Amerigroup RealSolutions® in healthcare

Provider Quick Reference Card

Precertification and notification requirements

Important phone numbers ▪ Revenue codes

Georgia

https://providers.amerigroup.com/GA

GAAGP-CD-018482-23-CPN18476

Easy access to **precertification and notification requirements** and other important information

For more information about requirements, benefits and services, see the most recent version of our provider manual — available on the Amerigroup Community Care provider website at https://providers.amerigroup.com/GA. If you have questions about this *Quick Reference Card (QRC)* or recommendations to improve it, call your local Provider Relations representative at **800-454-3730**. We are always looking for ways to improve our service so you can focus on your patients!

Precertification/notification instructions and definitions

Request precertification and give us notifications:

- Online: https://providers.amerigroup.com/GA
- By phone: **800-454-3730**

Precertification may be submitted on the Alliant Georgia Medical Care Foundation (GMCF) portal at www.mmis.ga.gov or by logging in to the Availity Portal on the Amerigroup provider website at https://providers.amerigroup.com/GA.

Precertification — the act of authorizing specific services or activities before they are rendered or occur

Notification — telephonic or electronic communication received from a provider to inform of the intent to render covered medical services to a member:

- Notify us prior to rendering services outlined in this document.
- For emergency or urgent services, notify us within 24 hours or by the next business day.
- We will verify member eligibility and provider participation status.

To see code-specific requirements for all services, visit **https://providers.amerigroup.com/GA** and select **Precertification Lookup** from our *Quick Tools* menu.

Requirements listed are for network providers.
Out-of-network providers must request precertification for nonemergency services prior to rendering care to the member.

Behavioral health/substance abuse

- Precertification is required for coverage of inpatient mental health and chemical dependency services and residential treatment.
- Precertification is required for coverage of traditional outpatient services such as individual and family therapy after the first 20 units of services have been provided to a member.
- Precertification is required for coverage of psychological and neuropsychological testing.
- The Partial Hospitalization Program and Intensive Outpatient Program require precertification for coverage.

Cardiac rehabilitation

Precertification is required for all services.

Chemotherapy

- Precertification is required for coverage of inpatient chemotherapy services.
- Procedures related to the administration of pre-approved chemotherapy medication do not require approval when performed in outpatient settings by a participating facility, provider office, outpatient hospital or ambulatory surgery center.

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

Court-ordered services

Precertification is required for coverage of all services. Nonparticipating providers require an authorization.

Dental services

- Members may self-refer for dental checkups and cleaning exams. Dental benefits are administered through our network vendor DentaQuest, available at **800-895-2218**.
- Preventive, diagnostic and treatment services are covered for members under age 21. Preventive services, extractions and emergency services are available for members age 21 and over.
- Pregnant women receive preventive, diagnostic and treatment services. Orthodontia is covered for special problems.

For temporomandibular joint (TMJ) disorder services, see the ***Plastic/cosmetic/reconstructive surgery*** *section of this QRC.*

Dermatology services

- Precertification is not required for network providers for Evaluation and Management (E&M), testing, or most procedures.
- Services considered cosmetic in nature or related to previous cosmetic procedures are not covered.

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

Diagnostic testing

- Precertification is not required for routine diagnostic testing.
- Precertification through Carelon Medical Benefits Management, Inc. is required for coverage of computed tomography angiography (CTA), magnetic resonance angiogram (MRA), MRI, CT scan, nuclear cardiology, stress echocardiography, transesophageal echocardiography, echocardiogram and PET scan. Contact Carelon Medical Benefits Management, Inc. by phone at **800-714-0040** or online at **www.carelon.com**. Carelon Medical Benefits Management, Inc. will locate a preferred imaging facility from the Amerigroup network of radiology service providers.
- Registered users may visit **www.providerportal.com**.

