

Members have the right to:

- Receive information pursuant to *42 CFR 438.10.*
- Receive information about Amerigroup, our services, policies and procedures, providers, member rights and responsibilities and any changed made upon request.
- Be treated with respect with due consideration for dignity and privacy.
- Privacy during a visit with their doctor.
- Talk about their medical record with their provider and ask for a summary of that record and request to amend or correct the record as appropriate.
- Know what benefits and services are included and excluded from coverage.
- Candidly discuss their illness and the available health care treatment options for their condition regardless of cost or benefit coverage.
- Participate in the decision making about the health care services they receive with their doctor.
- Refuse health care (to the extent of the law) and understand the consequences of their refusal.
- Be free from any form of restraint or seclusion as a means of coercion, discipline, inconvenience or retaliation as specified in other federal regulations on the use of restraints and seclusion.
- Decide ahead of time the kinds of care they want if they become sick, injured or seriously ill by making a living will and/or providing Amerigroup your advance directive.
- Decide ahead of time the person you want to make decisions about your care if you are not able to by making a durable power of attorney.
- Expect that their records (including medical and personal information) and communications will be treated confidentially and not released without your permission.
- If under age 18 and married, pregnant or have a child, be able to make decisions about themselves and/or their child's health care.
- If you are under 18, expect that you will be able to participate in and make decisions about your own and your child's healthcare if you are married or declared emancipated by a court order.
- Choose their PCP or a new PCP from the Amerigroup network of providers and have privacy during a visit with a doctor.
- Voice a complaint or appeal about Amerigroup or the care the organization provides and get a response within 10 days.
- Have information about Amerigroup, our services, our providers, and member rights and responsibilities.
- Know the Amerigroup process for evaluating new technology for inclusion as a covered benefit.

- Receive information on the *Notice of Privacy Practices* as required by *HIPAA*.
- Be furnished health care services in accordance with *42 CFR 438.206* through *438.210*.
- Get a current member handbook and a directory of health care providers within the Amerigroup network.
- Choose any Amerigroup network specialist.
- Change their doctor to another Amerigroup network doctor if the doctor is unable to refer them to the Amerigroup network specialist of their choice.
- Be referred to health care providers for ongoing treatment of chronic disabilities.
- Have access to their PCP or a backup 24 hours a day, 365 days a year for urgent or emergency care.
- Get care right away from any hospital when their medical condition meets the definition of an emergency.
- Get post-stabilization services following an emergency condition in some situations.
- Call the Amerigroup 24-hour Nurse HelpLine 24 hours a day, 7 days a week.
- Call the Amerigroup Member Services number from 7 a.m.-7 p.m. Eastern time, Monday-Friday.
- Know what payment methodology Amerigroup uses with health care providers.
- Receive assistance in filing a grievance and/or an appeal, and file the appeal through the Amerigroup internal system.
- Make recommendations regarding the Amerigroup member rights and responsibilities policy.
- File a grievance appeal if they are not happy with the results of their grievance and receive an acknowledgement within 10 days and a resolution within 30 days.
- Ask Amerigroup to reconsider previously denied service; upon receipt of the member's medical information, Amerigroup will review the request.
- Freely exercise the right to file a grievance or an appeal such that exercising of these rights will not adversely affect the way the member is treated.
- Receive notification to present supporting documentation for their grievance.
- Receive information on available treatment options and alternatives, regardless of cost or benefit coverage.
- Examine files before, during and after a grievance.
- Request a state fair hearing when dissatisfied with the Amerigroup decision.
- Continue to receive benefits pending the outcome of a grievance decision or a state fair hearing.
- Only be responsible for cost-sharing in accordance with *42 CFR 447.50-42 CFR 447.60* and Georgia Medicaid provisions as follows:
    - Not be held liable for a contractor's debts in the event of insolvency
    - Not be responsible for covered services provided for which DCH does not pay a contractor
    - Not be liable for covered services for which DCH or the CMO does not pay the provider that furnished the service
    - Not be liable for payment of covered services furnished under a contract, referral or other arrangement to the extent that the payments are in excess of amount the member would owe if the contractor provided the services directly

- Discuss any issues regarding medical management issues or concerns by calling Member Services at **800-600-4441**

Members have the responsibility to:

- Treat their doctors, their doctors' staff and Amerigroup employees with respect and dignity.
- Not be disruptive in the doctor's office.
- Respect the rights and property of all providers.
- Cooperate with people providing their health care.
- Tell their PCP about their symptoms and problems and ask questions.
- Get information and consider treatments before they are performed.
- Discuss anticipated problems with following their doctor's directions.
- Consider the outcome of refusing treatment recommended by a doctor.
- Help their doctor obtain medical records from their previous doctor and help their doctor complete new medical records as necessary.
- Respect the privacy of other people waiting in doctors' offices.
- Get referrals from their PCP before going to another health care provider unless it is a medical emergency.
- Call Amerigroup to change their PCP before seeing a new PCP.
- Make and keep appointments, and be on time; call if they need to cancel or change an appointment, or if they will be late.
- Discuss complaints, concerns and opinions in an appropriate and courteous way.
- Tell their doctor who they want to receive their health information.
- Obtain medical services from their PCP.
- Learn and follow the Amerigroup policies outlined in the member handbook.
- Read the member handbook to understand how Amerigroup works.
- Notify Amerigroup if a member or family member who is enrolled in Amerigroup has died.
- Give Amerigroup proper identification when they enroll.
- Provide Amerigroup and their doctor information they need to take care of their medical needs.
- Understand and become involved in their health care and cooperate with their doctor about recommended treatment.
- Understand their health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.
- Follow plans and instructions for care to which they have agreed with their practitioners.
- Know the correct way to take their medications.
- Carry their Amerigroup ID card at all times and report any lost or stolen cards to Amerigroup quickly; report incorrect/new information or marital status.
- Carry their Medicaid or PeachCare for Kids ID card at all times.
- Show their ID cards to each provider.
- Tell Amerigroup about any doctors they are currently seeing.
- Provide true and complete information about their circumstances.
- Report changes in their circumstances.

- Notify their PCP as soon as possible after they receive emergency services.
- Go to the emergency room when they have an emergency.
- Report suspected fraud and abuse.
- Give information that Amerigroup providers and practitioners need in order to render care.
- Follow agreed-upon treatment plans and instructions for care.

Nondiscrimination Notice
Amerigroup is a Health Plan licensed as a Care Management Organization in the state of Georgia who administers the Medicaid, and Children's Health Insurance Programs in Georgia. Amerigroup doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by Amerigroup directly or through a contractor or any other entity with which Amerigroup arranges to carry out its programs and activities.

Fraud or other Misrepresentation Notice
Amerigroup will not intentionally misrepresent information or furnish false statements to a Member, Potential Member, or health care Provider.

Member *Explanation of Benefits*

Amerigroup will provide an *Explanation of Benefits (EOB)* to members who receive services that are not paid for by Amerigroup. The provider of service will also receive a notice of the denial of payment. The member is advised on the *EOB* that it is not a bill and he or she is not responsible for payment of services.

The *EOB* indicates that an appeal may be requested by the member or the provider for this payment decision. The request must be received within 30 calendar days from the date of notice (*EOB* date). To request an appeal for medical necessity, the member or provider (with written member consent) should send the request and medical information for the service(s) to:

Appeals Specialty Unit
Amerigroup Community Care
P.O. Box 62429
Virginia Beach, VA 23466-2429

Members may also call Member Services to request a review but must follow up in writing and send any documents or medical records they would like reviewed. The *EOB* also provides additional information on further appeal rights following the appeal.

Appeals and Grievances

Member appeal process
Amerigroup maintains an internal process for the appeal of an adverse benefit determination.

Appeal: a review of an adverse benefit determination

Adverse benefit determination:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit
2. The reduction, suspension or termination of a previously authorized service
3. (3) The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at §447.45(b) of this chapter is not an adverse benefit determination.
4. The failure to provide services in a timely manner as defined by the state
5. The failure of Amerigroup to act within the time frames provided in *§ 438.408(b) (1)* and *(2)* regarding the standard resolution of grievances and appeals
6. For a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right under *§ 438.52(b) (2) (ii)* to obtain services outside the network
7. The denial of a member's request to dispute a financial liability, including cost sharing, copays, premiums, deductibles, coinsurance, and other enrollee financial liabilities

The Amerigroup process allows for a physician or any other health care provider to advocate for medically appropriate health care services for his or her patients without retaliation. No member or provider is penalized for initiating a standard or expedited appeal.

Types of appeals

Expedited appeal: expression of dissatisfaction related to an adverse benefit determination about care currently being given that has a clinical urgency

Pre-service appeal: a review to change an adverse benefit determination for care or service in advance of the member obtaining the care or service

Post-service/retrospective appeal: a review to change an adverse benefit determination for care or service that has already been received by the member

Filing an appeal

Information about how to file an appeal is available in writing in English and Spanish. Amerigroup provides a Member Services representative to assist a member in writing an appeal. Other assistance is provided as needed, including other language translations, formats accessible to the visually impaired, and TDD and TTY lines for the hearing impaired.

For standard pre-service appeals, the member, a member's authorized representative or a provider on behalf of a member (with the member's written consent) may file an appeal request within 60 calendar days of the date of the *Adverse Benefit Determination Letter*.

For post-service/retrospective appeals, the member, a member's authorized representative or a provider may file a post-service appeal request (no consent required) within 60 calendar days of the date of the *Adverse Benefit Determination Letter*.

All appeal requests should be sent to:

Medical Appeals

Amerigroup Community Care
P.O. Box 62429
Virginia Beach, VA 23466-2429
Phone: **800-600-4441**

If a decision is required immediately due to the member's health needs, providers may request an expedited appeal. Requests may be initiated by calling Member Services at **800-600-4441**.

If the appeal request is not received within 60 calendar days from the date of notice of *Adverse Benefit Determination Letter*, it is considered untimely. Amerigroup will send written notice, and the appeal request will be closed.

Amerigroup provides the member an opportunity to present evidence and allegations of fact or law in person (as well as in writing) at any time during the standard or expedited appeal process. For expedited appeals, the member or member's representative can submit additional evidence within 72 hours of the expedited appeal request.

Member appeal resolution
Amerigroup fully investigates the content of each appeal and documents the substance of the appeal. Amerigroup ensures each appeal is reviewed by an appropriate health care provider that is in the same or similar specialty as the health care provider who typically manages the medical condition, procedures or treatment under review. The health care provider will not have had any involvement in the initial action that is the subject of the appeal and will not be a subordinate of the initial reviewer. However, the medical director who made the initial decision may review the case and overturn the initial decision.

Amerigroup will notify the member and provider in writing, in the member's primary language, of the decision and the reason for the decision. We will do this according to the following within the following time frames:

- Expedited appeals: within 72 hours of receiving the appeal request
    - If Amerigroup denies a request for expedited appeal, Amerigroup will transfer the appeal to the time frame for standard resolution (specified herein) and must make reasonable efforts to give the member prompt, oral notice of the denial. Amerigroup must follow up within two calendar days with a written notice. Amerigroup should also make reasonable efforts to provide oral notice for resolution of an expedited review of an appeal. If the member disagrees with this decision, they can file a grievance
- Pre-service nonurgent appeals: within 30 calendar days of receipt of the appeal request
- Post-service appeals: within 30 calendar days of receipt of the appeal request

The appeal decision time frame may be extended to resolve appeals and to obtain additional information by up to 14 calendar days if:

1. The member voluntarily agrees or requests to extend the appeal time frame or
2. The health plan demonstrates the need for additional information and clarification about how the delay is in the member's interest

3. If the member disagrees with the decision, the member or authorized representative may file a grievance

Amerigroup will not take, or threaten to take, any punitive action against any provider acting on behalf of or in support of a member requesting an appeal or an expedited appeal. Members have the opportunity to review their files and other applicable information relevant to the reviews of the decision, upon request and free of charge. Members may also submit additional information, or documents of fact or law. The time frame to submit additional information is limited for expedited appeals.

Administrative Law Hearing State fair hearing: Medicaid members
An administrative law hearing/ state fair hearing is an appeal process administered by the state in accordance with *O.C.G.A. §49-4-153*. As required by federal law, it is available to members and providers after they exhaust the Amerigroup appeals process. The administrative law hearing /state fair hearing process provides Medicaid members an opportunity for a hearing before an administrative law judge. Upon receipt of an adverse decision regarding a pre-service appeal, a member or member's authorized representative has the right to request an administrative law hearing / state fair hearing. For post service appeals, the provider has the right to request a state fair hearing.

The Amerigroup appeal process must be exhausted before the member (pre-service) or provider (post-service) can request an administrative law hearing / a state fair hearing. The member or provider must request a state fair hearing no later than 120 calendar days from the date of the appeal resolution letter. The request should be mailed to:

Administrative Law Hearing/State Fair Hearing Request
Amerigroup Community Care
740 W Peachtree St NW
Atlanta, GA 30308

Formal grievance review: PeachCare for Kids members

The Georgia Department of Community Health allows a state review on behalf of PeachCare for Kids members. If the member, parent or other authorized representative believes that a denied service should be covered, the parent or other authorized representative must send a written request for review to Amerigroup.

If the Amerigroup review decision maintains the denial of service, a letter will be sent to the parent or representative detailing the reason for denial. If the parent or representative elects to dispute the decision, the parent or representative will have the option of having the decision reviewed by the formal grievance committee.

Upon receipt of an adverse decision regarding an appeal, a member or member's authorized representative has the right to request a formal grievance committee review. A provider cannot

request a formal grievance committee review on behalf of a member. The request must be in writing and submitted within 30 calendar days of the appeal resolution letter. The request should be mailed to:

Georgia Department of Community Health
PeachCare for Kids
Administrative Review Request
2 Martin Luther King Jr. Drive SE East Tower
Atlanta, GA 30334

Continuation of Benefits

Amerigroup members may request that benefits continue while the appeal, administrative law hearing or formal grievance committee review is pending. To request continuation of benefits, members can call Member Services at **800-600-4441** or complete the *Continuation of Benefits* form included in the *Adverse Benefit Determination Letter*. To ensure continuation of currently authorized services, the request must be made on or before the latter of:

- Ten calendar days following our mailing of the notice of adverse benefit determination.
- The intended effective date of the adverse benefit determination.
- The intended effective date of the resolution letter from the appeal process.

Amerigroup shall continue the member's coverage of benefits if all the following occur:

- The member or member's authorized representative files a timely appeal (within 10 calendar days of Amerigroup mailing the notice of adverse benefit determination or the intended effective date of the adverse benefit determination).
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment.
- The services were ordered by an authorized provider.
- The original period covered by the original authorization has not expired.
- The member requests a continuation of benefits within 10 calendar days of the notice of adverse benefit determination or the intended effective date of the adverse benefit determination.

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

- The member withdraws the appeal or request for state fair hearing.
- The member fails to request an administrative law hearing/ state fair hearing and continuation of benefits within 10 calendar days after Amerigroup sends the notice of an adverse resolution to the member's appeal.
- The administrative law hearing/ state fair hearing office issues a hearing decision adverse to the member.

If the final determination of the state fair hearing (state's administrative law hearing) is not in the member's favor, the member may be responsible for the cost of the continued benefits. If the final determination of the appeal is in the member's favor, Amerigroup will authorize coverage of and arrange for disputed services promptly and as expeditiously as the member's health

condition requires. If the final determination is in the member's favor and the member received the disputed services, Amerigroup will pay for those services.

Member Grievances

Grievance: an expression of dissatisfaction about any matter other than an adverse benefit determination; examples of a grievance may include but are not limited to:

- Quality of care or services provided
- Rudeness of staff
- Unfulfilled requests

Amerigroup provides an internal grievance process for member concerns. Member grievances are resolved in a way consistent with health plan policies, covered benefits, and member rights and responsibilities.

A member or member's authorized representative (with written consent from the member) may file a grievance at any time. Any supporting documentation must accompany the grievance. All requests should be sent to:
Appeal and Grievance Department

Amerigroup Community Care
P.O. Box 62429
Virginia Beach, VA 23466

Fax: 877-842-7183

A provider cannot file a grievance on behalf of a member or Planning for Healthy Babies enrollee.

Filing a member grievance
Information about how to file a grievance is available in writing in English and Spanish.

Amerigroup provides a Member Services representative to assist a member in initiating a grievance. Other assistance is provided as needed, including other language translations, formats accessible to the visually impaired, and TDD and TTY lines for the hearing impaired.

Upon receipt of the member grievance, Amerigroup will acknowledge the grievance in writing within 10 business days of receipt.

Member grievance resolution
Amerigroup will fully investigate each grievance to include, collecting pertinent facts from all parties involved and issue a disposition. A resolution letter will be mailed to the member within 90 calendar days from the date the grievance was received by Amerigroup.

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. It includes any act that constitutes Fraud under applicable Federal or State law.
- *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* — Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to benefit programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care; it also includes beneficiary practices that result in unnecessary cost to the benefit program.

General obligation to prevent, detect and deter fraud, waste and abuse
As a recipient of funds from state and federally sponsored health care programs, we each have a duty to help prevent, detect and deter fraud, waste and abuse. The Amerigroup commitment to detecting, mitigating and preventing fraud, waste and abuse is outlined in our Corporate Compliance Program. As part of the requirements of the federal *Deficit Reduction Act*, each Amerigroup provider is required to adopt Amerigroup policies on detecting, preventing and mitigating fraud, waste and abuse in all the federally and state-funded health care programs in which Amerigroup participates.

If you suspect a provider (for example, provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (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 **fighthealthcarefraud.com** education site; at the top of the page, select **Report it** and complete the ***Report Waste, Fraud and Abuse*** form
    - Calling provider services (contracted providers)
    - Calling customer service (non-contracted providers)
    - Calling our Special Investigations Unit fraud hotline at **866-847-8247**

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. 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.

In order to meet the requirements under the *Deficit Reduction Act*, you must adopt the Amerigroup fraud, waste and abuse policies and distribute them to any staff members or contractors who work with Amerigroup. If you have questions or would like more details concerning the Amerigroup fraud, waste and abuse detection, prevention and mitigation program, visit our educational website, **fighthealthcarefraud.com** or contact our Special Investigations Unit at the fraud hotline **866-847-8247**.

Importance of detecting, deterring and preventing fraud, waste and abuse
Health care fraud costs taxpayers increasingly more money every year. There are state and federal laws designed to address these crimes and impose strict penalties. Fraud, waste and abuse in the health care industry may be perpetuated by every party involved in the health care process. There are several stages to inhibiting fraudulent acts, including detection, prevention, investigation and reporting. In this section, we educate providers on how to help prevent member and provider fraud by identifying the different types so you can be the first line of defense.

Many types of fraud, waste and abuse have been identified, including the following:

Examples of Provider Fraud, Waste and Abuse (FWA):
- 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 Member Fraud, Waste and Abuse

- Forging, altering or selling prescriptions
- Letting someone else use the member's ID (Identification) card
- Relocating to out-of-service Plan area and not notifying us
- Using someone else's ID card

When reporting concerns involving a member include:

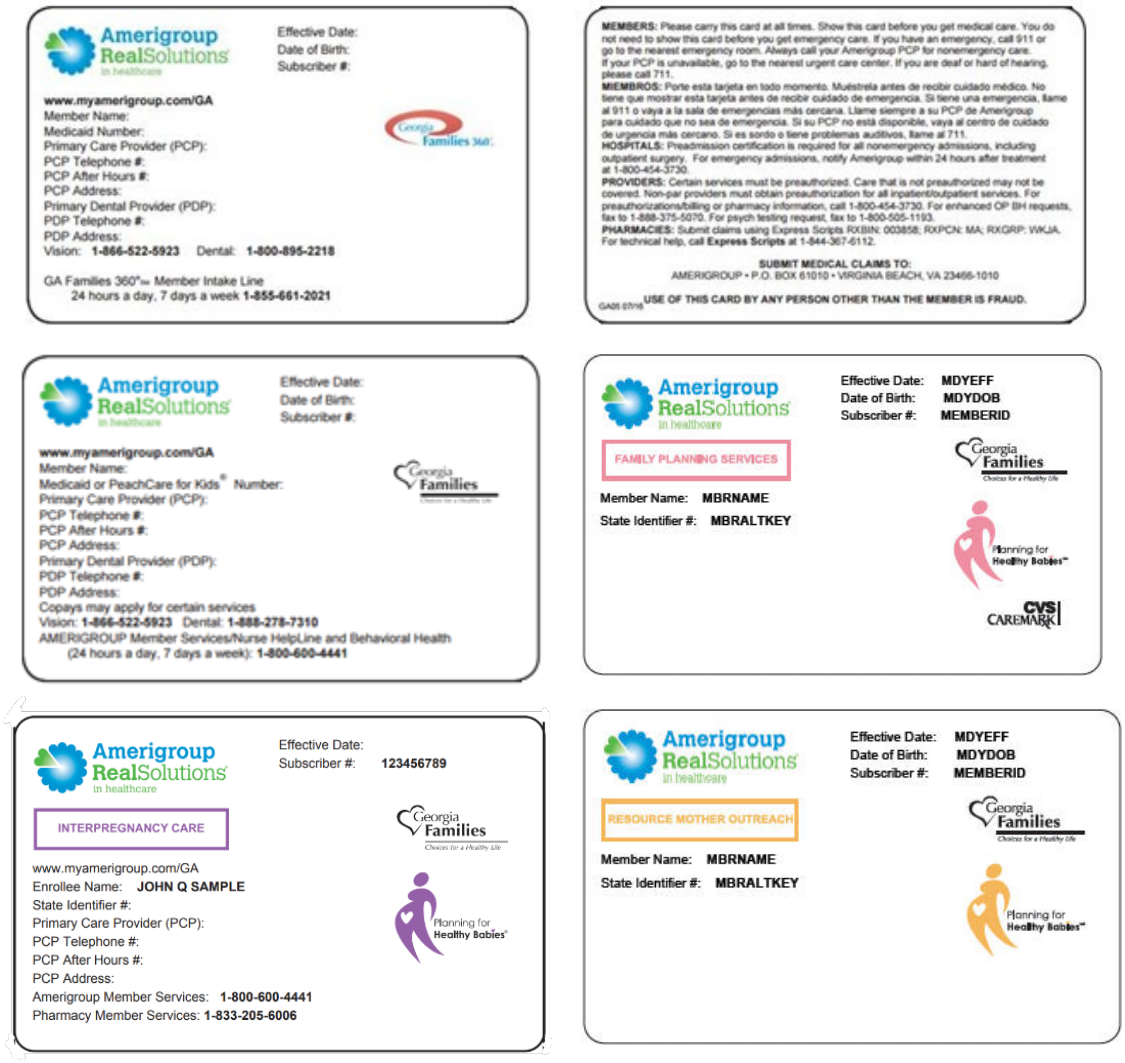
- The member's name
- The member's date of birth, member ID or case number if you have it
- The city where the member resides
- Specific details describing the fraud, waste, or abuse

To help prevent fraud, waste and abuse, providers can educate members about the types of fraud and the penalties levied. Also, spending time with patients and reviewing their records for prescription administration will help minimize drug fraud and abuse. One of the most important steps to help prevent member fraud is as simple as reviewing the Amerigroup member identification card. It is the first line of defense against fraud. Amerigroup may not accept responsibility for the costs incurred by providers rendering services to a patient who is not a member even if that patient presents an Amerigroup member ID. Providers should take measures to ensure the cardholder is the person named on the card.

Additionally, encourage members to protect their cards just as they would a credit card or cash, carry their Amerigroup member ID card at all times, and report any lost or stolen cards to Amerigroup as soon as possible.

Amerigroup believes that awareness and action are vital to keeping the state and federal programs safe and effective. Understanding the various opportunities for fraud, waste or abuse, and working with members to protect their Amerigroup ID can help prevent fraud, waste and abuse. We encourage our members and providers to report any suspected instance of fraud, waste or abuse by calling Customer Service at **800-600-4441** or our Special Investigations Unit fraud hotline at **866-847-8247**. An anonymous report can also be made by visiting **amerigroup.alertline.com/gcs/welcome**. No individual who reports violations or suspected fraud, waste or abuse will be retaliated against. Amerigroup will make every effort to maintain anonymity and confidentiality.

Amerigroup member ID card samples



Presentation of an Amerigroup member ID card does not guarantee eligibility; therefore, you should verify a member's status by inquiring online or via telephone. Online support is available for provider inquiries at **provider.amerigroup.com/GA**. You can also call Provider Services at **800-454-3730**.

Understanding the various opportunities for fraud and working with members to protect their Amerigroup ID card can help prevent fraud. Individuals reporting violations or suspected fraud and abuse will not be retaliated against.

Investigation Process

We investigate all reports of fraud, abuse and waste for all services provided under the contract. If appropriate, allegations and the investigative findings are reported to all appropriate state,

regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste or abuse, which may include, but is not limited to:

- *Written warning and/or education*: We send certified letters to the provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries or may advise of further action.
- *Medical record review*: We review medical records in context to previously submitted claims and/or to substantiate allegations.
- *Prepayment Review*: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- *Recoveries*: We recover overpayments directly from the provider. Failure of the provider to return the overpayment may result in reduced payment of future claims and/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.

About Prepayment Review
One method we use to detect FWA is through prepayment Claim review. Through a variety of means, certain Providers (Facilities or Professionals), or certain Claims submitted by Providers, may come to our attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or Claims activity that indicates the Provider is an outlier compared to his/her/its peers.

Once a Claim, or a Provider, is identified as an outlier or has otherwise come to our attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination the Provider's action(s) may involve FWA, unless exigent circumstances exist, the Provider is notified of their placement on prepayment review and given an opportunity to respond.

When a Provider is on prepayment review, the Provider will be required to submit medical records and any other supporting documentation with each Claim so the SIU can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation in accordance with this requirement will result in a denial of the Claim under review. The Provider will be given the opportunity to request a discussion of his/her/its prepayment review status.

Under the prepayment review program, we may review coding, documentation, and other billing issues. In addition, one or more clinical utilization management guidelines may be used in the review of Claims submitted by the Provider, even if those guidelines are not used for all Providers delivering services to Plan Members.

The Provider will remain subject to the prepayment review process until the health plan is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the Provider could face corrective measures, up to and including termination from the network at the direction of the State.

Providers are prohibited from billing a Member for services the health plan has determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue or for failure to submit medical records as set forth above. Providers whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of their Provider Agreement, proper billing procedures and state law. Providers also may appeal such a determination in accordance with applicable grievance and appeal procedures.

Acting on Investigative Findings
If, after investigation, the SIU determines a Provider appears to have committed fraud, waste, or abuse the Provider:

- May be presented to the credentials committee and/or peer review committee for disciplinary action, including Provider termination
- Will be referred to other authorities as applicable and/or designated by the State
- The SIU will refer all suspected criminal activity committed by a Member or Provider to the appropriate regulatory and law enforcement agencies.

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

If a Member appears to have committed fraud, waste or abuse or has failed to correct issues, the Member may be involuntarily dis-enrolled from our health care plan, with state approval.

