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Amerigroup Community Care

Medical appeal process

February 2019

Coverage provided by Amerigroup Inc.

Topics covered

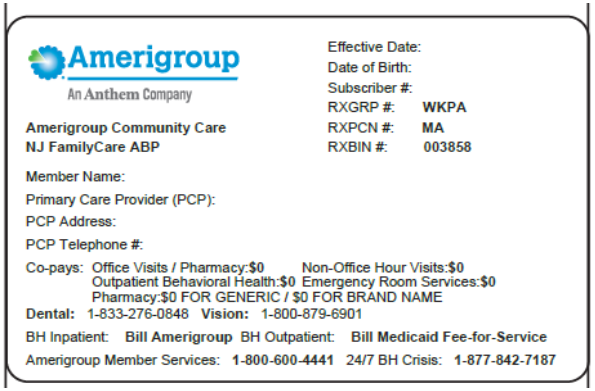
- Available products from Amerigroup
- Identifying an Amerigroup member
- Medicaid:
  - Medical/behavioral health (BH) appeal process definitions
  - Process for filing a medical/BH appeal
- Medicare:
  - Medical/BH appeal process definitions
  - Process for filing a medical/BH pre-service appeal
- Submitting an initial appeal request

Available products from Amerigroup

Line of business	Name	Eligibility	Plan description
Medicaid	NJ FamilyCare	Member meets state Medicaid requirements	Amerigroup coordinates Medicaid benefits
	MLTSS	Member meets state Medicaid requirements for MLTSS	Amerigroup coordinates Medicaid benefits
Medicare	Amerigroup Amerivantage (Medicare Advantage)	Member meets federal Medicare requirements	Amerigroup coordinates Medicare benefits and offers two different plans (Balance and Classic)
	Dual Special Needs Plan (FIDE SNP)	Member meets federal Medicare **and** state Medicaid requirements	Both Medicare and Medicaid benefits are coordinated by Amerigroup under one plan
	Chronic Special Needs Plan (CSNP)	Member meets federal Medicare requirements **and** has a diagnosis of end-stage renal disease (ESRD)	Amerigroup coordinates Medicare benefits

Identifying an Amerigroup member

NJ FamilyCare and MLTSS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Amerigroup Community Care
NJ FamilyCare ABP

Effective Date:
Date of Birth:
Subscriber #:
RXGRP #: WKPA
RXPCN #: MA
RXBIN #: 003858

Member Name:
Primary Care Provider (PCP):
PCP Address:
PCP Telephone #:

Co-pays: Office Visits / Pharmacy:$0 Non-Office Hour Visits:$0
Outpatient Behavioral Health:$0 Emergency Room Services:$0
Pharmacy:$0 FOR GENERIC / $0 FOR BRAND NAME

Dental: 1-833-276-0848 **Vision:** 1-800-879-6901

BH Inpatient: **Bill Amerigroup** BH Outpatient: **Bill Medicaid Fee-for-Service**

Amerigroup Member Services: **1-800-600-4441** 24/7 BH Crisis: **1-877-842-7187**


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Amerigroup Community Care
NJ FamilyCare A

Effective Date:
Date of Birth:
Subscriber #:
RXGRP #: WKPA
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RXBIN #: 003858

Member Name:
Primary Care Provider (PCP):
PCP Address:
PCP Telephone #:

Co-pays: Office Visits: $0 Emergency Room Visits: $0
Pharmacy: $0 FOR GENERIC / $0 FOR BRAND NAME

Dental: 1-833-276-0848 **Vision:** 1-800-879-6901

BH Inpatient: **Bill Amerigroup** BH Outpatient: **Bill Medicaid Fee-for-Service**

Amerigroup Member Services: **1-800-600-4441** 24/7 BH Crisis: **1-877-842-7187**


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Amerigroup Community Care
Managed Long Term Services and Supports

Effective Date:
Date of Birth:
Subscriber #:
RXGRP #: WKPA
RXPCN #: MA
RXBIN #: 003858

Member Name:
Primary Care Provider (PCP):
PCP Address:
PCP Telephone #:

Dental: 1-833-276-0848 **Vision:** 1-800-879-6901

Behavioral Health: **BILL AMERIGROUP**

Amerigroup Member Services: **1-800-600-4441** 24/7 BH Crisis: **1-877-842-7187**

Medicaid medical/BH appeal process definitions

NJ FamilyCare and MLTSS

Appeal type	Medicaid definition
Member pre-service	A request from a member or authorized representative, with member's written consent, to change an adverse determination made by the organization for care or service that requires a clinical review in order to determine whether covered or not, prior to the care or service being rendered
Member postservice	A request from a member or authorized representative, with member's written consent, to change an adverse determination made by the organization for payment of care or service that requires a clinical review in order to determine appropriate payment, including whether covered or not, after the care or service has been rendered
Provider pre-service	A request from a provider, not acting as an authorized representative on behalf of the member, to change an adverse determination made by the organization for care or service that requires a clinical review in order to determine whether covered or not, prior to the care or service being rendered
Provider postservice	A request from a provider, not acting as an authorized representative on behalf of the member, to change an adverse determination made by the organization for payment, care or service that requires a clinical review in order to determine appropriate payment, including whether covered or not, after the care or service has been rendered.

Note: Peer-to-peer review is **not** part of the medical/BH appeal process.

Process for filing a medical/BH internal appeal

NJ FamilyCare and MLTSS

Appeal Type	Requirement to initiate	Time frame to file	Review time frame
Member	• Request can be initiated verbally, but must be followed-up with a written request. • Authorized representatives must include a written member consent.	60 days from the date of the initial denial letter	• Standard = 30 days • Expedited = 72 hours
Provider	• Request must be submitted in writing. • No member written consent.	60 days from date of initial denial letter	• Standard = 30 days • Expedited = 72 hours

Note: Expedited handling is only appropriate if up to 30 calendar days to decide the appeal would cause serious harm to the member.

Process for filing a medical/BH external appeal

NJ FamilyCare, MLTSS and FIDE SNP

Appeal type	Requirement to initiate	Time frame to file	Review time frame
External appeal — administered by DOBI	• Used for review of medical necessity of health services • Exclusions include: PCA/PPP, chore services, social day, adult family and respite care, assisted living, home-delivered meals, home-based supportive care, etc. • Available to all members • Request must be in writing • Authorized representatives must include a written member consent	60 days from the date of the internal appeal letter	• Standard = 45 days • Expedited = 72 hours

Process for filing a medical/BH fair hearing

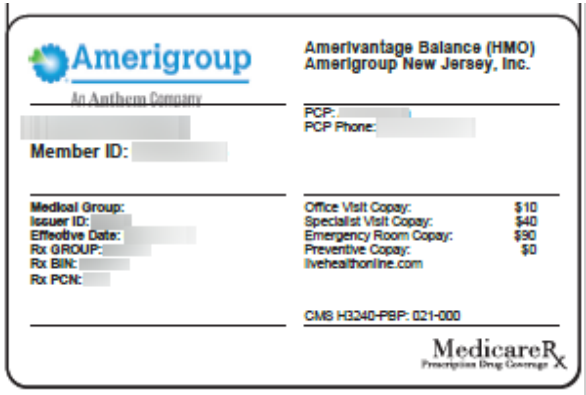
NJ FamilyCare, MLTSS and FIDE SNP

Appeal type	Requirement to initiate	Time frame to file	Review time frame
Fair hearing — administered by Office of Administrative Law (OAL)	• NJ FamilyCare Plan A and NJ FamilyCare Plan ABP members are eligible • Request must be submitted in writing by member to OAL • Use for medical and non-medical services • Provider cannot request a fair hearing	120 days from date of internal appeal letter	• Varies

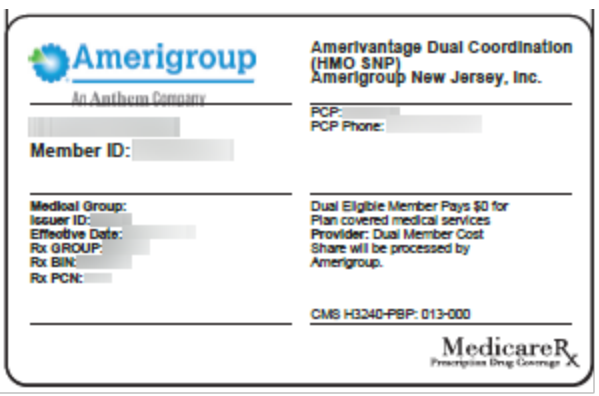
Identifying an Amerigroup Amerivantage member

Medicare Advantage HMO, FIDE SNP, CSNP (ESRD SNP)

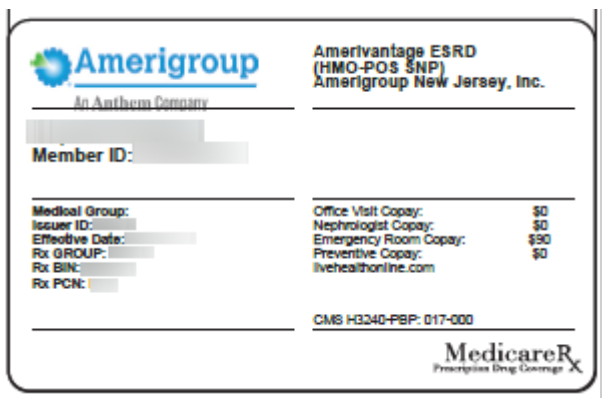
Medicare Advantage HMO Example:



FIDE SNP Example*:



CSNP (ESRD SNP) Example:



* FIDE SNP members have a single ID card for their Medicare and Medicaid benefits.

Medicare appeal process definitions

Amerigroup Amerivantage, FIDE SNP, CSNP

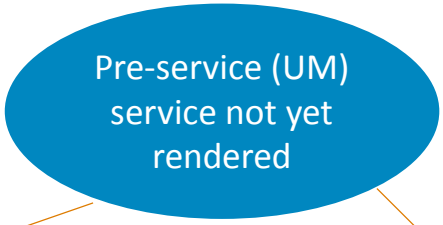
Appeal type	Medicare definition
Pre-service appeal (member or provider)	• Reconsideration of a utilization management decision* • The services have not yet been provided to the member
Postservice appeal (regulated) (member or provider)	• **Claims appeal**: the member has received the service • Member liability: o **Note:** While FIDE SNP members do not have a co-payment obligation, a post-service appeal that is not a contracted provider appeal under the terms of the provider agreement will be decided using the "member liability" or "regulated" appeal process. • Includes appeals by out-of-network providers on their own behalf with a waiver of liability
Postservice appeal (Nonregulated) (provider only)	• **Claims appeal:** the member has received the service • No member liability • Appeal brought by a contracted provider under the terms of the *Participating Provider Agreement*

***** Peer-to-peer review is **not** part of the appeal process.

Note: BH and medical appeals follow the same process.

Process for filing a pre-service appeal

Amerigroup Amerivantage, FIDE SNP, CSNP



Appeal time frame starts when the *Medicare Notice of Denial of Medical Coverage* is issued (integrated denial notice for FIDE SNP members).

Expedited appeal:

Urgent appeal where applying the standard procedure could seriously jeopardize the enrollee's life, health, or ability to regain maximum function

- 60 days to submit
- Verbal decision in 72 hours followed by written notice
- Can be submitted verbally
- Providers other than the treating physician may require an *Appointment of Representative* form

Standard appeal

- 60 days to submit
- Written decision in 30 days
- Can be submitted verbally for the FIDE SNP
- Providers other than the treating physician may require an *Appointment of Representative* form

Submitting an initial appeal request

Product	Medical	Behavioral health	Dental
• NJ FamilyCare • MLTSS	Amerigroup Community Care 101 Wood Ave. S., 8th Floor Iselin, NJ, 08830 1-800-600-4441 (TTY 711)	Amerigroup Community Care BH Appeals P.O. Box 62429 Virginia Beach, VA 23466-2429 1-800-600-4441 (TTY 711)	Amerigroup Community Care 101 Wood Ave. S., 8th Floor Iselin, NJ, 08830 1-800-600-4441 (TTY 711)
• Amerigroup Amerivantage • FIDE SNP • CSNP	Medicare Complaints, Appeals & Grievances **Mailstop:** OH0102-B325 4361 Irwin Simpson Road Mason, OH 45040 **Fax:** 1-888-458-1406	Medicare Complaints, Appeals & Grievances **Mailstop:** OH0102-B325 4361 Irwin Simpson Road Mason, OH 45040 **Fax:** 1-888-458-1406	Medicare Complaints, Appeals & Grievances **Mailstop:** OH0102-B325 4361 Irwin Simpson Road Mason, OH 45040 **Fax:** 1-888-458-1406

Note: Information on how to file an appeal will be provided on the denial notice.

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