Disposable medical supplies

- Precertification is not 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)

- **All DME billed with an RR modifier (rental) requires precertification.**
- Precertification is required for coverage of certain prosthetics, orthotics and DME.
- Precertification is not required for network providers for coverage of glucometers, nebulizers, dialysis and end-stage renal disease (ESRD) equipment, gradient pressure aid, UV light therapy, sphygmomanometers, or walkers.
- Request precertification by submitting supporting clinical information and completing a *Certificate of Medical Necessity (CMN)* (available at **https://providers.amerigroup.com/GA**) or by submitting a physician order and a *Precertification 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 (CPAP) devices, lymphedema pumps, osteogenesis stimulators, seat-lift mechanisms, power-operated vehicles, external infusion pumps and oxygen tanks. Amerigroup and the provider must agree on HCPCS and/or other codes for billing covered services.
- Precertification for all custom wheelchairs require a medical director's review.
- Orthopedic shoes, hearing aids and supportive devices for feet (not a basic part of a leg brace) are not covered for members age 21 and older.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visit

- Members may self-refer for these services.
- Vaccine serums are received under the Vaccines for Children Program (VFC).
- Use the EPSDT schedule and document visits.

Educational consultation

No notification or precertification is required if a member visits a participating provider.

Emergency room (ER)

- No notification is required for emergency care given in the ER.
- If emergency care results in admission, notify Amerigroup within 24 hours or the next business day of the admission.

Ear, nose and throat (ENT) services (otolaryngology)

- Precertification is not required for network provider E&M, testing, and most procedures.
- Precertification is required for tonsillectomy and/or adenoidectomy, nasal/sinus surgery, cochlear implant surgery/services, and tympanostomy.

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

Family planning/sexually transmitted infection (STI) care

- Members may self-refer to an in-network provider.
- Precertification is required for out-of-network care.
- Covered services include pelvic and breast examinations, lab work, medications (including biologic medications), genetic counseling, and devices and supplies related to family planning (e.g., intrauterine device IUD).
- Infertility services and treatment are **not** covered.

Gastroenterology services

- E&M, testing, and most procedures do not require precertification for network providers.
- Precertification is required for upper endoscopy and bariatric surgery, including insertion, removal and/or replacement of adjustable gastric restrictive devices and subcutaneous port components.

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

Gynecology

- Members may self-refer to participating providers.
- Precertification is not required for E&M, testing, or most procedures.

Hearing aids

- Hearing aids are not covered for members age 21 and older.

Hearing screening

- Notification/precertification is not required for coverage of diagnostic and screening tests, hearing aid evaluations, or counseling.
- Hearing screening is not covered for members age 21 and older.

Home health care

- Precertification is required for skilled nursing and home health aide services. Rehabilitation therapy, drugs and DME require separate precertification.
- Covered services include skilled nursing; care by a home health aide; physical, occupational and speech therapy services; and physician-ordered supplies.
- Services not covered include social services, chore services, Meals on Wheels and audiology services.
- All service requests should be completed by submitting a physician order.

Hospital admission

- Elective admissions require precertification for coverage.
- Emergency admissions require notification within 24 hours or by the next business day.
- For preadmission testing, see the provider referral directory for a complete listing of our preferred lab vendors.
- Same-day admission is required for surgeries.
- There is no coverage for rest cures, personal comfort or convenience items, or services and supplies not directly related to the care of the patient (e.g., telephone chargers, take-home supplies and similar items).

Laboratory services (outpatient)

- All laboratory services furnished by nonparticipating providers require precertification, except 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 one of our preferred lab vendors. See the provider referral directory for a complete listing of participating vendors.

Refer to the provider manual for more information on laboratory services.

Neurology

- No precertification is required for network providers for E&M or testing.
- Precertification is required for neurosurgery, spinal fusion and artificial intervertebral disc surgery.

*See the **Diagnostic testing** section in this QRC.*

Observation

- No precertification or notification is required for in-network observation.
- If observation results in admission, notify Amerigroup within 24 hours or by the next business day.

Obstetrical care

- Precertification is not required for coverage of obstetrical (OB) services, including OB visits, diagnostic testing and laboratory services when performed by a participating provider.
- Notify Amerigroup after the first prenatal visit.
- No precertification is required for coverage of labor and delivery, but notification to Amerigroup is required upon admission to the hospital.
- No precertification is required for circumcision of newborns up to 12 weeks in age.
- No precertification is required for the ordering physician for OB diagnostic testing.
- Notification of delivery is required within 24 hours, including newborn information.
- **Contact us to learn about our OB case management program for high-risk members.**

*See the **Diagnostic testing** section in this QRC.*

Opthalmology

- No precertification is required for E&M, testing, or most procedures.
- Precertification is required for repair of eyelid defects.
- Services considered cosmetic in nature are not covered.