Well-child visits/EPSDT preventive health services

Amerigroup members are encouraged to contact their physician within the first 90 days of enrollment to schedule a well-child visit. Providers are required to provide screenings to all Medicaid, PeachCare for Kids and Georgia Families 360°SM members in accordance with the American Academy of Pediatrics (AAP) Bright Futures recommendations for preventive health/well-child checkups (located in **Appendix A — Forms**). Preventive health services are available according to the following guidelines:

Population	Preventive health services available through:
Medicaid	The end of the month of their 21st birthday (unless they are blind or disabled)

Population	Preventive health services available through:
PeachCare for Kids	The end of the month of their 19th birthday
Georgia Families 360°SM	The end of the month of their 21st birthday

Amerigroup shall ensure that all providers administer appropriate vaccines to Medicaid, PeachCare for Kids and Georgia Families 360°SM members under 21 years of age. The Vaccines for Children program provides free immunizations to members through 18 years of age. Immunizations shall be given in conjunction with well-child/preventive health care. Preventive health services are provided without cost to Amerigroup members.

It is recommended that providers enroll in the Vaccines for Children (VFC) program to provide immunizations to Medicaid-eligible children from birth to 18 years of age. If the provider giving the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) preventive health exam does not wish to participate in VFC, it is expected that they administer vaccines at the time of service and understand that only the administration fee will be reimbursed. The VFC program is a federally funded and state operated vaccine supply program that began October 1, 1994. The program supplies federally purchased vaccines to children in certain populations, at no cost to public health and private health care providers.

Note: The *Recommended Childhood Immunization Schedule* from the Advisory Committee on Immunization Practices (ACIP) should be followed. Follow the latest ACIP version/recommendations at **cdc.gov/vaccines/schedules**.

The EPSDT provider manual is available for download at **mmis.georgia.gov**. Providers should reference *Part II Policies and Procedures* for the EPSDT program. At the time of the preventive health visit, the provider must perform all of the EPSDT required components, along with the required components in the *Bright Futures Periodicity Schedule*:

- A comprehensive health and developmental history and developmental appraisal (including mental, emotional and behavioral)
- A comprehensive unclothed physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate examination)
- Measurements (including head circumference for infants and BMI)
- Health education and anticipatory guidance for both the child and caregiver
- Dental/oral health assessment
- Vision and hearing assessments
- Laboratory testing (including blood lead screening appropriate for age and risk factors)
- Appropriate immunizations (in accordance with the pediatric and adult schedules for vaccines established by the Advisory Committee on Immunization Practices)
- Screening for and, if suspected, reporting of child abuse and neglect
- Tuberculosis testing per recommendations by the Committee on Infectious Diseases
- Referrals/follow-up where appropriate, based on history and exam findings
- Sexually transmitted infection/HIV screening

Well-child services should be performed for newborns in the hospital and then as follows:

- 3-5 days old
- 12 months old

- By 1 month
- 2 months old
- 4 months old
- 6 months old
- 9 months old
- 15 months old
- 18 months old
- 24 months old
- 30 months old
- 3 years old, and annually thereafter

Amerigroup educates our members about these guidelines and monitors encounter data for compliance.

Diagnostic and treatment services

All suspicious or abnormal findings identified during a preventive health visit as described above must be treated or be further evaluated. If a suspected problem is detected that is outside the scope of the PCP, the member must be referred to a specialist as necessary for further diagnosis to determine treatment needs.

The EPSDT benefit provides coverage for all follow-up diagnostic and treatment services deemed medically necessary to ameliorate or correct a problem discovered during a preventive health visit. The provider will provide medically necessary diagnostic and treatment services either directly or by referral.

CMS defines an EPSDT referral as a member scheduled for another appointment with the EPSDT provider, or a referral to another provider for further needed diagnostic and treatment services as a result of at least one health problem identified during the EPSDT preventive health visit.

Effective with *HIPAA* implementation, CMS, the Georgia Department of Community Health and Amerigroup require documentation of EPSDT referral codes when submitting EPSDT screening code claims (for examples, see Appendix K in *Part II Policies and Procedures* of the EPSDT provider manual). When completing the *Health Insurance Claim Form* (*CMS-1500*), the EPSDT referral codes must be entered in the shaded area of box 24H.

Example 1: If the EPSDT screening is normal, the referral code is NU (no follow-up visit needed)
Example 2: If the EPSDT screening indicates the need for further diagnostic and treatment services and a follow-up visit is necessary, use the applicable referral code(s):

- AV - available, not used: patient refused referral
- S2 - under treatment: patient is currently under treatment for health problem and has a return appointment
- ST - new services requested: referral to another provider for diagnostic or corrective treatment/scheduled

Well-Child Visits Reminder Program

Amerigroup encourages members to receive preventive health care. To assist with this process, Amerigroup prepares a list of members who, based on our claims data, may not have received well-child services according to the periodicity schedule. A letter and the list are sent to the member's PCP each month. Additionally, Amerigroup mails or sends a text message with information to these members encouraging them to contact their PCP office to set up an appointment for needed services. Please note that:

- The specific service(s) needed for each member is listed in the report. Reports are based only on services received during the time the member is enrolled with Amerigroup.
- Services must be rendered on or after the due date in accordance with federal EPSDT and Georgia Department of Community Health (DCH) guidelines. This list is generated based on Amerigroup claims data received prior to the date printed on the list. In some instances, the appropriate services may have been provided after the report run date.
- To ensure accuracy in tracking preventive services, please submit a completed claim form for those dates of service to:

Amerigroup Community Care
P.O. Box 61010
Virginia Beach, VA 23466-1010

Blood Lead Screening

Blood lead risk assessment
The blood lead risk assessment is required at 6, 9 and 18 months and 3-6 years of age per the Bright Futures Guidance (BFG) periodicity schedule. A questionnaire, based on currently accepted public health guidelines, should be administered to determine if the child is at risk for lead poisoning. A recommended tool is the Georgia Healthy Homes and Lead Poisoning Prevention Program (GHHLPPP) Blood Lead Risk Assessment Questionnaire, which can be found at **dph.georgia.gov/environmental-health/healthy-homes-and-lead-poisoning-prevention**

When using the questionnaire, a blood lead test should be done immediately if the child is at high risk (one or more *yes* or *I don't know* answers on the lead risk assessment questionnaire) for lead exposure. Completing this questionnaire does not count as a blood lead screening. Please see the blood lead risk forms located in **Appendix A – Forms**.

Note: Assessment questions are not needed if a blood lead level (BLL) screening (test) will be done at the visit.

Blood Lead Level (BLL) screen
A BLL screening (test) is required at 12 and 24 months of age. For children between the ages of 36 months and 72 months, one BLL screening is required IF they have not previously been tested for lead exposure.

HIPAA

The *Health Insurance Portability and Accountability Act* (*HIPAA*, also known as the Kennedy-Kassebaum bill) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud, and simplifies the administration of health insurance.

Amerigroup strives to ensure that both Amerigroup and contracted participating providers conduct business in a manner that safeguards patient/member information in accordance with the privacy regulations enacted pursuant to *HIPAA*. Effective April 14, 2003, contracted providers were required to have the following procedures implemented to demonstrate compliance with the *HIPAA* privacy regulations:

Amerigroup recognizes its responsibility under the *HIPAA* privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting Amerigroup. However, please note that the privacy regulations allow the transfer or sharing of member information, which may be requested by Amerigroup to conduct business and make decisions about care, such as a member's medical record, to make an authorization determination or resolve a payment appeal. Such requests are considered part of the *HIPAA* definition of treatment, payment, or health care operations.

Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to Amerigroup, verify that the receiving fax number is correct, notify the appropriate staff at Amerigroup and verify that the fax was appropriately received.

Internet email (unless encrypted) should not be used to transfer files containing member information to Amerigroup (for example, Excel spreadsheets with claim information). Such information should be mailed or faxed.

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

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

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

7 Member management support

Welcome call

As part of our member management strategy, Amerigroup conducts welcome calls to all new Georgia Families, PeachCare for Kids and Adoption Assistance members. During the welcome call, new members who have been identified through their health risk assessment as possibly needing additional services are educated regarding the health plan and available services. Additionally, Member Services representatives offer to assist the member with any current needs, such as scheduling an initial checkup.

Appointment scheduling

Amerigroup ensures that members have access to primary care services for routine, urgent and emergency services and to specialty care services for chronic and complex care. Providers shall respond to an Amerigroup member in a timely manner as to his or her needs and requests. The PCP should make every effort to schedule Amerigroup members for appointments using the guidelines outlined in the **PCP Access and Availability** section of this manual.

24-hour Nurse HelpLine

The 24-hour Nurse HelpLine is a service designed to support the provider by offering information and education about medical conditions, health care and prevention to members after normal physician practice hours. The 24-hour Nurse HelpLine provides triage services and helps direct members to appropriate levels of care.

The 24-hour Nurse HelpLine telephone number is **800-600-4441** and is listed on the member's ID card. This ensures that members have an additional avenue of access to health care information when needed. Features of the 24-hour Nurse HelpLine include:

- Available 24 hours a day, 7 days a week
- Provides information based upon nationally recognized and accepted guidelines
- Offers free translation services for 150 different languages and a TTY service for members who have difficulty hearing
- Provides education for members about appropriate alternatives for handling nonemergent medical conditions
- Responds to requests for members' assessment reports; a nurse faxes a member's report to the provider's office within 24 hours of receiving the call

Health Promotion

Amerigroup strives to improve healthy behaviors, reduce illness and improve quality of life for our members through comprehensive programs. Educational materials are developed or purchased and disseminated to our members, and health education classes are coordinated with Amerigroup-contracted community organizations and network providers.

Amerigroup manages projects that offer education and information for our members' health. Ongoing projects include:

- Member newsletter
- Creation and distribution of Amerigroup health education tools used to inform members of health promotion issues and topics
- Health Tips on Hold (educational telephone messages while the member is on hold)
- Monthly calendar of health education programs offered to members
- Development of health education curricula and procurement of other health education tools (for example, breast self-exam cards)
- Relationship development with community-based organizations to enhance opportunities for members to improve health outcomes
- Member outreach and education around the importance of preventive health screenings
- Member text message and automated (IVR) campaigns that promote wellness visits to PCP, importance of immunizations, and self-care
- Healthy Rewards program to promote/encourage/incentivize healthy behaviors

Case Management

The goal of the case management program is to provide high-quality, integrated, culturally competent case management services to members assessed as having high medical and/or nonmedical case management needs. The case management program meets this goal by:

- Using qualified clinical and nonclinical staff who work to collaboratively identify and assess the physical, behavioral, cognitive, functional and social needs of members for case management services.
- Developing a comprehensive care plan with input from the member and provider.
- Working with the members and their providers to establish and prioritize goals and interventions that are tailored to meet the individual needs of members and their support system.

Program staff encourages members to take action to improve their overall quality of life, functional status and health outcomes, and strives to ensure the delivery of services in the most cost-effective manner. Case management is designed to proactively anticipate a member's needs when conditions or diagnoses require care and treatment for long periods of time. When a member is identified as needing case management (usually through predictive modeling, inpatient and ER reports, provider referral and/or member request), the Amerigroup Case Manager performs an initial needs assessment to evaluate current health status so the member can receive the appropriate services and resources.

Our mission
To coordinate the physical and behavioral health care of eligible members, offering a continuum of targeted interventions, education and enhanced access to care to ensure improved outcomes and quality of life for eligible members.

Amerigroup case management programs
We encourage our providers to refer members to our programs. When we receive the referral, a member of our Case Management team will call the member to discuss available programs and benefits. A provider, on behalf of the member, may request participation in the program. The nurse will work with the member, provider and/or the hospital to identify the following as necessary:

- Intensity level of case management services
- Appropriate alternate settings where care may be delivered
- Health care services
- Home Health Equipment and/or supplies
- Available Community-based services available
- Communication and collaboration with both member and provider

Amerigroup developed the Chronic Illness Intensity Index (CI3), our predictive model, to compare the illness complexity of all members in our diverse population. This allows us to appropriately stratify all members, thus identifying the sickest and most complex members — those in need of intensive case management. These members receive outreach through our complex case management program, allowing us to deploy integrated outreach services in a prioritized fashion. Our licensed clinical staff uses evidence-based *Clinical Practice Guidelines* to help create a plan of care in collaboration with the member and their treating providers. We update providers about outreach in order to monitor and evaluate progress. We work with our providers to coordinate care, prevent hospital readmissions and improve the member's health outcomes.

Amerigroup case managers are licensed nurses/behavioral health clinicians and are available Monday- Friday 8 a.m.-5 p.m. Eastern Standard Time, Monday-Friday. The 24-hour Nurse HelpLine is available 24 hours a day, 7 days a week for our members at **800-600-4441**. Please call **800-454-3730** to reach an Amerigroup case manager. Members can get information about case management services by visiting **provider.amerigroup.com/GA** or calling **800-600-4441**.

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. We use several resources to identify pregnancies as early as possible. Sources of identification include, state enrollment files, claims data, hospital census reports, the Availity Maternity form, and notification of pregnancy forms, as well as provider and member self-referrals. Once pregnant members are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care and case management services to mitigate risk.

To initiate a new pregnancy notification via the Georgia website, please follow these instructions:

1. Go to the Georgia website at **mmis.georgia.gov.**
2. Login with assigned user ID and password.
3. On the website secure homepage, select the **Prior Authorization** tab.

4. Select **Submit/View** (or select **Provider Workspace** to open the workspace and then select **Enter a New Authorization Request**).
5. A request menu displays with the notification forms and request types applicable to the requesting provider's category of service.
6. Select the *Pregnancy Notification Form*.
7. On the next page that displays, select the CMO, in which the member is enrolled, by selecting the button next to the CMO name.
8. Enter the mother's Medicaid ID in the Member Medicaid ID box.
9. The next field that must be populated is the Facility Reference ID. This is the facility where it is anticipated that the delivery will occur.
10. The final field on this screen is the Medical Practitioner Provider ID. This should be populated automatically based on the website login.
11. Select **Submit** to open the notification form.

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

When it comes to pregnant members, Amerigroup is committed to keeping both mom and baby healthy. That's why Amerigroup encourages all moms-to-be to take part in this program, which offers:

- Individualized, one-on-one case management support for women at the highest risk.
- Care coordination for moms who may need extra support.
- Educational materials and information about community resources.
- Incentives to keep up with prenatal and postpartum checkups and well-child visits after the baby is born.

As part of the Taking Care of Baby and Me program, perinatal members have access to a digital maternity program. The digital program provides pregnant and postpartum members with proactive, culturally appropriate education via a smartphone app. Once members are identified as being pregnant, they will receive an invitation to access this program by downloading the app. After the app is installed and the member registers, they are asked to complete a pregnancy screener. The answers provided in the screener allows Amerigroup to assess their pregnancy risk.

Amerigroup encourages providers to complete the Maternity form in Availity Essentials: Perform an Eligibility and Benefits (E&B) request on the desired member.

- 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 member is pregnant. Choose "Yes", if applicable. If you indicate "Yes", provide the estimated due date, if it is known, or leave it blank if the due date is unknown. You may update the estimated due date as soon as it is known.

- After submitting your answer, the E&B will display. If the member was identified as pregnant, a Maternity form will be generated. Once generated, you may access the form in the Maternity work queue.
- After delivery, go into the Maternity Work Queue and update details, complete the questions in the form, and SUBMIT the form for all PENDING status forms.

We encourage healthcare providers to share information about the Taking Care of Baby and Me program and the digital maternity tools offered at Amerigroup with members. Members may access information about the products that are available by visiting the Amerigroup member website.

For more information about the Taking Care of Baby and Me program or the digital maternity tools, reach out to your OB Practice Consultant or Provider Services at **800-454-3730.**

NICU Case Management

For parents with infants admitted to the neonatal intensive care unit (NICU), we offer the NICU Case Management program. This program provides education and support designed to help parents cope with the day-to-day stress of having a baby in the NICU, encourages parent/caregiver involvement, and helps them to prepare themselves and their homes for discharge. Highly skilled and specialized NICU case managers provide education and resources that outline successful strategies parents may use to collaborate with their baby's NICU care team while inpatient and manage their baby's health after discharge. Post discharge, the NICU case manager continues to foster improved outcomes, prevent unnecessary hospital readmissions, and ensure efficient community resource consumption.

The stress of having an infant in the NICU may result in post-traumatic stress disorder (PTSD) symptoms for parents and loved ones. To reduce the impact of PTSD among our members, we assist by:

- Guiding parent(s) into hospital-based support programs, if available.
- Screening parent(s) for PTSD approximately one month after their baby's date of birth.
- Referring parent(s) to behavioral health program resources, if indicated.
- Reconnecting with a one-month follow-up call to assess if the parent(s) received benefit from initial contact and PTSD awareness.

Our NICU case managers are here to help you. If you have a patient in your care that would benefit from participating in our NICU Case Management program, please call Provider Services at **800-454-3730**. Members can also call our 24-hour NurseLine at **800-600-4441**, available 24 hours a day, 7 days a week.

Preventive care: long-acting reversible contraception (LARC)

Members have access to immediate postpartum placement of LARC (intrauterine devices [IUDs] and etonogestrel implants) during their inpatient delivery admission; physicians will implant the device of the patient's choice. Facilities and providers will receive the same reimbursement as if the device were implanted on an outpatient basis.

To help ensure the devices are immediately available to patients, postpartum facilities are encouraged to stock obstetrical units with the LARC devices. The device HCPCS codes and insertion CPT codes for the inpatient procedure are noted below:

HCPCS code	Description
J7300	Intrauterine copper contraceptive (Paragard®)
J7301	Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg (Skyla®)
J7307	Etonogestrel (contraceptive) implant system (Nexplanon®), including implant and supplies
J7296	Levonorgestrel-releasing intrauterine contraceptive system (Kyleena®)
J7297	Levonorgestrel-releasing intrauterine contraceptive system (Liletta®)
J7298	Levonorgestrel-releasing intrauterine contraceptive system (Mirena®)

CPT code	Description
11981	Insertion, drug-delivery implant (in other words, bioresorbable, biodegradable, non-biodegradable)
58300	Insertion of IUD

As you are well aware, unintended pregnancies continue to be a major health problem in the United States. These unintended pregnancies are associated with higher rates of maternal and neonatal complications of pregnancy.[1] Long-acting methods:

- Are more effective at preventing unintended pregnancies.
- Have significantly greater continuation rates than oral contraceptives, the vaginal contraceptive ring or the contraceptive patch.
- Have very low rates of serious side effects.[2]

We respectfully ask that providers discuss reproductive life planning with their patients early (for example, during the third trimester of pregnancy) and, if appropriate, the option of immediate postpartum placement of the IUD or implant. Teenage and young patients (ages 13-19) should receive additional counseling and support, as this group is at the greatest risk for early discontinuation of contraception.[3] It appears that there is lower discontinuation rate after two years of IUDs compared to the etonogestrel implant.[4] When clinically appropriate, IUDs should be considered over the implant.

1 Hellerstedt W.L., Pirie P.L., Lando H.A., Curry S.J., McBride C.M., Grothaus L.C., et al. *Differences in Prenconceptional and Prenatal Behaviors in Women with Intended and Unintended Pregnancies*. American Journal of Public Health 1998; 88:663-6.
2 Winner B., Peipert J.F., Zhao Q., Buckel C., Madden T., Allsworth J.E., et al. *Effectiveness of Long-Acting Reversible Contraception*. New England Journal of Medicine 2012; 366 1998-2007.
3 Aoun J., Dines V.A., Stovall D.W., Mete M., Nelson C.B., et al. *Effects of Age, Parity, and Device Type on Complications and Discontinuation of Intrauterine Devices*. Obstetrics & Gynecology 2014; 123:585-92.
4 O'Neil-Callahan M., Peipert J.F., Zhao Q., Madden T., Secura G. *Twenty-Four Month Continuation of Reversible Contraception*. Obstetrics & Gynecology 2013; 122:1083-91.

If you have questions about providing this service to your patients, contact Provider Services at **800-454-3730**, Monday-Friday from 7 a.m.-7 p.m.

Condition Care

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

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

In addition to our condition-specific Condition Care programs, our member-centric, holistic approach also allows us to manage members with smoking cessation and weight management education.

Program features include:

- Proactive population identification process.
- Program content is based on evidence-based, national *Clinical Practice Guidelines*
- Collaborative practice models that include physician and support providers in treatment planning.
- Continuous patient self-management education.
- Ongoing communication with primary and ancillary providers regarding patient 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 compliance and enhance self-care.

Condition Care services, such as direct outreach and face-to-face intervention, are also available at the local level for those members needing additional support and assistance.

Additionally, all of our programs are based on nationally approved clinical practice guidelines and are located at **provider.amerigroup.com/GA**. A copy of the guidelines can be printed from the website.

Who is eligible?
Members diagnosed with one or more of the above conditions are eligible for CNDC services.

We welcome provider referrals for patients who can benefit from additional education and care management support. Our case managers will work collaboratively with providers to obtain input on care plan development and provide telephonic and/or written updates regarding patient status and progress. Members identified for participation are assessed and risk-stratified based on the severity of their condition. They are provided with continuous education on self-management concepts including primary prevention, coaching related by healthy behaviors and compliance/monitoring. We also offer case/care management for high-risk members.

Condition Care provider rights and responsibilities
Providers 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 the Amerigroup programs and services.
- Be informed about how we coordinate our interventions with members' treatment plans.
- Know how to contact the person who manages and communicates with patients.
- Be supported by our organization when interacting with patients 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 Condition Care case managers are registered nurses. They are available from 8:30 a.m. - 5:30 p.m. local time. Confidential voicemail is available 24 hours a day.

Contact information
You can call a Condition Care team member at **888-830-4300**. Additional information about our Condition Care program is located at **provider.amerigroup.com/GA**. Providers can go to the provider website and download the Condition Care referral form.

Health education advisory committee

The health education advisory committee (HEAC) provides advice to Amerigroup regarding health education and outreach program development. The HEAC includes providers, representatives from community based organizations, and members or the parents/guardians of members.

The committee strives to ensure that materials and programs meet cultural competency requirements, are easily understood by members and address the health education needs of the member.

The HEAC's responsibilities are to:

- Identify members' health education needs based on review of demographic and epidemiologic data.

- Identify cultural values and beliefs that must be considered in developing a culturally competent health education program.
- Assist in the review, development, implementation and evaluation of the member health education tools for the outreach program.
- Review the health education plan and make recommendations on health education strategies.

Please contact your Marketing Representative if you are interested in participating in the Amerigroup HEAC or any other committees.

Women, Infants, and Children (WIC) Program

Medicaid recipients eligible for WIC benefits include the following classifications:

- Pregnant women
- Women who are breastfeeding infant(s) up to one year postpartum
- Women who are not breastfeeding up to six months postpartum
- Infants less than 1 year old
- Children less than 5 years old

Members may apply for WIC services at their local WIC agency or county health department. A WIC referral form is located in **Appendix A — Forms**.

How Amerigroup works with the State for initial screenings and assessments

Benefit/service description	Requirements and exclusions
Children First and Babies Can't Wait	Federal laws on children (for example, *20 U.S.C. §1435 (a)(5); 34 C.F.R. §303.321(d)*) require network providers to identify and refer to the designated Children First program for assessment and evaluation any Georgia Families or Georgia Families 360°$_{SM}$ member age birth-35 months of age who is: • Suspected of having a developmental delay or disability. • At risk of delay The purpose of Babies Can't Wait is to: ▪ Provide early identification and screening of children with developmental delays and chronic health conditions. ▪ Improve the developmental potential of infants and toddlers birth to age three, with developmental or chronic health conditions. ▪ Support family members and caregivers to enhance children's learning and development through everyday learning opportunities
Health risk screenings (for Georgia Families 360°$_{SM}$ newly enrolling members)	Amerigroup will: • Provide a health risk screening within 30 calendar days of receipt of the eligibility file from DCH. • Complete a new health risk screening when necessary based on a change in the Georgia Families 360°$_{SM}$ member's medical or behavioral health as identified by providers or annually

Benefit/service description	Requirements and exclusions
Medical assessments for newly entering or re-entering FCAA members	Amerigroup is responsible for: • Sending the outcomes of medical assessments to the DFCS-contracted CCFA provider slated to prepare the final CCFA report within 20 calendar days of receipt of the eligibility file from DCH or written notification from DFCS, whichever comes first.
Medical assessment for newly entering or re-entering DJJP members	Amerigroup is responsible for: • Ensuring medical assessments are completed within 10 calendar days of our receipt of the eligibility file from DCH or written notification from DJJ, whichever comes first. • Sending the outcome of the medical assessment to the DJJ member's residential placement provider within 15 calendar days of our receipt of the eligibility file from DCH or electronic notification from DJJ. • Sending the outcomes of medical assessments to the DJJP members' residential placement providers within 15 calendar days of our receipt of the eligibility file from DCH or written notification from DJJ, whichever comes first.
Trauma assessments newly entering or re-entering FCAAP members	Amerigroup contracts with behavioral health providers for all trauma assessments required for a FCAAP member. The trauma assessment, at a minimum, shall include: • A trauma history with information about any trauma the child may have experienced or been exposed to, as well as how the child coped with that trauma in the past and present. • Completion of the age-appropriate assessment tool. • A summary of assessment results and recommendations for treatment (if needed). Amerigroup is responsible for ensuring each contracted behavioral health provider who conducts trauma assessments for these program members meet the following requirements: • Has initiated contact or visit(s) with the member as a FCAAP member • Begins the trauma assessment within 10 calendar days of our receipt of written notification from DFCS of the foster care member's 72-hour hearing Amerigroup will coordinate all necessary visits with our contracted behavioral health provider to ensure the final trauma assessment is completed timely. Our contracted behavioral health providers must prepare written trauma assessment reports and submit them to the DFCS-contracted CCFA providers who prepare final CCFA reports within 20 calendar days of our receipt of written notification from DFCS of the foster care member's 72-hour hearing. If our contracted behavioral health provider is unable to meet the time frame for the written trauma assessment report, he or she may verbally report the trauma assessment findings and recommended treatment during the foster care member's multi-disciplinary team (MDT) meeting. In the case of a verbal report, Amerigroup is responsible for assuring our contracted behavioral health provider submits the final written trauma assessment report to the DFCS-contracted CCFA

Benefit/service description	Requirements and exclusions
	provider who prepares the final CCFA report within 35 calendar days of our receipt of written notification from DFCS of the foster care member's 72-hour hearing. MDTs are teams consisting of persons representing various disciplines associated with key components of the Georgia foster care assessment process. The purpose of the MDT meeting is to review the outcome and recommendations of the CCFA provider related to the assessment of the member and the member's family. The disciplines that can participate as part of MDT include but are not limited to: • Legal custodian (for example, DFCS case manager, CPS investigator, CPS ongoing case manager, DFCS supervisor and/or independent living coordinator for any youth 14 years of age or older). • The behavioral health provider conducting the trauma assessment. • A school system representative with direct knowledge of the educational status of the child. • A medical health provider with direct knowledge of the medical and dental status of the foster care child, including the Babies Can't Wait service coordinator if applicable. • A representative from the appropriate court system if the child had any court or law enforcement involvement, including local law enforcement officials or a court appointed special advocate (CASA). • A mental health representative with direct knowledge of the mental health or substance abuse issues affecting the child or family. • Foster parent(s) or an out-of-home placement provider where the child resided during the assessment process with direct knowledge of the child's behavior and activity during the assessment. • Any other individual having appropriate information directly related to the foster care child's case. The MDT meeting is coordinated and facilitated by the individual who completed the family assessment.
Trauma assessments for FCAAP members	Amerigroup contracts with behavioral health providers for all trauma assessments required for FCAAP members. The trauma assessment, at a minimum, shall include: • A trauma history with information about any trauma the child may have experienced or been exposed to, as well as how the child coped with that trauma in the past and present. • Completion of the age-appropriate assessment tool. • A summary of assessment results and recommendations for treatment (if needed). Trauma assessments may be required for Adoption Assistance members in the event of abuse or neglect as reported by a provider, adoptive parent or others.

Benefit/service description	Requirements and exclusions
	Trauma assessments may also be required for a member who has been a foster care member for a period of 12 or more months and whose completed CCFA is more than 12 months old. Under these two circumstances, Amerigroup will: • Ensure our behavioral health provider initiates contact with or visit(s) with the Adoption Assistance or foster care member and begins the trauma assessment within 10 calendar days of our receipt of written notification from DFCS. • Coordinate all necessary visits with our contracted behavioral health provider to ensure the final trauma assessment is completed timely. Our contracted behavioral health provider must prepare a written trauma assessment report and submit it to the DFCS-contracted CCFA provider who prepares the final CCFA report within 20 calendar days of our receipt of written notification from DFCS. If our contracted behavioral health provider is unable to meet the time frame for the written trauma assessment report, he or she may verbally report the trauma assessment findings and recommended treatment. In the case of a verbal report, Amerigroup is responsible for ensuring our contracted behavioral health provider submits the final written trauma assessment report to the DFCS-contracted CCFA provider preparing the final CCFA report within 35 calendar days of our receipt of written notification from DFCS. Amerigroup will coordinate and ensure FCAAP members follow up on and receive any care specified within the trauma and medical assessments in accordance with the following timeline requirements. Amerigroup will: • Provide follow-up for dental treatment within 30 days of the EPSDT dental visit if the dental screening yields any concerns or the need for dental treatment. • Obtain an audiological assessment and treatment or prescribed corrective devices initiated within 30 days of the screening, based on the results of the hearing screening. Provide a developmental assessment if the developmental screening completed as part of the EPSDT visit yields any developmental delays or concerns; the EPSDT provider is responsible for making a referral for the assessment, and Amerigroup is responsible for ensuring the child has the assessment within 30 days of the screening.

8 Provider responsibilities

Medical home

The PCP is responsible for providing, managing and coordinating all aspects of the member's medical care and is expected to provide all care that is within the scope of his or her practice. The PCP is responsible for coordinating member care to specialists and conferring and collaborating with the specialist, a concept known as a medical home.

Amerigroup promotes the medical home concept. It is the member's and family's initial contact point when accessing health care. It is a relationship between the member and family, the health care providers within the medical home, and the extended network of consultants and specialists with whom the medical home has an ongoing and collaborative contractual relationship. The providers in the medical home are knowledgeable about the member's and family's special, health-related social and educational needs and are connected to necessary resources in the community that will assist the family in meeting those needs. When a member is referred for a consultation, specialty/hospital services, or health and health-related services through the medical home, the medical home provider maintains the primary relationship with the member and family. He or she keeps abreast of the current status of the member and family through a planned feedback mechanism and receives them into the medical home for continuing primary medical care and preventive health services.

Amerigroup does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, the risks, benefits, and consequences of treatment or non-treatment.

Responsibilities of the PCP

The PCP is a network physician who has the responsibility for the complete care of his or her members, whether providing it himself or herself or through coordination with the appropriate provider of care within the network. Federally qualified health center (FQHC) and rural health clinic (RHC) providers may be included as PCPs. Below are highlights of the PCP's responsibilities.

The PCP shall:

- Manage the medical and health care needs of members, including:
    - Monitoring and following up on care provided by other providers, including fee-for-service (FFS) providers.
    - Providing coordination necessary with specialists and FFS providers (both in- and out-of-network coordination should be by Amerigroup participating providers).
    - Providing and promoting preventive health care services.
    - Maintaining a medical record of all services rendered by the PCP and other providers:
        - Medical records for Georgia Families 360°SM newly enrolling foster care and Department of Juvenile Justice (DJJ) members should be faxed to **888-375-5064**.
- Provide 24 hours a day, 7 days a week coverage and clearly define and communicate regular hours of operation.
- Provide services ethically and legally; provide all services in a culturally competent manner and meet the unique needs of members with special health care needs.
- Participate in any system established by Amerigroup to facilitate the sharing of records, subject to applicable confidentiality and *HIPAA* requirements.
- Make provisions to communicate in the language or fashion primarily used by his or her membership.

- Participate and cooperate with Amerigroup in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by Amerigroup.
- Participate in and cooperate with Amerigroup complaint and grievance procedures; Amerigroup will notify the PCP of any member grievance.
- Not balance bill members; however, the PCP is entitled to collect applicable copays for certain services.
- Continue care in progress during and after termination of his or her contract for up to 60 days until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records.
- Develop and have an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens.
- Establish an appropriate mechanism to fulfill obligations under the *Americans with Disabilities Act*.
- Support, cooperate and comply with the Amerigroup quality improvement program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner.
- Inform Amerigroup if a member objects to provision of any counseling, treatments or referral services for religious reasons.
- Treat all members with respect and dignity; provide members with appropriate privacy; and treat member disclosures and records confidentially, giving the members the opportunity to approve or refuse their release.
- Provide members with complete information concerning their diagnosis, evaluation, treatment and prognosis, and give members the opportunity to participate in decisions involving their health care except when contraindicated for medical reasons.
- Advise members about their health status, medical care or treatment options, including medication treatment options, regardless of whether benefits for such care are provided under the program, and advise members on treatments which may be self-administered.
- When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.
- Have a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
- Agree to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide high-quality patient care.
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research shall be clearly contrasted with entries regarding the provision of nonresearch-related care.
- Be aware that materials created by the provider for the purpose of distributing to Amerigroup members for the sole purpose of marketing must be approved by Amerigroup as well as the state of Georgia per state contractual guidelines.

PCP access and availability

All providers are expected to meet the federal and state accessibility standards and those defined in the *Americans with Disabilities Act of 1990*, as well as the Kenny A. consent decree. Health care services provided through Amerigroup must be accessible to all members.

In June 2002, Children's Rights filed a class action (Kenny A. v. Deal) against state and county officials responsible for the foster care system in metropolitan Atlanta on behalf of the approximately 3,000 children in foster care in Atlanta. The federal complaint cited numerous systemic problems. A settlement agreement was reached with Georgia officials in July 2005, requiring infrastructure changes, service guarantees, and improved oversight over child safety, and requiring the state to meet specific benchmarks and reforming the child welfare system. The federal court approved the settlement in October 2005 and appointed two independent monitors to report on the state's performance in implementing the required reforms. These reforms, specific to foster care, include providing physical, dental, mental and developmental health screenings within specified periods of time.

Amerigroup is dedicated to arranging access to care for our members. The ability to provide quality access depends upon the accessibility of network providers. Providers are required to adhere to the following access standards:

Service	**Access requirement**
Emergent or emergency visits	Immediately upon presentation (24 hours a day, 7 days a week) and without preauthorization
Urgent, nonemergency visits	Not to exceed 24 hours
PCP routine visits	Not to exceed 14 calendar days
PCP adult sick visit	Not to exceed 24 hours
PCP pediatric sick visit	Not to exceed 24 hours
Specialists	Not to exceed 30 calendar days
Initial visit for pregnant women	• For first trimester: 14 days • For second trimester: seven days • For third trimester: three days • High risk: within three days or sooner if needed
Visits for EPSDT-eligible children	Within 90 calendar days of enrollment
Mental health providers	Not to exceed 14 calendar days
Nonemergency hospital stays	Not to exceed 30 calendar days
Georgia Families 360º Initial Visit	
Service	**Access requirement**
Initial EPSDT Exam	10 days from eligibility date
Dental Cleanings	10 days from the eligibility date for members ages 3years and older
Trauma Assessment	10 days from the eligibility date for members ages 5years and older

Providers may not use discriminatory practices such as preference to other insured or private pay patients, separate waiting rooms, or appointment days.

Appointment wait times

Scheduled appointment wait times must not exceed 60 minutes. After 30 minutes, the patient must be given an update on the waiting time and the option of either continuing to wait or rescheduling the appointment. Wait times for work-in or walk-in appointments shall not exceed 90 minutes. After 45 minutes, the patient must be given an update on the waiting time and the option of either continuing to wait or rescheduling the appointment.

Amerigroup will routinely monitor providers' adherence to the access care standards. To ensure continuous 24-hour coverage, PCPs must maintain one of the following arrangements for their members to contact the PCP after normal business hours:

- Have the office telephone answered after hours by an answering service that meets language requirements of the major population groups (this is defined federally as a group comprising 10 percent or more of Amerigroup members). The answering service must be able to contact the PCP or another designated network medical practitioner. All urgent calls answered by an answering service must be returned within 20 minutes; all other calls must be returned within one hour.
- Have the office telephone answered after normal business hours by a recording in the language of each of the major population groups served by the PCP. The recording must direct the member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable.
- Have the office telephone transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or a designated Amerigroup network medical practitioner. The PCP or designated medical practitioner must return urgent calls within 20 minutes and all other calls within one hour.

The following telephone answering procedures are NOT acceptable:

- Office telephone is only answered during office hours.
- Office telephone is answered after hours by a recording that tells members to leave a message.
- Office telephone is answered after hours by a recording that directs members to go to an emergency room for any services needed.
- Returning after-hours calls outside of 20 minutes.

Member missed appointments

Amerigroup members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to the member's health. Amerigroup requires providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling the appointment. The contact can either be in writing or by telephone and should be designed to educate the member about the importance of keeping appointments and encourage the member to reschedule the appointment.

Amerigroup members who frequently cancel or fail to show up for an appointment without rescheduling the appointment may need additional education in appropriate methods of accessing care. The Amerigroup goal is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCP.

Noncompliant Amerigroup members

Amerigroup recognizes that providers may need help in managing noncompliant members. If a provider has an issue with a member regarding behavior, treatment cooperation and/or completion of treatment, and/or making or appearing for appointments, call Provider Services at **800-454-3730**. Please note: members cannot be billed a fee for missed appointments.

Terminating member from a panel

To remove a member from a provider's panel, the provider must send a certified letter to the member or head of household and indicate that the member must select a new PCP within 30 days of the notice. A copy of the letter must be mailed to:

Amerigroup Community Care
740 W Peachtree St NW
Atlanta, GA 30308

Note: The provider must continue to give care until the effective date of assignment to the new PCP.

PCP transfers

In order to maintain continuity of care, Amerigroup encourages members to remain with their PCP. However, members may request to change their PCP for any reason by contacting Member Services at **800-600-4441**.

Members can call to request a PCP change any day of the month. PCP change requests will be processed generally on the same day or by the next business day. Members will receive a new ID card within seven days of the request.

Covering physicians

During a provider's absence or unavailability, the provider needs to arrange coverage for his or her members. The provider will either (i) make arrangements with one or more network providers to provide care for his or her patients or (ii) make arrangements with another similarly licensed and qualified provider who has appropriate medical staff privileges at the same network hospital or medical group, as applicable, to provide care to the patients in question. In addition, the covering provider shall agree to the terms and conditions of the Participating Provider Agreement, including, without restrictions, any applicable limitations on compensation, billing and participation. Providers will be solely responsible for a non-network provider's adherence to such provisions. Providers will be solely responsible for any fees or monies due and owed to any non-network provider providing substitute coverage to a member on the provider's behalf. Covering providers should bill using a Q5 modifier when billing CPT/HCPCS codes to indicate that they are covering for another provider.

Specialist as a PCP

Under certain circumstances, a specialist may be approved by Amerigroup to serve as a member's PCP when a member requires the regular care of the specialist. The criteria for a specialist to serve as a member'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 needs to be given by a specialist.
- The administrative requirements arranging for care exceed the capacity of the PCP; this would include members 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 member's health care including preventive care. When such a need is identified, the member or specialist must contact the Amerigroup Case Management department and complete a *Specialist as PCP Request Form*. An Amerigroup case manager will review the request and submit it to the Amerigroup medical director. Amerigroup will notify the member and the provider of our determination in writing within 30 days of receiving the request. Should Amerigroup deny the request, Amerigroup will provide written notification to the member and provider the reason(s) for the denial of the request within one day. Specialists serving as PCPs will continue to be paid FFS while serving as the member's PCP. The designation cannot be retroactive. For further information, see the *Specialist as PCP Request Form* located in **Appendix A — Forms**.

Reporting changes in practice status

Please report any practice status changes to DCH at **mmis.georgia.gov/portal/PubAccess.Enrollment/tabId/27/Default.aspx.**

Provider and facility digital guidelines

Amerigroup understands that working together digitally streamlines processes and optimizes efficiency. We developed the Provider and Facility Digital Guidelines to outline our expectations and to fully inform Providers and Facilities about our digital platforms.
Amerigroup expects Providers and Facilities will utilize digital tools, unless otherwise prohibited by law or other legal requirements.

Digital guidelines establish the standards for using secure digital Provider platforms (websites) and applications when transacting business with Amerigroup. These platforms and applications are accessible to both participating and nonparticipating Providers and Facilities and encompass Availity.com, electronic data interchange (EDI), electronic medical records (EMR) connections and business-to-business (B2B) desktop integration.

The Digital Guidelines outline the digital/electronic platforms Amerigroup has available to participating and nonparticipating Providers and Facilities who serve its Members. The expectation of Amerigroup is based on our contractual agreement that Providers and Facilities will use these digital platforms and applications, unless otherwise mandated by law or other legal requirements.

Digital and/or electronic transaction applications are accessed through these platforms:

- Availity EDI Clearinghouse
- B2B application programming interfaces (APIs)
- EMR connections

Digital guidelines available through Availity Essentials include:

- Acceptance of digital ID cards
- Eligibility and benefit inquiry and response
- Prior authorization submissions including updates, clinical attachments, authorization status, and clinical appeals
- Claim submission, including attachments, claim status
- Remittances and payments
- Provider enrollment
- Demographic updates

Additional digital applications available to Providers and Facilities include:

- Pharmacy prior authorization drug requests
- Services through Carelon Medical Benefits Management, Inc.
- Services through Carelon Behavioral Health, Inc.

Amerigroup expects Providers and Facilities transacting any functions and processes above will use available digital and/or electronic self-service applications in lieu of manual channels (paper, mail, fax, call, chat, etc.). All channels are consistent with industry standards. All EDI transactions use version 5010.

Note: As a mandatory requirement, all trading partners must currently transmit directly to the Availity EDI gateway and have an active Availity Trading Partner Agreement in place. This includes providers using their practice management software & clearinghouse billing vendors.

Providers and Facilities who do not transition to digital applications may experience delays when using non-digital methods such as mail, phone, and fax for transactions that can be conducted using digital applications.

Section 1: Accepting digital ID cards

As our Members transition to digital Member ID cards, Providers and Facilities may need to implement changes in their processes to accept this new format. Amerigroup expects that Providers and Facilities will accept the digital version of the member identification card in lieu of a physical card when presented. If Providers and Facilities require a copy of a physical ID card, Members can email a copy of their digital card from their smartphone application, or Providers and Facilities may access it directly from Availity Essentials through the Eligibility and Benefits Inquiry application.

Section 2: Eligibility and benefits inquiry and response

Providers and Facilities should leverage these Availity Clearinghouse hosted channels for electronic eligibility and benefit inquiry and response:

- EDI transaction: X12 270/271 – eligibility inquiry and response
  - Amerigroup supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by HIPAA.
- Availity Essentials
  - The Eligibility and Benefits Inquiry verification application allows a Provider and Facility to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.
- Provider desktop integration via B2B APIs
  - Amerigroup has also enabled real-time access to eligibility and benefit verification APIs that can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration opportunities.
  -
  - **Section 3: Prior authorization submission, attachment, status, and clinical appeals.**

Providers and Facilities should leverage these channels for prior authorization submission, status inquiries and to submit electronic attachments related to prior authorization submissions:

- EDI transaction: X12 278 – prior authorization and referral:
  - Amerigroup supports the industry standard X12 278 transaction for prior authorization submission and status inquiry as mandated per HIPAA.
- EDI transaction: X12 275 – patient information, including HL7 payload for authorization attachments:
  - Amerigroup supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation including medical records via the HL7 payload.
- Availity Essentials:

    - Authorization applications include the Availity Essentials multi-payer Authorization and Referral application for authorization submissions not accepted through Availity Essentials' multi-payer application.
        - Both applications enable prior authorization submission, authorization status inquiry and the ability to review previously submitted authorizations.
- Provider desktop integration via B2B APIs:
    - Amerigroup has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Section 4: Claims: submissions, claims payment disputes, attachments, and status

Claim submissions status and claims payment disputes

Providers and Facilities should leverage these channels for electronic Claim submission, attachments (for both pre- and post-payment) and status:

- EDI transaction: X12 837 – Professional, institutional, and dental Claim submission (version 5010):
    - Amerigroup supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per HIPAA.
    - 837 Claim batch upload through EDI allows a provider to upload a batch/file of Claims (must be in X12 837 standard format).
- EDI transaction: X12 276/277 – Claim status inquiry and response:
    - Amerigroup supports the industry standard X12 276/277 transaction set for Claim status inquiry and response as mandated by HIPAA.
- Availity Essentials: The Claims & Payments application enables a provider to enter a Claim directly into an online Claim form and upload supporting documentation for a defined Claim.
    - Claim Status application enables a provider to access online Claim status. Access the Claim payment dispute tool from Claim Status. Claims Status also enables online claim payment disputes in most markets and for most claims. It is the expectation of Amerigroup that electronic Claim payment disputes are adopted when and where it is integrated.
- Provider desktop integration via B2B APIs:
    - Amerigroup has also enabled real-time access to Claim Status via APIs, which can be directly integrated within participating vendor's practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Claim attachments

Providers and Facilities should leverage these channels for electronic Claim attachments from Availity.com:

- EDI transaction: X12 275 – Patient information, including HL7 payload attachment:

    - Amerigroup supports the industry standard X12 275 transaction for electronic transmission of supporting Claim documentation including medical records via the HL7 payload.
- Availity Essentials – Claim Status application enables a Provider or Facility to digitally submit supporting Claims documentation, including medical records, directly to the Claim.
    - Digital Request for Additional Information (Digital RFAI) – The Medical Attachments application on Availity Essentials enables the transmission of digital notifications when additional documentation including medical records are needed to process a Claim.

Section 5: Electronic remittance advice and electronic claims payment

Electronic remittance advice

Electronic remittance advice (ERA) is an electronic data interchange (EDI) transaction of the explanation of payment of your claims. Amerigroup supports the industry standard X12 835 transaction as mandated per HIPAA.
Providers and Facilities can register, enroll and manage ERA preference through **Availity.com**.
Printing and mailing remittances will automatically stop thirty (30) days after the ERA enrollment date.

- Viewing an ERA on Availity Essentials is under Claims & Payments, Remittance Viewer. Features of remittance viewer, include the ability to search a two (2) year history of remittances and access the paper image.
- Viewing a portable document format (PDF) version of a remit is under Payer Spaces which provides a downloadable PDF of the remittance.

To stop receiving ERAs for your claims, contact Availity Client Services at **1-800-AVAILITY** (282-4548).
To re-enable receiving paper remittances, contact Provider Services.

Electronic claims payment

Electronic claims payment is a secure and fast way to receive payment, reducing administrative processes. There are several options to receive claims payments electronically.

- Electronic Funds Transfer (EFT)
- Electronic funds transfer (EFT) uses the automated clearinghouse (ACH) network to transmit healthcare payments from a health plan to a Provider's or Facility's bank account at no charge for the deposit. Health plans can use a Provider's or Facility's banking information only to deposit funds, not to withdraw funds. The EFT deposit is assigned a trace number (TRN) to help match the payment to the correct 835 electronic remittance advice (ERA), a process called reassociation.
- To enroll in EFT: Providers and Facilities can register, enroll, and manage account changes for EFT through EnrollSafe at enrollsafe.payeehub.org. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest cost payment method. For help with enrollment, use this convenient EnrollSafe User Reference Manual.

To disenroll from EFT: Providers and Facilities are entitled to disenroll from EFT. Disenroll from EFT payments through EnrollSafe at **enrollsafe.payeehub.org**.

- **Virtual Credit Card (VCC)**

  For Providers and Facilities who don't enroll in EFT, and in lieu of paper checks, Amerigroup is shifting some reimbursements to virtual credit card (VCC). VCC allow Providers and Facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply.

  Note that Amerigroup may receive revenue for issuing a VCC.

  Opting out of virtual credit card payment. Providers and Facilities are entitled to opt out of electronic payment. To opt out of virtual credit card payment, there are two (2) options:

  - Enrolling for EFT payments automatically opts you out of virtual credit card payments. To receive EFT payments instead of virtual credit cards payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.

    OR

  - To opt out of virtual credit card payments, call **800-833-7130** and provide your taxpayer identification number.

- **Zelis Payment Network (ZPN) electronic payment and remittance combination**

  The Zelis Payment Network (ZPN) is an option for Providers and Facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included together with additional services. For more information, go to **Zelis.com**. Zelis may charge fees for their services.

  Note that Amerigroup may receive revenue for issuing ZPN.

  ERA through Availity is not available for Providers and Facilities using ZPN.

  To disenroll from ZPN payment, there are two (2) options:

  - Enrolling for EFT payments automatically removes you from ZPN payments. To receive EFT payments instead of ZPN payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.

    OR

  - To disenroll from ZPN payments, update your Zelis registration on the Zelis provider portal or contact Zelis at **877-828-8770**.

Not being enrolled for EFT, VCC, or ZPN will result in paper checks being mailed.

Specialty referrals

In order to reduce the administrative burden in the medical office, Amerigroup has established procedures that are designed to permit a member with a condition that requires ongoing care from a specialist physician or other health care provider to request an extended authorization.

The provider can request an extended authorization by contacting Amerigroup. The provider shall supply the necessary clinical information that will be reviewed by Amerigroup in order to complete the authorization review.

On a case-by-case basis, an extended authorization will be approved. In the event of termination of a contract or loss of eligibility with the treating provider, the continuity of care provisions in the provider's contract with Amerigroup will apply. The provider may renew the authorization by submitting a new request to Amerigroup. Additionally, Amerigroup requires the specialist physician or other health care provider to provide regular updates to the member's PCP (unless he or she is the designated PCP for the member). Should the need arise for a secondary referral, the specialist physician or other health care provider shall contact Amerigroup.

If the specialist or other health care provider needed to provide ongoing care for a specific condition is not available in the Amerigroup network, the referring physician shall request authorization from Amerigroup for services outside the network. Access will be approved to a qualified non-network health care provider within a reasonable distance and travel time at no additional cost.

If a provider's application for an extended authorization is denied, the member (or the provider on behalf of the member) may appeal the decision through the Amerigroup medical appeal process.

Second opinions

A member or the member's PCP may request a second opinion for serious medical conditions or elective surgical procedures at no cost to the member. A member of the health care team, parents and guardians, or social workers may also request a second opinion. These conditions and/or procedures include 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
    - Spinal fusion (except for children younger than age 18 with a diagnosis of scoliosis)
    - Laminectomy (except for children younger than age 18 with a diagnosis of scoliosis)
- Other medically necessary conditions, including the exceptions listed above, as circumstances dictate

The second opinion must be obtained from a network provider (see the Amerigroup provider referral directory) or a non-network provider if there is not a network provider with the expertise required for the condition. Once approved, the PCP will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The PCP will notify the member of the outcome of the second opinion.

Amerigroup may also request a second opinion at our discretion for, but not limited to, the following reasons:

- Whenever there is a concern about care expressed by the member or the provider
- Whenever potential risks or outcomes of recommended or requested care are discovered by the plan during its regular course of business
- Before initiating a denial of coverage of service
- When denied coverage is appealed
- When an experimental or investigational service is requested

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

Role and responsibility of the specialist

Specialist providers will only treat members who have been referred to them by network PCPs (with the exception of mental health and substance abuse providers and services that the member may self-refer) and will render covered services only to the extent and duration indicated on the referral. Obligations of the specialists also include the following:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program
- Meeting eligible requirements to participate in the Medicaid program
- Accepting all members referred to them
- Submitting required claims information including source of referral and referral number to Amerigroup
- Arranging for coverage with network providers while off duty or on vacation
- Verifying member eligibility and preauthorization of services (if required) at each visit
- Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis, following a referral or routinely scheduled consultative visit; notifying the member's PCP when scheduling a hospital admission or any other procedure requiring the PCP's approval

Be aware that materials created by the provider for the sole purpose of distributing to Amerigroup members for marketing purposes must be approved by Amerigroup as well as the Georgia Department of Community Health, per state contractual guidelines.

Specialist access and availability

Specialists must adhere to the following access guidelines:

Service	Access requirement
Emergent or emergency visits	Immediately upon presentation (24 hours a day, 7 days a week) and without preauthorization
Urgent nonemergency visits	Not to exceed 24 hours
Nonemergency hospital stays	Not to exceed 30 calendar days
Specialists	Not to exceed 30 calendar days
Mental health providers	Not to exceed 14 calendar days
Initial visit for pregnant women	Within 14 calendar days

Appointment wait times
Scheduled appointment wait times must not exceed 60 minutes. After 30 minutes, the patient must be given an update on the waiting time and the option of either continuing to wait or rescheduling the appointment.

Wait times for work-in or walk-in appointments shall not exceed 90 minutes. After 45 minutes, the patient must be given an update on the waiting time and the option of either continuing to wait or rescheduling the appointment.

Integration of physical and behavioral health services

Integration program overview
We're committed to supporting the Georgia Department of Community Health's (DCH's) goals of integrating behavioral health and physical health providers to provide the best care for the member.

The behavioral health provider will:

- Obtain the member's or the member's legal guardian's consent to send behavioral health status reports to the member's PCP/specialists.
- Send initial and quarterly (or more frequently if clinically indicated) summary reports of a member's behavioral health status to the member's PCP/specialist(s). This can be in the form of a treatment plan, care plan, updated crisis plans and/or any other pertinent information.
- Utilize specific billing codes to document the time and effort spent on this task. This documentation can and will be audited for compliance.
- Upon being informed that a member who's been seen and billed by him/her within the last six months has an inpatient admission, confirm whether the member is still receiving services there, collaborate on the importance of the seven-day follow-up appointment following discharge, and address any barriers to treatment, past and present.

Amerigroup will:

- Add appropriate billing codes to the provider fee schedule to allow providers the opportunity to document the time and effort spent in engaging in integration with the member's PCP/specialist(s).
- Audit providers as necessary to review this documentation.
- Contact behavioral health providers when a member who's been seen/billed by that provider within the last six months has an inpatient admission.

- Assist providers in removing any barriers to successful discharge planning and continued step-down services.
- Create an *Annual Health Coordination and Integration Report*, due to DCH June 30 of each calendar year for the prior calendar year, beginning 2017. This report includes program goals and objectives, a summary of activities and efforts to integrate and coordinate behavioral and physical health, success and opportunities for improvement, plans to implement initiatives to address identified opportunities for these improvements, which improvements were achieved, and a roadmap of activities planned for the next reporting period.

Fraud, Waste and Abuse – Prepayment Review

One method Amerigroup uses to detect FWA is through prepayment Claim review. Through a variety of means, certain Providers or Facilities, or certain Claims submitted by Providers or Facilities, may come to the attention of Amerigroup for behavior that might be identified as unusual for coding, documentation and/or billing issues, or Claims activity that indicates the Provider or Facility is a variation compared to his/her/its peers.

Once a Claim, or a Provider or Facility, is identified as a variation or has otherwise come to the attention of Amerigroup for reasons mentioned above, further investigation is conducted by the SIU to determine the reason(s) for the variation status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the investigation results in a determination that the Provider's or Facility's actions may involve FWA, the Provider or Facility is notified and given an opportunity to respond.

If, despite the Provider's or Facility's response, Amerigroup continues to believe the Provider's or Facility's actions involve FWA, or some other inappropriate activity, the Provider or Facility may be placed on prepayment review. If that occurs, the Provider or Facility will receive written notice of being placed on prepayment review. This means that the Provider or Facility will be required to submit medical records and any other supporting documentation with each Claim so Amerigroup can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation to Amerigroup in accordance with this requirement will result in a denial of the Claim under review. The Provider or Facility will be given the opportunity to request a discussion of his/her/its prepayment review status.

Under the prepayment review program, Amerigroup may review coding, documentation, and other billing issues. In addition, we may use one or more clinical utilization management guidelines in the review of Claims submitted by the Provider or Facility, even if those guidelines are not used for all Providers or Facilities delivering services to Plan Members. Amerigroup will notify the provider in writing prior to the start date of the Prepayment Review

The Provider or Facility will remain subject to the prepayment review process until Amerigroup is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the Provider or Facility could face corrective measures, up to and including termination from our network. Providers may not appeal

Amerigroup decision to place the provider on Prepayment Review. Provider may appeal the denial of any claims, reduction or reimbursement or the withholding of reimbursement, which occurred during the Prepayment Review Process. Finally, Providers and Facilities are prohibited from billing a Member for services.

Amerigroup requires providers to submit 100% of claims for the codes active on prepayment review. To be considered for removal from prepayment review, providers must bill the greater of 10% of normal billing volume or a minimum of 40 claims for dates of service that occurred while on Prepayment Review. The aggregate of claims reviewed must meet an 85% pass rate to be considered for removal. Providers who have an error rate of less than 15% (based on claim line items) for a period of six months will be considered for removal after they have fulfilled the requirements for all CPT codes under review. Providers will be notified in writing of the effective end date of review.

Finally, Providers and Facilities are prohibited from billing a Member for services we have determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue or for failure to submit medical records as set forth above. Providers or Facilities whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of their Provider and Facility Agreement, proper billing procedures and state law. Providers or Facilities also may appeal such a determination in accordance with applicable grievance and appeal procedures.

Homeland Security requirements

The provider shall perform the services under our agreement entirely within the boundaries of the United States. If the provider must maintain a Department of Homeland Security-approved work visa in order to perform the services under the agreement, any failure to comply is a material breach of the contract. If this occurs, the provider is liable to Amerigroup for any costs, fees, damages, claims or expenses we may incur. Additionally, the provider is required to hold harmless and indemnify DCH pursuant to the indemnification provisions of the agreement.

9 Culturally and linguistically appropriate services

Patient panels are increasingly diverse and needs are becoming more complex. It is important for providers to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. Amerigroup wants to help, as we all work together to achieve health equity.

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that healthcare is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

- Where and how care is accessed, how symptoms are described,
- Expectations of care and treatment options,
- Adherence to care recommendations.

Providers also bring their own cultural orientations, including the culture of medicine.

Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.
- Develop understanding of others' needs, values and preferred means of having those needs met
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family members, especially minors, to act as interpreters for limited English proficient patients.
- Understand and adhere to regulations to support the needs of diverse patients, such as the *Americans with Disabilities Act (ADA).*
- Use culturally appropriate community resources as needed to support patient needs and care.

Amerigroup ensures providers have access to resources to help support delivery of culturally and linguistically appropriate services. Amerigroup encourages providers to access and utilize:

MyDiversePatients.com: The My Diverse Patient website offers resources, information, and techniques, to help provide the individualized care every patient deserves regardless of their diverse backgrounds. The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.
- **My Inclusive Practice- Improving Care for LGBTQIA+ Patients:** Helps providers understand the fears and anxieties LGBTQIA+ patients often feel about seeking medical care, learn key health concerns of LGBTQIA+ patients, & develop strategies for providing effective health care to LGBTQIA+ patients.
- **Improving the Patient Experience:** Helps providers identify opportunities and strategies to improve patient experience during a health care encounter.
- **Medication Adherence:** Helps providers identify contributing factors to medication adherence disparities for diverse populations & learn techniques to improve patient-centered communication to support needs of diverse patients.
- **Moving Toward Equity in Asthma Care:** Helps providers understand issues often faced by diverse patients with asthma & develop strategies for communicating to enhance patient understanding.
- **Reducing Health Care Stereotype Threat (HCST):** Helps providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both providers' patients and practices, and how to do so.

Cultural Competency Training (Cultural Competency and Patient Engagement): A training resource to increase cultural and disability competency to help effectively support the health and health care needs of your diverse patients.

Caring for Diverse Populations Toolkit: A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse patients.

The *Cultural Competency Plan* is available at **provider.amerigroup.com/GA**. To request a printed copy of the *Cultural Competency Plan*, call Provider Services at **800-454-3730**.

Amerigroup appreciates the shared commitment to ensuring members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

10 Member records

Using nationally recognized standards of care, Amerigroup works with providers to develop clinical policies and guidelines of care for our membership. The medical advisory committee (MAC) oversees and directs Amerigroup in formalizing, adopting and monitoring guidelines. Amerigroup requires medical records to be maintained in a manner that is current, detailed, organized and permits effective and confidential patient 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 handled as follows:

- Maintained in an appropriately secure location at the primary care site for every member
- Easily retrievable and available to the PCP and other providers
- Handled in a manner to protect confidentiality of member information

Medical records must be kept in accordance with Amerigroup and state standards as indicated below.

Medical record standards

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

1. Date of service
2. Purpose of visit
3. Diagnosis or medical impression
4. Objective finding
5. Assessment of patient's findings
6. Plan of treatment, diagnostic tests, therapies, and other prescribed regimens
7. Medications prescribed
8. Health education provided
9. Signature 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:

1. Patient identification information: Each page or electronic file in the record must contain the patient's name or patient ID number.
2. Personal/biographical data: Must include age, sex, address, employer, home and work telephone numbers, and marital status.
3. All entries must be dated and author identified.
4. Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
5. Allergies: Medication allergies and adverse reactions must be prominently noted on the record. Absence of allergies (no known allergies — NKA) must be noted in an easily recognizable location.
6. Past medical history (for patients seen three or more times): Past medical history must be easily identified, including serious accidents, operations and illnesses. For children, past medical history relates to prenatal care and birth.
7. Physical examination: A record of physical examination(s) appropriate to the presenting complaint or condition.
8. Immunizations: For pediatric records of members 13 years and younger, a completed immunization record or a notation of prior immunization must be recorded, including vaccines and dates given when possible.
9. Diagnostic information: Documentation of clinical findings and evaluation for each visit.
10. Medication information (includes medication information/instruction to patient).
11. Identification of current problems: Significant illnesses, medical and behavioral health conditions, and health maintenance concerns must be identified in the medical record. A current *Problem List* must be included in each patient record.

12. Patient must be provided with basic teaching/instructions regarding physical and/or behavioral health condition.
13. Smoking/alcohol/substance abuse: A notation concerning cigarettes and alcohol use and substance abuse must be stated if present for patients age 12 and older. Abbreviations and symbols may be appropriate.
14. Preventive services/risk screening: The record must include consultation and provision of appropriate preventive health services and appropriate risk screening activities.
15. Consultations, referrals, and specialist reports: Notes from any referrals and consultations are in the record. Consultation, lab and X-ray reports filed in the chart have the ordering physician's initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results must have an explicit notation in the record of follow-up plans.
16. Emergencies: All emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions while the patient is part of the PCP's panel must be noted.
17. Hospital discharge summaries: Discharge summaries must be included as part of the medical record for all hospital admissions, which occur while the patient is enrolled and for prior admissions as necessary. Prior admissions as necessary pertain to admissions that may have occurred prior to the patient being enrolled and are pertinent to the patient's current medical condition.
18. Advance directives: For medical records of adult patients, the medical record must document whether or not the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.
19. Security: Provider must maintain a written policy to ensure that medical records are safeguarded against loss, destruction, or unauthorized use. Physical safeguards require records to be stored in a secure manner that allows access for easy retrieval by authorized personnel only. Staff receives periodic training in member information confidentiality.
20. Release of information: Written procedures are required for the release of information and obtaining consent for treatment.
21. Documentation: There must be documentation of all treatment provided and results of such treatment.
22. Multidisciplinary teams: Documentation is required of the team members involved in the multidisciplinary team of a patient needing specialty care.
23. Integration of clinical care: Documentation of the integration of clinical care in both the physical and behavioral health records is required. Such documentation must include:
    - Screening for behavioral health conditions (including those that may be affecting 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/outcome of those referrals.
    - A quarterly (or more often if clinically indicated) summary of the status/progress from the behavioral health provider to the PCP; a written release of information that permits specific information sharing between providers.
    - Documentation that behavioral health professionals are included in primary and specialty care service teams described in this contract when a patient with

disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder.

Patient visit data

At a minimum, documentation of individual encounters must provide adequate evidence of:

1. History and physical exam — Appropriate subjective and objective information must be obtained for the presenting complaints.
2. At-risk factors — For patients receiving behavioral health treatment, documentation must indicate danger to self/others, ability to care for self, effect of treatment, perceptual disorders, cognitive functioning, and significant social health.
3. Support systems — Admission or initial assessment must include current support systems or lack of support systems.
4. Behavioral health treatment — An assessment must be done with each visit relating to client status/symptoms to the treatment process. Documentation may indicate initial symptoms of the behavioral health condition as decreased, increased or unchanged during the treatment period.
5. Activities/therapies and goals — The plan of treatment must include activities/therapies and goals to be carried out.
6. Diagnostic tests.
7. Therapies and other prescribed regimens — For patients 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.
8. Follow-up — Encounter forms or notes must have a notation when indicated concerning follow-up care, call or visit. Specific time to return must be noted in weeks, months or as needed. Unresolved problems from previous visits are addressed in subsequent visits.
9. Referrals — Referrals and results thereof, and all other aspects of patient care, including ancillary services.

Amerigroup will systematically review medical records to ensure compliance with the standards. The performance goal is 80 percent pass on the provider's medical record review. We will institute actions for improvement when standards are not met.

Amerigroup maintains an appropriate record keeping system for services to members. This system will collect all pertinent information relating to the medical management of each member and make that information readily available to appropriate health professionals and appropriate state agencies. All records will be retained in accordance with the record retention requirements of *45 CFR 74.164* (in other words, records must be retained for seven years from the date of service). Records will be made accessible on request to agencies of the state of Georgia and the federal government.

A copy of the member's medical record is available, without charge, upon the written request of the member or authorized representative within 14 calendar days of the receipt of the written request.

Advance directives

Amerigroup respects the right of the member to control decisions relating to his or her own medical care, including the decision to have provided, withheld, or withdrawn the medical or surgical means or procedures calculated to prolong his or her life. 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 Patient 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 (durable power) allows the member to name a patient advocate to act on behalf of the member. A living will allows the member to state his or her wishes in writing but does not name a patient advocate.

Member Services and outreach associates encourage members to request an advance directive form and education from their PCP at their first appointment.
Members older than 18 years of age and emancipated minors are able to make an advance directive. His or her response is to be documented in the medical record. Amerigroup will not discriminate or retaliate based on whether a member has or has not executed an advance directive. While each member has the right without condition to formulate an advance directive within certain limited circumstances, a facility or an individual physician may conscientiously object to an advance directive.

Member Services and outreach associates will assist members regarding questions about advance directives; however, no associate of Amerigroup may serve as witness to an advance directive or as a member's designated agent or representative.

The member may obtain a copy of the *Georgia Advance Directive for Health Care* by visiting **aging.georgia.gov/** and selecting **Publications** from the top navigation. Copies of this form and its instructions are available at no cost from the Georgia Division of Aging Services:

Georgia Division of Aging Services
47 Trinity Ave. S.W.
Atlanta, GA 30334

For additional information, or if the attending physician, health care provider and/or health care facility refuse to honor the *Georgia Advance Directive of Health Care*, call the Division's information and referral specialist at **404-657-5319**.

Amerigroup notes the presence of advance directives in the medical records when conducting medical chart audits. A living will and durable power of attorney are located in **Appendix A — Forms**.

11 Medical management

Inpatient and outpatient medical review criteria

Amerigroup has its own nationally recognized medical policy process for all its subsidiary entities.

Medical policies are the primary benefit plan policies for determining whether services are considered to be a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive for Amerigroup subsidiaries.

InterQual® criteria will continue to be used when no specific medical policies exist. In the absence of licensed InterQual criteria, Amerigroup subsidiaries may use *Clinical Utilization Management (UM) Guidelines*. A list of the specific *Clinical UM Guidelines* used will be posted and maintained on the Amerigroup subsidiary websites and can be obtained in hard copy by written request. The policies described above will support precertification requirements, clinical-appropriateness claims edits and retrospective review.

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

We primarily use current editions of InterQual level of care criteria to review the medical necessity and appropriateness of both physical and behavioral health inpatient services and criterion for outpatient services. Amerigroup medical coverage policies are also used in the health plan as well as state-approved plans' clinical policies as additional guidelines in medical decision making. We work with network providers to develop clinical guidelines of care for our members. Review criteria are objective and based on medical evidence and nationally recognized standards of care. The medical advisory committee assists us in formalizing and monitoring guidelines.

If we use noncommercial criteria, the following standards apply to the development of the criteria:

- Criteria are developed with involvement from appropriate providers with current knowledge relevant to the content of treatment guidelines under development.
- Criteria are based on review of market practice and national standards/best practices.
- Criteria are evaluated at least annually by appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria of treatment guidelines under review and updated as necessary. The criteria must reflect the names and qualifications of those involved in the development, the process used in the development, and the timing and frequency at which the criteria will be evaluated and updated.

Clinical criteria
We primarily use InterQual and criteria for clinical decision support for medical management coverage decisions. The criteria provide a system for screening proposed medical care based on member-specific, best medical care practices and rule-based systems to match appropriate services to member needs based upon clinical appropriateness. Criteria include:

- Acute care.
- Rehabilitation.
- Subacute care.
- Home care.
- Surgery and procedures.
- Neonatal intensive care unit.
- Imaging studies and X-rays:
    - Carelon Medical Benefits Management manages preauthorization for computerized tomography, computerized axial tomography, nuclear cardiology, magnetic resonance imaging, magnetic resonance angiogram and positron emission tomography scans. You may visit their website at **carelon.com/capabilities/medical-benefits-management or via phone at 844-423-0877.**

Amerigroup utilization reviewers use these criteria as part of the preauthorization of scheduled admission, concurrent review and discharge planning process to determine clinical appropriateness and medical necessity for coverage of continued hospitalization. Copies of the criteria used in a case to make a clinical determination may be obtained by calling Amerigroup Provider Services at **800-454-3730** or the local health plan at **678-587-4840**. Providers may also submit their request in writing to:

Medical Management
Amerigroup Community Care
740 W Peachtree St NW
Atlanta, GA 30308

Peer-to-peer discussion

If the medical director denies coverage of the request, the adverse benefit determination (including the member's appeal rights) will be mailed to the requesting provider, the member's PCP and/or attending physician, and the member. You have the right to discuss this decision with our medical director. You can request a peer-to-peer by emailing GApeer2peer@anthem.com within two business days of the denial decision.

A member of the peer-to- peer team will acknowledge receipt and communicate the status of the peer-to-peer request and provide specific next steps as they relate to the member authorization inquiry. If applicable, a peer-to-peer review will be scheduled with the medical director, within seven business days after receipt of the peer-to-peer email request.

Pharmacy-related peer-to-peer requests should not be submitted through this email address.

Preauthorization and notification process

Preauthorization: The prospective process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered, a member's severity of illness, medical history and previous treatment to determine the medical necessity and appropriateness of a given coverage request; *prospective* means the coverage request occurred prior to the service being provided.

DCH implemented the centralized prior authorization (PA) feature which is the preferred method for submitting preauthorization requests. This feature allows participating Georgia Medicaid providers to submit PA requests to fee-for-service (FFS) and care management organizations (CMOs) through a centralized source: the Georgia Medicaid Management Information System (GAMMIS) at **mmis.georgia.gov**. Authorization services that should be submitted via the centralized PA portal functionality include:

- *Newborn Delivery Notification* forms through the electronic portal for all obstetric deliveries that will be submitted for claims payments to the CMOs.
- *Pregnancy Notification* forms through the electronic portal for all pregnant members, to ensure high-risk OB members are identified and get appropriate assistance and support.
- Notification of Pregnancy (NOP) Standalone Notification
- Newborn Delivery Notification Standalone Notification Form
- Newborn Intensive Care Unit (NICU)/ Sick Baby Standalone Notification Form
- Pas For The Following Places Of Services (POS):
    - 12: home (CIS, DME)
    - 21: inpatient hospital services
    - 22: outpatient hospital services
    - 24: ambulatory surgery services
- In-state transplants.
- Children's Intervention Services (CIS).
- Durable medical equipment (DME).
- Hospital outpatient therapy.
- Orthotics and prosthetics.
- Hearing aids.
- Reconsideration requests for authorizations submitted on GAMMIS.
- Submission of initial and additional clinical data attachments.

Additional PA types will be added at a future date. These will be determined by the Georgia Department of Community Health, with notification and education for all providers. Fax pharmacy preauthorization requests to **844-490-4736** for Retail Pharmacy and **844-490-4870** for Medical Injectables.

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

- Initiating preauthorization requests online — eliminating the need to fax. The ICR allows detailed text, photo images and attachments to be submitted along with your request.

- Making inquiries on previously submitted requests via phone, fax, ICR or other online tool.
- Having instant accessibility from almost anywhere, including after business hours.
- Utilizing a dashboard that provides a complete view of all utilization management requests with real-time status updates, including email notifications if requested using a valid email address.
- Viewing real-time results for common procedures with immediate decisions.
- Requesting eligible denied authorizations affiliated with your tax ID.

You can access the ICR from Availity Essentials.
Select **Patient Management** select **Authorizations and Referrals**. For an optimal experience with the ICR, use a browser that supports 128-bit encryption. This includes Chrome, Firefox and Microsoft Edge.

The ICR is not currently available for:

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

We'll update our website as additional functionality and lines of business are added.

Notification: Electronic communication received from a provider informing Amerigroup of the intent to render covered medical services for a member; eligibility and provider status (network and non-network) are verified. Notification should be provided prior to rendering services to determine if preauthorization of a service is required. For services that are emergent or urgent, notification should be given within 24 hours or the next business day.

Additionally, PCPs should assist members with coordinating all specialist care Members may self-refer for obstetrical, gynecological, family planning and outpatient behavioral health services without PCP coordination. Participating specialists are not required to submit referral forms with claims.

12 Hospital and elective admission preauthorization requirements

Amerigroup requires preauthorization of all inpatient elective admissions. The referring primary care or specialist physician is responsible for preauthorization. Amerigroup will also accept preauthorization requests for elective admissions from facilities.

The referring physician identifies the need to schedule a hospital admission and must submit the request to the Amerigroup Medical Management department via the Georgia Medicaid Management Information System (GAMMIS) at **mmis.georgia.gov**.

Requests for preauthorization with all supporting documentation should be submitted immediately or at least 72 hours prior to the scheduled admission. This will allow Amerigroup to verify benefits and process the preauthorization request. Amerigroup uses InterQual and criteria for services that require preauthorization.

The hospital can confirm that an authorization is on file by calling Provider Services at **800-454-3730** (see the Amerigroup website and the Provider Services sections for instructions on use of the Provider Services automated features). If an admission has not been approved, the facility should call Amerigroup at **800-454-3730**. We will contact the referring physician directly to resolve the issue. Providers may also check authorization status through GAMMIS at **mmis.georgia.gov**.

We're available 24 hours a day, 7 days a week to accept preauthorization requests. When a request is received from the physician via the GAMMIS portal for medical services, the preauthorization assistant will verify eligibility and benefits. This information will be forwarded to the preauthorization nurse.

The preauthorization nurse will review the request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures against approved criteria and guidelines. When appropriate, the preauthorization nurse will assist the physician in identifying alternatives for health care delivery as supported by the medical director.

When the clinical information received meets criteria, an Amerigroup reference number will be issued to the referring provider. If medical necessity criteria for the admission are not met on the initial review, the medical director may contact the requesting physician to discuss the case.

Emergent admission notification requirements

We prefer immediate notification by network hospitals of emergent admissions. Network hospitals must notify us of emergent admissions within one business day. We use InterQual criterion for review of emergent admissions. Our medical management staff will verify eligibility and determine benefit coverage. We're available 24 hours a day, 7 days a week to accept emergent admission notification at **800-454-3730**.

Coverage of emergent admissions is authorized based on review by a concurrent review nurse. When an inpatient admission is ordered for a member, clinical information should be submitted to the assigned concurrent review nurse via the GAMMIS portal. When the clinical information received meets criteria, an Amerigroup reference number will be issued to the hospital. If the notification documentation provided is incomplete or inadequate, we will not approve coverage of the request and refer the case to be reviewed by the plan medical director. If the medical director denies coverage of the request, the appropriate notice of proposed action will be mailed to the hospital, the member's PCP and/or attending physician, and the member.

Nonemergent outpatient and ancillary services — preauthorization and notification requirements

Amerigroup requires preauthorization for coverage of selected nonemergent outpatient and ancillary services (see the chart on the following pages). Providers should use our website and the **Prior Authorization Lookup Tool** to identify those services requiring prior authorization. Nonurgent requests will be reviewed within three business days from the receipt of the request.

An extension may be granted for an additional 14 calendar days if the member or the provider requests an extension, or if Amerigroup justifies to the DCH a need for additional information, and the extension is in the member's best interest. All decisions and notifications must occur by the end of the 14-day extension.

To ensure timeliness of the authorization, the expectation of the facility and/or provider is that the following must be provided:

1. Member name and ID
2. Name and telephone number of physician performing the elective service
3. Name of the facility and/or other place of service where the service is to be performed
4. Telephone number where the service is to be performed
5. Date of service
6. Member diagnosis
7. Name of elective procedure to be performed with CPT or Procedure codes
8. Medical information to support requested services (medical information includes current signs/symptoms, past and current treatment plans, response to treatment plans, and medications)

Please consult the scope of benefits to understand coverage limits.

Hospital notification — newborn screening

The Georgia Department of Community Health notified hospitals of the requirement to perform additional screenings on newborns as of January 1, 2007. When the screening is performed, the hospital will receive an additional reimbursement of $40 to the diagnosis-related group (DRG) reimbursement. This is a one-time reimbursement per newborn member per lifetime and applicable to computed DRG codes 385-391 and 600-630.

Amerigroup added this additional newborn reimbursement to the DRG claim for hospitals only. This will not apply to birthing centers or ancillary providers.

In order for the hospital to receive the $40 additional reimbursement, an A1 condition code must be entered in fields 18-28 of the *UB-04* form. Claims submitted without the proper information will need to be resubmitted as a corrected claim within the timely filing requirements per the hospital contract or Amerigroup claims filing limits.

Corrected claims can be submitted through the Amerigroup website or as a paper claim clearly marked as a corrected claim. Corrected claims must be submitted within 90 days from the date of the original claim submission.

Amerigroup preauthorization/notification coverage guidelines

Service	Requirement	Comments
Behavioral health/ substance abuse		• Preauthorization is required for coverage of inpatient mental health services. • Preauthorization is required for coverage of traditional outpatient services such as individual and family therapy after the first 20 units of services per member. • Preauthorization is required for coverage of psychological testing. • Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP) require preauthorization for coverage.
Cardiac rehabilitation	Preauthorization	Preauthorization is required for coverage of all services.
Chemotherapy	Use the **Prior Authorization Lookup Tool**.	For information on coverage of chemotherapy drugs, please see the Pharmacy section of these guidelines. Note: Preauthorization is required for coverage of inpatient chemotherapy, as well as all blood additive drugs given in conjunction with outpatient chemotherapy.
Court-ordered services	Preauthorization	Preauthorization is required for coverage of all services.
Dental services		• Members may self-refer for dental checkups and cleaning exams. Dental benefits are administered through our network vendor DentaQuest. You may call DentaQuest at **800-895-2218**. • Preventive, diagnostic and treatment services for members under age 21 with a $10 copay. Preventive services and extractions are available as an additional benefit for members age 21 and older. Emergency services are also available for members age 21 and older. • Pregnant women receive preventive, diagnostic and treatment services. Orthodontia is covered for special problems. • For TMJ services, see the Plastic/Cosmetic/ Reconstructive Surgery section of these guidelines.
Dermatology services	No preauthorization required for network provider for E&M, testing and procedures. Use the **Prior Authorization Lookup Tool**.	• Services considered cosmetic in nature are not covered. • Services related to previous cosmetic procedures are not covered. • See the Diagnostic Testing section below.

Service	Requirement	Comments
Diagnostic testing	Use the **Prior Authorization Lookup Tool**.	• No preauthorization is required for routine diagnostic testing. • Preauthorization is required for coverage of MRA, MRI, CAT scans, nuclear cardiac, PET scans and video EEG. • Carelon Medical Benefits Management manages preauthorization for computerized tomography, computerized axial tomography, nuclear cardiology, magnetic resonance imaging, magnetic resonance angiogram and positron emission tomography scan. They can be contacted at **844-423-0877** or via the internet at **carelon.com/capabilities/medical-benefits-management**
Disposable medical supplies		• No preauthorization is required for coverage of disposable medical supplies. • Disposable medical supplies are disposed of after a one-time use on a single individual.
Durable medical equipment (DME)	Preauthorization and *Certificate of Medical Necessity*; use the **Prior Authorization Lookup Tool**.	• Lookup: No preauthorization is required for coverage of glucometers and nebulizers, dialysis and ESRD equipment, gradient pressure aid, UV light therapy, sphygmomanometers, walkers and orthotics for arch support, heels, lifts, and wedges by network provider. • Preauthorization is required for coverage of certain prosthetics, orthotics and DME. For code-specific preauthorization requirements for DME, prosthetics and orthotics ordered by network provider or network facility, please refer to **provider.amerigroup.com/GA** or log in to the Availity website to access Interactive Care Reviewer to submit your prior authorization request. • All DME billed with an RR modifier (rental) requires preauthorization. Providers may or use the Georgia Medicaid Management Information System (GAMMIS) at **mmis.georgia.gov**. • Preauthorization may be requested by completing a *Certificate of Medical Necessity (CMN)* — available at **provider.amerigroup.com/GA** — or by submitting a physician order and *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, lymphedema pumps, osteogenesis stimulators, transcutaneous electrical nerve stimulator, seat lift mechanism, power operated vehicle, external infusion pump, parenteral nutrition, enteral nutrition and oxygen. Amerigroup

Service	Requirement	Comments
		and provider must agree on HCPCS and/or other codes for billing covered services. All custom wheelchair preauthorizations require the medical director's review. • Orthopedic shoes, hearing aids and supportive devices for feet that are not a basic part of a leg brace are not covered for members age 21 and older.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visit	Self-referral	• Use the *Bright Futures Periodicity Schedule* and document visits. • Vaccine serum is received under the Vaccines for Children (VFC) Program.
Educational consultation		• No notification or preauthorization is required.
Emergency room (ER)	Self-referral	• No notification is required for emergency care given in the ER. • If emergency care results in admission, notification to Amerigroup is required within 24 hours or the next business day.
ENT services (otolaryngology)	No preauthorization required for network provider for E&M, testing and procedures. Use the **Prior Authorization Lookup Tool**.	• Preauthorization is required for tonsillectomy and/or adenoidectomy for members 12 years and older, nasal/sinus surgery, and cochlear implant surgery/services. • See the Diagnostic Testing section in these guidelines.
Family planning/STD care	Self-referral	• Members may self-refer to an in-network or out-of-network provider. • Covered services include pelvic and breast examinations; lab work; drugs; biological, genetic counseling; devices and supplies related to family planning (for example, IUD). • Infertility services and treatment are not covered.
Gastroenterology services	No preauthorization required for network provider for E&M, testing and procedures. Use the **Prior Authorization Lookup Tool**.	• Preauthorization is required for bariatric surgery, including insertion, removal and/or replacement of adjustable gastric restrictive devices and subcutaneous port components. • See the Diagnostic Testing section of these guidelines.
Gynecology	Self-referral to network provider	• No preauthorization is required for E&M, testing and procedures. • Preauthorization is required for coverage of an elective surgery.

Service	Requirement	Comments
Hearing aids	No preauthorization is required for members under age 21.	• Hearing aids are not covered for members age 21 and older.
Hearing screening		• No notification or preauthorization is required for coverage of diagnostic and screening tests, hearing aid evaluations, and counseling. • Not covered for members age 21 and older.
Home health care	Preauthorization	• Preauthorization is required. • Covered services include skilled nursing; home health aide; and physical, occupational and speech therapy services, as well as physician-ordered supplies. • Skilled nursing and home health aide require preauthorization. • Services not covered include social services, chore services, Meals On Wheels and audiology services. • Rehabilitation therapy, drugs and DME require separate preauthorization. • All service requests should be completed by submitting a physician order and clinical information to support the need for home health services.
Hospital admission	Preauthorization	• Elective admissions require preauthorization for coverage. • Emergency admissions require notification within 24 hours or the next business day. • For preadmission testing, see the provider referral directory for a complete listing of Amerigroup preferred lab vendors. • Same-day admission is required for surgeries. • No coverage for rest cures, personal comfort and convenience items, services and supplies not directly related to the care of the patient (for example, telephone charges, take-home supplies and similar costs).
Laboratory services (outpatient)	Use the **Prior Authorization Lookup Tool**.	• All laboratory services furnished by nonparticipating providers require preauthorization by Amerigroup except for hospital laboratory services in the event of an emergency medical condition. • For offices with limited or no office laboratory facilities, lab tests may be referred to an Amerigroup preferred lab vendor. • See provider referral directory for a complete listing of participating vendors.
Neurology	No preauthorization required for	• Preauthorization is required for neurosurgery, spinal fusion and artificial intervertebral disc surgery.

Service	Requirement	Comments
	network provider for E&M and testing. Use the **Prior Authorization Lookup Tool**.	• See the Diagnostic Testing section of these guidelines.
Observation		• No preauthorization or notification is required for in-network observation. • If observation results in an admission, notification to Amerigroup is required within 24 hours or the next business day.
Obstetrical care		• No preauthorization is required for coverage of obstetrical services including obstetrical visits, diagnostic testing and laboratory services when performed by a participating provider. • Notification to Amerigroup is required at the first prenatal visit. • No preauthorization is required for coverage of labor and delivery. • No preauthorization is required for circumcision of newborns up to 12 weeks in age. • No preauthorization is required for the ordering physician for OB diagnostic testing for the coverage of ultrasounds, biophysical profile, and nonstress test and amniocentesis (Codes 59000, 59001, 59012 and 59015). • Notification of delivery is required within 24 hours with newborn information. • OB case management programs are available. • See the Diagnostic Testing section of these guidelines.
Ophthalmology	No preauthorization required for E&M, testing and procedures. Use the **Prior Authorization Lookup Tool**.	• Preauthorization is required for repair of eyelid defects. • Services considered cosmetic in nature are not covered.
Oral maxillofacial	Preauthorization; use the **Prior Authorization Lookup Tool**.	See the Plastic/Cosmetic/Reconstructive Surgery section of these guidelines.
Otolaryngology	See ENT Services. Use the **Prior Authorization Lookup Tool**.	See the Plastic/Cosmetic/Reconstructive Surgery section of these guidelines.
Out-of-Area/Out-of-Plan Care	Preauthorization	Preauthorization is required except for coverage of emergency care (including self-referral).

Service	Requirement	Comments
Outpatient/ ambulatory surgery	See specific category for preauthorization requirements. Use the **Prior Authorization Lookup Tool**.	
Pain management	Preauthorization; use the **Prior Authorization Lookup Tool**.	Preauthorization is required for coverage of all services and procedures.
Pharmacy	Preauthorization: Use the **Prior Authorization Lookup Tool** or **Formulary Search (formularynavigator.com)**	• Preauthorization (or prior authorization) may be required to cover certain medically necessary drugs under the medical and pharmacy benefits. • Please refer to the *PDL* for the preferred products within therapeutic categories, as well as requirements around generics, prior authorization, step therapy, age limits, and quantity limits.
Physical medicine and rehabilitation	Preauthorization; use the **Prior Authorization Lookup Tool**.	• Preauthorization is required for coverage of all services and procedures related to pain management. • See the Diagnostic Testing section of these guidelines.
Plastic/cosmetic / reconstructive surgery (including oral maxillofacial services)	Preauthorization; use the **Prior Authorization Lookup Tool.**	• No preauthorization is required for coverage of E&M codes. • All other services require preauthorization for coverage. Services considered cosmetic in nature are not covered. Reduction mammoplasty requires the medical director's review. Services related to previous cosmetic procedures are not covered. • No preauthorization is required for coverage of oral maxillofacial E&M services. • Preauthorization is required for the coverage of trauma to the teeth and oral maxillofacial medical and surgical conditions including TMJ. • See the Diagnostic Testing section of these guidelines.
Podiatry	Preauthorization; use the **Prior Authorization Lookup Tool.**	• No preauthorization is required for coverage of E&M testing and procedures required when provided by a participating podiatrist. • Preauthorization is required for coverage of all elective surgical procedures. • Notification is required for coverage of annual diabetic foot exam. See the Diagnostic Testing section of these guidelines. • The following are not covered for members age 21 and older: services for flatfoot, subluxation, routine foot care, supportive devices or vitamin B-12 injections.

Service	Requirement	Comments
Radiation therapy	Use the **Prior Authorization Lookup Tool.**	• No preauthorization is required for coverage of radiation therapy procedures when performed in the following outpatient settings by a participating facility or provider: office, outpatient hospital and ambulatory surgery center. • Please note that CAT scans, nuclear cardiology, MRA, MRI and PET scans will continue to require preauthorization for coverage. • Carelon Medical Benefits Management at **844-423-0877** or via the internet at **carelon.com/capabilities/medical-benefits-management**
Radiology services	Use the **Prior Authorization Lookup Tool.**	• See the Diagnostic Testing section of these guidelines.
Rehabilitation therapy (short-term): OT, PT, RT and ST		• Preauthorization from Amerigroup is required for coverage of treatment beyond the initial evaluation. • Therapy services that are required to improve a child's ability to learn or participate in a school setting should be evaluated for school-based therapy. Other therapy services for rehabilitative care will be covered as medically necessary. • Services are covered for children under age 21 when medically necessary and for adults 21 and older when medically necessary for short-term rehabilitation.
Skilled nursing facility	Preauthorization	• Preauthorization is required for coverage.
Sterilization		• Sterilization services are a covered benefit for members age 21 and older. • No preauthorization or notification is required for coverage of sterilization procedures, including tubal ligation and vasectomy. • A sterilization consent form is required for claims submission. • Reversal of sterilization is not a covered benefit.
Transplants	Preauthorization	Preauthorization is required for coverage.
Transportation		• Nonemergent transportation is covered under Medicaid FFS. Call Member Services at **800-600-4441** for the Georgia NET vendor in your region. • No preauthorization or notification is required except for coverage of planned air transportation (airplane or helicopter).
Urgent care center		• No notification or preauthorization is required.
Vision services	Self-referral	• Members under 21 years of age receive routine refractions, routine eye exams, and medically necessary contacts or eyeglasses as part of the EPSDT benefit every 12 months.

Service	Requirement	Comments
		• Members age 21 and older receive an additional benefit, including routine refractions, routine eye exams, medically necessary contacts or eyeglasses every 12 months with a $10 copay. • Diabetic retinal exams are covered for all ages.
Well-woman exam	Self-referral	• Well-woman exams are covered one per calendar year when performed by a PCP or in-network GYN. • Exam includes routine lab work, STD screening, Pap smear and mammogram (age 35 or older).
Revenue codes		To the extent the following services are covered benefits, preauthorization or notification is required for all services billed with the following revenue codes: • All inpatient and behavioral health accommodations • 0023 — Home health prospective payment system • 0240-0249 — All-inclusive ancillary psychiatric • 0632 — Pharmacy multiple source • 3101-3109 — Adult day care and foster care

For services that require preauthorization, utilize current editions of InterQual level of care criteria to review the medical necessity and appropriateness of both physical and behavioral health inpatient services and criterion for outpatient services. Amerigroup medical coverage policies are also used in the health plan as well as state approved plan clinical policies as additional guidelines in medical decision making.

Amerigroup is staffed with clinical professionals who coordinate services provided to members and are available 24 hours a day, 7 days a week to accept preauthorization requests. When a request for medical services is received from the physician via Availity or the MMIS portal, the preauthorization assistant will verify eligibility and benefits, which will then be forwarded to the nurse reviewer.

The nurse or behavioral health clinician will review the request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. When appropriate, the nurse will assist the physician in identifying alternatives for health care delivery as supported by the medical director. When the clinical information received meets criteria, an Amerigroup reference number will be issued to the referring physician.

If the preauthorization documentation is incomplete or inadequate, the nurse or behavioral health clinician will not approve coverage and will refer the case along with the available clinical information to the medical director for final review determination. If the medical director denies the request for coverage, the appropriate notice of proposed action will be mailed to the requesting provider, the member's primary care physician or specialist, the facility, and the member. Written notification will be provided according to the decision time frames below for services that were not approved or were modified in the amount, duration or scope that is less than what was requested.

Decision time frames

Standard service authorizations
Amerigroup will decide on pre-service nonurgent care services within three business days from when we receive the request for service. Providers will be notified of services that have been approved or denied via the Availity or MMIS portal within three business days from when we receive the request.

An extension may be granted for an additional 14 calendar days if the member or provider requests an extension, or if Amerigroup justifies to DCH a need for additional information and the extension is in the member's best interest. All decisions and notifications must occur by the end of the 14-day extension.

Expedited service authorizations
Prior authorization for expedited service requests where the standard time frame could seriously jeopardize the member's life or health shall be made within 24 clock hours from when we receive the request for service. Providers will be notified of services that have been approved or denied via GAMMIS Portal or Availity/ICR no later than 72 hours from the receipt of the request.

Amerigroup may extend the 24 clock hours period for up to five business days if Amerigroup can justify to DCH a need for additional information and how the extension is in the member's best interest.

Inpatient reviews

Inpatient admission reviews
All inpatient hospital admissions, including urgent and emergent admissions, will be reviewed within one business day of the notification of admission. The Amerigroup utilization review nurse determines the member's medical status through communication with the hospital's Utilization Review department. Appropriateness of stay is documented and concurrent review is initiated. Cases may be referred to the medical director who renders a decision regarding the coverage of hospitalization. Diagnoses meeting specific criteria are referred to the medical director for possible coordination by the care management program.

Affirmative statement about incentives
Amerigroup requires associates who make utilization management (UM) decisions to adhere to the following principles:

- UM decision making is based only on appropriateness of care and service and existence of coverage.
- Amerigroup does not reward practitioners or other individuals for issuing denials of coverage or service.
- Financial incentives for Amerigroup UM decision makers do not encourage decisions that result in underutilization.

Inpatient concurrent review
Each network hospital will have an assigned concurrent review nurse. Clinical documents submitted through the GAMMIS portal are reviewed to determine the authorization of coverage for a continued stay. Amerigroup uses InterQual criteria for neonatal intensive care unit (NICU) services and for all other inpatient admissions for clinical decision support of medical coverage.

When an Amerigroup concurrent review nurse reviews the medical record, the nurse also reviews for discharge planning needs. A concurrent review nurse will conduct continued stay reviews as required and review discharge plans unless the patient's condition is such that it is unlikely to change within the upcoming 24 hours and discharge planning needs cannot be determined.

When an inpatient admission is ordered for a member, clinical information should be submitted to the assigned concurrent review nurse via the GAMMIS portal. When the clinical information received meets criteria, approved days and bed level will be communicated to the hospital for the continued stay.

If the discharge is approved, the Amerigroup concurrent review nurse will coordinate discharge planning needs with the hospital utilization review staff and attending physician. The attending physician is expected to coordinate with the member's PCP regarding follow-up care after discharge. The PCP is responsible for contacting the member to schedule all necessary follow-up care.

Amerigroup will authorize covered length of stay based on the clinical information that supports the continued stay. Exceptions to the one-day length of stay authorizations are made for confinements when the severity of the illness and subsequent course of treatment is likely to be several days or is predetermined by state law. Examples of treatment include ICU, CCU, rehabilitation and C-section or vaginal deliveries. Exceptions are made by the medical director.

If, based upon appropriate criteria and after attempts to speak to the attending physician, the medical director denies coverage for an inpatient stay request, the appropriate notice of proposed action will be mailed to the hospital, member's primary care provider and/or attending physician, and member.

Discharge planning

Discharge planning is designed to assist the provider in the coordination of the member's discharge when acute care (hospitalization) is no longer necessary.

When long-term care is necessary, Amerigroup works with the provider to plan the member's discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital facility, such as:

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

When the provider identifies medically necessary and appropriate services for the member, Amerigroup will assist the provider and the discharge planner in providing a timely and effective transfer to the next appropriate level of care. Providers should crosswalk any discharge prescription medications against the Amerigroup pharmacy formulary to confirm whether or not medications require a prior authorization. This will ensure the member can fill the prescription without delay.

Discharge plan authorizations follow InterQual criterion and documentation guidelines. Authorizations include and are not limited to transportation, home health, DME, pharmacy, follow-up visits to practitioners or outpatient procedures.

Confidentiality

Utilization management, case management, condition care, discharge planning, quality management and claims payment activities ensure that patient-specific information obtained during review is kept confidential in accordance with applicable laws, including *HIPAA*. Information is used solely for the purposes defined above. Information is shared only with entities who have the authority to receive such information and only with those individuals who need access to such information in order to conduct utilization management and related processes.

Emergency services

Amerigroup provides a 24-hour Nurse HelpLine service with clinical staff to provide triage advice, referral and, if necessary, arrange for treatment of the member. The staff has access to qualified behavioral health professionals to assess behavioral health emergencies. Amerigroup does not discourage members from using the 911 emergency system or deny access to emergency services. Emergency services are provided to members without requiring prior authorization from their PCP or from Amerigroup. Emergency response is coordinated with community services including the police, fire and EMS departments, juvenile probation, the judicial system, child protective services, chemical dependency, emergency services and local mental health authorities, if applicable.

When a member seeks emergency services at a hospital, the determination as to whether the need for those services exists will be made for purposes of treatment by a physician licensed to practice medicine in all its branches, or to the extent permitted by applicable law by other appropriately licensed personnel under the supervision of, or in collaboration with, a physician licensed to practice medicine in all of its branches. The physician or other appropriate personnel will indicate in the member’s chart the results of the emergency medical screening examination.

Emergency room visits that cannot be documented as true medical emergencies or potential medical emergencies will be reimbursed at the hospital’s contracted rate, or the all-inclusive flat rate whichever is applicable. The flat rate is for all in-state and out of state emergency medical services. This rate will cover all ancillary services rendered as well as the fee for use of the emergency room.

If there is concern surrounding the transfer of a patient (in other words, whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) actually caring for the member at the treating facility prevails and is binding on Amerigroup. If the emergency department is unable to stabilize and release the member, Amerigroup will assist in coordination of the inpatient admission regardless of whether the hospital is network or non-network. All transfers from non-network to network facilities are to be conducted only after the member is medically stable and the facility is capable of rendering the required level of care.

If the member is admitted, the Amerigroup concurrent review nurse will implement the concurrent review process to ensure coordination of care.

Urgent care

We require our members to contact their PCP in situations where urgent, unscheduled care is necessary. Prior authorization with Amerigroup is not required for a member to access a participating urgent care center.

Hospital Statistical and Reimbursement report

The Hospital Statistical and Reimbursement (HS&R) report is a detailed claim report that can be used to reconcile claim payments over a specific period of time, usually a calendar or fiscal year. To request a copy of your hospital HS&R report, send an email to amghsr@amerigroup.com. In the email please include your Medicaid ID, the name of the facility, the service to and from date, the paid to and from date and whether you would like a detailed or summary report. Upon receipt of your request, Amerigroup will send your HS&R report within the required 30 calendar days of the request by secured email.

13 Quality Management and Credentialing

Quality Management program

Overview

The Amerigroup Quality Management (QM) program is an ongoing comprehensive, and integrated system to objectively monitor and systematically evaluate the care and service provided to members. The scope and content of the program reflects the demographic and epidemiological needs of the population served. The QM Program addresses issues related to quality management and quality performance measures for both state and national compliance and is a cohesive plan for addressing member needs across the continuum of care. Members and providers have opportunities to make recommendations for areas of improvement. The QM program goals and outcomes are available upon request to providers by calling Provider Services at **800-454-3730** Eastern time. Studies are planned across the continuum of care and service with ongoing proactive evaluation and refinement of the program.

The initial program development was based on a review of the needs of the population served. Systematic re-evaluation of the needs of the plan's specific population occurs on an ongoing basis. This includes not only age/gender distribution, but also a review of utilization data — inpatient, emergent/urgent care and office visits by type, cost and volume. This information is used to understand the population served and identify areas of opportunity for improvement.

There is a comprehensive committee structure in place with oversight from the Amerigroup governing body. Not only is the traditional Medical Advisory Committee (MAC) in place, but a Health Education Advisory Committee (HEAC)/Member Advisory Committee is also an integral component of the Quality Management committee structure.

Amerigroup adopts Clinical Practice and Preventive Health Guidelines based on the health care needs of the member population and identified opportunities for improvement. Guidelines are based on member health needs and are developed using valid and reliable clinical data and research. Amerigroup reviews, adopts and revises Clinical Practice Guidelines (CPGs) relevant to the needs of health plan membership to:

- Assist practitioners and enrollees in making decisions about preventive, acute, chronic and behavioral health care services;
- Ensure that the health plan's programs incorporate current, evidence-based clinical practice guidelines from recognized sources; and
- Meet National Committee for Quality Assurance (NCQA), Regulatory and/or contractual requirements. Providers are encouraged to utilize adopted guidelines. Their performance against guidelines is measured by NCQA and DCH contractual requirements. Provider compliance with the CPG's is assessed quarterly through medical record review audit. If a provider's CPG compliance rates fall below organization and/or State goals, Amerigroup implements interventions as applicable. These guidelines are based on current research and national standards. Guidelines are updated at a minimum of every two years or sooner if new information is identified. These guidelines can be downloaded and printed from **provider.amerigroup.com/GA**. Providers may request a copy of the Amerigroup *Clinical Practice Guidelines* by calling Provider Services at **800-454-3730**, Monday-Friday from 7 a.m.-7 p.m. Eastern time.

Use of performance data
Practitioners and providers must allow Amerigroup to use performance data in cooperation with our quality improvement program and activities.

Patient safety
Amerigroup strives and reinforces efforts to build a safer, equitable high-quality health care system; decrease the occurrence of patient safety events, provider preventable conditions (PPCs) and hospital-acquired and healthcare-acquired conditions (both referred to as HCAs); and ensure compliance with Federal and State regulatory requirements and BCBSA contractual requirements. We advocate for a safety culture that improves the delivery of healthcare, health outcomes, and alignment with national patient safety efforts. In doing so, we are committed to work with physicians, hospitals, and other healthcare partners to support patient safety efforts.

Patient safety activities are designed to promote safe practices by identifying opportunities for improvement and refining processes throughout the healthcare delivery system, including as it applies to health disparities. We advocate for safe clinical care and services; collaborate and engage with medical and behavioral health Providers, as well as Members, concerning patient safety; and identify opportunities for system and process improvements that promote patient safety within individual practices and across the healthcare continuum.

Amerigroup provides information and resources for providers regarding health care safety and standards. An example of a resource is the CMS website **medicare.gov/hospitalcompare**, which provides specific information on hospitals. This user-friendly site compiles quality indicators for all Medicaid-certified hospitals and provides a comparison of quality indicators for services rendered by the selected hospital.

Our goal is to support physicians and hospitals in using appropriate processes, technologies, and strategies to address never events and healthcare acquired conditions, and, ultimately, to enhance the quality of care delivered to patients. Amerigroup strives to eliminate inpatient PPCs and HCACs as defined by the Centers for Medicare & Medicaid Services (CMS), remaining consistent with CMS payment policy and as stated in Elevance's Health reimbursement policy/contracts. Reimbursement policies may be superseded by mandates in provider, state, federal or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.

Performance Measures
To keep ourselves accountable to the Department of Community Health, you and our members, we compare our performance against benchmarks for certain quality performance measures (in other words, HEDIS) developed by agencies such as the National Committee for Quality Assurance (NCQA), the Agency for Healthcare Research & Quality (AHRQ), and the Centers for Medicare & Medicaid Services (CMS). The reporting of these performance measure rates is a contractual requirement and is used for public reporting. Proper coding is critical to ensuring accurate reporting of performance measures, and it may also decrease the need for medical record reviews. Accurate coding not only helps us assess your performance on the quality of care that is provided to our members, but also helps to accurately report rates.

Quality of Care (QOC)
Amerigroup is committed to providing and maintaining safe and high quality care and services to our members. The Amerigroup QM program includes review of quality of care issues identified for all care settings. Amerigroup staff have criteria/triggers for identifying QOC issues during the performance of utilization review activities, the review of member complaints and grievances, medical necessity appeals, the tracking and trending of member and provider practice monitoring activities.

The review standards are based on medical community standards, external regulatory and accrediting agencies requirements, and contractual compliance.

Reviews are accomplished by QM staff and associate professionals who strive to develop relationships with providers and hospitals that will positively impact the quality of care and services provided to our members. Results are submitted to the Amerigroup QM department and incorporated into a profile.

Georgia Families Monitoring and Oversight Committee (GFMOC)

Amerigroup participates in the Georgia Families Monitoring and Oversight Committee and associated subcommittees. The GFMOC and associated subcommittees assist the DCH in assessing the performance of Amerigroup and developing improvements and new initiatives specific to the Georgia Families and Georgia Families 360°SM programs.

The GFMOC serves as a forum for the exchange of best practices; fosters communication; and provides opportunity for feedback and collaboration between state agencies, Amerigroup and external stakeholders. Members of the GFMOC are appointed by the DCH commissioner or their designee. The GFMOC meetings are attended by Amerigroup decision makers defined as one of the following: chief executive officer, chief operations officer (or equivalent named position) and chief medical officer.

Quality Management Committee (QMC)

The purpose of the quality management committee is to establish quality as a cornerstone of Amerigroup culture and to be an instrument of change through demonstrable improvement in care and service.

The QMC's responsibilities are to:

- Establish strategic direction; monitor and support implementation of the QM program.
- Establish processes and structure that ensure National Committee for Quality Assurance (NCQA) compliance.
- Review planning, implementation, measurement and outcomes of clinical/service quality improvement studies.
- Coordinate communication of quality management activities throughout the health plans.
- Review performance measures, including HEDIS data and action plans for improvement.
- Review and approve the annual quality management program description.
- Review and approve the annual work plans.
- Provide oversight and review of delegated services.

- Provide oversight and review of subordinate committees.
- Receive and review reports of utilization review decisions and take action when appropriate.
- Analyze member and provider satisfaction survey responses.
- Monitor the plan's operational indicators through the health plan's senior staff.

Medical Advisory Committee (MAC)

The Medical Advisory Committee is comprised of contracted providers from each DCH designated region in Georgia. The MAC has multiple purposes. The MAC assesses levels and quality of care provided to members and recommends, evaluates and monitors standards of care. The committee identifies opportunities to improve services and clinical performance by establishing, reviewing and updating *Clinical Practice Guidelines* based on review of demographics and epidemiologic information to target high-volume, high-risk and problem prone conditions. The MAC oversees the peer review process that provides a systematic approach for the monitoring of quality and the appropriateness of care. The MAC advises the health plan administration in any aspect of the health plan policy or operation affecting network providers or members. The committee approves and provides oversight of the peer review process, the QM program and the utilization review program. It oversees and makes recommendations regarding health promotion activities.

The MAC's responsibilities include but are not limited to:

- Use an ongoing peer review system to monitor practice patterns to identify appropriateness of care and to improve risk prevention activities.
- Approve clinical protocols/guidelines that ensure the delivery of quality care and appropriate resource use.
- Review clinical study design and results.
- Develop action plans/recommendations regarding clinical quality improvement studies.
- Consider/act in response to provider sanctions.
- Oversee member access to care.
- Review and provide feedback regarding new technologies.
- Approve recommendations from subordinate committees.

Credentialing

The Georgia Department of Community Health (DCH) assumes responsibility for all credentialing and recredentialing activities for the providers and facilities within the state of Georgia. All providers and facilities must obtain credentialing approval from the DCH Centralized Credentialing Verification Organization (CVO) before they can become eligible to participate as an Amerigroup provider.

Contracted delegated providers are excluded from the DCH CVO requirements. Pharmacies are also excluded from the DCH CVO requirements. After obtaining a GA Medicaid ID and NPI, pharmacies must contact CVS/Caremark who oversees the pharmacy network for CarelonRx to enroll into our network.

Contracting and credentialing are separate and distinct processes. You must enter into a participating agreement if you are interested in participating in the Amerigroup network. To enroll in the Amerigroup network, visit **Georgia Provider - Amerigroup**.

Georgia Families 360°SM Credentialing and Quality Management
Amerigroup also includes providers recommended by DFCS, Department of Behavioral Health and Developmental Disabilities (DBHDD), DJJ, Department of Education (DOE), Department of Early Care and Learning (DECAL), Department of Human Services (DHS) or Department of Public Health (DPH) in our provider network if the provider or agency meets the enrollment criteria for Georgia fee-for-service Medicaid and meets DCH's credentialing requirements.

Value-Based Purchasing
Value-Based Purchasing (VBP) is a component of the Georgia Families and Georgia Families 360°SM quality strategy plan and is designed to leverage the expertise and experience of the state, Amerigroup and providers to improve health outcomes and lower costs. It is based on focusing on a select number of priority areas to drive results, aligning financial incentives, encouraging provider and member participation in rapid cycle quality improvement activities, sharing best practices, and assigning members to Patient-Centered Medical Homes™ (PCMH) and patient-centered dental homes.

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

- Participate in the implementation of the established peer review system.
- Review and make recommendations regarding individual provider peer review cases.
- Work in accordance with the executive medical director.

If the investigation of a member grievance or internal review generates concern regarding a physician's compliance with community standards of care or service, all elements of peer review will be followed.

Dissatisfaction severity codes and levels of severity are applied to quality issues. The medical director assigns a level of severity to the case. 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 and level of severity, invites the cooperation of the provider, and consults and informs the MAC and peer review committee. The medical director informs the provider of the committee's decision, recommendations, follow-up actions and/or disciplinary actions to be taken. Outcomes are reported to the appropriate internal and external entities that include the QM committee.

The Amerigroup policy on peer review is available upon request.

The Georgia Department of Community Health's fiscal agent

The Georgia Medicaid Management Information System (GAMMIS) serves as the primary web portal for Medicaid, PeachCare for Kids and all related waiver programs administered by the Department of Community Health's (DCH) Medical Assistance Plans Division. The GAMMIS portal provides timely communications, data exchange and self-service tools for members and providers with both secure and public-access areas. GAMMIS is managed by Hewlett Packard Enterprises (HPE), the fiscal agent for the DCH. For additional information regarding GAMMIS, please visit their website at **mmis.georgia.gov**.

14 Practitioner termination

Each Amerigroup network practitioner is contractually obligated to notify us of an intention to terminate a *Participating Provider Agreement*, a primary care site or provider group. Each practitioner must notify Amerigroup within the timeframe specified in the *Provider Agreement* to ensure coordination of care for all assigned members. Amerigroup policy and procedures for practitioner termination notification are detailed below.

Primary care practitioners

Each provider shall notify all assigned Amerigroup members of the termination no later than 120 days prior to the effective date of the requested contract termination date without cause. The intent to terminate must be submitted in writing on the practitioner's letterhead to our Provider Relations department. Amerigroup will notify members of a PCP's termination no less than 30 days prior to the effective date of the termination and not more than 10 calendar days after the receipt of the termination notice. The notification shall contain instructions to the members about how to continue to receive covered services.

Specialty practitioners

Each Amerigroup network specialty practitioner is contractually obligated to notify us of an intention to terminate a *Participating Provider Agreement*, an independent practice association or a physician-hospital organization. Each practitioner must notify Amerigroup 120 days prior to the effective date of the request for contract termination without cause to ensure coordination of care for all assigned members. A specialty practitioner must provide advance notice of the termination to all Amerigroup members under the practitioner's care. The intent to terminate must be submitted in writing on the practitioner's letterhead to our Provider Relations department.

Facility termination

Our Provider Solutions department must be notified of facility terminations in writing. Facility terminations without cause should be communicated 120 days prior to the effective termination. Authorized covered services to members (including inpatient services) will continue as outlined under the Georgia Families 360°SM Continuity of Care section below.

Continuity of care

Amerigroup recognizes the importance of our members' established relationships with both participating and nonparticipating practitioners. In the event of a voluntary provider termination, members receiving active health care services for a chronic or terminal illness, or who are receiving inpatient services, may continue to receive health care services from an approved provider for up to 60 days from the date of the termination.

A pregnant member receiving treatment at the time of termination may continue to receive health care services from the practitioner for the remainder of her pregnancy and six weeks postpartum.

In order to preserve the clinical relationship with the nonparticipating practitioner or the recently terminated practitioner, Amerigroup will authorize services on a case-by-case basis. Priority in preserving the clinical relationship will be given to members in the following situations:

- Members who are currently hospitalized
- Pregnant members who are high-risk and in the third trimester or 30 days from due date
- Members who are in the process of receiving major organ or tissue transplant services
- Members with chronic illnesses that have classified the member in a high-risk category (for example, diabetes, hypertension, pain control)
- Members receiving chemotherapy and/or radiation treatment
- Members receiving dialysis
- Members who use durable medical equipment or home health services
- Members receiving regularly scheduled medically necessary transportation
- Members using prescription medication

Providers who plan to remain in the service area will:

- Continue to see members.
- Continue to update Amerigroup regarding the member's treatment plan.
- Not charge the member beyond the applicable copay.

If a provider has a patient who qualifies for continuity of care, he or she should submit a prior authorization request form along with all supporting clinical documentation to our Medical Management department. Documents can be faxed to **877-842-7187**. The authorization form must have *continuity of care* clearly written across the top of the form to indicate the request for continuity of care.

Georgia Families 360°$_{SM}$ care coordination and case management

Within one business day of enrollment with Amerigroup, each Georgia Families 360°$_{SM}$ member is assigned to a Care Coordination team based on geographic location.

- Our care coordinators help to coordinate care and create linkages with external organizations, including but not limited to school districts, Child Protective Services and early intervention agencies, and behavioral health and developmental disabilities service organizations.
- We use the results of all assessments and screenings outlined within *How Amerigroup works with the state* to develop a health care service plan for all new members within 30 calendar days of enrollment. Health care service plans include:
    - The detailed description of the involvement of the member's PCP, dentist, behavioral health providers, specialists or other providers in the development of the plan, including:
        - Medication review.
        - Assessment of medical and social needs and concerns.
        - Member short-term and long-term outcome goals.
    - The approach for updating or revising the plan.
    - Details on the monitoring and follow-up activities conducted by Amerigroup and our network providers.

- We document the involvement of the member's PCP, dentist, behavioral health providers, specialists, or other providers in the development of the health care service plan, and provide evidence of such documentation to DCH, DFCS and DJJ.
- We regularly review and update the member's health care service plan.
- We are responsible for ensuring the plan for members with severe emotional disturbance (SED) and complex physical health needs, which includes a safety and contingency crisis plan.

Our interdisciplinary care coordination teams:

- Are responsible for coordinating all services identified in the member's health care service plan.
- Include care coordinators who provide information and coordinate access to care in collaboration with providers, members, foster parents, caregivers, and DFCS or DJJ staff with access to care and coordination of services.
- Ensure access to primary, dental and specialty care and support services, including assisting members, caregivers, foster and adoptive parents, and DFCS and DJJ staff with locating providers and scheduling and obtaining appointments as necessary.
- Assist with coordinating nonemergent transportation for members, as needed, for provider appointments and other health care services.
- Document efforts to obtain provider appointments, arrange transportation, establish meaningful contact with the member's PCP, dentist, specialists and other providers.
- Arrange for referrals to community-based resources, and document any barriers or obstacles to obtaining appointments, arranging transportation, establishing meaningful contact with providers or arranging referrals to community-based resources.
- Ensure providers, DFCS, DJJ and DBHDD staff, caregivers, foster and adoptive parents and Georgia Families 360°SM members have access to information about the Amerigroup preauthorization process.
- Define program requirements and processes, including the member appeals process and how Amerigroup assists providers and members with navigating the process.
- Educate other Amerigroup staff about when medical information is required by DFCS and DJJ and/or necessary for court hearings.
- Offer application assistance to members who may qualify for supplemental security income (SSI) benefits.

Georgia Families 360°SM coordination

Amerigroup physical and behavioral health care coordinators support health treatment providers by facilitating communication between all members of a child's/youth's treatment team.

Recognizing that children in Georgia Families 360°SM have diverse and unique needs, Amerigroup has developed specialized case management programs to address these specific populations. These specialized programs have a specific focus on specific concerns to be addressed in addition to the standard care coordination processes for all members. The specialized focus case management programs include:

- Physical health programs focusing on members with complex medical needs.
- Intellectual and developmental disabilities (IDD).
- Members transitioning out of foster care and juvenile justice into adulthood.

These programs are enhancements to the traditional care coordination that is performed with our members. They are designed to help address the specific concerns of these special populations.

Georgia Families 360°SM care coordinators collaborate with all state agencies and community programs to ensure all needs of each child are addressed. This allows joint service planning to occur with greater ease to better support the member.

The attending physician maintains responsibility for the member's ongoing care needs. The Georgia Families 360°SM Care Coordination team, assigned based on the member's geographical location:

- Supports the physician by tracking compliance with treatment plan and facilitating communication between the PCP and other members of the Care Coordination team.
- Facilitates referrals and linkages to available community resources providers like specialty services, local health departments and school-based services.

The Care Coordination team determines whether coordination of services will result in more appropriate and cost-effective care through care management plan intervention through a health risk screening (HRS), which is completed within 30 days of enrollment. During this assessment, information is obtained from the member or legal guardian/caretaker, attending physician, and other health care providers.

The Care Coordination team develops a proposed health care service plan, and the proposed service plan is based on:

- Medical necessity.
- Appropriateness of discharge plan and level of care.
- Member/family/support systems to assist the member in the home setting.
- Community resources/services available.
- Member compliance with the prescribed treatment plan.
- The results of all assessments and screenings.
- The documented involvement of the member's PCP, dentist, behavioral health providers, specialists and caregivers.

When the attending physician, member or medical consenter agrees, the health care service plan is implemented. Check points are put into place to evaluate the effectiveness of the plan and the quality of care provided. Care coordination and collaboration with physician or specialty services will be facilitated as applicable to ensure delivery of adequate and appropriate preventive health services and follow-up on existing medical issues identified through the assessment process.

When necessary, the Care Coordination team will assist the member in transitioning to other care providers when benefits end. The Care Coordination team can be reached at **855-661-2021**.

See the **Case Management** section of this provider manual for additional details on the case management process for those members with complex behavioral or medical needs.

Georgia Families 360°SM continuity of care
To ensure continuity of care for program members receiving services authorized in all treatment plans by their prior care management organization, private insurer or fee-for-service Medicaid, the care coordinator will ensure the member is able to continue with his or her providers and current services, including issuing an out-of-network authorization to ensure the member's condition remains stable and services are consistent to meet the member's needs.

All such authorizations or allowances will continue for the latter of a period of at least 30 days or until the Amerigroup authorized health care service plan is completed.

Transition of members
Amerigroup will coordinate with all Georgia state agency departments and offices as contracted and as needed when a Georgia Families 360°SM member transitions into or out of enrollment with Amerigroup.

If a Georgia Families 360°SM member transitions from another CMO or from private insurance, we will contact the Georgia Families 360°SM member's prior CMO or other insurer and request information about the member's needs, current medical necessity determinations, authorized care and treatment plans within two business days of receipt of the eligibility file from DCH and receipt of a signed release of information form from DFCS, the adoptive parent or the DJJ.

If a Georgia Families 360°SM member transitions from fee-for-service Medicaid, we will coordinate with DCH staff designated to coordinate administrative services and contact the member's prior service providers, including PCPs, specialists and dental providers. We will request information about the member's needs, current medical necessity determinations, authorized care and treatment plans within two business days of the receipt of the eligibility file from DCH and receipt of a signed release of information form from DFCS, the adoptive parent or the DJJ.

For FCAAP members turning age 18 and exiting foster care, we will support DFCS and participate in transitional roundtables for transition planning for members returning to their homes. We assess the member's home and community support needs to remain in the community and maintain stability through the transition out of foster care, including but not limited to:

- Determining and identifying the array of services needed and providers of these services.
- Assessing needs and providing recommendations for access to specialized supports, including:
    - Ongoing behavioral supports.
    - Medication support.
    - Durable medical equipment.
    - Communication devices, vehicles or home adaptations.

For all Georgia Families 360°SM members, we will:

- Review the member's health status and other appropriate factors to determine whether the member meets the general eligibility criteria for entering a home- and community-based services (HCBS) waiver program.

- Initiate the waiver application process and, if necessary, place youth on waiver waiting list(s).
- In collaboration with the DFCS and DJJ, educate members about options for services and supports available after eligibility terminates; such options may include Independence Plus, IDEA participation and application for postsecondary options (housing and vocational opportunities); education will include information on accessing disability services available from educational institutions and employers where appropriate.

15 Provider payment disputes and complaints resolution process

Provider payment dispute and complaint resolution process

Amerigroup maintains a formal provider payment dispute and complaint resolution process and will respond to providers in a timely manner. Provider payment disputes and complaints are resolved fairly and are consistent with plan policies and covered benefits. All provider payment disputes and complaints are kept confidential. Providers are not penalized for filing payment disputes and/or complaints.

Provider Claim Payment Dispute Process

If you disagree with the outcome of a claim, you may begin the Amerigroup GA 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 GA requests further information to finalize a claim; typically includes medical records, itemized bills or information about other insurance a member 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 GA 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 member.

1. **Claim payment reconsideration:** This is the first step in the Amerigroup GA 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.
2. **Claim payment appeal:** This is the second step in the Amerigroup GA provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.
3. **Regulatory complaint:** The state of Georgia supports an external review process if you have exhausted both steps in the Amerigroup GA 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 through our secure provider website, in writing, or verbally 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 GA professionals will review it.

Amerigroup will make every effort to resolve the 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 GA 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 GA claim payment appeal process is a necessary requirement before requesting a state 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.

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 GA 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 GA 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:

- Verbally (for reconsiderations only): Call Provider Services at **800-454-3730**.
- **Online (for reconsiderations and claim payment appeals):** Use the secure provider Availity Appeal application at **https://Availity.com** . Through Availity, you can upload supporting documentation and receive immediate acknowledgement of your submission.
- Locate the claim you want to dispute on Availity using **Claim Status** from the **Claims & Payments** menu. If available, select **Dispute Claim** to initiate the dispute. Go to **Request**" to navigate directly to the initiated dispute in the appeals dashboard add the documentation and submit.
- Written (for Reconsiderations and Claim Payment Appeals): Mail all required documentation (see below for more details), including the *Claim Payment Appeal Form* or the *Reconsideration Form,* to:

Payment Dispute Unit
Amerigroup Community Care
P.O. Box 61599
Virginia Beach, VA 23466-1599

Submit reconsiderations on the Provider Payment Dispute and Correspondence *Form*, located at: **provider.amerigroup.com/GA**

Required Documentation for Claims Payment Disputes

Amerigroup GA requires the following information when submitting a claim payment dispute (Reconsideration or Claim Payment Appeal):

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

In the event the Claim Payment Appeal is not resolved to the satisfaction of the provider, the provider may request an administrative law hearing (state fair hearing) in accordance with *O.C.G.A. § 49-4-153(e)*. The request for a hearing must be received by Amerigroup in writing within 15 business days from the date of the payment dispute resolution letter and must include the following information:

- A clear expression by the provider that he or she wishes to present his or her case to an administrative law judge
- Identification of the action being appealed and the issues that will be addressed at the hearing
- A specific statement explaining why the provider believes the Amerigroup action is wrong
- A statement explaining the relief sought

Providers are required to exhaust the Amerigroup internal payment dispute process prior to requesting a state fair hearing. If required by state regulations, the complaint may be forwarded to an external body for secondary review. Requests for a state fair hearing should be mailed to:

State Fair Hearing Request
Amerigroup Community Care
740 W Peachtree St NW
Atlanta, GA 30308

All arbitration costs, not including attorney's fees, shall be shared equally between parties.

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 **800-454-3730** and select the *Claims* prompt within our voice portal. We connect you with a dedicated resource team 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.

We are available to assist you in determining the appropriate process to follow for resolving your claim issue.

Claim Correspondence

Claim correspondence is different from a payment dispute. Correspondence is when Amerigroup GA requires more information to finalize a claim. Typically, Amerigroup GA 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 GA will use it to finalize the claim.

Medical Necessity Appeals

Medical necessity appeals refer to a situation in which an authorization for a service was denied prior to the service. Medical necessity appeals/prior authorization appeals are different than claim payment disputes and should be submitted in accordance with the medical necessity appeal process.

Provider complaints

Amerigroup has a formal provider complaint process that begins with providers filing a written complaint (or sometimes called grievances). Provider complaints are resolved fairly — consistent with plan policies and covered benefits. All provider complaints are kept confidential, and providers are not penalized for filing complaints. Any supporting documentation should accompany the complaint.

A provider can file a complaint in writing to:

Health Plan Operations
Amerigroup Community Care
740 W Peachtree St NW
Atlanta, GA 30308

Amerigroup will send an acknowledgement letter to the provider within 10 business days of receipt. At no time will Amerigroup cease coverage of care pending a complaint investigation.

16 Claim submission and adjudication procedures

Electronic Data Interchange

Amerigroup prefers the submission of claims electronically through electronic data interchange (EDI). Providers must submit claims within 6 months from the date of discharge for inpatient services or from the date of service for outpatient services after the month the service is rendered. Corrected claims must be submitted within 90 days from the date of the original claim submission.

Amerigroup uses Availity as its exclusive partner for managing all electronic data interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient and cost-effective way for providers and employers to do business.

Use Availity for the following EDI transactions

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Claim: Dental (837D)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

Availity's EDI submission Options

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software). To register for direct EDI transmissions, visit – **https://Availity.com** > Provider Solutions > EDI Clearinghouse.
- Use your existing vendor for your EDI transactions (work with your vendor to ensure connection to the Availity EDI Gateway)

EDI Response Reports

Claims submitted electronically will return response reports that may contain rejections. If using a Clearinghouse or Billing Vendor, please work with them to ensure you are receiving all reports. It's important to review rejections as they will not continue through the process and require correction and resubmission. For questions on electronic response reports contact your Clearinghouse or Billing Vendor or Availity at **800-AVAILITY** (**800-282-4548**).

EDI Submission for Corrected Claims

For corrected electronic claims the following frequency code:

- 7 – Replacement of Prior Claim

EDI segments required:

- Loop 2300- CLM - Claim frequency code
- Loop 2300 - REF - Original claim number

Please work with your vendor on how to submit corrected claims.

Electronic Remittance Advice (835)
The 835 eliminates the need for paper remittance reconciliation.
Use Availity to register and manage ERA account changes with these three easy steps:

1. Log in to **Availity** **apps.https://Availity.com /availity/web/public.elegant.login**
2. Select **My Providers**
3. Click on **Enrollment Center** and select **Transaction Enrollment**

Note: *If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERA's.*

Electronic Funds Transfer (EFT)

Electronic claims payment through electronic funds transfer (EFT) is a secure and fastest way to receive payment reducing administrative processes. EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.
Use EnrollSafe (**enrollsafe.payeehub.org**) to register and manage EFT account changes.

Contact Availity
Please contact Availity Client Services with any questions at 1-800-Availity (282-4548).

Payer ID
Your Payer Name is Amerigroup and the Payer ID is 26375

Note: If you use a clearinghouse, billing service or vendor, please work with them directly to determine payer ID.

Paper claims submission
Providers have the option of submitting paper claims. Amerigroup uses optical character recognition (OCR) technology as part of its front-end claims processing procedures. The benefits include the following:

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

In order to use OCR technology, claims must be submitted on original red claim forms (not black and white or photocopied forms) and laser printed or typed (not handwritten) in a large, dark font. Providers must submit a properly completed *UB-04* or *CMS-1500 (08-05)* within 6 months from the date of discharge for inpatient services or from the date of service for outpatient services after the month the service is rendered. The exceptions are in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. Corrected claims must be submitted within 90 days from the date of the original claim submission.

For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date that 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 that Amerigroup receives notification of the member's eligibility/enrollment.

Amerigroup requires the use of the *CMS-1500 (08-05)* and *UB-04* for the purposes of accommodating the NPI.

Amerigroup has aligned our NPI and taxonomy code requirements with those of the state of Georgia. Claims submitted to Amerigroup without the required NPI will be rejected. *CMS-1500 (08-05)* and *UB-04* must include the following information (*HIPAA* compliant where applicable):

- Patient's name
- Patient's permanent ID number
- Patient's date of birth
- Provider name according to contract
- Provider tax ID number and state Medicaid ID number
- Amerigroup provider number
- Date of service
- Place of service
- ICD-10 diagnosis code/revenue codes
- Description of services rendered CPT-4 codes/HCPCS codes/DRGs
- Itemized charges
- Days or units
- Modifiers as applicable
- *COB*/other insurance information
- Authorization/preauthorization number or copy of authorization/preauthorization
- Any other state-required data
- NPI and taxonomy code
- CLIA Identification number when applicable (CMS-1500 only)

Amerigroup cannot accept claims with alterations to billing information. We do not accept computer-generated or typewritten claims with information that is marked through, handwritten or otherwise altered. 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 within 6 months of the date of service after the month the service is rendered, except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. Corrected claims must be submitted within 90 days from the date of the original claim submission.

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 claims. For cases of retroactive eligibility, the time frames for filing a claim will begin on the date that Amerigroup receives eligibility notification of the member's eligibility/enrollment. Paper claims must be submitted to the following address:

Amerigroup Community Care
P.O. Box 61010
Virginia Beach, VA 23466-1010

Encounter data

Amerigroup established and maintains a system to collect member encounter data. Due to reporting needs and requirements, network providers who are reimbursed by capitation must send encounter data to Amerigroup for each member encounter. Encounter data is submitted on a *CMS-1500 (08-05)* claim form unless other arrangements are approved by Amerigroup. Data shall be submitted in a timely manner but no later than 6 months from the date of service after the month the service is rendered. Corrected claims must be submitted within 90 days from the date of the original claim submission.

The encounter data shall include the following:

- Patient's name (first and last name)
- Patient's permanent ID number
- Patient's date of birth
- Provider name according to contract
- Provider tax ID number and state Medicaid ID number
- Amerigroup provider number
- Date of service
- Place of service
- ICD-10 diagnosis code/revenue code
- Description of services rendered CPT-4 codes/HCPCS codes/DRGs
- Itemized charges
- Days or units
- Modifiers as applicable
- *Coordination of Benefits*/other insurance information
- Authorization/preauthorization number or copy of authorization/preauthorization
- Any other state-required data
- NPI and taxonomy code
- CLIA Identification number when applicable (CMS-1500 only)

Encounter data should be submitted to the following address:

Amerigroup Community Care
P.O. Box 61010
Virginia Beach, VA 23466-1010

Through claims and encounter data submissions, HEDIS information is collected. This includes but is not limited to the following:

- Preventive services (for example, childhood immunization, mammography and Pap smears, etc.)
- Prenatal and postpartum care (for example, low birth weight, general first-trimester care)
- Acute and chronic illnesses (for example, 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 a quarterly basis. The PCP is monitored for compliance with reporting of utilization. Lack of compliance will result in training and follow-up audits and possible termination.

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

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with *HIPAA* requirements and in accordance with the rule issued by the U.S. Department of Health and Human Services (HHS).

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

Although we often use the term ICD-10 alone, there are actually 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 1 and 2 for diagnosis coding, and ICD-10-PCS replaces ICD-9-CM, volume 3 for inpatient hospital procedure coding.

Claims adjudication

Amerigroup is dedicated to providing timely adjudication of provider claims for services rendered to members. All network and non-network provider claims that are 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 on a *UB-04* with the facility's NPI number and Georgia Medicaid ID number. Physician services should be submitted on a *CMS-1500 (08-05)* with the physician's NPI number.

Amerigroup uses a code auditing software to comply with an ever-widening array of code edits and rules. Additionally, this review increases consistency of payment for providers by ensuring correct coding and billing practices are being followed. Using a sophisticated auditing logic determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes, and processes those services according to industry standards. The auditing software is updated periodically to conform to changes in coding standards and include new procedure and diagnosis codes. For questions regarding any edits that you receive on your *EOP*, please contact Provider Services at **800-454-3730**.

For claims payment to be considered, providers must adhere to the following time limits:

- Submit claims within 6 months from the date the service is rendered after the month the service is rendered, or for inpatient claims filed by a hospital, within 6 months from the date of discharge after the month the service is rendered.
- In the case of other insurance, submit the claim within 6 months of receiving a response from the third-party payer.
- Claims for members whose eligibility has not been added to the state's eligibility system must be received within 6 months from the date the eligibility is added.
- Claims submitted after the 6 months filing deadline will be denied.
- Corrected claims must be submitted within 90 days from the date of the original claim submission.

After filing a claim with Amerigroup, review the weekly *EOP*. If the claim does not appear on an *EOP* within 15 business days as adjudicated or you have no other written indication that the claim has been received, check the status of your claim using the Amerigroup online resource at **provider.amerigroup.com/GA** or by calling Provider Services at **800-454-3730**. If the claim is not on file with Amerigroup, resubmit your claim within 6 months from the date of service. If filing electronically, check the confirmation reports for acceptance of the claim that you receive from your EDI or practice management vendor.

Clean claims adjudication

Clean claims are adjudicated within 15 business days of receipt of a clean claim. If Amerigroup does not adjudicate the clean claim within the time frames specified above, we will pay all applicable interest as required by law.

Nonclean claims are externally pended to the provider in writing within 15 business days identifying the claim number, the reason the claim could not be processed, the date the claim was received by Amerigroup and the information required from the provider in order to adjudicate the claim. We produce and mail weekly *EOPs* delineating the status of each claim adjudicated the previous week. Upon receipt of the requested information from the provider, Amerigroup must complete processing of the clean claim within 15 business days.

Denied claims

Claims that have been denied due to erroneous or missing information must be received within six months from the month the service was rendered or within three months of the month in which the denial occurred, whichever is later. In order to be considered, the denied claim must be resubmitted. The corrected claim process requires the claim be resubmitted within 90 days from the date of the original claim submission with corrected information or be resubmitted via the website. When resubmitting a denied claim on paper more than six months after the month of service, a copy of the remittance advice with the denial must be attached to demonstrate that the original claim was submitted timely.

Technical denials

Claims are flagged as *technical denials* when the facility and/or provider in question has failed to respond to requests for medical records. Claim(s) will be denied or recouped if the provider/facility fails to provide the requested member records.

Claims status

Log in to **provider.amerigroup.com/GA** or call Provider Services at **800-454-3730** to check claims status.

Reimbursement Policies
Reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if Amerigroup covered the service is for the member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and, when billed must fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Amerigroup

strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Reimbursement Hierarchy
Claims submitted for payments must meet all aspects of criteria for reimbursement. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity/clinical criteria, authorization requirements and/or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

Review Schedules and Updates to Reimbursement Policies
Reimbursement policies undergo reviews for updates to state contracts, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to a Amerigroup business decision. We reserve the right to review and revise our policies when necessary. When there is an update, we will publish the most current policies to our provider website.

Medical Coding
The Medical Coding department ensures that correct coding guidelines have been applied consistently through Amerigroup. Those guidelines include, but are not limited to:

- Correct modifier use
- Effective date of transaction code sets (CPT, HCPCS, ICD diagnosis/procedures, revenue codes, etc.)
- Code editing rules are appropriately applied and within regulatory requirements
- Analysis of codes, code definition and appropriate use

Reimbursement by Code Definition
Amerigroup allows reimbursement for covered services based on their procedure code definitions or descriptor, as opposed to their appearance under particular CPT categories or sections, or descriptors unless otherwise noted by state or provider contracts or state, federal or CMS contracts and/or requirements. There are eight CPT sections:

1. Evaluation and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Category II codes: supplemental tracking codes that can be used for performance measurement
8. Category III codes: temporary codes for emerging technology, services or procedures

Newborn claim payment requirements and coordination of care

Amerigroup will pay for services provided to a newborn that is born to a mother currently enrolled in our health plan, including Georgia Families 360°SM, until such time the newborn is discharged from all inpatient care to a home environment.

In the event a newborn is disenrolled from Amerigroup and re-enrolled in the Georgia Medicaid fee-for-service program (or transferred to another CMO) during the hospital stay (for example, SSI eligible), we will ensure the coordination of care for that child until the child has been appropriately discharged from the hospital and placed in an appropriate care setting. All claims relating to this newborn inpatient stay may be billed to Amerigroup for reimbursement.

Provider reimbursement

Amerigroup reimburses PCPs according to their contractual arrangement.

Increased Medicaid payments for primary care physicians and eligible providers
In compliance with the *Patient Protection and Affordable Care Act (PPACA)*, as amended by *Section 1202 of the Health Care and Education Reconciliation Act*, Amerigroup reimburses eligible Medicaid primary care providers (PCPs) at parity with Medicare rates for qualified services in calendar years 2013 and 2014.

If you meet the requirements for the *PPACA* enhanced physician reimbursement and haven't yet submitted a completed attestation, you should do so as soon as possible to qualify for enhanced payments. Visit **provider.amerigroup.com/GA** and look in our *News & Announcements* section for links to information and instructions to follow.

Amerigroup process for supporting enhanced payments to eligible providers
As set forth in *Section 1202* of the *PPACA*:

- Conditioned upon the state of Georgia requiring and providing funding to Amerigroup, Amerigroup will provide increased reimbursement to Medicare levels or some other federal or state-mandated level for specified CPT-4 codes for primary care services furnished with dates of service in 2013 and 2014 by providers who have attested to their eligibility to receive such increased reimbursement as set forth in the *Section 1202* of the *PPACA*.
- Such CPT-4 codes will be paid in accordance with the requirements of *PPACA* and the state and will not be subject to any further enhancements from Amerigroup or any other source.

Provider responsibilities with regard to payments
If you completed the attestation process outlined in your state, the following procedures and guidelines apply to you regarding payments received from Amerigroup:

If you are a group provider, entity or any person other than the eligible provider who performed the service, you acknowledge and agree you will direct any and all increased reimbursements to such eligible providers or otherwise ensure such eligible providers receive direct and full benefit of the increased reimbursement in accordance with the final rule implementing *PPACA*. You also acknowledge and agree you will provide Amerigroup with evidence of your compliance with this requirement upon request by Amerigroup.

Specialist reimbursement
Reimbursement to network specialists and network providers not serving as PCPs is based on their contractual arrangement with Amerigroup.

Specialists shall obtain PCP and Amerigroup approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized by that PCP's referral.

Specialist services will be covered only when there is documentation of appropriate notification or preauthorization as appropriate and receipt of the required claims and encounter information to Amerigroup.

Additional payment can be appealed within 30 days of the date of the letter sent to the provider. The appeal must include any additional supporting documentation and the reason for the second-level appeal.

Outliers that have reduced charges and an outlier payment being paid to the hospital can be appealed within 30 days of the date of the *EOP*. The appeal must include any additional supporting documentation and the reason for the second-level appeal.
All outlier first- and second-level appeals must be sent to:

Health Plan Operations Department
Amerigroup Community Care
740 W Peachtree St NW
Atlanta, GA 30308

If an outlier second-level appeal is upheld and the provider disagrees, the hospital may request a fair hearing or binding arbitration. We must receive your request in writing within 30 days from the date of the letter that upheld the second-level appeal. Please note that if binding arbitration is requested, then the cost of the arbitration, not including attorney's fees, will be equally shared between the hospital and Amerigroup.

Hospital Outlier Requests

Hospitals must submit the request for an outlier with all supporting documentation within the requirements listed in attachment A of their participating provider agreement. Outlier requests for both participating and nonparticipating hospitals must be received within 90 days from the date of the *EOP* of the initial DRG payment.

Requests can be sent to:

Health Plan Operations Department Outlier Requests
Amerigroup Community Care
740 W Peachtree St NW
Atlanta, GA 30308

Upon receipt, the outlier request of the hospital is reviewed to see if it initially meets the requirements for outlier review. **The request must be submitted within the timelines stated in *Attachment A* of the participating provider agreement**. It must meet the threshold requirements for the DRG under which the claim computed and is processed to pay the initial DRG payment. If the request meets the qualifications, then all information provided by the hospital is forwarded to a vendor contracted by Amerigroup for a forensic review.

Amerigroup uses a vendor to assist in the reviews of the outlier cases; the vendor has an extensive background in case reviews and utilizes board-certified physicians, coding experts, nurses and other individuals with extensive backgrounds in this area.

Upon review, a response with the applicable supporting documents or *EOP* is sent to the provider that submitted the outlier request. The forensic review lists the categories of the exceptions with exhibits providing line-item details in the particular areas or revenue codes as applicable.

If the provider disagrees with the review that was performed based on the documents that were received with the initial request, the following will need to occur:
Outliers that do not meet the threshold of the reviewed documentation and have no additional payment can be appealed within 30 days of the date of the letter sent to the provider. The appeal must include any additional supporting documentation and the reason for the second-level appeal
Outliers that have reduced charges and an outlier payment being paid to the hospital can be appealed within 30 days of the date of the EOP. The appeal must include any additional supporting documentation and the reason for the second-level appeal.

All outlier first- and second-level appeals must be sent to:
Health Plan Operations Department
Amerigroup Community Care
740 W Peachtree St NW
Atlanta, GA 30308

If an outlier second-level appeal is upheld and the provider disagrees, the hospital may request a fair hearing or binding arbitration. We must receive your request in writing within 30 days from the date of the letter that upheld the second-level appeal. Please note that if binding arbitration is requested, then the cost of the arbitration, not including attorney's fees, will be equally shared between the hospital and Amerigroup.

Georgia Hospital Outlier Request Checklist

Step	Items to provide
1	Outlier appeal cover letter naming the hospital contact person (make sure to indicate on the cover letter that this is regarding a Georgia Outlier Request)
2	Copy of the original claim

Step	Items to provide
3	Copy of the paid remittance(s) advice (RA)
4	Detailed itemized charges with revenue codes
5	Charges documented on itemized bill that correlate with *UB-04* claim
6	Itemized bill numbered by provider and quantities billed
7	Check that total charges and DOS match on itemized bill, RA and *UB-04*
8	Check that charges documented in the itemized bill but not billed on the *UB-04* are identified and marked through on the itemized bill
9	Utilization review notes documenting severity of illness and intensity of service criteria met; notes signed and dated
10	Physician discharge summary
11	Physician orders
12	Operating room procedure notes (if applicable)
13	Physical/occupational/speech/radiology orders/respiratory therapy notes (if applicable)
14	Check that the chart is organized and labeled for review (Please do not include tabs or insert tabs; however, it is acceptable to insert a page indicating documents that will follow.)
15	Other documents (for example, laboratory reports, anesthesiology records, etc.)
16	Ensure that request is submitted within deadline of paid remittance advice
17	Indicate total number of pages submitted for review

Note: The outlier request submissions must include all of the documentation detailed above for proper consideration.

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 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, Blood Products, and Administration

Blood and blood products such as platelets or plasma are reimbursable. Administration of Blood or Blood Products by nursing/facility personnel are not separately reimbursable on inpatient claims. Administration of Blood or Blood Products by nursing/facility personnel billed on outpatient claims are separately reimbursable when submitted without observation/treatment room charges.

Charges for blood storage, transportation, processing, and preparation such as thawing, splitting, pooling, and irradiation are also not separately reimbursable. Lab tests such as typing, Rh, matching, etc., are separately reimbursable charges.

Changes during Admission

There are elements that could change during an admission. The following table shows the scenarios and the date to be used for the entire Claim:

Change effective date	**Change effective date**
Member's Insurance Coverage	Admission
Facility's Contracted Rate (other than DRG)	Admission
DRG Base Rate	Admission
DRG Grouper	Discharge
DRG Relative Weight	Discharge
CPT & HCPCS coding changes	Discharge

Emergency Room Supply and Services Charges

The Emergency Room level reimbursement includes all monitoring, equipment, supply, and 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 patients. This reimbursement does not typically include the cost of physician services.

Evaluation and Management (E&M) Services

Prior to payment, Amerigroup may review E&M claims to determine, in accordance with correct coding requirements and/or reimbursement policy as applicable, whether the E&M code level submitted is higher than the E&M code level supported on the Claim. If the E&M code level submitted is higher than the E&M code level supported on the Claim, Amerigroup reserves the right to:

- Deny the Claim and request resubmission of the Claim with the appropriate E&M level;
- Pend the Claim and request that the Facility or Provider submit documentation supporting the E&M level billed; and/or
- Adjust reimbursement to reflect the lower E&M level supported by the Claim

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.

General Industry Standard Language
Per Amerigroup policy and the Agreement, Provider and Facility will follow industry standards related to billing. Examples of general industry standards include, but are not limited to, HCPCS, ICD10/CM, health service codes (also known as Revenue Codes) per the UB-04 Claim billing manual or subsequent forms CPT codes.

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 Member'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. Facility shall not bill Amerigroup, and Amerigroup shall not reimburse Facility for implants that are deemed contaminated and/or considered waste and/or were not implanted in the Member. Additionally, Amerigroup will not reimburse Facility for implants that are deemed contaminated and/or considered waste and/or were not implanted in the Member.

Interim Bill Claims
Amerigroup shall not adjudicate Claims submitted as interim bills for services reimbursed under DRG methodology.

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
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.

Medical Care Provided to or by Family Members
Services for any type of medical care rendered by a Provider to him/herself or to an immediate family Member (as defined below), who is a Member, are not eligible for coverage and should not be billed to Amerigroup. In addition, a Provider may not be selected as a Primary Care Physician (PCP) by his/her immediate family Member.

Unless otherwise set forth in a Member's Health Benefit Plan, an immediate family Member includes: father, mother, children, spouse, domestic partner, legal guardian, grandparent, grandchild, sibling, step-father, step-mother, step-children, step-grandparent, step-grandchild, and/or step-sibling.

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, OP chemotherapy administration, or OP infusion administration which are submitted without a room charge, observation charges, or procedure charges other than blood, chemotherapy, or infusion administration.)

Observation Services (Facility Reimbursement Policy)
Amerigroup considers outpatient observation services to mean active, short-term medical and/or nursing services performed by an acute Facility on that Facility's premises that includes the use of a bed and monitoring by that acute Facility's nursing or other staff and are required to observe a patient's condition to determine if the patient requires an inpatient admission to the Facility. Observation services include services provided to a patient designated as "observation status", and in general, shall not exceed 24 hours.

Observation services may be considered eligible for reimbursement when rendered to patients who meet one or more of the following criteria:

- Active care or further observation is needed following emergency room care to determine if the patient is stabilized.

- The patient has a complication from an outpatient surgical procedure that requires additional recovery time that exceeds the normal recovery time.
- The patient care required is initially at or near the inpatient level; however, such care is expected to last less than a 24 hour time frame.
- The patient requires further diagnostic testing and/or observation to make a diagnosis and establish appropriate treatment protocol.
- The patient requires short term medical intervention of Facility staff which requires the direction of a physician.
- The patient requires observation in order to determine if the patient requires admission into the Facility.

Policy
The payment, if any, for observation services is specified in the Plan Compensation Schedule or Contract with the applicable Facility. Nothing in this Policy is intended to modify the terms and conditions of the Facility's Agreement with Amerigroup. If the Facility's Agreement with Amerigroup does not provide for separate reimbursement for observation services, then this Policy is not intended to and shall not be construed to allow the Facility to separately bill for and seek reimbursement for observation services.

The patient's medical record documentation for observation status must include a written order by the physician or other individual authorized by state licensure law and Facility staff bylaws to admit patients to the Facility that clearly states "admit to observation". Additionally, such documentation shall demonstrate that observation services are required by stating the specific problem, the treatment and/or frequency of the skilled service expected to be provided.

The following situations are examples of services that are considered by Amerigroup to be inappropriate use of observation services:
- Physician, patient, and/or family convenience
- Routine preparation and recovery for diagnostic or surgical procedures
- Social issues
- Blood administration
- Cases routinely cared for in the Emergency Room or Outpatient Department
- Routine recovery and post-operative care after outpatient surgery
- Standing orders following outpatient surgery
- Observation following an uncomplicated treatment or procedure

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 patient enters the room until the patient leaves the room, as documented on the OR nurse's notes. The Operating Room is defined as surgical suites, major and minor, treatment rooms, endoscopy labs, cardiac cath labs, Hybrid Rooms, X-ray, pulmonary and cardiology procedural rooms. The operating room charge will reflect the cost of:
- The use of the operating room

- The services of qualified professional and technical personnel

- Any supplies, items, equipment, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services. Refer to Routine Supplies section of the manual.

Other Agreements
If Facility currently maintains a separate Agreement(s) with Amerigroup solely for the provision and payment of home health care services, skilled nursing Facility services, ambulatory surgical Facility services, or other agreements that Amerigroup designates (hereinafter collectively "Other Agreement(s)"), said Other Agreement(s) will remain in effect and control the provision and payment of Covered Services rendered there under.

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

Pharmacy Charges
Pharmacy charges will be reimbursed to include only the cost of the 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. Examples 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 area 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.

Preventable Adverse Events (Facility Reimbursement Policy)

Preventable Adverse Event	Definition / Details
1. Surgery Performed on the Wrong Body Part	Any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.
2. Surgery Performed on the Wrong Patient	Any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.
3. Wrong surgical procedure performed on a patient	Any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.

CMS Healthcare Acquired Conditions ("HCAC") Amerigroup follows CMS' current and future recognition of HACs. Current and valid Present on Admission ("POA") indicators (as defined by CMS) must be populated on all inpatient acute care Facility Claims.

When a HCAC does occur, all inpatient acute care Facilities shall identify the charges and/or days which are the direct result of the HCAC. Such charges and/or days shall be removed from the Claim prior to submitting to the Plan for payment. In no event shall the charges or days associated with the HCAC be billed to either the Plan or the Member, remaining consistent with CMS payment policy and as stated in the Amerigroup reimbursement policy/contracts.

Providers and Facilities (excluding Inpatient Acute Care General Hospitals)
Four (4) Major Surgical Never Events When any of the Provider Preventable Conditions (PPCs)/Preventable Adverse Events ("PAEs") set forth in the grid below occur with respect to a Member, the Provider or Facility shall neither bill, nor seek to collect from, nor accept any payment from the Plan or the Member for such events. If the Provider or Facility receives any payment from the Plan or the Member for such events, it shall refund such payment within ten (10) business days of becoming aware of such receipt. Further, Providers and Facilities shall cooperate with Amerigroup in any Amerigroup initiative designed to help analyze or reduce such PPCs. Amerigroup is committed to working collaboratively with network providers and hospitals to promote safe practices and to identify and implement appropriate strategies, processes, and technologies to address and avoid PPCs and HCACs, including as it applies to health disparities. It is the goal of Amerigroup to enhance the quality of care received not only by members but by all patients receiving care within individual practices and across the healthcare continuum.

Whenever any of the events described in the grid below occur with respect to a Member, Providers and Facilities are encouraged to report the PAE to the appropriate state agency, The Joint Commission ("TJC"), or a patient safety organization ("PSO") certified and listed by the Agency for Healthcare Research and Quality.

Preventable Adverse Event	Definition/Details
1. Surgery Performed on the Wrong Body Part	Any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.
2. Surgery Performed on the Wrong Patient	Any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.
3. Wrong surgical procedure performed on a patient	Any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.
4. Retention of a foreign object in a patient after surgery or other procedure	Excludes objects intentionally implanted as part of a planned intervention and objects present prior to surgery that were intentionally retained.

Provider and Facility Records
Provider and Facility shall prepare and maintain all appropriate medical, financial, administrative and other records as may be needed for Members receiving Health Services. All of Provider's and Facility's records on Members shall be maintained in accordance with prudent record keeping procedures and as required by any applicable federal, state or local laws, rules or regulations.

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 patient's welfare and safety during his/her 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.

Respiratory Services

Mechanical Ventilation / CPAP / BIPAP support and other respiratory and pulmonary function services provided at the bedside are considered facility personnel, equipment, and/or supply charges and not eligible for separate reimbursement.

30 Special Procedure Room Charge

Charges for Special procedure room, billed in addition to the procedure itself, are included in the reimbursement for the procedure. If the procedure takes place outside of the OR (Refer to Operating Room Time and Procedure Charges for OR definition), then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Example: procedures performed in the ICU, ER, 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.

Submission of Claim/Encounter Data
Facilities and Providers will submit Claims and encounter data to Amerigroup on a CMS-1500, UB04, or subsequent form, in a manner consistent with industry standards and policies and procedures as approved by Amerigroup. Amerigroup will make best efforts to pay all complete and accurate Claims for Covered Services submitted by Facilities and Providers in accordance with the applicable state statute, exclusive of Claims that have been suspended due to the need to determine Medical Necessity, to the extent of our payment liability, if any, because of issues such as coordination of benefits, subrogation or verification of coverage.

Supplies and Equipment
Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, isolation carts, mechanical ventilators, continuous positive airway pressure (CPAP)/ bilevel positive airway pressure (BIPAP) machines, and related supplies are not separately reimbursable. Oxygen charges, including but not limited to, oxygen therapy per minute/per hour when billed with room types ICU/CCU/NICU or any Specialty Care area are not separately reimbursable.

Routine Supplies
Items used for the patient 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. Reimbursement is included in the reimbursement for the room, procedure, or observation charges.

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

Test or Procedures Prior to Admission(s) or Outpatient Services
The following diagnostic services, defined by specific Coded Service Identifier(s), are considered part of pre-admission/pre-surgical/preoperative testing:
0254 – Drugs incident to other diagnostic services
0255 – Drugs incident to radiology
030X – Laboratory
031X – Laboratory pathological
032X – Radiology diagnostic
0341 – Nuclear medicine, diagnostic
035X – CT scan
040X – Other imaging services
046X – Pulmonary function
048X – Cardiology
053X – Osteopathic services
061X – MRI
062X – Medical/surgical supplies, incident to radiology or other services
073X – EKG/ECG
074X – EEG
092X – Other diagnostic services

Non-diagnostic services are also considered part of pre-admission/pre-surgical/preoperative testing if they are furnished in connection with the principal diagnosis that necessitates the outpatient procedure or the Member's admission as an inpatient.

Unless the Provider or Facility Agreement with Amerigroup specifies a different timeframe, pre-admission/pre-surgical/ pre-operative testing that occurs within seventy-two (72) hours prior to the inpatient admission or outpatient procedure will be included in the DRG Rate, Per Diem Rate, Case Rate or any other Amerigroup Rate for Covered Services, and will not be paid separately. All Claims billed separately for these services must be accompanied with the appropriate ICD-10 codes

Time Calculation

- Operating Room ("OR") –Time should be calculated on the time the patient enters the room until the patient 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 patient enters the operating room (OR) until the patient leaves the room, as documented on the OR nurse's notes. The time the anesthesiologist spends with the patient 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 patient enters the recovery room until the patient 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 patient leaves the Recovery Room until discharge.

Video or Digital Equipment used in Procedures
Charges for video or digital equipment used for visual enhancement during a procedure are included in the reimbursement for the procedure and are not separately reimbursable. Examples include but not limited to Ultrasound and Fluoroscopy guidance. Charges for batteries, covers, film, anti-fogger solution, tapes etc., are also 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. Please 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 • Patient Convenience Items (0990) • Cafeteria, Guest Tray (0991) • Private Linen Service (0992) • Telephone, Telegraph (0993) • TV, Radio (0994) • Non-patient Room Rentals (0995) • Beauty Shop, Barber (0998) • Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room 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**
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge
0480 – 0489	Stand-by Charges
0220, 0949	Add on Stat Charges
0270 – 0279, 0360	Video Equipment Used in Procedures
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

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 carts/supplies; • Dressing Change Trays/Packs/Kits • Dressings/Gauze/Sponges; • Kerlix/Tegaderm/OpSite/Telfa • 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.)

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**
	• IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, 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) • Patient transport fees
0223	Utilization Review Service Charges
0263	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 Compounded fees

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**
	• Medication prep • Nonspecific descriptions • 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 (subject to UM determination- Medical Policies)
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 Patient 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 (including rentals)** • Oxygen • Oxygen (ICU/CCU/Progressive) O.R., ER and Recovery • Instrument Trays and/or Surgical Packs • Drills/Saws (All power equipment used in O.R.) • Drill Bits

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**
	• Blades • IV pumps and PCA (Patient Controlled Analgesia) pumps • Isolation supplies • Daily Floor Supply Charges • X-ray Aprons/Shields • Blood Pressure Monitor • Beds/Mattress • Patient Lifts/Slings • Restraints • Transfer Belt • Bair Hugger Machine/Blankets • SCD Pumps • Heal/Elbow Protector • Burrs • Cardiac Monitor • EKG Electrodes • Vent Circuit • Suction Supplies for Vent Patient • Electrocautery Grounding Pad • Bovie Tips/Electrodes • Anesthesia Supplies • Case Carts • C-Arm/Fluoroscopic Charge • Wound Vacuum Pump and supplies • Bovie/Electro Cautery Unit

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**
	• Wall Suction • Retractors • Single Instruments • Oximeter Monitor • CPM Machines • Lasers • Da Vinci Machine/Robot
0370 – 0379, 0410, 0460, 0480 – 0489	• Anesthesia • Anesthesia (Specifically, conscious/moderate sedation by same physician or procedure nurse) • Nursing care • Monitoring • Intervention • Pre- or Post-evaluation and education • IV sedation and local anesthesia by same physician or procedure nurse • Intubation/Extubation • CPR
0410	Respiratory Functions: • Oximetry reading by nurse or respiratory • Respiratory assessment/vent management • Medication Administration via Nebs, Metered dose (MDI), etc. • Postural Drainage • Suctioning Procedure • Respiratory care performed by RN

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**
0940 – 0945	Education/Training

Provider payment disputes

Claim adjustment reconsiderations

If the amount reimbursed by Amerigroup to a provider is not correct, a positive or negative adjustment to the claim may be necessary. The following process would occur in appealing a claim adjustment reconsideration and must occur within 90 days from the date of the *Explanation of Payment* (*EOP*).

Positive adjustments

When a provider can substantiate that additional reimbursement is appropriate, the provider may adjust and resubmit a corrected claim within 90 days from the date of the original claim submission. All documentation for the claim adjustment reconsideration must be received within 90 days from the month of payment. The adjustment request must include all sufficient documentation to identify each claim. Documentation includes but is not limited to: *Coordination of Benefits* (*COB*), explanation of benefits/payment (*EOB*/*EOP*), etc. If an adjustment is warranted after receipt of the documentation, then Amerigroup will make additional reimbursement upon processing the request, and the provider will be notified via remittance advice. If an adjustment to reimbursement is not warranted, then the provider will receive a written response.

To submit a request for review, please complete the *Provider Payment Dispute and Correspondence Submission* form with all supporting documentation. The *Provider Payment Dispute and Correspondence Submission* form can be located at **provider.amerigroup.com/GA**. Log in using your password and submit it to:

Payment Disputes
Amerigroup Community Care
P.O. Box 61599
Virginia Beach, VA 23466-1599

Negative adjustments

If a provider believes that a negative adjustment is appropriate, the provider may follow the Amerigroup refund notification process by submitting a *Refund Notification Form* (*RNF*) and all related documentation needed to appropriately reconcile the overpayment that the provider has identified. The *RNF* will be used in processing the overpayment refunds in a timely, consistent and efficient manner to ensure proper processing. The *RNF* form can be found online at **provider.amerigroup.com/GA**.

All refund checks should be mailed with a copy of this form to:

Amerigroup Community Care
P.O. Box 933657
Atlanta, GA 31193-3657

Once the Amerigroup Cost Containment unit has reviewed the overpayment, you will receive a confirmation letter explaining the details of the reconciliation.

Coordination of Benefits

State-specific guidelines will be followed when *Coordination of Benefits (COB)* procedures are necessary. Amerigroup agrees to use covered medical and hospital services whenever available or other public or private sources of payment for services rendered to enrollees in the Amerigroup plan.

Amerigroup agrees that the Medicaid program will be the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicaid members. When Amerigroup is aware of these resources prior to paying for medical services, we will avoid payment by either rejecting a provider's claim and redirecting the provider to bill the appropriate insurance carrier or, if Amerigroup does not become aware of the resource until sometime after payment for the service was rendered, by pursuing post-payment recovery of the expenditure. Providers must not seek recovery in excess of the Medicaid payable amount.

Amerigroup will avoid payment of claims where third-party resources are payable. We will require members to cooperate in the identification of any and all other potential sources of payment for services.

Any questions or inquiries regarding paid, denied or pended claims should be directed to Provider Services at **800-454-3730**.

Billing members

Overview
Before rendering services, providers should always inform members that the cost of services not covered by Amerigroup will be charged to the member.

A provider who chooses to provide services not covered by Amerigroup:

- Understands that Amerigroup only reimburses for services that are medically necessary, including hospital admissions and other services.
- Obtains the member's signature on the *Client Acknowledgment Statement* specifying that the member will be held responsible for payment of noncovered services only.
- Understands that he or she may not bill for or take recourse against a member for denied or reduced claims for services that are within the amount, duration and scope of benefits of the Medicaid program.

Amerigroup members must not be balance billed for the amount above that which is paid by Amerigroup for covered services.

In addition, providers may not bill a member if any of the following occurs:

- Failure of timely submission of a claim, including claims not received by Amerigroup
- Failure to submit a claim to Amerigroup for initial processing within the 6 months filing deadline
- Failure to submit a corrected claim within the 6 months filing resubmission period
- Failure to appeal a claim within the 30-day administrative appeal period
- Failure to appeal a utilization review determination within 30 days of notification of denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made in claims preparation, claims submission or the appeal process

Client Acknowledgment Statement

A provider may bill an Amerigroup member for a service that has been denied as not medically necessary or not covered by Amerigroup only if both of the following conditions are met:

- The member requests the specific service or item
- The provider obtains and keeps a written acknowledgement statement signed by the member and the provider stating:

> "I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under Amerigroup as being reasonable and medically necessary for my care. I understand that Amerigroup determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be medically necessary for my care."
>
> Signature: _____
>
> Date: _____

Amerigroup website and Provider Services

We offer an automated interactive voice response system called Nuance®.

Nuance is a state-of-the-art system carefully selected to better serve our thousands of members and participating providers. Nuance technology allows us to provide more detailed enrollment, claims and authorization status information along with new self-service features for our members. These features allow each member to:

- Update his or her address and telephone number.
- Request a new member ID card.
- Search for and/or change his or her primary care provider.

We recognize that, in order for you to provide the best service to our members, we must give you accurate, up-to-date information. We offer two methods of accessing claims status, member eligibility and authorization determination status 24 hours a day, 365 days a year.

Our provider self-service website, **provider.amerigroup.com/GA**, offers a host of resources. It features our online provider inquiry tool for real-time claim status, eligibility verification and referral authorization. Detailed instructions for use of the online provider inquiry tool can be found on this website.

Claim status inquiry and follow-up

Claim status

Check the status of a claim anytime by logging in to Availity Essentials **at https://Availity.com and selecting Claims & Payments > Claim Status**

Claim follow-up/resubmission

If there has been no response to a submitted claim after 30 business days from the date the claim was submitted, providers can initiate follow-up action to determine the claim status.

To follow-up on a claim:

- Check **https://Availity.com** for disposition of the claim.

Access the following using the claim status results page: Chat with Payer, Copy of Electronic Remittance Advice (835) and also submit and attachment or dispute when available. Provider Services — 800-454-3730

This resource can be used to automatically check member eligibility, claim status and authorization determination status. This option also offers the ability to be transferred to the appropriate department for other needs, such as requesting new authorizations, ordering referral forms or directories, seeking advice in case management, obtaining a member roster, or requesting pharmacy services. Detailed instructions on the use of the Provider Services tools are set forth below.

To access **member eligibility** information:

Verify member eligibility
To verify member eligibility, log on to Availity at **https://Availity.com** . From Availity's homepage, select **Patient Registration > Eligibility & Benefits**.

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

To review claim status:

1. Dial **800-454-3730** and listen for the prompt.
2. 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***.
3. 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 authorization status:

1. Dial **800-454-3730** and listen for the prompt.
2. At the main menu, say **authorizations**.
    - Say **authorization status** to hear one inpatient or up to 10 outpatient authorization determinations.
    - Say **new authorization** and be transferred to the correct department based on authorization type.
    - Be prepared to say the member's **Amerigroup 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/CCYY format.

Say **repeat** to hear the information again.
Say **another authorization** to review the status of another authorization.
Say **main menu** to perform other transactions.
Say **representative** to be transferred to a live agent.
Or simply **hang up** if you are done.

To submit a **pharmacy peer-to-peer (PTP)**:

1. Dial **800-454-3730** and listen for the prompt.
2. Select these prompts: Something else → Pharmacy → Something else → "Prompt #4" to speak to a PTP technician or leave a voicemail to request a PTP.
3. From the Pharmacy Prior Authorization Call Center, a customer care representative can transfer the call to the PTP technician or voicemail.

17 Appendix A — Forms

Medical record forms

Specialist as PCP Request Form

Date: _____

Member's name: _____

Member's ID #: _____

PCP's name (if applicable): _____

Specialist's name/specialty: _____

Member's diagnosis: _____

Describe the medical justification for selecting a specialist as PCP for this member.

_____

_____

_____

_____

_____

The signatures below indicate agreement by the specialist, Amerigroup and the member for whom the specialist will function as this member's PCP, including providing PCP access to the member 24 hours a day, 7 days a week.

Specialist's signature: _____ Date: _____

Medical director's signature: _____ Date: _____

Member's signature: _____ Date: _____

Medical Record Review Checklist

Provider name: _____
Date of review: _____
Specialty: _____
Reviewer: _____
Check One: Audit_____ Credentialing visit _____ Recredentialing visit _____

Member Name: **D.O.B** **Member #**												
CRITERIA (Critical indicators are in bold type)	**Y**	**N**	**NA**	**Y**	**N**	**NA**	**Y**	**N**	**NA**	**Y**	**N**	**NA**
1. Patient identification on each page												
2. Biographical/personal data documented												
3. Medical record entries are legible												
4. All entries dated and signed by provider												
5. Medication log												
6. Immunization log up to date												
7. Immunization log complete (route, dose, lot number, expiration date)												
8. Immunization log signed by appropriate provider												
9. Allergies and adverse reactions flagged												
10. Completed problem list												
11. Past medical history												
12. Follow-up on past visit problems												
13. Mental health screening												
13. Psychosocial assessment												
14. EtOH/substance/smoking screen counseling												
15. HIV education, counseling, and screening												
16. Domestic violence/child abuse screening												
17. Pertinent history and Physical exam												
18. Working diagnosis consistent with findings												
19. Tx Plan appropriate and consistent with Dx.												
20. Return date and follow-up plan on encounter with time												
21. Labs and other studies as appropriate												

22. Labs and other studies reviewed and initialed												
23. Appropriate use of specialist/consultants												
24. Continuity and coordination of care with specialist												
25. Consultative reports reviewed and initialed												
26. Preventive services rendered appropriately												
27. Age appropriate education provided												
28. Appropriate reporting of communicable disease												

HIV antibody blood forms

Counsel for HIV Antibody Blood Test

Use patient imprint.

Name: _____

In accordance with Chapter 174, P.L. 1995:

I acknowledge that _____ has counseled
(Name of physician or other provider)
and provided me with:

A. Information concerning how HIV is transmitted
B. The benefits of voluntary testing
C. The benefits of knowing if I have HIV or not
D. The treatments which are available to me and my unborn child should I test positive
E. The fact that I have a right to refuse the test and I will not be denied treatment

I have consented to be tested for infection with HIV. ☐

I have decided not to be tested for infection with HIV. ☐

This record will be retained as a permanent part of the patient's medical record.

_____ _____
Signature of patient Date

_____
Signature of witness

Consent for the HIV Antibody Blood Test

I have been told that my blood will be tested for antibodies to the virus named HIV (Human Immunodeficiency Virus). This is the virus that causes AIDS (Acquired Immunodeficiency Syndrome), but it is not a test for AIDS. I understand that the test is done on blood.

I have been advised that the test is not 100 percent accurate. The test may show that a person has antibodies to the virus when he or she really doesn't — this is a false positive test. The test may also fail to show that a person has antibodies to the virus when he or she really does — this is a false negative test. I have also been advised that this is not a test for AIDS and that a positive test does not mean that I have AIDS. Other tests and examinations are needed to diagnose AIDS.

I have been advised that if I have any questions about the HIV antibody test, its benefits or its risks, I may ask those questions before I decide to agree to the blood test.

I understand that the results of this blood test will only be given to those health care workers directly responsible for my care and treatment. I also understand that my results can only be given to other agencies or persons if I sign a release form.

By signing below, I agree that I have read this form or someone has read this form to me. I have had all my questions answered and have been given all the information I want about the blood test and the use of the results of my blood test. I agree to give a tube of blood for the HIV antibody tests. There is almost no risk in giving blood. I may have some pain or a bruise around the place that the blood was taken.

_____ _____

Date Patient's/guardian's signature

_____ _____

Witness's signature Patient's/guardian's printed name

_____

Physician's signature

Amerigroup recognizes the need for strict confidentiality guidelines.

Results of the HIV Antibody Blood Test

A. EXPLANATION

This authorization for use or disclosure of the results of a blood test to detect antibodies to HIV, the probable causative agent of Acquired Immunodeficiency Syndrome (AIDS), is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, Civil Code Section 56 et seq. and Health and Safety Code Section 199.21(g).

B. AUTHORIZATION

I hereby authorize _____ to furnish
(Name of physician, hospital or health care provider)
to _____ the results of the blood
(Name or title of person who is to receive results)
test for antibodies to HIV.

C. USES

The requester may use the information for any purpose, subject only to the following limitation: _____.

D. DURATION

This authorization shall become effective immediately and shall remain in effect indefinitely or until _____, 20____, whichever is shorter.

E. RESTRICTIONS

I understand that the requester may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

F. ADDITIONAL COPY

I further understand that I have a right to receive a copy of this authorization upon my request.
Copy requested and received: ☐ Yes ☐ No _____ Initial

Date: _____, 20_____ _____
Signature

_____
Printed name

This form must be in at least eight-point type.

Hysterectomy and sterilization forms

Visit the U.S. Department of Health & Human Services website at **hhs.gov/forms** to access the hysterectomy and sterilization forms.

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 doctor. If you need help in understanding or filling out this form, call Member Services at **800-600-4441**.

I _____,
(Name)
want_____,
(Name of person I want to carry out my wishes and 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 that 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) and (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 will not get any part of the person's estate when he or she dies. I am not a patient in the health care facility where this person is a patient. 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 a patient, I am not involved in providing direct patient care to him or her. I am not directly involved in the financial affairs of the health facility.

Witness: _____

Date: _____

Address: _____

Living Will

You can make a living will by filling out 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 doctor. If you need help in understanding or filling out this form, call Member Services at **800-600-4441**.

I, (print your name here) _____, am of sound mind. I want to have what I say here followed. I am writing this in the event that 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 you want 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 that I want to change it or forgo a living will entirely.

Signature: (*if minor, signature of parent or guardian)* _____

Date: _____

Address: _____

Managed Care Hospice Election/Revocation Form

Georgia Families
Choices for a Healthy Life

MANAGED CARE HOSPICE ELECTION/REVOCATION FORM

This form is used to inform and enable care management organizations (CMOs) to authorize hospice services provided to eligible Georgia Families members. After completing this form, fax to the appropriate CMO. **Please note: Members will remain in their CMO until their category of aid is changed to hospice**.

CHECK ONE:

☐ Amerigroup Community Care:
Phone: **800-454-3730**
Fax: **877-842-7155**
ATTN: Case Management
.amerigroupcorp.com

☐ Peach State Health Plan:
Phone: **800-704-1483**
Fax: **866.532.8835**
ATTN: Case Management
pshpgeorgia.com

☐ Wellcare:
Phone: ***866-231-1821***
Fax: ***877-431-8860***
ATTN: Case Management
/georgia.wellcare.com

SECTION I- FACILITY AND/OR MD TO COMPLETE FOR ALL HOSPICE MEMBERS

Member Information

Member Name (Last, First, MI) _____

Medicaid Number (MHN): _____ Date of Birth:(MM/DD/YYYY) _____

CMO ID # (if applicable): _____

Additional Information: _____

Hospice Information

Facility Name: _____

Phone Number: _____ Fax Number _____

Facility Address: _____ City/State: _____ Zip Code: _____

Attending Physician: _____ Medicaid Provider Number: _____

Clinical Information and Diagnosis (ICD-9 Code): _____

SECTION II- MEMBER STATEMENT
TO BE COMPLETED BY MEMBER

☐ **ELECTION STATEMENT:**

- The Georgia Medicaid Hospice Service has been explained to me. I have been given the opportunity to discuss services, benefits, requirements and limitations of this program and the terms of the election statement.
- I can choose to discontinue hospice care at any time. To discontinue care, I must complete a revocation statement.

- I understand that I am entitled to change the designated hospice provider one time during a benefit period.
- I understand that I am entitled to Medicaid sponsored Hospice as long as I am Medicaid eligible. The services are provided in benefit periods of initial ninety (90) day period, subsequent ninety (90) day period, and unlimited subsequent sixty day periods.

Print Name (Member/Representative): _____ Date: _____

Signature (Member/Representative): _____ Date: _____

Hospice Representative Signature: _____ Date: _____

SECTION III- REVOCATION STATEMENT

An individual or representative may revoke the election of hospice care at any time during an election period. To revoke the election of hospice care, the individual or representative must file a revocation statement with the hospice.

☐ **REVOCATION STATEMENT:**

- I desire to voluntarily revoke the election of hospice care.
- The Georgia Medicaid Hospice Services Program has been explained to me. I have been given the opportunity to discuss the services, benefits, requirements and limitations of the program and the terms of the revocation of these services.
- I understand that by signing the revocation statement that, if eligible, I will resume Medicaid coverage of benefits waived when hospice care was elected.
- I understand I will forfeit all hospice coverage days remaining in this benefit period.
- I understand that I may at any time elect to receive hospice coverage for any other hospice benefit period for which I am eligible.

I therefore revoke the hospice benefit because: _____

_____

_____

Effective Date: _____

Print Name (Member/Representative): _____ Date: _____

Signature (Member/Representative): _____ Date: _____

Hospice Representative Signature: _____ Date: _____

SECTION IV- CMO USE ONLY

Date Received: _____ Approved: ☐ YES ☐ NO Date Effective: _____

Notification of Member Date: _____ Notification of Provider Date: _____

Reason for Denial: _____

_____

_____

Recommendations for Preventive Pediatric Health Care (RE9535)

Each child and family is unique; these recommendations for preventive pediatric health care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal. Developmental, psychosocial and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

The rest of the page is left intentionally blank. Recommendations are on the page that follows.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving nurturing parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require more frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest concerns.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

	INFANCY							EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																			
Weight for Length		●	●	●	●	●	●	●	●	●	●																				
Body Mass Index[4]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[5]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																															
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing		●[8]	●[9]	——→	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	★	●	●[10]	——→	★	●	——→	★	●	——→	
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																															
Maternal Depression Screening[11]				●	●	●	●																								
Developmental Screening[12]								●				●		●																	
Autism Spectrum Disorder Screening[13]												●	●																		
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral/Social/Emotional Screening[14]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[15]																						★	★	★	★	★	★	★	★	★	★
Depression and Suicide Risk Screening[16]																							●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																															
Newborn Blood		●[19]	●[20]	——→																											
Newborn Bilirubin[21]		●																													
Critical Congenital Heart Defect[22]		●																													
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★														
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	——→	●	——→	★	★	★	★	★	◄——	——→	●	——→
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	●	——→				
Hepatitis B Virus Infection[31]		★	——→																												——→
Hepatitis C Virus Infection[32]																													●	——→	
Sudden Cardiac Arrest/Death[33]																						★	——→								——→
Cervical Dysplasia[34]																															●
ORAL HEALTH[35]							●[36]	●[36]	★		★	★	★	★	★	★	★														
Fluoride Varnish[37]				◄——			◄——		——→		●	——→																			
Fluoride Supplementation[38]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★				
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (https://doi.org/10.1542/peds.2018-1218).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (https://doi.org/10.1542/peds.2011-3552). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborn Infants" (https://doi.org/10.1542/peds.2015-0699).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (https://doi.org/10.1542/peds.2007-2329C).
6. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (https://doi.org/10.1542/peds.2017-1904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (https://doi.org/10.1542/peds.2015-3596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (https://doi.org/10.1542/peds.2015-3597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (https://doi.org/10.1542/peds.2007-2333).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (https://www.sciencedirect.com/science/article/abs/pii/S1054139X16000483).
11. Screening should occur per "Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice" (https://doi.org/10.1542/peds.2018-3259).
12. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening" (https://doi.org/10.1542/peds.2019-3449).
13. Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder" (https://doi.org/10.1542/peds.2019-3447).

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ◄——★ or ●——► = range during which a service may be provided

BFNC 2023 PSFEB
3-365/0223

EPSDT medical record review

Form A – Office Review

Form A - Office Review		**CMO: Amerigroup**
Provider Name:		**Region:**
Address:		
Place an X (equivalent to "YES") in the box next to each item that is confirmed. Absence of an X is equivalent to "NO" or "Not Confirmed."		
Checklist of Office Physical Environment Requirements:		
	Scale for weighing infants (O)	
	Scale for weighing children and adolescents (O)	
	Measuring board or appropriate device for measuring length or height in recumbent position for infants and children up to the age of two (2) years (O)	
	Measuring board or accurate device for measuring height in the vertical position for children who are over two (2) years old (O)	
	Blood pressure apparatus with infant, child and adult cuffs (O)	
	Audiometer (O)	
	Vision charts (O)	
	Ophthalmoscope (O)	
	Otoscope (O)	
	Autism, Developmental/Behavioral, Alcohol/Substance Abuse, and Depression screening tools and supplies: CRAFFT (O)	
	> Validated Developmental Screening Tool (standardized): ASQ, ASQ-3, BDI-ST, BINS, BSII, CDI, IDI, PEDS, PEDS-DM (O) > Standardized Depression Screening Tool: PHQ 2 (O) > Standardized Screening Tool for Alcohol/Substance Abuse (O) > Autism Screening Tool	
	Process to report vaccines to GRITS (R)	
	Vaccines and immunization administration supplies (including refrigerator) (O)	
	Method for sending mandated information to GHHLPPP (R)	
	(Optional) Blood Lead Analyzer with Protocols/ Procedures (O) Assess Process for reporting all results to GHHLPP (O)	
	(Optional) Device for measuring Hct and Hgb (O)	
Legend: O = Observation; must see the item (R) = Report from provider is acceptable		
List below any missing or inappropriate tools/ equipment		

Form B - ***Provider*** **Audit**						CMO name: **Amerigroup**		Reporting period: MM/DD/YYYY-MM/DD/YYYY		
Physician ID/name:			Office contact:						Date of audit:	
Telephone:			Address:						Auditor:	
INDICATORS	**MEDICAL RECORDS**					**Numerator**	**Denominator**	**Rate**	**Follow-Up**	
Match Number to Member in Confidential Manner	**1**	**2**	**3**	**4**	**5**	# of charts compliant with indicators	total # of charts audited	Compliance Rate (%)	Indicate if follow-up is required	
Age of Child (at date service was performed)										
1 - Documentation is legible 2 - Initial and Interval History are present										
**** Growth: Measured, Plotted on Graph/ BMI Present ****										
3 - Length/Height and Weight 4 - Head Circumference 5 - Weight for length 6 - BMI percentile present 7 - Blood Pressure assessment 8 - Vision: Measurement and method 9 - Hearing: Measurement and method										
**** Developmental/Behavioral Assessments/ Surveillance Documented ****										
10 - Standardized Developmental Screen 11 - Standardized Autism Screen 12 - Psychosocial/Behavioral Assessment 13 - Alcohol & Drug Assessment as age appropriate 14 - Standardized Depression Screen 15 - Comprehensive Physical Exam										
**** Procedures ****										
16 - Newborn Metabolic/Hemoglobin Screening										

17 - Immunizations completed for age per ACIP 18 - Hemoglobin/Hematocrit Screening or Assessment 19 - Blood Lead Risk Assessment 20 - Blood Lead Level Test (12 and 24 months) 21 - Tuberculin Risk Assessment completed 22 - Tuberculin Test completed 23 - Dyslipidemia Assessment/Screening 24 - STI/HIV Screening 25 - Oral Health 26 - Anticipatory Guidance 27 - Referral/Treatment or Follow-up noted 28 – Fluoride Varnish									
					AVERAGE COMPLIANCE RATE:				

* To achieve an acceptable rating on the clinical medical record review, these critical elements must be met, and an average score of 80 percent must be received.

Physician ID/Name:		Office Contact:						Date of Audit:		
Telephone:	Address:							Auditor:		
INDICATORS	MEDICAL RECORDS					Numerator	Denominator	Rate	Follow-Up
Match Number to Member in Confidential Manner	1	2	3	4	5	# of charts compliant with indicators	total # of charts audited	Compliance Rate (%)	Indicate if follow-up is required
Age of Child (at date service was performed)									
1 - Documentation is legible									
2 - Initial and Interval History are present									
** Growth: Measured, Plotted on Graph/ BMI Present **									
3 - Length/Height and Weight									
4 - Head Circumference									
5 - Weight for length									
6 - BMI percentile present									
7 - Blood Pressure assessment									
8 - Vision: Measurement and method									
9 - Hearing: Measurement and method									
** Developmental/Behavioral Assessments/ Surveillance Documented **									
10 - Standardized Developmental Screen									
11 - Standardized Autism Screen									
12 - Psychosocial/Behavioral Assessment									
13 - Alcohol & Drug Assessment as age appropriate									
14 - Standardized Depression Screen									
15 - Comprehensive Physical Exam									
** Procedures **									
16 - Newborn Metabolic/Hemoglobin Screening									
17 - Immunizations completed for age per ACIP									
18 - Hemoglobin/Hematocrit Screening or Assessment									
19 - Blood Lead Risk Assessment									
20 - Blood Lead Level Test (12 and 24 months)									
21 - Tuberculin Risk Assessment completed									
22 - Tuberculin Test completed									
23 - Dyslipidemia Assessment/Screening									
24 - STI/HIV Screening									
25 - Oral Health									
26 - Anticipatory Guidance									
27 - Referral/Treatment or Followup noted									
AVERAGE COMPLIANCE RATE:									
Note: Additional space has been provided in the event more than one medical record is selected for a provider.									

EPSDT Required Equipment Form

☐	Scale for weighing Infants **present**
☐	Scale for weighing children and adolescents **present**
☐	Measuring board or appropriate device for measuring length or height in recumbent position for infants and children up to the age of two (2) years **present**
☐	Measuring Board or Device for measuring Height in the vertical position for children who are over two (2) years old **present**
☐	Blood Pressure apparatus with infant, child, and adult cuffs **present**
☐	Audiometer **present**
☐	Vision Charts **present**
☐	Ophthalmoscope **present**
☐	Otoscope **present**
☐	Developmental /Behavioral, Alcohol/Substance Abuse, and Depression screening tools and supplies **present**
☐	> Validated Developmental Screening Tool (standardized): ASQ, ASQ-3, BDI-ST, BINS, BSII, CDI, IDI, PEDS, PEDS-DM > Standardized Depression Screening Tool > Standardized Screening Tool for Alcohol/Substance Abuse **ALL present**
Check all that apply:	☐ ASQ ☐ BINS ☐ IDI ☐ ASQ-3 ☐ BSII ☐ PEDS ☐ BDI-ST ☐ CDI ☐ PEDS-DM
☐	Process to report vaccines to GRITS **present**
☐	Vaccines and immunization administration supplies (including refrigerator) **present**
☐	Method for sending mandated information to GHHLPPP **present**
☐ ☐	(Optional) Blood Lead Analyzer with Protocols/ Procedures **present** Process for reporting all results to GHHLPP **present**
☐	(Optional) Device for measuring Hct and Hgb **present**
Question	Do you use an electronic medical record system? ☐ Yes ☐ No

The information supplied in this document is true, accurate and complete and is hereby released to the Georgia Department of Community Health, Medicaid Division, for purpose of enrolling in the EPSDT program. I understand that falsification, omission or misrepresentation of any information in this enrollment document will result in a denial of enrollment, the closure of current enrollment, and the denial of future enrollment request, and may be punishable by criminal, civil or other administrative actions. I understand that my completion of this form certifies that I have the necessary equipment as listed in Part II Policies and Procedures for EPSDT program manual.

_____ _____

Provider name Date

_____

Provider number

Additional forms

The following forms are also available on our website at **provider.amerigroup.com/GA**. Select **Resources** and then select **Forms** or **Pharmacy Information** to view them. You may also download them for use as needed.

Referral and claim submission forms:

- *Authorization Request Form*
- *GA Universal Pregnancy Form*
- *Behavioral Health Outpatient Treatment Form*
- *Behavioral Health Outpatient Treatment Report Form C*
- *Specialist as PCP Request*
- *WIC*
- *CMS-1500 (08-05) Claim Form*
- *UB-04 Claim Form*
- *COB Explanation of Benefits Co-Payment Request Form*

Medical record forms

- *Clinical Information Form*
- *Immunization Record*
- *Patient Drug Profile*
- *Problem List 1*
- *Problem List 2*

Provider grievances and appeals

- *Provider Payment Dispute & Correspondence Submission*
- *Grievance Form*
- *Bundled Appeal Form*

Blood lead risk forms

- *Blood Lead Testing for High-Risk Children*
- *Verbal Blood Lead Risk Assessment*

Pharmacy forms

- *Synagis/Respiratory Syncytial Virus (RSV) Enrollment Form*
- *Pharmacy (General) Prior Authorization Form*
- *Medical Injectable Prior Authorization Form*

Behavioral health forms

- *BH Minimum Data Sets*
- *Behavioral Health Outpatient Treatment Form*
- *Behavioral Health Outpatient Treatment Report Form C*
- *Request For Authorization — Psychological Testing Authorization Form*

Cost Containment form

- *Refund Notification Form*

18 Appendix B — *Clinical Practice Guidelines*

Visit **provider.amerigroup.com/GA** and select **Resources** and **Provider Manuals, Policies and Guidelines**. For a printed copy of the *Clinical Practice Guidelines*, contact Provider Services at **800-454-3730**.

19Appendix C – Acronyms

1. AA member – Adoption Assistance member
2. *CAPTA – Child Abuse Prevention and Treatment Act*
3. CBAY – community-based alternatives for youth
4. *CCFA – Comprehensive Child and Family Assessments*
5. COMP – Comprehensive Supports Waiver Program
6. DBHDD – Department of Behavioral Health and Developmental Disabilities
7. DCH – Georgia Department of Community Health
8. DECAL – Department of Early Care and Learning
9. DFCS – Division of Family and Children Services
10. DHS – Department of Human Services
11. DJJ – Department of Juvenile Justice
12. DJJP – Department of Juvenile Justice Population
13. DOE – Department of Education
14. DPH – Department of Public Health
15. GCAL – Georgia Crisis and Access Line
16. FC member – Foster Care member
17. FCAAP – Foster Care and Adoption Assistance population
18. GAPP – Georgia Pediatric Program
19. GFMOC – Georgia Families 360°$_{SM}$ Monitoring and Oversight Committee
20. HCBS – home- and community-based services
21. ICAMA – Interstate Compact on Adoption and Medical Assistance
22. ICPC – Interstate Compact on the Placement of Children
23. ICWP – Independent Care Waiver Program
24. IFI – intensive family intervention
25. LIPT – Local Interagency Planning Team
26. MSHCN – members with special health care needs
27. MDT – multidisciplinary team
28. NCM – nurse care manager
29. NCTSN – National Child Traumatic Stress Network
30. NOW – New Options Waiver Program
31. RIAT – Regional Interagency Team
32. SSI – supplemental security income
33. SUCCESS – System for the Uniform Calculation and Consolidation of Economic Support
34. VBP – value-based purchasing
35. EHR – electronic health record

Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan.

CarelonRx, Inc. is an independent company providing pharmacy benefit management services on behalf of the health plan.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