Oral maxillofacial

- No precertification is required for coverage of oral maxillofacial E&M services.
- All other services require precertification for coverage.

*See the **Plastic/cosmetic/reconstructive surgery** section of this QRC.*

Otolaryngology

*See the **ENT services (otolaryngology)** section of this QRC.*

Out-of-area/out-of-plan care

Precertification is required except for coverage of emergency care (including self-referral).

Outpatient/ambulatory surgery

See specific category for precertification requirements.

Pain management

Precertification is required for coverage of all services and procedures.

Pharmacy

- Benefits under Pharmacy Services cover medically necessary prescription and certain over-the-counter (OTC) medications prescribed by a licensed provider.
- Exceptions and restrictions exist as the benefit is provided under a closed formulary or the *Preferred Drug List (PDL)*.
- Please refer to the PDL (available at https://providers.amerigroup.com/QuickTools/Pages/FormularyCaid.aspx) for the preferred products within therapeutic categories, as well as requirements around generics, precertification, step therapy, quantity edits and the precertification process.
- Most self-injectable drugs are available as a pharmacy benefit through CarelonRx Specialty Pharmacy and may require precertification by Amerigroup. Once you receive a precertification approval notice, please call CarelonRx Specialty Pharmacy at 1-833-255-0646.
- Drugs administered as a medical benefit are available through CVS CareMark Specialty Pharmacy. Once you receive precertification from Amerigroup, please call CVS CareMark Specialty Pharmacy at 1-877-254-0015 or fax orders to 1-866-336-8479.
- The following injectable drugs and their counterparts in the same therapeutic class are examples of medications that require precertification by Amerigroup (by calling 1-800-454-3730) when administered from a provider's supply as a Medical benefit:
  - Synagis®, Epogen®, Procrit®, Aranesp®, Neupogen®, Neulasta®, Neumega®, Leukine®, intravenous immunoglobulin (IVIG), Enbrel®, Remicade®, Kineret®, Humira®, Amevive®, Synvisc®, Erbitux®, Avastin®, Rituxan®, Camptosar®, Eloxatin®, Gemzar®, Ixempra®, Tasigna®, Taxol®, Taxotere®, growth hormone, Xolair®, Lupron®, Zoladex®, Botox®, Cinryze®, Mozobil®, Nplate®, octreotide, Berinert®, hemophilia-factor products
- To determine if a specific medication requires precertification, please refer to our **Precertification Lookup Tool** on our provider self-service site.

Physiatry

Precertification is required for coverage of all services and procedures related to pain management.

Physical medicine and rehabilitation

Precertification is required for coverage of all services and procedures related to pain management.

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

Plastic/cosmetic/reconstructive surgery (including oral maxillofacial services)

- No precertification is required for coverage of E&M services and oral maxillofacial E&M services.
- All other services require precertification for coverage.
- Services considered cosmetic in nature and services related to previous cosmetic procedures are not covered.
- Reduction mammoplasty requires a medical director's review.
- Precertification 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 this QRC.*

Podiatry

- No precertification is required for coverage of E&M testing or most procedures provided by a participating podiatrist.
- 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.

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

Radiation therapy

- Precertification is required for coverage of some radiation treatment such as intracavitary, intraoperative, interstitial and stereotactic radiation.
- Precertification is not required for coverage of radiation therapy procedures when performed by a participating facility or provider in the following outpatient settings: office, outpatient, hospital or ambulatory surgery center.

Radiology services

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

Rehabilitation therapy (short-term): occupational, physical, rehabilitative and speech therapies

- Precertification from Amerigroup is required for treatment beyond the initial evaluation.
- Services covered for members under age 21 when medically necessary:
  - Medically necessary — refers to services prescribed by a physician or other licensed practitioner which, pursuant to the EPSDT program, diagnose, correct or ameliorate defects, physical and mental illnesses, and health conditions, whether or not such services are in the state plan.
    - Correct or ameliorate — means to improve or maintain a child´s health, compensate for a health problem, prevent a problem from worsening, prevent the development of additional health problems, or improve or maintain a child's overall health, even if treatment or services will not cure the health problem.
  - Duplication of services will be denied as medically unnecessary. Duplicated services are defined as therapy services that provide the same general areas of treatment, treatment goals, or ranges of specific treatment or processing codes (notwithstanding a difference in the setting, intensity or modalities of skilled services) and address the same types and degrees of disability as other concurrently provided services (via an individualized education plan IEP or other community- or hospital-based provider).
- Services are covered for members 21 and older when medically necessary for short-term rehabilitation.

Skilled nursing facility

Precertification is required.

Sleep study

Precertification is required.

Sterilization

- Sterilization services are a covered benefit for members age 21 and older.
- No precertification or notification is required for sterilization procedures including tubal ligation and vasectomy.
- **A sterilization consent form is required for claims submission.**
- Reversal of sterilization is **not** a covered benefit.

Transplants

- Precertification is required.
- Heart, lung, and heart and lung transplants are not covered for members age 21 and older.

Transportation

- No precertification or notification is required, except for coverage of planned air transportation (airplane or helicopter).
- Nonemergent transportation is covered under Medicaid Fee-for-Service. Call Member Services at 1-800-600-4441 for assistance in locating the nonemergent medical transportation (NEMT) vendor in your region.
- For PeachCare for Kids® members, contact Member Services at 1-800-600-4441 to arrange NEMT.

Urgent care center

No notification or precertification is required.

Vision services

- Members may self-refer to a participating provider.
- Members under 21 receive routine refractions, routine eye exams and medically necessary contacts or eyeglasses as part of the EPSDT benefit every 12 months.
- Members 21 and over receive an additional benefit including routine refractions, routine eye exams, and medically necessary contacts or eyeglasses every 12 months; a $10 copay is required.
- Diabetic retinal exams are covered for all ages.

Well-woman exam

- Members may self-refer to an in-network provider.
- Well-woman exams are covered once per calendar year when performed by the PCP or in-network gynecologist. Exam includes routine lab work, STI screening, Pap test and mammogram for women 35 and older.

Routine (RV) codes

To the extent the following services are covered benefits, precertification 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

Important contact information

Our service partners

Avesis (vision services)	**866-522-5923** (Member Services) **800-231-0979** (general)
DentaQuest (dental services)	**800-516-0124**
CarelonRx, Inc. (Retail pharmacy help desk)	**833-235-2031**
Carelon Medical Benefits Management, Inc. (medical necessity review, precertification for high-tech imaging services)	**800-714-0040**

Provider experience program

Our Provider Services team offers precertification, automated member eligibility, claims status, health education materials, outreach services, case and disease management, pharmacy Peer-to-Peer consults, and more. Call **800-454-3730**, Monday-Friday, 7 a.m.-7 p.m. Eastern time.

Provider self-service site and interactive voice response (IVR) available 24 hours a day, 7 days a week:
To verify eligibility, check claims and referral authorization statuses, or look up precertification/notification requirements, visit **https://providers.amerigroup.com/GA**.

If you can't access the internet, call Provider Services and say your NPI when prompted by the recorded voice. The recording guides you through our menu of options — Just select the information or materials you need when you hear it.

Claims services

Timely filing is within 180 calendar days of the date of service.

Electronic data interchange (EDI)

Call our EDI hotline at **800-590-5745** to get started. We accept claims through three clearinghouses:

- Emdeon (payer 27514)
- Capario (payer 28804)
- Availity (payer 26375)

Paper claims

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

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

Payment disputes

Claims payment disputes, or grievances, must be filed within 90 calendar days of the adjudication date of the *Explanation of Payment*. Forms for appeals are available on our provider self-service site. Mail to:

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

Medical appeals

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 postservice/retrospective appeals, the member, a member's authorized representative or a provider may file a postservice 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

Health services

Care management services — 800-454-3730

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

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

DMCCU services include educational information about community support agencies and events in the state of Georgia. Services are available for members with the following medical conditions: asthma, bipolar disorder, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD), diabetes, HIV/AIDS, hypertension, obesity, major depressive disorder, schizophrenia and transplants.

24-hour Nurse HelpLine — 800-600-4441

Members can call our 24-hour Nurse HelpLine for health advice 7 days a week, 365 days a year. When a member uses this service, a report is faxed to your office within 24 hours of receipt of the call.

Member Services — 800-600-4441

CarelonRx, Inc. is an independent company providing pharmacy benefit management services on behalf of the health plan. Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan.