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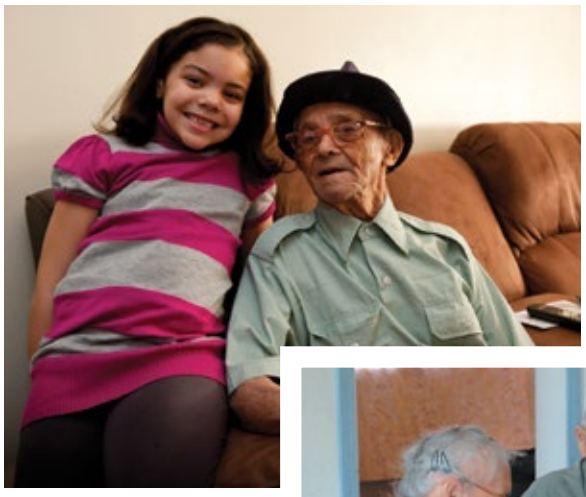

Solutions

Provider Manual

Amerigroup Community Care of New Mexico, Inc.

New Mexico Coordination of
Long-Term Services Program

How to apply for participation

If you are interested in applying for participation with Amerigroup Community Care of New Mexico, Inc., please visit us at providers.amerigroup.com/NM; or call a Provider Relations Representative at 505-875-4320.

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1 INTRODUCTION

Welcome to the Amerigroup Community Care network provider family. Incorporated as Amerigroup Community Care of New Mexico, Inc., we are pleased that you have joined a network that represents some of the finest health care providers in the state.

Amerigroup is a licensed health maintenance organization (HMO). We bring the best expertise available nationally to operate local community-based health care plans with experienced local staff to complement our operations. We are committed to assisting you in providing quality health care.

Amerigroup participates in the Coordination of Long-Term Services (CoLTS) program, a managed Medicaid program for persons with disabilities or advanced age that are eligible for Medicaid. Amerigroup was one of the two health plans selected to participate in the program in 2005. Design work for the CoLTS program started in November 2004 and has proceeded since that time with the State, selected contractors and stakeholders. We have been working collaboratively with the Human Services Department, Medical Assistance Division (HSD/MAD) and the Aging and Long Term Services Department (ALTSD) since this time to develop a comprehensive program that streamlines access to medical and home- and community-based waiver services for consumers and providers. This program extends statewide and includes:

- Standard New Mexico Medicaid benefits
- CoLTS “c” waiver (formerly the Disabled and Elderly waiver) services
- Personal Care Option (PCO) services
- Nursing facility services

We believe that hospitals, physicians and other 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 through a Participating Provider agreement.

If you are interested in participating in any of our quality improvement committees 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 our National Customer Care Department at 1-800-454-3730 with any suggestions, comments or questions that you may have. Together, we can arrange for and provide an integrated system of coordinated, efficient and quality care for our members and your patients.

2 OVERVIEW

Who is Amerigroup Community Care?
Amerigroup is a wholly owned subsidiary of Amerigroup Corporation. As a leader in managed health care services for the public sector, the Amerigroup Corporation subsidiary health plans provide health care coverage exclusively to low-income families, children, pregnant women, elderly, people with disabilities and those eligible for Medicare Advantage plans, including Special Needs Plans.

Mission
Our mission is to operate a community-focused managed care company with an emphasis on the public sector health care market. We will coordinate the members' physical and behavioral health care, offering a continuum of education, access, care and outcome programs, resulting in lower cost, improved quality and better health status for these individuals.

Strategy
Our strategy is to:

- Improve access to preventive primary care services by ensuring the selection of a Primary Care Provider (PCP) who will serve as provider, service manager and coordinator for all basic medical services
- Improve the health status and outcomes of members
- Educate members about their benefits, responsibilities and the appropriate use of health care services
- Encourage stable, long-term relationships between providers and members
- Discourage medically inappropriate use of specialists and emergency rooms
- Commit to community-based enterprises and community outreach
- Facilitate the integration of physical and behavioral health care
- Foster quality improvement mechanisms that actively involve providers in re-engineering health care delivery
- Encourage a customer service orientation with regular measurement of member and provider satisfaction

Summary
Escalating health care costs are driven in part by fragmented services and, quite often, unmanaged health problems of members. Amerigroup strives to educate members to encourage the appropriate use of the managed care system and to be involved in all aspects of their health care.

What is the Coordination of Long-Term Services (CoLTS) program?
The CoLTS program is a managed Medicaid program for persons with disabilities or advanced age, as well as certain other recipients of home- and community-based waiver services. CoLTS serves an estimated 38,000 Medicaid recipients statewide. CoLTS integrates primary, acute Medicaid services, Medicaid home- and community-based services (HCBS), and nursing facility and social services, and coordinates with Medicare services.

The CoLTS program has has been designed based on the following goals:

- Offer access to a choice of culturally responsive, appropriate and quality HCBS, as well as long-term-care facility services
- Provide a system of services that reduces stays in institutional settings by increasing access to less restrictive HCBS
- Promote improved health status and quality of life and reduced dependency on institutional care
- Use best practices from other states seeking to improve coordination and reduce fragmentation

CoLTS will be a mandatory program for those in the following categories:

- Individuals receiving Medicaid and residing in nursing facilities
- CoLTS "c" waiver participants
- Individuals aged 21 years or older who participate in the Personal Care Option (PCO)
- Dual-eligible individuals (individuals who are eligible for Medicaid and Medicare) not otherwise described above
- Mi Via participants who receive their eligibility through the CoLTS "c" waiver or the brain injury category of eligibility — for state health plan Medicaid services only

It is important to note that CoLTS is not limited to SSI recipients. Any Medicaid-eligible person that requires a nursing home level of care may be eligible to participate.

The benefits of the CoLTS program include:

- Promoting of services within the home and community in lieu of nursing home care
- Reintegrating of nursing home residents into the community via Money Follows the Person statute
- Streamlining access to care through a single point of contact, the Service Coordinator, for enrollees
- Simplifying access to care for dual-eligible members

Eligible members will receive all covered Medicaid State Plan services and additionally may be eligible for certain HCBS.

HCBS will include:

- Personal assistant services
- Adult day activity health services
- Home modifications
- Emergency response services
- Assisted living
- Physical therapy, occupational therapy and speech therapy for the purpose of maintaining function and not otherwise meeting the definition of skilled care
- Durable medical equipment (DME) and medical supplies not otherwise covered by the Medicaid benefit set

3 QUICK REFERENCE INFORMATION

providers.amerigroup.com
Amerigroup provides access to a website that contains the full complement of online provider resources. The website features an online provider inquiry tool for real-time eligibility, claims status and authorization status. In addition, the website provides general information that is helpful for the provider such as forms, a preferred drug list, drugs requiring a prior authorization, provider manuals, referral directories, provider newsletter, claims status, electronic remittance advice and electronic funds transfer information, updates, clinical guidelines, and other information to assist providers in working with Amerigroup. The website may be accessed at providers.amerigroup.com/NM.

Please call Provider Services at the National Customer Care Department for precertification/notification, health plan network information, member eligibility, claims information, inquiries and recommendations that you may have about improving our processes and managed care program.

Amerigroup Community Care Phone Numbers
Provider Services at the National Customer Care Department Telephone: 1-800-454-3730

Provider Services at the National Customer Care Department Fax: 1-800-964-3627

AT&T Relay Service: 1-800-855-2880

Automated Provider Inquiry Line for Member Eligibility: 1-800-454-3730

Nurse HelpLine: 1-800-600-4441

Member Services: 1-800-600-4441

- Member Services and Nurse HelpLine TTY: 1-800-855-2880

Pharmacy Services: 1-800-454-3730

  - Caremark: 1-800-378-5697

Dental services: Administered through DentaQuest

- DentaQuest Provider Services: 1-888-291-3765
- DentaQuest Member Services: 1-800-235-8849

Vision Services- Administered through Block Vision

- Block Vision Provider Services: 1-800-243-1401
- IVR (members/providers); 1-800-879-6901
- Block Vision Member Services: 1-800-428-8789
- Block Vision TTY: 1-800-735-2258

Amerigroup Electronic Data Interchange (EDI) Hotline: 1-800-590-5745

Amerigroup Local Health Plan: 1-877-269-5660

Health Plan Provider Relations: 1-877-269-5706

Precertification Fax

- Skilled nursing facility, DME, therapies: 1-866-920-8358
- PCO, CoLTS "c" waiver, disposable supplies, nonskilled nursing: 1-866-920-8356

Quality Management Fax: 1-866-920-8354

Transportation services: administered through Access2Care: 1-866-442-4937

Behavioral health services are carved out to the statewide entity, OptumHealth New Mexico: 1-866-660-7182

New Mexico Phone Numbers

New Mexico Aging and Long-Term Services Department: 1-800-432-2080

Human Services Department, Medical Assistance Division (HSD/MAD) Solution Center: 1-888-997-2583

Ongoing Provider Communications

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

Below you will find additional information that will assist you in your day-to-day interaction with Amerigroup.

Additional Information	
Member Eligibility	Contact the Provider Inquiry Line at 1-800-454-3730.
Notification/Precertification	• May be telephoned, submitted online or faxed to Amerigroup: Telephone: 1-800-454-3730 Fax: 1-800-964-3627 • Data required for complete notification/precertification: o Member ID number o Legible name of referring provider o Legible name of individual referred to provider o Number of visits/services o Date(s) of service o Diagnosis o CPT code • In addition, clinical information is required for precertification • Certification forms are located at providers.amerigroup.com
National Provider Identifier	**National Provider Identifier (NPI)** – The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires the adoption of a standard unique provider identifier for healthcare providers.

Additional Information	
	All Amerigroup participating providers must have an NPI number. NPI is a 10-digit intelligence-free numeric identifier. Intelligence free means the numbers do not carry information about healthcare providers such as the state in which they practice or their specialty. For more information about National Provider Identifier (NPI) and the application process, please visit www.hsd.state.nm.us/mad/npi.html. Providers can apply for an NPI by: • Completing the application online at https://nppes.cms.hhs.gov: estimated time to complete the NPI application is 20 minutes • Completing a paper copy by downloading it at https://nppes.cms.hhs.gov • Calling 1-800-465-3203 and requesting an application
Claims Information	• **Submit paper claims to:** Amerigroup Community Care of New Mexico, Inc. P.O. Box 61010 Virginia Beach, VA 23466-1010 • **Electronic claims payer ID:** o Emdeon (formerly WebMD) is 27514 o Capario (formerly MedAvant) is 28804 o Availity (formerly THIN) is 26375 • Timely filing requirement of a clean claim is within 90 days of the date of service or per the terms of the provider agreement • Amerigroup provides an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status and authorization status. Visit our website at providers.amerigroup.com/NM • If you are unable to access the internet, you may receive claims, eligibility and authorization status over the telephone at anytime by calling our toll-free automated Provider Inquiry Line at 1-800-454-3730
Medical Necessity Appeals Information	• Medical appeals must be filed within 90 days of the date of the notice of action • **File a Medical Appeal to:** Amerigroup Payment Dispute Unit 6565 Americas Parkway NE, Suite 110

Additional Information	
	Albuquerque, NM 87110
Payment Dispute	• Provider has 45 calendar days from receipt of the Explanation of Payment (EOP) to request an informal claim dispute resolution review. Amerigroup will send a determination letter within 30 calendar days of receiving all necessary or required information. If the provider is dissatisfied with the resolution, the provider may submit an appeal of the resolution within 30 calendar days of receipt of the notification. • **File a Payment Dispute to:** Amerigroup Payment Disputes Unit P.O. Box 61599 Virginia Beach, VA 23466-1599
Grievances	**Provider grievances should be submitted to:** Amerigroup Community Care of New Mexico, Inc. Two Park Square 6565 Americas Parkway NE, Suite 110 Albuquerque, NM 87110
Service Coordinators	• Amerigroup Service Coordinators are available during normal business hours from 8:00 a.m. to 5:00 p.m. Mountain Time at 1-877-269-5660 • For urgent issues, assistance is available after normal business hours, weekends and on holidays through the Provider Services Line at 1-800-454-3730
Provider Service Representatives	For more information, contact Provider Services at 1-800-454-3730.
Local Contact	Provider Relations: 505-875-4320 or 1-877-269-5706

4 PRIMARY CARE PROVIDERS

Primary Care Providers

The Primary Care Provider (PCP) is a network provider who has the responsibility for the complete care of his or her patient, who is an Amerigroup member. The PCP serves as the entry point into the health care system for the member. The PCP is responsible for the complete care of his or her patient including, but not limited to, providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services, and maintaining continuity of care.

A PCP:

- May be a physician, certified nurse practitioner or physician assistant
- May include a specialist determined by Amerigroup on an individualized basis for members whose care is more appropriately managed by a specialist
- May be part of a faculty-led primary care team consisting of residents and a supervising faculty physician
- May include other network providers who meet our credentialing requirements as a PCP

The PCP's responsibilities include, at a minimum:

- Managing the medical and health care needs of members to assure that all medically necessary services are made available in a timely manner
- Monitoring and following up on care provided by other medical service providers for diagnosis and treatment, to include services available under Medicaid fee-for-service
- Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through fee-for-service Medicaid
- Promoting and providing preventive health care services
- Maintaining a medical record of all services rendered by the PCP and other referral providers

To participate in the program, the provider must be an authorized Indian Health Services, Tribal 638 or a licensed provider by the State before signing a contract with Amerigroup. Tribal 638, Indian Health Services, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) may function as a PCP.

A PCP must be a physician or nurse practitioner or other network provider/subcontractor who provides or arranges for the delivery of medical services to ensure that all services which are found to be medically necessary are made available in a timely manner. The PCP may practice in a solo or group setting or may practice in a clinic (e.g., a Federally Qualified Health Center or Rural Health Center) or outpatient clinic, including Tribal 638 or Indian Health Services clinics.

We encourage enrollees to select a PCP who provides preventive and primary medical care, as well as authorization and coordination of all medically necessary specialty services. If the member does not select a PCP, he or she will be assigned one. During a member's initial assessment, the member is encouraged to make an appointment with his or her PCP.

Providers must arrange for coverage of services to assigned members:

- In person or through an on-call physician 24 hours a day, 7 days a week
- By responding to emergency telephone calls from members within 30 minutes of receiving the calls
- By providing a minimum of 20 office hours per week as a PCP

Providers who furnish services to Medicaid recipients agree to comply with all federal and state laws and regulations relevant to the provision of medical services, including but not limited to, Title XIX of the Social Security Act, the Medicare and Medicaid Anti-Fraud Act, HIPAA and the state Medicaid Fraud Act. Providers also agree to conform to Medical Assistance Division (MAD) policies and instructions as specified in this manual and its appendices, as updated.

Providers must arrange for covered services to assigned members as follows:

- Emergencies are triaged through the PCP or by a hospital emergency room through medical screening or evaluation
- Urgent care is available within 24 hours of notification to the PCP or sooner as required by the medical exigencies of the case
- For both emergent and urgent care, the health plan ensures that PCPs provide 24 hours-a-day, 7 days-a-week access to triage services. Each PCP will have backup coverage by another provider.
- Routine appointments are scheduled as soon as practicable given the medical needs of the enrollee and the nature of the provider's medical practice. Appointments must be within 14 days unless the member requests a later time.
- Routine physical exams are scheduled within 30 days unless the member requests a later time
- All appointments are scheduled either during normal business hours or after hours (if applicable), depending upon the individual patient's needs and in accordance with the individual physician's scheduling practice
- Specialty care: Referrals to participating or nonparticipating specialty physicians or providers are accessible to enrollees on a timely and appropriate basis in accordance with generally accepted medical guidelines. For specialty outpatient referral and consultation appointments, the request-to-appointment time will generally be consistent with the clinical urgency, but no more than 21 days, unless the member requests a later time. For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time will be consistent with the clinical urgency, but no more than 14 days, unless the member requests a later time. For outpatient diagnostic laboratory, diagnostic imaging and other testing, if a walk-in rather than an appointment system is used, the member wait time will be consistent with severity of the clinical need. For urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability will be consistent with the clinical urgency but no longer than 48 hours.

PCP Specialties

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

- Family practitioners
- Federally qualified health centers and rural health centers
- Geriatricians
- General internists

- General pediatricians
- General practitioners
- Indian Health Services and Tribal 638 clinics
- Nurse practitioners certified as specialists in family practice or geriatrics
- Physician assistants who are certified by the National Commission on Certification of Physician Assistants, Inc. and licensed by the New Mexico Board of Medical Examiners may furnish services within the scope of his or her practice, as defined by state law; direction and supervision of physician assistants must be performed by licensed physicians who are enrolled Medicaid providers and are approved by the New Mexico Board of Medical Examiners as supervisory physicians.

PCP On-site Availability

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

- PCPs must offer 24 hours-a-day, 7 days-a-week telephone access for members
- A 24-hour telephone service may be used. The service may be answered by a designee such as an on-call physician, nurse practitioner and physician assistant with physician backup, an answering service or a pager system; however, this must be a confidential line for member information and/or questions. An answering machine is not acceptable. If an answering service or pager system is used, the call must be returned within 30 minutes.
- The PCP or another physician/nurse practitioner must be available to provide medically necessary services
- Covering physicians are required to follow the referral/precertification guidelines
- It is not acceptable to automatically direct the member to the emergency room when the PCP is not available
- We encourage our PCPs to offer after-hours office care in the evenings and on weekends

Provider Disenrollment Process

Providers may cease participating with Amerigroup for either mandatory or voluntary reasons.

Mandatory disenrollment occurs when a provider becomes unavailable due to immediate, unforeseen reasons. Examples of this include death and loss of license. Members are auto-assigned to another PCP to ensure members' continuous access to covered services, as appropriate. Amerigroup will notify members of any termination of PCPs or other providers from whom they receive ongoing care.

We will provide notice to affected members when a provider disenrolls for voluntary reasons, such as retirement. Providers must provide written notice to Amerigroup within the time frames specified in the participating provider agreement with Amerigroup. Members linked to a PCP who has disenrolled for voluntary reasons will be notified to self-select a new PCP.

We will make a good faith effort to provide written notice of a provider's termination within 15 days after receipt or issuance of termination to each member who received primary care from, or was treated by, the provider at least four times within the last 12 calendar months.

Member Enrollment

Medicaid recipients who meet the State's eligibility requirements for participation in the CoLTS program are eligible to join our health care plan. Members are enrolled without regard to the applicant's health status.

Medicaid members are enrolled in CoLTS for a period of 12 months, contingent upon continued CoLTS eligibility. The member may request a change of CoLTS plans at any time during the first 90 days following the date of the member's initial enrollment with Amerigroup. Unless the member loses eligibility or submits a written disenrollment request to change managed care service plans for cause, the member remains enrolled in a health plan for the remainder of the 12-month period.

Member Eligibility

HSD/MAD will determine financial eligibility for enrollment into the CoLTS program and a third-party assessor will determine clinical eligibility for CoLTS "c" waiver, PCO and NH populations. Mandatory populations include:

- Full benefit dual eligibles (members who have Medicaid and Medicare)
- Members 21 years of age or older who are receiving or who qualify for current Medicaid State Plan PCO services
- Members receiving Medicaid and residing in a nursing facility
- Members currently receiving, or who qualify for, CoLTS "c" home- and community-based waiver services
- Members in the Mi Via 1915(c) waiver who meet current CoLTS "c" waiver or brain injury categories of eligibility
- Native Americans that fall into one of the categories above

Excluded populations include individuals of any age who meet the following eligibility criteria:

- New Mexico's 1915(c) Developmental Disabilities
- New Mexico's 1915(c) Medically Fragile
- New Mexico's 1915(c) AIDS/AIDS-related Conditions (ARC) home- and community-based waivers
- Those eligible for Salud! who do not meet a nursing facility level of care
- Newborns (A newborn whose mother is a member of CoLTS at the time of the baby's birth is enrolled to Medicaid fee-for-service until the parent selects a Salud! MCO for the baby.)

Special Situations

Hospitalized Members

For a member who is hospitalized at the time of disenrollment from Amerigroup, whether disenrollment is due to disenrollment from CoLTS or an approved switch to another CoLTS MCO, Amerigroup will be responsible until the date of discharge for payment of all covered facility and professional services provided within a licensed acute care facility or nonpsychiatric specialty unit as designated by the New Mexico Department of Health.

For hospitalized members who are transferring into Amerigroup, the members' existing CoLTS MCO or fee-for-service Medicaid remains accountable through the members' discharge. **Note:** This situation does not apply to members transferring from CoLTS to Salud! or from Salud! to CoLTS.

Nursing Home Residents
For a member who is receiving services in a nursing facility at the time of disenrollment from Amerigroup, whether disenrollment is due to disenrollment from CoLTS or an approved switch to another CoLTS MCO, Amerigroup will be responsible for covered services through the last date of the month in which the member is enrolled in Amerigroup. The new health plan assumes the cost of the ongoing nursing facility care on the first date of the month the members becomes eligible for a new health plan.

Amerigroup assumes nursing home liability on the first date the member is assigned to Amerigroup and continues that responsibility until the last date of the month assigned to Amerigroup.

Members Eligibility Listing

The PCP will receive a listing of his or her panel of assigned members monthly. If a member calls to change his or her PCP, the change will be effective the next business day. The PCP should verify that each member receiving treatment in his or her office is on the membership listing. If a PCP does not receive the list in a timely manner, he or she should contact a Provider Relations representative. For questions regarding a member's eligibility, providers may access Amerigroup at providers.amerigroup.com or call the automated Provider Inquiry Line at 1-800-454-3730. Member information will be available to providers within 24 hours of receipt of the enrollment roster. This will be available through providers.amerigroup.com.

Providers can report changes in PCP panel capacity to an Amerigroup Provider Representative at any time.

The first day that a member is assigned to Amerigroup, providers will be able to check the member's eligibility at the New Mexico Medicaid Portal at https://nmmedicaid.acs-inc.com/nm/secure/publicHome.do and the Medicaid Eligibility Verification System (MEVS) www.state.nm.us/hsd/mad/pdf_files/Regs/MEVSlist.pdf.

Member Identification Cards

Each Amerigroup eligible member will be provided an identification card, which identifies the member as a participant in the Amerigroup program. The identification card will include:

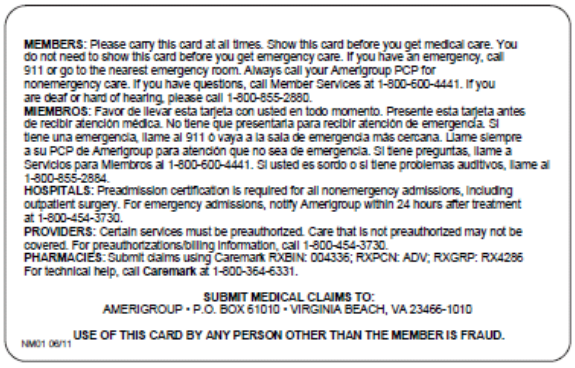
- The member's identification number
- The member's name (first and last name and middle initial)
- The member's date of birth
- The member's enrollment effective date
- Toll-free phone numbers for information and/or authorizations
- Toll-free Nurse HelpLine 24 hours a day, 7 days a week
- Descriptions of procedures to be followed for emergency or special services

- PCP name, address and telephone number
- Toll-free line for OptumHealth New Mexico behavioral health services

Amerigroup member identification card sample:

Front

Back



Note: There is no PCP name and address information on the dual-eligible member ID Card.

Member Payment Liability

New Mexico's CoLTS and federal regulations prohibit providers from charging members for covered services except in specific, limited circumstances. Providers are required to accept our determination of payment for covered services as payment in full, except for copayments and any other patient liability payment as authorized by law.

Americans with Disabilities Act Requirements

Our policies and procedures are designed to promote compliance with the Americans with Disabilities Act of 1990. Providers are required to take actions to remove existing barriers and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes:

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

Medically Necessary Services

Medically necessary services means clinical and rehabilitative physical, mental or behavioral health services that are:

- Essential to prevent, diagnose or treat medical conditions or are essential to enable the member to attain, maintain or regain the member's optimal functional capacity
- Delivered in the amount, duration, scope and setting that is both sufficient and effective to reasonably achieve their purposes and clinically appropriate to the specific physical, mental and behavioral health care needs of the member

- Provided within professionally accepted standards of practice and national guidelines
- Required to meet the physical, mental and behavioral health needs of the member and are not primarily for the convenience of the member, the provider or Amerigroup

Amerigroup is required to provide medically necessary services. AMERIGROUP applies the definition of medically necessary services for CoLTS consistent with the following:

- A determination that a health care service is medically necessary does not mean that the health care service is a covered service or an amendment, modification or expansion of a covered service
- Amerigroup, making the determination of medical necessity of clinical, rehabilitative and supportive services consistent with the Medicaid covered benefit package applicable to an eligible individual, will do so by:
    - Evaluating an individual's physical, mental and behavioral health information provided by qualified professionals who have personally evaluated the individual within their scope of practice, taken into consideration the individual's clinical history, including the impact of previous treatment and service interventions, and consulted with other qualified health care professionals with applicable specialty training, as appropriate
    - Considering the views and choices of the individual or the individual's legal guardian, agent or surrogate decision-maker regarding the proposed covered service as provided by the clinician or through independent verification of those views
    - Considering the services being provided concurrently by other service delivery systems.
- Physical health services will not be denied solely because the member has a poor prognosis; required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible individual solely because of the diagnosis, type of illness or condition
- Decisions regarding benefit coverage for children will be governed by EPSDT coverage rules to the extent they are applicable

Affirmative Statement

Amerigroup makes medical necessity decisions based on the appropriateness of care or service and benefit coverage. Amerigroup does not specifically reward practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for utilization management decision-makers and providers do not encourage decisions that result in underutilization.

New Technology

The Amerigroup Medical Director and participating doctors review and evaluate new medical advances in technology, or the new application of existing technology, in medical procedures, pharmaceuticals and devices 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 or new application of existing technology must provide equal or better outcomes than the existing covered benefit treatment or therapy.

Public Health Offices

Amerigroup coordinates with public health offices regarding the following services as required by applicable federal and New Mexico state laws.

- Sexually transmitted disease services, including screening, diagnosis, treatment, follow-up and contact investigations
- HIV prevention counseling, testing and early intervention
- Tuberculosis screening, diagnosis and treatment
- Disease outbreak prevention and management, including reporting according to New Mexico law and regulations, responding to epidemiology requests for information and coordination with epidemiology investigations and studies
- Referral and coordination to ensure maximum participation in the Supplemental Food Program for Women, Infants and Children (WIC)
- Health education services for individuals and families with a particular focus on injury prevention, including car seat use, domestic violence and lifestyle issues; and tobacco use, exercise, nutrition and substance use
- Development and support for family support programs, such as home visiting programs for families of newborns and other at-risk families and parenting education
- Participation and support for local health councils to create healthier and safer communities with a focus on coordination of efforts, such as DWI councils, maternal and child health councils, tobacco coalitions, safety counsel, safe kids and others

Indian Health Services and Tribal Health Centers

In order to promote culturally sensitive, convenient health care services to our members, Amerigroup supports members who are Native American to seek care from any Indian Health Services (IHS) or Tribal provider defined in the Indian Health Care Improvement Act, 25 U.S.C. §§1601, et seq.), whether or not the provider participates in the Amerigroup provider network.

Amerigroup will not prevent members who are IHS beneficiaries from seeking care from IHS and Tribal Providers or from network providers due to their status as Native Americans.

Precertification is not required for services provided within the IHS and Tribal 638 network.

Amerigroup will accept from any individual provider employed by the IHS or Tribal 638 facility a current license to practice in the United States or its territories as meeting licensure requirements.

5 AMERIGROUP HEALTH CARE BENEFITS AND COPAYMENTS

Amerigroup Covered Services

The following list shows the health care services and benefits that Amerigroup covers for CoLTS members.

Covered Services	Limitations or Exclusions
Adaptive Aid Supply	Adaptive aids are devices, controls, or medically necessary supplies/appliances that enable persons with functional impairments to increase their ability to perform activities of daily living, control the environment in which they live, and ensure safety, security, and accessibility.
Adult Day Health Services/Day Health Services	Adult day health services are generally provided for 2 or more hours per day on a regularly scheduled basis for 1 or more days per week by a licensed adult day-care, community-based facility that offers health and social services to assist members to achieve optimal functioning. Private duty nursing services and skilled maintenance therapies (physical, occupational and speech) may be provided in conjunction with adult day health services by the adult day health provider or by another provider. The private duty nursing and skilled maintenance therapies must be provided in a private setting at the facility. Service is limited to those members approved for CoLTS "c" waiver services only.
Ambulatory Surgical Services	Ambulatory surgical center facility services, as required by the condition of the member and if the following conditions are met: • The surgical procedure and use of the facility are medically necessary and are covered • All Amerigroup requirements for the surgery such as applicable consent forms or precertification requirements are met by the physician • The facility must be a CMS-certified or an IHS Tribal 638 ambulatory surgical center
Anesthesia Services	Amerigroup covers anesthesia and monitoring services which are medically necessary for performance of surgical or diagnostic procedures.
Assisted Living/ Residential Care Services	Services include residential services such as personal support services, companion services and assistance with medication administration. Service covered for those members approved for CoLTS "c" waiver services only.
Audiology Services	Amerigroup covers audiologic and/or vestibular function studies rendered by an audiologist or a physician. Additionally, the following services are covered when furnished by physicians, licensed audiologists or licensed hearing aid dealers: • Hearing aid purchase, rental, loans, repairs, hearing aid repair and handling, and replacements; binaural hearing aid fitting will be covered for a recipient with bilateral hearing loss who is attending an educational institution, seeking employment or currently employed or for individuals with a current history of binaural fitting; binaural hearing aid fitting will be considered on a case-by-case basis for a legally blind individual

	• Hearing aid accessories and supplies, including the batteries required after the initial supply furnished at the time the hearing aid is dispensed • Hearing aid insurance against loss and breakage up to 4 years for all purchased hearing aids; hearing aid insurance is required when the aid is dispensed; 4 years of hearing aid insurance is required for recipients under 21 years of age, nursing home residents and recipients who are mentally retarded • Replacement of hearing aids is limited to the provisions of the hearing aid insurance; the providers are responsible for obtaining insurance for every hearing aid purchased • Amerigroup does not pay for hearing aid checks; hearing aid selection and fitting is considered included in the hearing aid dispensing fee and will not be reimbursed separately
Behavioral Health Services	Behavioral health (BH) services, other than those delivered by Amerigroup providers, are the responsibility of OptumHealth New Mexico (1-866-660-7182). Amerigroup providers are expected to screen members for BH disorders (validated screening tools are available on the Amerigroup website at providers.amerigroup.com/NM) When members screen positive for primary or co-occurring disorders, Amerigroup providers should evaluate the appropriateness of a referral to BH specialty care. The following are common indicators for possible referral to BH services: • Suicidal/homicidal ideation or behavior • At-risk of hospitalization due to a BH condition • Children or adolescents at imminent risk of out-of-home placement • Trauma victims (abuse or neglect) • Serious threat of physical or sexual abuse or risk of life or health due to impaired mental status • Request by member, parent, or legal guardian for BH services • Clinical status that suggests the need for BH services • Identified psychosocial stressors and precipitants • Treatment nonadherence complicated by behavioral characteristics • Behavioral, psychiatric, or substance abuse factors influencing a medical condition • Victims or perpetrators of abuse or neglect • Nonmedical management of substance abuse • Follow-up to medical detoxification • Initial PCP contact or routine physical examination, including lab values, indicating a substance abuse or mental health problem • A prenatal visit indicating a substance abuse or mental health problem • A pattern of inappropriate use of medical, surgical, trauma, urgent care or emergency room services that could be related to substance abuse or other BH conditions • Persistence of serious functional impairment When a referral is made for BH specialty care, Amerigroup providers should

	coordinate care with the BH provider as appropriate, with appropriate member, parent or guardian consent.
Blood Lead Screening	Providers will furnish a screening program for the presence of lead toxicity in children that consists of a screening and blood test. During every EPSDT visit for children between the ages of 6 months and 6 years old, the PCP will screen each child for lead poisoning. A blood test will be performed at 12 months and 24 months of age to determine lead exposure and toxicity. In addition, children over the age of 24 months and up to 72 months should receive a blood screening lead test if there is not a past record of a test. Members 9 to 15 months old (ideally 12 months old) will receive a blood lead measurement at least once. Please see blood lead risk forms located in Appendix A – Forms.
Clinic Services	Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and End Stage Renal Disease Clinics (ESRDs) will provide covered services including preventive, diagnostic, therapeutic, rehabilitative or palliative services in their service region.
Community Relocation Specialist Services	Amerigroup covers community relocation specialist services, which are specialized services provided while the member is a resident in an institutional setting and during the member's transition to and residence in the community. These services may include but are not limited to: • Assessing the member's needs and assisting the member to arrange for and procure needed resources for the move from the institution to the community, such as establishing Medicaid medical and financial eligibility for HCBS and eligibility for other HSD programs; identifying needed state plan or other services; coordinating the array of services and providers needed on or after the move, and arranging the time-sensitive transition services • Developing a comprehensive person-centered, community-based services and transition plan • Carefully monitoring the first 60 days the member resides in the community to make certain that services are delivered according to the plan and are sufficient to meet the member's needs, and the member is comfortable and safe in his or her environment • Ensuring the member has an opportunity to educate/train his or her respective caregivers • Ensuring that the member's service plan is implemented as written • Linking the individual to appropriate home and community-based services Service is limited to those members approved for CoLTS "c" waiver services and nursing facility residents with Money Follow the Person.
Community Transition Goods and Services	Amerigroup covers community transitional goods and services incurred by members who are transitioning from an institutional setting to the community. These services may include such things as security deposits, essential household furnishings and moving expenses required to occupy a community domicile, setup fees or deposits for utility or service access, and services necessary for the member's health and safety. This is a service available for members residing in nursing facilities.

	Covered for members that have been in a nursing home level of care on a long-term basis that are reintegrating into the community. Coverage is limited to a $2,500 lifetime benefit. The following are examples of covered services: • Deposit for rent • Utilities • Household goods • Clothing • Community transition specialist • Medicaid services as applicable
Dental Services	Preventive services are limited to: • Oral exams • Prophylaxis (cleaning) • Fluoride treatment • Molar sealants • Space maintenance • Dental X-rays Comprehensive services are limited to: • Emergency services • Diagnostic services • Restorative services • Endodontics/periodontics/extractions • Oral exam and prophylaxis are limited to one every 6 months for individuals under 21 years of age • Oral exam and prophylaxis are limited to one per year for individuals 21 years of age or older • Oral exam and prophylaxis are limited to one every 6 months for individuals 21 years of age or older who have developmental disabilities • Fluoride treatments are limited to one every 6 months for individuals under 21 years of age • Fluoride treatments are not covered for individuals 21 years of age or older unless determined to be medically necessary • Sealants covered for permanent molars for individuals under 21 years of age; each eligible member can receive one treatment per tooth every 5 years; sealants are not covered when an occlusal restoration has been completed on the tooth • Diagnostic services are limited to one clinical oral examination every 6 months for individuals under 21 years of age • Diagnostic services are limited to one clinical oral examination per year for individuals 21 years of age or older • Dental X-rays: ○ One intraoral complete series every 3 years (includes bitewing X-rays)

	○ Additional bitewings X-rays once every 12 months ○ Panoramic films can be substituted for intraoral complete series and is limited to one every 3 years • Endodontic services – therapeutic pulpotomy for members under 21 years of age if performed on a primary or permanent tooth and no periapical lesion is present on a radiograph • Periodontic services – certain periodontic surgical, nonsurgical and other periodontic services subject to certain limitations ○ Collaborative practice dental hygienists may provide periodontal scaling and root planning, per quadrant after diagnosis by a dentist ○ Collaborative practice dental hygienists may provide periodontal maintenance procedures with precertification • Removable prosthodontic services – Two denture adjustments per calendar year per recipient; also repairs to complete and partial dentures • Fixed prosthodontic services – One recementation of a fixed bridge is covered • Oral surgery services: coverage includes local anesthesia and routine post-operative care; erupted surgical extractions are defined as extractions requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth and closure ○ Autogenous tooth reimplantation of a permanent tooth is covered for members under 21 years of age ○ Incision and drainage of an abscess is covered for all recipients Amerigroup does not cover dental services that are performed for aesthetic or cosmetic purposes. Amerigroup covers orthodontic services only for recipients less than 21 years of age and only when specific criteria are met.
Diagnostic Imaging and Therapeutic Radiology Services	Amerigroup covers medically necessary imaging, blood flow measurement, plethysmographic examinations and radiology services ordered by physicians or other licensed practitioners, which are either performed by the ordering providers or under their supervision in their office or furnished by a radiology laboratory that meets the requirements for Medicaid participation. Amerigroup also covers medically necessary-related services, including treatment planning, minor surgical procedures and injections. Benefits cover all X-ray services ordered by a physician and provided by independent laboratories and portable X-ray facilities. An X-ray facility is defined as a facility licensed by the appropriate state authority and not part of a hospital, clinic or physician's office. Amerigroup does not pay an additional amount for contrast media except in the following instances: • Radioactive isotopes • Nonionic radiographic contrast material • Gadolinium salts used in magnetic resonance imaging Reimbursement for imaging procedures includes all materials and minor services

	necessary to perform the procedure. Kits, films or supplies are not covered.
Durable Medical Equipment	Amerigroup covers Durable Medical Equipment (DME) that meet the definition of DME, medical necessity criteria and precertification requirements. Amerigroup covers repairs, maintenance, delivery of durable medical equipment and disposable and nonreusable items essential for use of the equipment, subject to the limitations specified in this section. All items purchased or rented must be ordered by providers who are currently enrolled in Medicaid. • Durable medical equipment is defined as equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not useful to individuals in the absence of an illness or injury and is appropriate for use at home • Equipment used in a recipient's residence must be used exclusively by the recipient for whom it was approved • To meet the medical necessity criterion, durable medical equipment must be necessary for the treatment of an illness or injury or to improve the functioning of a body part • Replacement of equipment is limited to one item every 3 years for adults, unless otherwise approved by the Medical Director Amerigroup covers medical supplies that are necessary for an ongoing course of treatment within the limits specified in this section. As distinguished from DME, medical supplies are disposable and nonreusable items. Amerigroup also covers oxygen, nutritional products and shipping charges as specified in this section. Coverage for DME and medical supplies may be limited for recipients in institutional settings when the institutions are expected to provide the necessary items. Institutional settings are hospitals, nursing facilities, intermediate care facilities for the mentally retarded and rehabilitation facilities. **Covered Services for Noninstitutionalized Recipients** Amerigroup covers certain medical supplies, nutritional products and durable medical equipment provided to eligible noninstitutionalized recipients without precertification. The following are covered for noninstitutionalized members: • Needles, syringes and intravenous (IV) equipment, including pumps for administration of drugs, hyper alimentation or enteral feedings • Diabetic supplies, chemical reagents, including blood, urine and stool testing reagents • Gauze, bandages, dressings, pads and tape • Catheters, colostomy, ileostomy and urostomy supplies, and urinary drainage supplies • Parenteral nutritional support products prescribed by a physician on the basis of a specific medical indication for a recipient who has a defined and specific pathophysiologic process for which nutritional support is considered specifically therapeutic and for which regular food, blenderized food or commercially available retail consumer nutritional supplements would not meet medical needs • Apnea monitors: precertification is required if the monitor is needed for 6

	months or longer • Disposable sterile gloves are limited to 200 per month; disposable nonsterile gloves are limited to 200 per month Exceptions on the limitations above are determined on a case-by-case basis by the Medical Director. **Covered Services for Institutionalized and Noninstitutionalized Recipients** Amerigroup covers the following items without precertification for both institutionalized and noninstitutionalized recipients: • Trusses and anatomical supports that do not need to be made to measure • Family planning devices • Repairs to DME; Amerigroup covers repair and replacement parts if recipients own the equipment for which the repair is necessary and the equipment being repaired is a covered Medicaid benefit; some replacement items used in repairs may require precertification; repairs to augmentative and alternative communication devices require precertification • Monthly rental includes monthly service and repairs • Replacement batteries and battery packs for augmentative and alternative communication devices owned by the recipient **Covered Oxygen and Oxygen Administration Equipment** Amerigroup covers the following oxygen and oxygen administration systems, within the specified limitations: • Oxygen contents, including oxygen gas and liquid oxygen • Oxygen administration equipment purchase with precertification: oxygen administration equipment may be supplied on a rental basis for 1 month without precertification; rental beyond the initial month requires precertification • Oxygen concentrators, liquid oxygen systems and compressed gaseous oxygen tank systems; Medicaid approves the most economical oxygen delivery system possible for a specific recipient when considering types of oxygen concentrators • Cylinder carts, humidifiers, regulators and flow meters • Purchase of cannulae or masks • Oxygen tents and croup or pediatric tents Amerigroup does not cover oxygen tank rental (demurrage) charges as separate charges when renting gaseous tank oxygen systems. If Amerigroup pays rental charges for systems, tank rental is included in the rental payments. Nursing homes are administratively responsible for overseeing oxygen supplied to their residents. Nursing homes are encouraged to collaborate with Amerigroup to ensure the delivery of oxygen to nursing home residents is seamless. **Augmentative and Alternative Communication Devices** Amerigroup covers medically necessary electronic or manual augmentative communication devices for Medicaid recipients. Medical necessity is determined by

	the medical assistance division or its designee(s). Communication devices whose purpose is also educational and/or vocational are covered only when it has been determined the device meets medical criteria.
	• A recipient must have the cognitive ability to use the augmentative communication device and meet one of the following criteria:
	  o The recipient cannot functionally communicate verbally or through gestures due to various medical conditions in which speech is not expected to be restored
	  o The recipient cannot verbally or through gestures participate in his or her own health care decisions (i.e., making decisions regarding medical care or indicating medical needs or communicating informed consent on medical decisions)
	• All of the following criteria must be met before an augmentative communication device can be considered for authorization. The communication device must be:
	  o A reasonable and necessary part of the recipient's treatment plan
	  o Consistent with the symptoms, diagnosis or medical condition of the illness or injury under treatment
	  o Not furnished for the convenience of the recipient, the family, the attending practitioner or other practitioner or supplier
	  o Necessary and consistent with generally accepted professional medical standards of care (i.e., not experimental or investigational)
	  o Established as safe and effective for the recipient's treatment protocol
	  o Furnished at the most appropriate level suitable for use in the recipient's home environment
	
	Rental of Durable Medical Equipment
	Amerigroup covers the rental of durable medical equipment. All rental payments must be applied toward purchase of the equipment. When the rental charges equal the amount allowed by Amerigroup for purchase, the equipment becomes the property of the recipient for whom it was approved.
	• Amerigroup covers routine maintenance and repairs for rental equipment as may be medically necessary.
	• Low-cost items, defined as those items for which the Medicaid allowed payment is less than $150, may only be purchased. Purchased DME becomes the property of the Medicaid recipient for whom it was approved. Amerigroup will address repairs or maintenance needs for member-owned DME on a case-by-case basis as may be medically necessary.
	• Oxygen concentrators, ventilators, stationary and portable liquid oxygen systems are not subject to the mandatory provisions of applying the rental payments toward purchase.
	
	Delivery of equipment and shipping charges: Amerigroup covers the delivery of DME only when the equipment is initially purchased or rented and if an out-of-home repair is required. Providers may bill delivery charges as separate additional charges only when the providers customarily charge a separate amount for delivery to non-

	Medicaid patients. Amerigroup does not pay delivery charges for equipment purchased by Medicare, for which Amerigroup is responsible only for the coinsurance and deductible. Amerigroup covers shipping charges for DME and medical supplies when it is cost effective or practical to ship items rather than have recipients travel to pick up items. Shipping charges are defined as the actual cost of shipping items from providers to recipients by a means other than that of provider delivery. Amerigroup does not pay shipping charges for items purchased by Medicare for which Amerigroup is only responsible for the coinsurance and deductible. Rental and purchase of used equipment: Amerigroup covers the rental and purchase of used equipment. The equipment must be identified and billed as used equipment. The equipment must have a statement of condition or warranty, and a stated policy covering liability. **Wheelchairs and Seating Systems for Institutionalized and Noninstitutionalized Recipients** Amerigroup covers customized wheelchairs and seating systems made for specific recipients, including recipients who are institutionalized. Written precertification is required. Amerigroup cannot give verbal authorizations for customized wheelchairs/seating systems. A customized wheelchair and seating system is defined as one that has been uniquely constructed or substantially modified for a specific recipient and is so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes. There must be a customization of the frame for the wheelchair base or seating system to be considered customized. Repairs to a wheelchair owned by a recipient residing in an institution may be covered. Customized or motorized wheelchairs required by an institutional recipient to pursue educational or employment activity outside the institution may be covered and will be reviewed on a case-by-case basis. Amerigroup does not cover durable medical equipment or medical supplies that meet any of the following criteria: • Items that are not generally accepted by the medical profession as being therapeutically effective • Hospital or physician diagnostic items • Instruments or devices manufactured for use by physicians, such as esophageal dilator • Items not essential to the administration of moist heat therapy, such as hydrocollator heating units • Exercise equipment not primarily medical in nature • Items that produce no demonstrable therapeutic effect, such as myoflex muscle stimulators

	• Support exercise equipment primarily for institutional use, such as parallel bars • Items that are not reasonable or necessary for monitoring the pulse of homebound recipients with or without cardiac pacemakers, such as pulse tachometers • Items that are used to improve appearance or for comfort purposes, such as sauna baths or wigs

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) or Well-Child Services	Amerigroup covers medically necessary health services furnished to eligible recipients. Services provided under EPSDT can only be accessed following an initial health screening service, called the Tot-To-Teen HealthCheck or a HealthCheck referral. This section describes general EPSDT services, the Tot-To-Teen HealthCheck and information given to eligible recipients about the services available under EPSDT. Specific EPSDT services, service providers and reimbursement for services are covered in subsequent sections of the manual.
	
	EPSDT includes a screening component. For New Mexico Medicaid, the screen is called the Tot-To-Teen HealthCheck. EPSDT also includes diagnostic, treatment and other necessary health care measures needed to correct or ameliorate physical and mental illnesses or conditions discovered during the Tot-To-Teen HealthCheck by the screening providers or during a HealthCheck referral.
	
	EPSDT programs cover screening and diagnostic services to determine physical or mental defects in recipients under age 21, except for newborns, as well as health care and other measures to correct or ameliorate any defects and chronic conditions discovered. All medically necessary EPSDT services are covered with no limitations or exclusions.
	
	A Tot-To-Teen HealthCheck can be performed during an office visit for an acute illness as long as the illness does not affect the results or the screening process.
	• Screening schedule for medical components – New Mexico Tot-To-Teen HealthCheck periodicity schedule allows for a total of 20 screens
	  ○ Under age 1: 6 screening/examination visits (1, 2, 4, 6, 9 and 12 months)
	  ○ Ages 1 – 5: 6 screening/examination visits (15, 18 and 24 months; 3, 4 and 5 years)
	  ○ Ages 6 – 14: 5 screening/examination visits (6, 8, 10, 12 and 14 years)
	  ○ Ages 15 – 20: 3 screening/examination visits (16, 18 and 20 years)
	• Complete medical screens include the following:
	  ○ Comprehensive health and developmental history, including an assessment of both physical and mental health development
	  ○ Comprehensive unclothed physical exam
	  ○ Appropriate immunizations, according to age and health history, unless medically contraindicated at the time
	  ○ Laboratory tests, including an appropriate lead blood level assessment
	  ○ Health education, including anticipatory guidance
	• Additional covered medical screens:

	○ Dental examinations performed at intervals which meet reasonable dental standards. Usually these examinations are furnished every 6 months; however, examinations can be furnished at other intervals as medically necessary. ○ Vision examinations performed at intervals which meet reasonable vision standards or at other intervals as medically necessary. A vision examination should be furnished before the recipient reaches 3 years of age and again prior to 5 years of age or prior to entering school. If no abnormalities are found, vision screenings should be furnished every 2 years and a complete examination furnished if indicated. ○ Hearing tests performed at intervals which meet reasonable standards or at other intervals as medically necessary for the diagnosis or treatment of defects in hearing. A hearing test using an audiogram should be given at 5 years of age or prior to entering school. Annual examinations should be furnished if abnormalities are identified. ○ Mental health examinations should be performed at intervals which meet reasonable standards or at other intervals as medically necessary for the diagnosis or treatment of mental illness. ○ Other necessary health care or diagnostic screens or examinations.
EPSDT Personal Care	Amerigroup covers EPSDT personal care services that are delivered pursuant to an individualized treatment plan. Personal care services provide a range of services to consumers who are unable to perform some/all activities of daily living (ADLs) or instrumental activities of daily living (IADLs) because of a disability or a functional limitation(s). A prescribed course of regular personal care services and daily living assistance permits a person to live in his or her home rather than an institution and allows him or her to achieve the highest possible level of independence. These services include, but are not limited to, such activities as bathing, dressing, grooming, eating, toileting, shopping, transporting, caring for assistance animals, cognitive assistance and communicating. An individual may be physically capable of performing ADLs or IADLs but may have limitations in performing these activities because of a cognitive impairment. Personal care services may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task. In such cases, personal care may include cuing along with supervision to ensure that the individual performs the task properly. **Eligible Population** Recipients of personal care services must meet all of the following eligibility criteria: • Be eligible for Medicaid at the time services are furnished • Be under the age of 21 • Have a medical condition, established by the recipient's PCP, that limits the recipient's physical functional or cognitive ability to such a degree that it adversely affects the recipient's overall ability to meet his or her physical requirements, excluding age-specific physical developmental needs, and results in the recipient's need for assistance with personal care • Have an individualized treatment plan developed by the Service Coordinator in

	conjunction with the recipient, if age-appropriate, parent(s) or guardian(s), primary care physician, and other appropriate health provider(s) **Coverage Criteria** Personal care services are defined as medically necessary tasks pertaining to a recipient's physical or cognitive functional ability. The goal of the provision of care is to avoid institutionalization and maintain the recipient's functional level. Services are covered under the following criteria: • The recipient must have a need for assistance with at least two physical requirements, such as eating, bathing, dressing and toileting activities, appropriate to his or her age • Personal care services must be medically necessary, prescribed by the recipient's PCP and included in the recipient's individualized treatment plan • The need for personal care services is evaluated based on the availability of family members, natural supports, such as other community resources and/or friends that can aid in providing such care • Personal care services must be provided with the consent of the recipient's parent(s) or guardian(s), if the recipient is under age 18, with the recipient's consent, if over age 18 and if the recipient is able to provide consent • Personal care services that are medically necessary are furnished in the recipient's place of residence and outside the home when medically necessary and when not available through other existing benefits and programs such as home health, early intervention or school programs; personal care services are services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded or institution for mental illness • Personal care services that are medically necessary for attending school are furnished in partnership with the recipient's school as an alternative to the recipient's participation in a homebound program; the personal care services should foster the child's independence; personal care services are furnished based on approval by Amerigroup and only to eligible recipients and not to others in the school setting • Services must be provided by a personal care attendant who is trained and has successfully demonstrated competency to provide assistance with personal care such as bathing, dressing, eating and toileting; the personal care attendant is employed by the personal care provider and works under the supervision of a registered nurse who is licensed in the State of New Mexico and employed by the personal care provider • The supervisory registered nurse must be employed or contracted by the personal care provider and have 1 year direct-patient-care experience; the supervisory registered nurse is also responsible for conducting and documenting visits to the member's residence for the purpose of assessing the recipient's progress and personal care attendant's performance **Covered Services**

	Amerigroup covers the following personal care services: • Help with basic personal care services, including bathing, care of the teeth, hair and nails, assistance with dressing, and assistance with toileting activities • Assistance with eating and other nutritional activities, when medically necessary, i.e., due to documented weight loss or other physical effects • Cognitive assistance such as prompting or cuing **Noncovered Services** The following services are not covered by Amerigroup: • Any task that must be provided by a person with professional or technical training, such as but not limited to: insertion and irrigation of catheters, nebulizer treatments, irrigation of body cavities, performance of bowel stimulation, application of sterile dressings involving prescription medications and aseptic techniques, tube feedings and administration of medications • Services that are not in the recipient's approved treatment plan and for which prior approval has not been received • Services not considered medically necessary for the condition of the recipient
EPSDT Private Duty Nursing	Amerigroup covers the following private duty nursing services: • Skilled nursing services furnished to recipients at home • Skilled nursing services which are medically necessary for attending school and furnished to the recipient in the school setting; these services are an alternative to the recipient's participation in a homebound program; nursing services are furnished only to eligible recipients and not to others in the school setting **Noncovered Services** Amerigroup does not cover the following specific services: • Services for which prior approval has not been received or which are not included in the recipient's approved treatment plan • Services not considered medically necessary for the condition of the recipient • Services which are not within the scope of practice of the nursing profession **Nursing Care Plan** The need for skilled nursing services must be included in the recipient's individualized treatment plan. A nursing care plan must be developed within 14 days of the initiation of services. The plan must contain the following: • Statement of the nature of the specific problem and the specific needs of the recipient • Description of the functional level of the recipient as documented by the primary care physician's clinical evaluation, including mental status, intellectual functioning and medical necessity, which identify and document the need for a private duty nurse • Specific clinical problems relating to: o Physical assessment needs, including the identification of durable medical equipment or medical supplies needed by the recipient o Psychosocial evaluation, including level of support from family in reaching

	projected clinical goals o Medication history, including status of compliance o Applicable clinical interventions related to the identified clinical problem, including measurable goals • Statement of the least restrictive conditions necessary to achieve the goals identified in the plan • Description of intermediate and long-range goals with the projected timetable for their attainment and duration and scope of services • Statement and rationale of the nursing care plan for achieving these intermediate and long-range goals, including provisions for the review and modification of the plan • Specification of nursing responsibilities, description of the proposed nursing care, orders for medication(s), treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the recipient • Plan for discontinuation of services, criteria for discontinuation of services and projected date of service discontinuation
Emergency and Poststabilization Services	Emergency and medically necessary poststabilization services do not require a referral or precertification. While Amerigroup does not require a referral or precertification for emergency services, we do request notification for poststabilization care so that we may assist the member in scheduling the needed services. 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 • For a pregnant woman having contractions: (i) there must be adequate time to effect a safe transfer to another hospital before delivery or (ii) transfer may pose a threat to the health or safety of the woman or the unborn child
Emergency Response System	Emergency response services provide an electronic device that enables members to secure help in an emergency. The member may also wear a portable help button to allow for mobility. The system is connected to the member's phone and programmed to signal a response center when the help button is activated. The response center is staffed by trained professionals. Amerigroup covers emergency response services which include testing and maintaining equipment; training members, caregivers and first responders on the use of the equipment; 24-hour monitoring for alarms; checking systems monthly or

	more frequently, if warranted by electrical outages, severe weather, etc.; and reporting member emergencies and changes in the member's condition that may affect service delivery. Emergency categories consist of emergency response, emergency response high need, and emergency response installation/disconnect. Covered for CoLTS "c" waiver eligible members only.
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 • Pregnancy termination services The following services are not covered: • Sterilization reversals • Fertility drugs • In vitro fertilization • Artificial insemination • Hysterectomies performed for the sole purpose of family planning
Home Health Services	Amerigroup covers home health services which are skilled, intermittent, and medically necessary. Services must be ordered by the member's attending physician and included in the plan of care established by the recipient's attending physician in consultation with home health agency staff. The plan of care must be reviewed, signed and dated by the attending physician. Covered services include: • Skilled nursing services • Home health aide services • Physical and occupational therapy services • Speech therapy services The following home health agency services are not covered: • Services beyond the initial evaluation which are furnished without prior approval • Home health services which are not skilled, intermittent and medically necessary • Services furnished to members who do not meet the eligibility criteria for home health services • Services furnished to recipients in places other than their place of residence • Services furnished to recipients who reside in intermediate care facilities for the mentally retarded or nursing faciltiy residents who require a high nursing faciltiy level of service

	• Skilled nursing services which are not supervised by registered nurses • Services not included in written plans of care established by physicians in consultation with the home health agency staff • Physical, occupational and speech therapy can be furnished to residents of nursing facilities who require a low level of service
Home Modifications	Home modifications are covered for CoLTS "c" waiver eligible members only. Home modifications are those physical adaptations to the home, required by the beneficiary's support plan, which are medically necessary to avoid institutional placement of the beneficiary and enable him or her to function with greater independence in the home. Home modifications are also known as Environmental Accessibility Adaptations (EAA). • Home modifications, adaptations or improvements cannot be part of any new construction. • Any repairs to the existing home which are not of direct medical or remedial benefit to the individual and automobile/vehicle retrofitting will not be approved • No duplicate adaptations modifications or improvements can be made • Services are limited to $5,000 every 5 years. Additional services may be requested if a member's health and safety needs exceed the specified limit
Hospice Services	Amerigroup covers hospice core services furnished to eligible recipients that are reasonable and necessary for the palliation or symptom management of a recipient's terminal illness and related conditions. Hospice core services include the medications, durable medical equipment and medical supplies needed to deliver palliative care. Amerigroup covers the following nursing, medical social service, physician and counseling services as core hospice services: • Nursing services furnished by or under the supervision of registered nurses and based on the treatment plan and recognized standards of practice • Medical social services furnished by a qualified social worker under the direction of a physician • Physician services performed by a doctor of medicine or osteopathy, including palliation and management of terminal illness and related conditions and the recipient's general medical needs not met by the recipient's attending physician • Counseling services available to recipients and family members; counseling can be furnished for training families to provide care and preparing recipients and families to adjust to the recipient's approaching death; counseling includes dietary, spiritual and other counseling for recipients and families and bereavement counseling furnished after a recipient's death; the following counseling services must be furnished by hospices: o Organized program of bereavement services under the supervision of qualified professionals; the plan of care for these services must reflect family needs and provide a clear outline of the type, frequency and duration of

	counseling; bereavement counseling is a required but nonreimbursed service ○ Dietary counseling, when applicable, furnished by qualified professionals ○ Spiritual counseling, including notice to recipients of the availability of clergy ○ Other counseling furnished by members of the interdisciplinary group or other qualified professionals • Home health aide and homemaker services at frequencies sufficient to meet the needs of recipients; home health aides must meet training and qualification requirements; registered nurses must visit a recipient's residence every 2 weeks to assess the performance of the aide or homemaker services • Physical therapy, occupational therapy and speech-language therapy must be available if needed to control symptoms or maintain activities of daily living • Durable medical equipment, medical supplies, and pharmacy services related to the palliation and management of the terminal illness and related conditions: ○ Amerigroup covers only drugs and biologicals defined in Section 1861 (t) of the Social Security Act and used primarily for pain relief and symptom control related to terminal illness; all drugs and biologicals must be administered in accordance with accepted standards of practice ○ Every hospice must have a policy for the disposal of controlled drugs kept in the recipient's home when those drugs are no longer needed ○ Drugs and biologicals are to be administered only by the following individuals: ▪ A licensed nurse or physician ▪ The recipient with the approval of the attending physician ▪ Any other individual in accordance with applicable state and local laws; the individual and each drug and biological they are authorized to administer must be specified in the recipient's plan of care • Short-term inpatient services for pain control and symptom management delivered in a facility which is a Medicaid provider • Short-term inpatient respite services furnished in a facility which is a Medicaid provider; Amerigroup covers 5 consecutive days of inpatient respite care which can be needed on an infrequent basis to provide respite for the recipient's family or primary caregivers ○ The need for and duration of inpatient respite services must be specified in the treatment plan ○ Inpatient respite must be furnished by a hospice facility, hospital, or nursing facility that meets the requirements in 42 CFR Section 418.100 **Continuous Nursing Care Services** Amerigroup covers continuous nursing care required to achieve pain control and symptom management. Continuous care can be covered during a period of crisis if the recipient needs such care to achieve palliation and manage acute medical symptoms at home. • To be considered continuous care, nursing care must be furnished for 8 consecutive hours in a 24-hour period. Amerigroup covers the homemaker

	and/or aide services furnished during the other 16 hours as routine home care • Amerigroup covers continuous nursing services for a maximum of 72 consecutive hours **Certification of Terminal Illness** To be eligible for hospice care, a physician must provide a written certification that the recipient has a terminal illness. The hospice must obtain a written certification statement signed by the hospice medical director, physician member of the hospice interdisciplinary team or recipient's attending physician that the recipient is terminally ill. The physician must sign the written certification within 7 calendar days of the date services are initiated. Certification statements must include information that is based on the recipient's medical prognosis, and the life expectancy is 6 months or less if the terminal illness runs its typical course. If a recipient receives hospice benefits beyond 210 days, the hospice must obtain a written recertification statement from the hospice medical director or the physician member of the hospice interdisciplinary group before the 210-day period expires. Hospice benefits furnished beyond the 210-day period may be subject to medical review. **Election of Hospice Care** Recipients who are eligible for hospice care must elect to receive hospice services. Recipients or their legal representatives elect hospice services by filing an election statement with a particular hospice designee. For the duration of the election, recipients who elect hospice care waive their right to Medicaid payment for the following services: • Services related to treatment of the terminal condition or related condition for which hospice care was elected • Services equivalent to hospice care, such as home health services, and private duty nursing services under enhanced EPSDT Recipients who are receiving home- and community-based waiver services or other in-home services based on a plan of care must have the plan of care coordinated with the hospice provider and adjusted as necessary to avoid duplicative or unnecessary services. Hospice coverage continues for 210-day time periods, as long as recipients remain in hospice care and do not cancel the election. Recipients or their representatives can designate an effective date for the election. The effective date begins with the first or any subsequent day of hospice services. **Election Statement**

	The election statement must include the following elements: • Designation of the hospice that will provide care • Designation of the recipient's attending physician • Acknowledgement that the recipients or representatives has been given a full understanding of the palliative rather than curative nature of hospice care • Effective date of the election • The recipient's or the representative's signature **Revocation of Hospice Care Services** A recipient or representative can cancel the election of hospice care at any time by filing a statement with Amerigroup. The statement must include the following information: • Recipient is revoking his or her election for Medicaid coverage of hospice care • Effective date of the revocation, which is not earlier than the actual date of the revocation • The recipient's or the representative's signature Upon revocation of the election of hospice services, recipients are no longer covered for Medicaid hospice services. Recipients can elect to receive hospice care services again at any time. The same process for approval of services must be followed when the second election occurs. A new plan of care, certification statement, and election statement must be submitted to Amerigroup. **Change of Designated Hospice** Recipients or their representatives can change designated hospice providers by filing statements with Amerigroup. A statement must contain the following information: • Name of the hospice the recipient is leaving • Name of the hospice the recipient is entering • Effective date of the change A change in ownership or name of a hospice is not considered a change in the recipient's designated hospice.
Hospital Outpatient Services	Amerigroup covers outpatient services which are medically necessary for prevention, diagnosis or rehabilitation as indicated by the condition of members. Covered hospital outpatient care includes the use of minor surgery or cast rooms, intravenous infusions, catheter changes, first aid care of injuries, laboratory and radiology services, and diagnostic and therapeutic radiation, including radioactive isotopes. The following specific outpatient benefits are not covered: • Outpatient hospital services not considered medically necessary for the condition of the recipient • Outpatient hospital services that require prior approval for which the approval

	was not requested • Outpatient hospital services furnished to individuals who were not eligible for Medicaid on the date of service • Experimental or investigational procedures, technologies or therapies and the services related to them, including hospitalization, anesthesiology, laboratory tests and imaging services • Drugs classified as ineffective by the federal Food and Drug Administration • Laboratory specimen handling or mailing charges • Formal educational or vocational services which relate to traditional academic subjects or training for employment
Hysterectomies /Sterilizations	Hysterectomy is a covered benefit for members at the time of consent only if: • The member is mentally competent; mentally incompetent is a declaration of incompetency as made by a federal, state, or local court; a recipient can be declared competent by the court for a specific purpose, including the ability to consent to sterilization • The member is not institutionalized in a correctional facility/mental hospital or rehabilitative facility • The member is informed orally and in writing that the hysterectomy will render the member permanently incapable of reproducing • The member has signed and dated a Patient's Acknowledgement of Prior Receipt of Hysterectomy Information form (located in Appendix A – Forms) prior to the procedure • Hysterectomy is not a covered benefit if performed solely for the purpose of rendering the member permanently incapable of reproducing, or if more than one purpose for performing the hysterectomy and the primary purpose is to render the member permanently incapable of reproducing or if performed for the purpose of cancer prophylaxis 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 • Members seeking sterilization must be given information regarding the procedure and the results before signing a consent form. This explanation must include the fact that sterilization is a final, irreversible procedure. Members must be informed of the risks and benefits associated with the procedure • Members seeking sterilization must also be instructed that their consent can be withdrawn at any time prior to the performance of the procedure and that they do not lose any other Medicaid benefits as a result of the decision to have or not have the procedure • The member voluntarily gives informed consent including executing a New Mexico MAD 345 Sterilization Consent form. This form is located on the New Mexico Human Services Department website at

	http://www.hsd.state.nm.us/mad/pdf_files/Forms/MAD-345.pdf. o 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 at least 72 hours have passed since the informed consent for sterilization was signed. In the case of premature delivery, the informed consent must have been given at least 30 calendar days before the expected date of delivery (the expected date of delivery must be on the consent form). o The consent is not valid if obtained during labor or childbirth, while the recipient is under the influence of alcohol or other drugs, or is seeking or obtaining a procedure to terminate pregnancy. o Providers obtaining the consent for sterilization must certify that to the best of their knowledge that the recipient is eligible, competent, and voluntarily signed the informed consent. o Providers must provide an interpreter if needed to ensure that the recipient understands the information furnished. o The recipient is given a copy of the completed, signed consent form and the original is placed in the recipient's medical record. Amerigroup covers medically necessary methods, procedures, pharmaceutical supplies and devices to prevent unintended pregnancy, or contraception, including oral contraceptives, condoms, intrauterine devices (IUD), depoprovera injections, diaphragms, and foams. Amerigroup does not cover the following specific services: • Sterilization reversals • Fertility drugs • In vitro fertilization • Artificial insemination • Hysterectomies performed for the sole purpose of family planning
Inpatient Hospital Services	Amerigroup covers inpatient hospital, and emergency services which are medically necessary for the diagnosis and/or treatment of illness or injury or required by the condition of the recipient. Amerigroup covers items or services ordinarily furnished by hospitals for the care and treatment of patients. The following specific inpatient hospital service benefits are not covered: • Hospital services which are not considered medically necessary for the condition of the recipient • Hospital services that require prior approval for which the approval was not requested • Hospital services which are furnished to individuals who were not eligible for Medicaid on the date of service • Experimental or investigational procedures, technologies or therapies and the

	services related to them, including hospitalization, anesthesiology, laboratory tests and imaging services • Drugs classified as ineffective by the federal Food and Drug Administration • Private duty or incremental nursing services • Laboratory specimen handling or mailing charges • Formal educational or vocational training services which relate to traditional academic subjects or training for employment
Laboratory Services	Amerigroup covers all laboratory services ordered by a physician and provided by independent laboratories. An independent laboratory is defined as a facility licensed by the appropriate state authority and not part of a hospital, clinic or physician's office. Amerigroup covers medically necessary laboratory services ordered by physicians or other licensed Medicaid providers which are either performed by ordering providers or under their supervision in an office laboratory or furnished by a clinical laboratory that meets the requirements for Medicaid participation. **Professional Component** A professional component associated with clinical laboratory services is payable only when the work is actually performed by a pathologist who is not billing for the complete procedure and is covered only for anatomic and surgical pathology including cytopathology, histopathology, bone marrow biopsy and pathology consultation. **Specimen Collection Fees** Amerigroup covers specimen collection fees when drawn by venipuncture, arterial stick, or collected by urethral catheterization, unless the member is in a nursing home or is a hospital inpatient. The following specific laboratory services are not covered: • Clinical laboratory professional components, except as specifically described under covered services above • Specimens, including Pap smears, collected in a physician's office or a similar facility and conveyed to a second physician's office, office laboratory or noncertified laboratory • Laboratory specimen handling or mailing charges • Specimen collection fees other than those specifically indicated in covered services • Laboratory specimen collection fees for recipients in nursing facilities or inpatient hospital settings Amerigroup covers laboratory and radiology services when a behavioral health provider orders lab or radiology work that is performed by an outside, independent laboratory or radiology facility, including those lab and radiology services provided for persons within a psychiatric unit, a freestanding psychiatric hospital or the UNMH psychiatric emergency room. If the services are performed/provided within a

	psychiatric unit of an acute hospital, a freestanding psychiatric facility or the UNMH psychiatric emergency room, they are the financial responsibility of OptumHealth New Mexico. Amerigroup does not cover laboratory specimen handling, mailing or collection fees. Specimen collection in a participating physician's office is covered only if the specimen is drawn by venipuncture or arterial stick or collected by urethral catheterization from recipients who are not residents of nursing facilities or hospital inpatients. All covered laboratory services must be furnished by contracted network providers **CLIA Reporting** The federal Clinical Laboratory Improvement Amendment (CLIA) requires all laboratories servicing Medicaid recipients to have a certificate of waiver or a certificate of registration. Those laboratories with a certificate of waiver may only provide the following nine tests: 1. Dipstick or tablet reagent urinalysis for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity and urobilinogen 2. Fecal occult blood 3. Ovulation tests 4. Urine pregnancy tests 5. Erythrocyte sedimentation rate — nonautomated 6. Hemoglobin-copper sulfate — nonautomated 7. Blood glucose by glucose monitoring devices cleared by the FDA specifically for home use 8. Spun microhematocrit 9. Hemoglobin by single analyte instruments with self-contained or component features to perform specimen/reagent interaction, providing direct measurement and readout When both a treating physician and a radiologist read an X-ray, only the radiologist can submit a claim for reading the film. If the physician feels there is a problem with the reading diagnosis, the physician should contact the radiological facility to discuss the concern.
Nurse Midwife/Lay Midwife Services	A certified nurse midwife is a registered professional nurse who is legally authorized under the state law to practice as a nurse midwife and has completed a program of study and clinical experience for nurse midwives or equivalent. A lay midwife is one who has entered the profession as an apprentice to a practicing midwife rather than attending a formal school program and is licensed by the Department of Health to practice midwifery. Covered services may be rendered by a certified nurse midwife and lay midwives as defined above.
Nurse Practitioner Services	Services are covered by a registered nurse practitioner who performs such services and who meets training, education and experience requirements.

Nursing Facilities	Amerigroup covers Nursing Facilities (NF) services identified as allowable costs. Amerigroup covers low NF and high NF care in accordance with New Mexico regulations. Amerigroup covers physical, occupational and speech therapy services furnished to members in the following manner: • If the resident is also eligible for Medicare and the facility does Part B billing • If the resident receives high NF- or low NF-level services, services are included in the Medicaid facility rate
Nutritional Services	Amerigroup covers the following nutritional services: • Nutritional assessments for all eligible pregnant women and for recipients under 21 years of age under the EPSDT program • Nutritional counseling to or on behalf of recipients under 21 years of age who have been referred for a nutritional need • Development and/or revision of the recipient's nutritional plan • Nutritional intervention • Observation and technical assistance related to implementation of the nutritional plan The following specific nutritional services are not covered: • Services not considered medically necessary for the condition of the recipient • Dietary counseling for the sole purpose of weight loss • Weight control and weight management programs • Commercial dietary supplements or replacement products marketed for the primary purpose of weight loss and weight management
Occupational Therapy Services	Amerigroup covers Occupational Therapy (OT) services which promote fine motor skills, coordination, sensory integration and/or facilitate the use of adaptive equipment or other assistive technology. Specific services include: teaching of daily living skills; development of perceptual motor skills and sensory integrative functioning; design, fabrication or modification of assistive technology or adaptive devices; provision of assistive technology services; design, fabrication or applying selective orthotic or prosthetic devices or selecting adaptive equipment; use of specifically designed crafts and exercise to enhance function; training regarding OT activities; and consulting or collaborating with other service providers or family members, as direct by the member.
Personal Care Option Services	Personal Care Option (PCO) services are limited to those meeting NF level of care and approved in advance for the PCO program by the HSD for the services. PCO is a program for qualified individuals 21 years of age or older who are eligible for full Medicaid coverage, and meet the nursing facility (high or low NF) level of care criteria as determined by the Third Party Assessor on behalf of HSD and ALTSD. It should be noted that personal care services for individuals under the age of 21 are reimbursed by the New Mexico Medicaid program through the EPSDT services described in EPSDT Personal Care Services. • The goal of the PCO program is to avoid institutionalization, maintain or increase the individual's functional level, and maintain or increase the individual's

	independence. The PCO program does not provide services 24 hours a day. PCO is a Medicaid service, not a Medicaid category, and services under this option are delivered pursuant to a service plan. PCO services include a range of services to consumers who are unable to perform some/all Activities of Daily Living (ADLs) or Independent Activities of Daily Living (IADLs) because of disability or functional limitation(s). These services include, but are not limited to, bathing, dressing, grooming, eating, toileting, shopping, transporting, caring for assistance animals, feeding livestock, cognitive assistance and communicating. • An individual may be physically capable of performing ADLs or IADLs but may have limitations in performing these activities because of a cognitive impairment. PCO services may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task. In such cases, personal care may include cueing along with supervision to ensure that the individual performs the task properly. • Individuals eligible for PCO services will have the option of choosing the consumer-directed personal care model or the consumer-delegated personal care model. The consumer-directed model allows the consumer to act as the employer and oversee his or her own service care delivery. The consumer is required to work with a fiscal intermediary agency to process all financial paperwork to Medicaid. Under the consumer-delegated model, the consumer chooses the agency to perform all employer-related tasks; the agency is responsible for ensuring all service delivery to the consumer. Effective April 1, 2009, homemaker services that are provided to people who participate in the CoLTS "c" waiver program are provided via the PCO program, codes and rates. The following PCO services are covered: **Personal Assistant Services for Adults** Homemaker agency licensed by the DOH, pursuant to 7.28.2.1 NMAC et seq., approved by ALTSD. Must adhere to ALTSD requirements including but not limited to: Federal and state regulations regarding OSHA training, i.e., Fire Safety, Blood Born Pathogens, AIDS/HIV, universal precautions, Criminal Background check, pertinent Labor Laws, etc. Homemaker agencies must comply with DOH abuse registry screening laws regulation in accordance with the Department of Health Act, NMSA 1978, section 90706 (E) and the Employee Abuse Registry Act, NMSA 1978, Sections 24-27-1 to 24-27-8. Must comply with all other administrative requirements outlined in the NM Aging and Long Term Services Department, Elderly and Disability Services Division, CoLTS "c" waiver program service standards. **Individualized Bowel and Bladder Services** Individualized bowel and bladder services include but are not limited to: diaper changes, catheter care, bowel programs, bladder programs, and perineal care. These services do not have to be performed by a nurse pursuant to NMSA 1978,

	Section 61-3-29(J) of the Nursing Practice Act. Bowel and bladder services may be "performed by a personal care provider in a noninstitutional setting of bowel and bladder assistance for an individual whom a health care provider certifies is stable, not currently in need of medical care and able to communicate and assess his own needs." **Meal Preparation and Assistance** At the direction of the member or his or her personal representative, these services include preparing meal(s) for the member or assisting the member pursuant to the Personal Care Service Provider (PCSP). This does not include assistance with eating. **Support Services** These services include providing additional assistance to the member in order to promote his or her independence and enhance his or her ability to live in the community and remain in a clean and safe environment. **Hygiene/Grooming** The PCSP may include the following tasks to be performed by the attendant. These services include but are not limited to: • Bathing • Dressing • Grooming • Oral care with intact swallowing reflex • Nail care • Perineal care • Toileting **Minor Maintenance of Assistive Device(s)** This service includes battery replacement and minor, routine wheelchair and DME maintenance. **Mobility Assistance** Assistance may include, but is not limited to: • Ambulation • Transferring • Toileting **Eating** This service includes the attendant assisting the member as determined by the PCSP. This does not include preparation of food/meals. Services requiring preparation of food/meals are covered under meal preparation and assistance in Subsection B of 8.315.4.14 NMAC. If the consumer has special needs in this area, the attendant is required to receive specific training to meet that need. **Assisting with Self-administered Medication** This service is limited to p*rompting and reminding only*. A member who needs

	assistance with taking self-administered medication as a reasonable accommodation under the Americans with Disabilities Act (ADA) due to a disability may receive assistance as per the PCSP. Examples of assistance include, but are not limited to, the following: • Getting a glass of water or juice as requested by the member • Handing the member his or her daily medication box or medication bottle or cutting/grinding pills • Helping a member with placement of oxygen tubes **Skin Care** The member must have a documented skin disorder. If documented by a physician, physician assistant, nurse practitioner or clinical nurse specialist, the attendant can perform skin care. Such assistance excludes wound care or application of prescription medications unless such assistance would be a reasonable accommodation under the ADA. **Cognitive Assistance** Cognitive assistance is intended to keep the member on task, and increase or maintain the member's safety, independence and quality of life. This service is primarily for a member with a traumatic brain injury, Alzheimer's disease, a mental illness or dementia or a member who has suffered a stroke. **Household Services** The attendant will assist the member in performing household activities as needed. Such activities are limited to the maintenance of the member's personal living area (e.g., kitchen, living room, bedroom and bathroom). These activities are considered necessary to maintain a clean and safe environment and to support the member living in his or her home. Examples of household services include: • Sweeping, mopping or vacuuming the member's carpets, hardwood floors, or linoleum • Dusting the member's furniture • Changing the member's linens • Washing the member's laundry • Cleaning the member's bathroom (tub and/or shower area, sink, and toilet) • Cleaning the member's kitchen and dining area (e.g., washing the member's dishes and putting the member's dishes away; cleaning counter tops and cleaning the area where the consumer eats, etc.) The following PCO services are not covered: • Any task that must be provided by a person with professional or technical training as specified by state and federal law • Services not approved in the consumer's service plan • Childcare or personal care for other household members
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 Caremark to process prescription drug claims using a computerized point-of-sale (POS) system. This system gives participating pharmacies online, real time access to beneficiary eligibility, drug coverage, prescription limitations, pricing and payment information, and prospective drug utilization review. Amerigroup covers most medically necessary prescription drugs and some over-the-counter drugs, subject to the limitations and restrictions delineated by the State of New Mexico. **Coverage Requirements** Legal requirements: All drug items must be assigned a national drug code by the respective manufacturer, repackager or labeler. All prescription must meet all federal and state laws. Providers must fulfill all the requirements of federal and state laws relating to pharmacy practice and ethics. **Noncovered Services or Service Restrictions** Amerigroup does not cover the following specific pharmacy items: • Medication supplied by state mental hospitals to recipients on convalescent leave from the center • Methadone for use in drug treatment programs • Personal care items such as nonprescription shampoos, soaps • Cosmetic items, such as retin-A for aging skin, Rogaine for hair loss • Drug items that are not eligible for federal financial participation, (i.e., drugs not approved as effective by the federal food and drug administration, known as DESI (Drug Efficacy Study Implementation) drugs) • Fertility drugs • Antitubercular drug items available from the New Mexico department of health or the United States public health service • Weight loss/weight control drugs unless precertified • Barbiturate hypnotic drugs, barbiturate drugs whose primary action is to induce sleep for recipients who do not reside in nursing homes; Amerigroup covers barbiturate hypnotic drugs for recipients in nursing homes and for other recipients when authorized on a prior approval basis if related to an appropriate medical diagnosis • Drug items used to treat sexual dysfunction Amerigroup covers certain nonprescription drug items without special authorization or prior authorization when prescribed by a licensed physician or other licensed practitioner. The pharmacy must maintain the prescription, written request, or telephone order reduced to writing. Other nonprescription items can be considered on a prior approval basis when related to an appropriate medical diagnosis requiring

	an ongoing course of treatment.
	
	Amerigroup covers routine nonprescription drug items supplied in nursing facilities or intermediate care facilities for the mentally retarded with specified restrictions.
	• Routine items are included in the facility's reimbursable cost and cannot be charged to the recipient or billed to Amerigroup by providers.
	• Routine drug items include the following:
	  o Laxatives
	  o Stool softeners
	  o Diabetic testing supplies and equipment
	  o Alcohol and body rubs
	  o Aspirin and acetaminophen
	  o Antacids and other agents for treating ulcers
	  o Ointments, lotions and creams
	  o Other nonprescription items stocked at nursing stations and distributed or used individually in small quantities
	
	Amerigroup does not cover drug items for recipients eligible for Medicare Part D when the drug item or class of drug meets the federal definition of a Medicare Part D covered drug. Medicaid does not cover any copayment due from the recipient towards a claim paid by Medicare Part D. Items or drug classes specifically excluded by Medicare Part D are covered, noncovered or limited to the same extent that Amerigroup covers the excluded drug items for full benefit Medicaid recipients who are not dual eligibles.
	
	The Amerigroup Preferred Drug List (PDL) will use the following guidelines:
	• Generic substitution will be based on AB Rating and/or clinical need
	• For a multiple source, brand name product within a therapeutic class, Amerigroup may select a representative drug
	• The PDL follows the CMS special guidelines relating to drugs used to treat HIV infection
	• The PDL includes coverage of certain Over-The-Counter (OTC) drugs by a licensed practitioner
	• Amerigroup has an appeals process for practitioners who think that an exception to the PDL will be made for an individual member

Physical Therapy (PT) Services	Amerigroup covers physical therapy services that promote gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities. Specific services include: professional assessment(s), evaluation(s) and monitoring for therapeutic purposes; physical therapy treatments and interventions; training regarding PT activities, use of equipment and technologies or any other aspect of the member's physical therapy services; designing, modifying or monitoring use of related environmental modifications; designing, modifying and monitoring use of related activities supportive to the ISP goals and objectives; and consulting and collaborating with other service providers of family members, as directed by the member.

Physician Services	All symptomatic visits to physicians or physician extenders within the scope of their licenses are covered benefits. Physician services, including services while admitted in the hospital, an outpatient hospital department, a clinic setting or a physician's office are covered benefits.
Pregnancy-Related Services	Services for pregnant women including prenatal care. Covered services include: • Pregnancy planning and perinatal health promotion and education for reproductive-age women • Childbirth education classes to all pregnant women and their chosen partner • Emergency care • Transfer and care of pregnant women, newborns and infants at tertiary care facilities if necessary • Network 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 caesarean delivery
Pregnacy Terminations	Amerigroup covers elective and therapeutic abortion services. Providers must document medical necessity in the member's medical records but are not required to submit this documentation with the claim.
Preventive Health Services	Amerigroup covers preventive health services unless a member refuses offered services and such refusal is documented. Member refusal is defined to include both failure to consent and refusal to access care. Preventive health services include: **Immunizations** Within 6 months of enrollment, members are immunized and current according to the type and schedule provided by the most current version of the Recommendations of the Advisory Committee on Immunization Practices, Centers for Disease Control and Prevention, Public Health Service, and the United States Department of Health and Human Services. This may be done by providing the necessary immunizations or by verifying the immunization history by a method deemed acceptable by the ACIP. Current is defined as no more than 4 months overdue. **Screens** Within 6 months of enrollment or within 6 months of a change in the standard, asymptomatic members receive and are current for at least the following screening services. **Screening for Breast Cancer** Female members, age 40 through 69 years of age who are not at high risk for breast cancer will be screened every 1 to 2 years by mammography alone or by mammography and annual clinical breast examination. Female members at high risk for developing breast cancer will be screened as often as clinically indicated.

	Screening for Cervical Cancer Female members with a cervix will receive cytopathology testing starting at the onset of sexual activity, but at least by 21 years of age, and every 3 years thereafter until reaching 65 years of age, if prior testing has been consistently normal and the member has been confirmed to be not at high risk. If the member is at high risk, the testing frequency will be at least annual. **Screening for Colorectal Cancer** Members aged 50 years and older at normal risk for colorectal cancer will be screened with annual fecal occult blood testing or sigmoidoscopy colonoscopy or double contrast barium at a periodicity determined by Amerigroup. **Blood Pressure Measurement** Members of all ages receive a blood pressure measurement as medically indicated. **Serum Cholesterol Measurement** Male members aged 35 and older and female members aged 45 and older who are at normal risk for coronary heart disease will receive serum cholesterol and HDL cholesterol measurement every 5 years. Adults aged 20 and older with risk factors for coronary artery disease will have serum cholesterol and HDL cholesterol measurements as clinically indicated. **Screening for Obesity** All members will receive annual body weight and height measurements to be used in conjunction with a calculation of the Body Mass Index or referenced to a table of recommended weights. **Screening for Elevated Lead Levels** Members aged 9 to 15 months old (ideally 12 months old) will receive a blood lead measurement at least once. **Screening for Type 2 Diabetes** Members with one or more of the following risk factors will be screened. Risk factors include a family history of diabetes (parent or sibling with diabetes); obesity (more than 20 percent over desired weight or BMI greater than 27 kg/m2); race/ethnicity (e.g., Hispanic, Native American, African American, Asian-Pacific Islander); previously identified impaired fasting glucose or impaired glucose tolerance; hypertension (greater than 140/90 mmHg); HDL cholesterol level lower than 35 mg/dl and triglyceride level greater than 250 mg/dl; history of Gestational Diabetes Mellitus (GDM) or delivery of babies over 9 pounds. **Screening for Tuberculosis** Routine tuberculin skin testing will not be required for all members. The following high-risk persons will be screened or previous screening noted: persons who immigrated from countries in Asia, Africa, Latin America or the Middle East in the preceding 5 years; persons who have substantial contact with immigrants from

	those areas; migrant farm workers; and person who are alcoholic, homeless or injecting drug users; HIV-infected persons will be screened annually. Members whose screening tuberculin test is positive (greater than 10 mm. of induration) must be referred to the local public health office in their community of residence for contact investigation. **Screening for Rubella** Female members of childbearing ages will be screened for rubella susceptibility by history of vaccination or by serology at their first clinical encounter in an office setting. **Screening for Visual Impairment** Members 3 to 4 years of age will be screened at least once for amblyopia and strabismus by physical examination and a stereo acuity test. **Screening for Hearing Impairment** Members 50 years and older will be routinely screened for hearing impairment by questioning them about their hearing. **Screening for Problem Drinking and Substance Abuse** Adolescent and adult members will be screened at least once by a careful history of alcohol use and/or the use of a standardized screening questionnaire such as the Alcohol Use Disorders Identification Test (AUDIT) or the four-question CAGE Instrument and the Substance Abuse Screening and Severity Inventory (SASSI). The frequency of screening will be determined by the results of the first screen and other clinical indications. **Prenatal Screening** Pregnant members will be screened for preeclampsia, D (Rh) Incompatibility Down Syndrome, neural tube defects and hemogloginopathies, vaginal and rectal Group B Streptococcal infection, and counseled and offered testing for HIV. **Screening for Chlamydia** All sexually active female members age 25 or younger will be screened for Chlamydia. All female members over age 25 will be screened for Chlamydia if they inconsistently use carrier contraception, have more than one sexual partner or have had a sexually transmitted disease in the past. **Behavioral Health Screening** During an encounter with a PCP, a behavioral health screen will occur. **Tot-To-Teen Health Checks** Within 6 months of enrollment, Amerigroup will endeavor to ensure the eligible members (up to age 21) are current according to the screening schedule in EPSDT services. **Counseling Services** Counseling services are provided to applicable asymptomatic members on the

	following unless member refusal is documented: to prevent tobacco use, to promote physical activity, to promote a healthy diet, to prevent osteoporosis and heart disease in menopausal female members, citing the advantages and disadvantages of calcium and hormonal supplementation, to prevent motor vehicle injuries, to prevent household and recreational injuries, to prevent dental and periodontal disease, to prevent HIV infection and other sexually transmitted diseases, and to prevent unintended pregnancies. **Family Planning Policy** Covered services for members of the appropriate age of both sexes who seek family planning services with counseling pertaining to the following: methods of contraception; evaluation and treatment of infertility; HIV and other sexually transmitted diseases and risk reduction practices; options for pregnant members who do not wish to keep a child; and options for pregnant members who may wish to terminate the pregnancy. **Prenatal Care Program** Prenatal care programs will include at least the following: • Educational outreach to all members of child-bearing ages • Prompt and easy access to obstetrical care, including providing an office visit with a practitioner within 3 weeks of having a positive pregnancy test (laboratory or home) unless earlier care is clinically indicated • Risk assessment of all pregnant members to identify high-risk cases for special management • Counseling which strongly advises voluntary testing for HIV • Case management services to address the special needs of members who have a high-risk pregnancy, especially if risk is due to psychosocial factors such as substance abuse or teen pregnancy • Screening for determination of need of a postpartum home visit • Coordination with other services in support of good prenatal care, including transportation and other community services and referral to an agency that dispenses free or reduced price baby car seats Screening services that are not used to make a diagnosis, such as chromosome screening, general health panels, executive profiles, paternity testing or premarital screens are not covered. Amerigroup covers screening services for children less than 21 years of age through the Tot-To-Teen HealthCheck program. Amerigroup covers screening services ordered by providers for cancer detection, such as Pap smears and mammograms.
Private Duty Nursing Services	Amerigroup covers private duty nursing services which include activities, procedures, and treatment for a physical condition, physical illness, or chronic disability. Services include medication management, administration and teaching; aspiration precautions; feeding tube management; gastrostomy and jejunostomy; skin care; weight management; urinary catheter management; bowel and bladder care; wound care; health education; health screening; infection control;

	environment management for safety; nutrition management; oxygen management; seizure management and precautions; anxiety reduction; staff supervision; and behavior and self-care assistance. Services are limited to those approved for as CoLTS "c" waiver services only.
Prosthetic and Orthotic Services	Amerigroup covers medically necessary prosthetics and orthotics supplied by providers only when specified requirements or conditions are satisfied. Prosthetic devices are replacements or substitutes for a body part or organ, such as an artificial limb or eye prosthesis. Orthotic devices support or brace the body, such as trusses, compression custom-fabricated stockings and braces. Prosthetics and orthotics will only be covered when all the following conditions are met: • The device has been ordered by a physician or other licensed practitioner and is medically necessary for recipient mobility, support or physical functioning • The need for the device is not satisfied by the existing device the recipient currently has • The device is covered by Amerigroup and any required prior approval requirements have been satisfied • Coverage of compression stockings for adults is limited to stockings that are custom-fabricated to meet the recipient's medical needs • Coverage of orthopedic shoes for adults is limited to the shoe that is attached to a leg brace • Replacement of items is limited to one item every 3 years, unless there are changes in medical necessity • Therapeutic shoes furnished to diabetics are limited to the following within 1 calendar year: ○ No more than one pair of depth shoes and three pairs of inserts (not including the noncustomized removable inserts provided with such shoes) The following orthotic and prosthetic services are not covered: • Orthotic supports for the arch or other supportive devices for the foot, unless they are integral parts of a leg brace or therapeutic shoes furnished to diabetics • Prosthetic devices or implants that are used primarily for cosmetic purposes
Rehabilitation Services	Amerigroup covers physical therapy, occupational therapy, and speech therapy services which are reasonable and necessary for the treatment of the member's specific condition. For all services, there must be an expectation that the member's condition will improve significantly in a reasonable and generally predictable period of time based on an assessment by physicians of the recipient's restoration potential. • If the member's expected restoration potential is insignificant in relation to the extent and duration of therapy required to achieve the potential, the therapy is not considered reasonable and necessary • If a determination that the expectations for restoration will not materialize is made at any point in the treatment, the services are no longer covered by

	Amerigroup Members who require low NF level of care and reside in a NF can receive services furnished by home health agencies, certified outpatient rehabilitation centers, certified independent physical therapists, and certified independent occupational therapists. Therapy providers can bill directly for these services. Reimbursement for rehabilitation services for recipients who require high NF level of care is included in the NF's per diem rate and cannot be billed separately by the therapy provider. Physical, occupational, and speech therapy services must be ordered by physicians and specifically related to active written treatment plans developed by physicians in consultation with qualified physical, occupational or speech therapists. Amerigroup covers speech therapy services furnished by hospitals, home health agencies, outpatient hospitals, rehabilitation hospitals and rehabilitation centers licensed and certified by the Department of Health. • Speech therapy services can be furnished by employees of the previously described providers or by an outside source such as an agency or clinic, under arrangements with the provider facility. Reimbursement for services is made to the facility. • Speech therapy services must be furnished by individuals who are licensed as speech pathologists by the New Mexico Regulation and Licensing Department. Services furnished in PPS-exempt psychiatric units of general acute care hospitals, PPS-exempt rehabilitation units of general acute care hospitals and freestanding psychiatric hospitals are included in the hospital reimbursement rate and cannot be billed separately by independent providers. The following rehabilitation services are not covered: • Services furnished by providers who are not licensed and/or certified to furnish services • Educational programs or vocational training not part of an active treatment plan for residents in an intermediate care facility for the mentally retarded or for members under the age of 21 receiving inpatient psychiatric services • Services billed separately by home health agencies, independent physical therapists, independent occupational therapists or outpatient rehabilitation centers to members in high-level nursing facilities or inpatient hospitals • Transportation, for members in low-level nursing facilities or other Medicaid recipients, to travel to outpatient hospital facilities unless there are no home health agencies, independent physical therapists or independent occupational therapists available in the area to provide the therapy at the recipient's residence • Services solely for maintenance of the member's general condition; these services include repetitive services needed to maintain a recipient's functional level that do not involve complex and sophisticated therapy procedures requiring the judgment and skill of a therapist; services related to activities for

	the general good and welfare of recipients, such as general exercises to promote overall fitness and flexibility and activities to provide general motivation, are not considered physical or occupational therapy for Medicaid reimbursement purposes
Respite Services	Respite services are provided to members unable to care for themselves and are furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite services may be provided in a member's home or in the community. Services include assistance with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation, and eating), enhancing self-help skills, and providing opportunities for leisure, play, and other recreational activities and to allow community integration. Respite services are a covered benefit for all CoLTS members not residing in a nursing facility.
School-based Services	Amerigroup covers the following services when medically necessary and furnished by specified providers in school settings: • Therapy services • Mental health services • Nutritional assessment and counseling • Transportation services • Service coordinator services • Administrative activities Services furnished in school settings are subject to the limitations and coverage restrictions that exist for other Medicaid services. The following school-based services are not covered: • Services classified as educational • Services furnished by practitioners outside their area of expertise • Vocational training that is related solely to specific employment opportunities, work skills or work settings • Services that duplicate services furnished outside the school setting, unless determined to be medically necessary and given precertification by Amerigroup • A service provided that was not on an Individualized Educational Plan or Individualized Family Service Plan and was not authorized by the member's PCP • Transportation that a recipient would otherwise receive in the course of attending school • Transportation for a recipient with special education needs under the Individuals with Disabilities Education Act (IDEA) who rides the regular school bus to and from school with other nondisabled children
Service Coordination	Service coordination is person-centered and intended to support members in pursuing their desired life outcomes by assisting them in accessing support and services necessary to achieve the quality of life that they desire in a safe and healthy environment. Service coordination assists members in gaining access to needed CoLTS waiver services, Medicaid State Plan services, and medical, social, educational and other services, regardless of the funding source for the services to which access

	is needed. All members are assigned a Service Coordinator. To reach a Service Coordinator, call 1-800-600-4441.
Skilled Maintenance Therapy	Amerigroup covers skilled maintenance therapy services which include occupational services, physical therapy services and speech language therapy services. This is a service limited to those approved for CoLTS "c" waiver services.
Special Rehabilitation Services	Amerigroup only covers special rehabilitation services necessary to enhance development in one or more of the following developmental domains: • Physical/motor • Communication • Adaptive • Cognitive • Social or emotional • Sensory Amerigroup does not cover the following specific services furnished by special rehabilitation providers: • Services furnished to individuals who are not Medicaid eligible • Services furnished that are not within the scope of practice of the professional performing them or supervising the activity • Services that are not included in the current treatment plan or individual family service plan (IFSP) • Services that are not medically necessary
Speech Language Therapy Services	Speech language therapy services preserve abilities for independent function in communication; facilitate oral motor and swallowing function; facilitate use of assistive technology; and/or prevent progressive disabilities. Specific services include: identification of communicative or oropharyngeal disorders and delays in the development of communication skills; prevention of communicative or oropharyngeal disorders and delays in the development of communication skills; development of eating or swallowing plans and monitoring their effectiveness; use of specifically designed equipment, tools, and exercises to enhance function; design, fabrication, or modification of assistive technology or adaptive devices; provision of assistive technology services; adaptation of the member's environment to meet his or her needs; training regarding SLT activities; and consulting or collaborating with other service providers or family members, as directed by the member.
Swing Bed Hospitals and Nursing Facilities	Amerigroup covers hospital and nursing facility (high- or low-level) services which are medically necessary for the diagnosis and/or treatment of an illness or injury as indicated by the condition of the recipient.
Transplant Services	Covered transplant services include the following: heart transplants, lung transplants, heart-lung transplants, liver transplants, kidney transplants, autologous bone marrow transplants, allegoric bone marrow transplants and corneal transplants.

Transportation	Emergency and nonemergency medical transportation is a covered benefit for all CoLTS members. Please call Access2Care to schedule transportation services at 1-866-442-4937.
Vision Services	Amerigroup offers an enhanced vision benefits for all members: • One eye exam every year for adults • Contact lenses every year for adults • One pair of eyeglasses (lenses and frames) for adults every year Amerigroup covers specific vision care services that are medically necessary for the diagnosis and treatment of eye diseases and for the correction of refractive errors, as required by the condition of the member. All services must be furnished within the limits of Medicaid benefits, within the scope and practice of the medical professional as defined by state law, and in accordance with applicable federal, state and local laws and regulations. **Exam** Amerigroup covers routine eye exams. Coverage for adults is limited to one routine eye exam in a 12-month period. Exams for an existing medical condition, such as diabetes, will be covered for required follow-up and treatment. The medical condition must be clearly documented on the visual examination form and indicated by diagnosis on the claim. **Corrective Lenses** Amerigroup covers corrective lenses. Coverage for adults is limited to one set of corrective lenses in a 12-month period, unless an ophthalmologist or optometrist recommends a change in prescription due to a medical condition affecting vision. The vision prescription must be appropriately recorded on the visual examination form. • For the purchase of eyeglasses, the diopter correction must meet or exceed one of the following diopter correction criteria: o -1.00 myopia (nearsightedness) o + 1.00 for hyperopia (farsightedness) o +0.75 astigmatism (distorted vision) o + 1.00 for presbyopia (farsightedness of aging) o +2.00 for diplopia (double vision) – prism lenses • If an existing prescription is updated, there must be a minimum 0.75 diopter change in the prescription. Exceptions are considered for the following: o Members with cataracts o Members under 21 years of age **Bifocal Lenses** Amerigroup covers bifocal lenses with a correction of 0.25 or more for distance vision and 1 diopter or more for added power (bifocal lens correction). **Tinted Lenses** Amerigroup covers tinted lenses with filtered or photochromic lenses if the

	examiner documents one or more of the following disease entities, injuries, syndromes or anomalies in the comments section of the visual examination form, and the prescription meets the dioptic correction purchase criteria: • Aniridia • Albinism, ocular • Traumatic defect in iris • Iris coloboma, congenital • Chronic keratitis • Sjogren's syndrome • Aphakia, U.V. filter only if intraocular lens is not U.V. filtered • Rod monochromaly **Balance Lenses** Amerigroup covers balance lenses without precertification in the following situations: • Lenses used to balance an aphakic eyeglass lens • Member is blind in one eye and the visual acuity in the eye requiring correction meets the diopter correction purchase criteria **Frames** Amerigroup covers frames for corrective lenses. Coverage for adults is limited to one frame in a 12-month period. **Contact Lenses** Amerigroup covers contact lenses, either the original prescription or replacement, only with precertification. Coverage for adults is limited to one pair of contact lenses in a 24-month period, unless an ophthalmologist or an optometrist recommends a change in prescription due to a medical condition affecting vision. Requests for precertification will be evaluated on dioptic criteria and/or visual acuity, the member's social or occupational need for contact lenses, and special medical needs. The criteria for authorization of contact lenses are as follows: • The member must have a diagnosis of keratoconus or diopter correction of +/- -6.00 or higher in any meridian, at least 3.00 diopters of anisometropia • Monocular aphakics may be provided with one contact lens and a pair of bifocal glasses **Replacement** Eyeglasses or contact lenses that are lost, broken or have deteriorated to the point that, in the examiner's opinion, they have become unusable to the recipient, may be replaced for the following: • Members under 21 years of age • Members 21 years of age or older who have developmental disabilities • Documentation for replacement: ○ The eyeglasses or contact lens (or lenses) must meet the diopter correction purchase criterion and must be recorded on the report of visual examination

	form o The loss, deterioration or breakage must be documented in the appropriate section of the visual examination form **Prisms** All prisms are covered if medically indicated to prevent diplopia (double vision). Documentation is required on the visual examination form. **Lens Tempering** Amerigroup covers lens tempering on new glass lenses only. **Lens Edging** Amerigroup covers lens edging and lens insertion. **Minor Repairs** Amerigroup covers minor repairs to eyeglasses. **Dispensing Fee** Amerigroup pays a dispensing fee to ophthalmologists, optometrists or opticians for dispensing a combination of lenses and new frames. This fee is not paid when contact lenses are dispensed. **Eye Prosthesis** Amerigroup covers eye prostheses (artificial eyes). The following vision services are not covered: • Orthoptic assessment and treatment • Photographic procedures, such as fundus or retinal photography and external ocular photography • Polycarbonate lenses other than for prescriptions for high-power lenses or monocular vision • Ultraviolet lenses • Trifocals • Progressive lenses • Tinted or photochromic lenses, except in cases of documented medical necessity • Oversize frames and oversize lenses • Low vision aids • Eyeglass cases • Eyeglass or contact lens insurance • Anti-scratch, anti-reflective, or mirror coating
Women's Health Specialties	Female members may self-refer to an in-network women's health specialist for her annual exam and routine health services (including a Pap smear and mammograms) and does not require precertification from the PCP.

Note: Amerigroup does <u>not</u> cover the use of any experimental procedures or experimental medications except under certain circumstances and in accordance with the New Mexico Medicaid Policy Manual.

General Noncovered Services

Amerigroup does not cover certain procedures, services or miscellaneous items. This section contains a general description of the types of services that Amerigroup does not cover.

Cosmetic Services and Surgeries
Amerigroup does not cover cosmetic items or services that are prescribed or used for aesthetic purposes. This includes items for aging skin, hair loss and personal care items such as nonprescription lotions, shampoos, soaps or sunscreens. Amerigroup does not cover cosmetic surgeries performed for aesthetic purposes. Cosmetic surgery is defined as procedures performed to improve the appearance of physical features. The procedures may or may not improve the functional ability of the area of concern. Amerigroup covers only surgeries that meet specific criteria and are approved as medically necessary reconstructive surgeries.

Foot Care
Amerigroup does not cover certain routine foot care services.

Hair or Nail Analysis
Amerigroup does not cover hair or nail analysis.

Pharmacy Services
Amerigroup does not cover methadone used in drug treatment programs. Amerigroup does not cover drug items that are classified as ineffective by the Food and Drug Administration (FDA) and antitubercular drug items that are available from the public health department. In addition, Amerigroup does not cover personal care items or pharmacy items used for cosmetic purposes only.

Postmortem Examinations
Amerigroup does not cover postmortem examinations.

Individuals with Special Health Care Needs

Individuals with Special Health Care Needs (ISHCN) means persons who have, or are at an increased risk for a chronic physical, developmental, behavioral, neurobiological or emotional condition, or who have low to severe functional limitation and who also require health and related services of a type or amount beyond that required by individuals generally.

Amerigroup defines all members that have met a nursing facility level of care as ISHCN (CoLTS “c” waiver, PCO, Institutional Nursing Facility and Mi Via). Other members may be identified based on referrals from Amerigroup staff, family members, caretakers, providers, service coordinators, state agencies or other third parties.

ISHCN require a broad range of primary, specialized medical, behavioral health and related services. ISHCN have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The Amerigroup provider network consists of primary, specialized, medical, behavioral and social services to meet these needs.

Amerigroup will:

- Incorporate into our Member Handbook a description of network providers and programs available to ISHCN
- Identify ISHCN among our membership, using the criteria for identification and information provided by HSD/MAD
- Work with HSD/MAD to develop and implement written policies and procedures, which govern how members with multiple and complex physical health care needs shall be identified
- Target members for the purpose of applying stratification criteria to ISHCN

Amerigroup will employ reasonable effort to identify ISHCNs based at least on the following criteria:

- Individuals eligible for SSI
- Individuals enrolled in the home-based waiver programs such as PCO, CoLTS "c" waiver or Mi Via
- Children receiving foster care or adoption assistance support
- Individuals identified by service utilization, clinical assessment, or diagnosis
- Referral by family or a public or community program

Within 30 days of enrolling in our CoLTS program, the member will receive a welcome call from Amerigroup.

Amerigroup manages the service needs of ISHCN through a Service Coordinator. The Service Coordinator will work with the member and his or her family or caregiver to:

- Assess the member's needs, including physical health, mental health, social and long term support services
- Develop an Individualized Service Plan (ISP). The ISP includes but is not limited to:
  - The member's medical history
  - A summary of the member's current medical and social needs and concerns
  - Short- and long-term care needs and goals
  - A list of required services and how often these services are needed
  - Details on who will provide these services
  - Information about CoLTS 1915(b) and 1915(c) waiver services
  - A list of specific waiver service network providers in your area from which the member can choose
- Help arrange timely access to a wide range of providers and services related to ISHCN, including but not limited to:
  - Direct access to CoLTS specialty providers as needed
  - Rehabilitation therapy services
  - Utilization management services
- Help arrange other services given outside the ISP, as needed
- Review the member's care needs and help him or her with access to care, specialty referrals, DME and PCP changes
- Contact the member based on his or her first health risk screen to find out if the member has a PCP that can best serve the member based on his or her health care needs
- Ensure a Case Manager is assigned at the time of the initial health screen, if needed
- Help set up PCP visits and referrals for ongoing case management as needed

- Teach and allow the member and his or her family or caregivers to make informed decisions based on the member's ISP or treatment plan

Amerigroup adheres to clear expectations and requirements related to ISHCNs that may include but are not limited to:

- Direct access to specialists, as needed
- Relevant CoLTS specialty providers for ISHCNs
- Relevant CoLTS emergency resource requirements for ISHCNs
- Relevant CoLTS rehabilitation therapy services to maintain functionality for ISHCNs
- Relevant CoLTS clinical practice guidelines for provision of care and services to ISHCNs
- Relevant CoLTS utilization management for services to ISHCNs

Home- and Community-based Waivers Programs

The State of New Mexico, Human Services Department, Medical Assistance Division (HSD/MAD) obtained a waiver from the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) to provide HCBS programs to individuals that require long-term supports and services so that the individuals may remain in their family residence, in their own home or in community residences. The programs serve as alternatives to institutional care. The following HCBS waiver programs are included in the CoLTS program:

- CoLTS "c" waiver
- Mi Via, a self directed waiver

CoLTS "c" Waiver Home- and Community-based Services

Homemaker services that are provided to people who participate in the CoLTS "c" waiver program are now provided via the PCO program, codes and rates.

This change took place on April 1, 2009. Providers should now use the PCO codes in the table below for homemaker services instead of the D&E codes that historically were used to bill D&E homemaker services.

Old D&E Code	New Code to Bill
99509 U1 homemaker visit	T1019 for delegated or 99509 for consumer directed as may be applicable
99509 UA homemaker supplemental hours	T1019 for delegated or 99509 for consumer directed as may be applicable
99505 U1 respite	99509 U1 respite; this includes respite allowed under the D&E waiver as well as Amerigroup value-added respite services available to members living in the community with natural supports in PCO and other categories
99505 U1 stoma care and maintenance	No change: 99505 U1
T1003 U1 LPN services	No change: T1003 U1
T1002 U1 RN services	No change: T1002 U1
S5125 EPSDT homemaker services	No change: S5125

	G9006 Coordinated care fee — home monitoring for consumer-directed model

All Amerigroup authorization requirements for HCBS continue to remain in place.

Eligible Members

The CoLTS "c" waiver services are limited to members who have received an allocation for CoLTS "c" waiver services and who meet institutional level of care criteria and institutional financial criteria as determined by HSD. After the State conducts the eligibility process, enrollees will receive Freedom of Choice counseling, select an MCO and then become a CoLTS member. The CoLTS Service Coordinator will conduct a face-to-face assessment with each member allocated a CoLTS "c" waiver slot to identify the member's goals and strengths, educate the member regarding the full range of options he or she has in the program, and assist the member in developing a service plan that addresses the member's goals in an effective manner.

The CoLTS "c" waiver covers the following services:

Adult Day Health Services

Adult day health services offer health and social services to assist participants in achieving optimal functioning and activates, motivates and rehabilitates participants in all aspects of their physical and emotional well-being, based on each recipient's individual needs. Services include:

- A variety of activities for recipients that promotes personal growth and enhances the member's self-esteem by providing opportunities to learn new skills and adaptive behaviors, improve capacity for independent functioning, or provide for group interaction in social and instructional programs and therapeutic activities; all activities must be supervised by program staff
- Involvement in the greater community
- Meals that do not constitute a full nutritional regime of three meals per day
- Practice Act NMSA 1978, Section 61-3-1, et seq.
- Supervision of self-administered medication
- Transportation to and from the adult day health program

Services are generally provided for 2 or more hours per day on a regularly scheduled basis, for 1 or more days per week by a licensed adult day care community-based facility.

Adult day health services include nursing services and skilled maintenance therapies (physical, occupational and speech) that must be provided in a private setting at the facility. The nursing and skilled maintenance therapies do not have to be directly provided by the facility. If directly provided, the facility must meet all program requirements for the provision of these services.

Assisted Living Services

Assisted living is a residential service that includes homemaker services, companion services, medication management (to the extent required under state law; medication oversight as required by state law), and 24-hour on-site response capability to meet scheduled or unpredictable participant

needs and provide supervision, safety and security. Services also include social and recreational programming:

- Coverage does not include 24-hour skilled care or supervision.
- Rates for room and board are excluded from the cost of services and are either billed separately by the provider or an itemized statement is developed that separates the costs of waiver services from the costs of room and board.
- Nursing and skilled therapy services are incidental, rather than integral to the provision of assisted living services. Nursing and skilled therapy services may be provided by third parties and must be coordinated with the assisted living provider.
- Assisted living providers must enter into an agreement with the recipient that details all aspects of care to be provided, including identified risk factors. The original agreement must be maintained in the recipient's file, and a copy must be provided by the assisted living provider to the Service Coordinator.
- Assisted living services must be provided as set forth by DOH as adult residential care facilities and all other applicable federal, state and waiver program regulations, policies and procedures, and Aging and Long-Term Services Department, Elderly and Disability Services Division (ALTSD/EDSD) CoLTS "c" waiver service standards.

Emergency Response Services

Emergency response services provide an electronic device that enables a member to secure help in an emergency. The member may also wear a portable help button to allow for mobility. The system is connected to the member's phone and programmed to signal a response center when a help button is activated. The response center reacts to the signal to ensure the member's health and safety. Emergency response services include:

- Testing and maintaining equipment
- Training participants, caregivers and first responders on use of the equipment
- 24-hour monitoring for alarms
- Checking systems monthly or more frequently if warranted by electrical outages, severe weather, etc.
- Reporting participant emergencies and changes in the member's condition that may affect service delivery

Emergency response services:

- Consist of emergency response and emergency response high need
- Must be provided in accordance with all applicable federal, state and waiver program regulations, policies and ALTSD/EDSD CoLTS "c" waiver service standards

The response center must be staffed by trained professionals. Emergency response providers must:

- Provide the member with information regarding services rendered, limits of services and information regarding agency service contracts
- Report member emergencies and changes in the member's condition that may affect service delivery to the service coordinator within 24 hours

- Complete quarterly reports for each member served; the original report must be maintained in the member's file, and a copy must be submitted by the emergency response provider to the Service Coordinator.

Environmental/Home Modification Services

Environmental modifications services include the purchase and installation of equipment and making physical adaptations to an individual's residence that are necessary to ensure the health, welfare and safety of the individual or enhance the member's level of independence. Adaptations include the following:

- Air filtering devices
- Fire safety adaptations
- Glass substitute for windows and doors
- Heating/cooling adaptations
- Installation of ramps and grab-bars
- Installation of specialized electric and plumbing systems to accommodate medical equipment and supplies
- Installation of trapeze and mobility tracks for home ceilings
- Modification of bathroom facilities (roll-in showers, sink, bathtub and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing)
- Purchase or installation of alarm and alert systems or signaling devices
- Purchase or installation of automatic door openers or doorbells, voice-activated, light-activated, motion-activated and electronic devices
- Purchase or installation of lifts or elevators
- Specialized accessibility, safety adaptations or additions
- Turnaround space adaptations
- Widening of doorways or hallways

Environmental modifications have a limit of $5,000 every 5 years.

The environmental modification provider must ensure proper design criteria is addressed in planning and design of the adaptation, provide or secure licensed contractor(s) or approved vendor(s) to provide construction or remodeling services, provide administrative and technical oversight of construction projects, provide consultation to family members, waiver providers and contractors concerning environmental modification projects to the individual's residence, and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

The environmental modification provider must submit the following information and documentation to Utilization Management:

- An environmental modification evaluation
- A service cost estimate including equipment, materials, supplies, labor, travel, per diem
- A letter of acceptance for environmental modifications signed by the recipient
- A letter of permission from owner of property
- A construction letter of understanding

- Photographs of the proposed modification site
- Documentation demonstrating compliance with the ADAAG, the UFAS and the New Mexico State Building Code

After the completion of work, the environmental modification provider must submit the following to Utilization Management:
- A letter of approval of work completed, signed by the recipient
- Photographs of the modifications in process and the completed modifications

Environmental modification services:
- Must be managed by professional staff available to provide technical assistance and oversight for environmental modification projects
- Will be provided in accordance with all applicable federal, state and waiver program regulations, policies and procedures, including applicable federal, state and local building codes and ALTSD/EDSD CoLTS "c" waiver service standards

Maintenance therapy

Skilled maintenance therapy includes PT, OT and Speech and Language Therapy (SLT) for adults.
- Skilled maintenance therapy services may be provided by eligible skilled maintenance therapy agencies or independent therapists
- Skilled maintenance therapy providers must:
  - Comply with all applicable federal, state and waiver regulations, policies, procedures and service standards regarding homemaker services
  - Ensure all therapy services are provided under the order of the waiver recipient's PCP; the therapy provider will obtain the order; the original of this order must be maintained by the therapy provider in the recipient's therapy file and the therapy provider must give a copy of the order to the Case Manager
  - Meet all other qualifications set forth in CoLTS "c" waiver service standards

Private Duty Nursing Services for Adults

Private duty nursing services include activities, procedures and treatment for a physical condition, physical illness or chronic disability. Services include the following:
- Anxiety reduction
- Aspiration precautions
- Behavior and self-care assistance
- Feeding tube management
- Gastrostomy and jejunostomy
- Health education
- Health screening
- Infection control and environmental management for safety
- Medication management, administration and teaching
- Nutrition management
- Oxygen management
- Seizure management and precautions

- Skin care and wound care
- Staff supervision
- Urinary catheter management and bowel and bladder care
- Weight management

Private duty nursing services must be provided under the order and direction of the member's PCP, in accordance with the New Mexico Nursing Practice Act NMSA 1978, Section 61-3-1, et seq. and in conjunction with the interdisciplinary team and the Service Coordinator.

Private duty nursing services must be provided in accordance with all applicable federal, state and waiver program regulations, policies and procedures, and ALTSD/EDSD CoLTS "c" waiver service standards. (Children receive this service through the Medicaid EPSDT program.)

Respite Services

Respite services are provided to members unable to care for themselves and are furnished on a short-term basis because of the absence or need for relief of the unpaid primary caregiver normally providing the care.

- Respite services are limited to a maximum of 100 hours annually per ISP year
- Respite services may be provided in a member's home, the respite member's home or the community
- Respite services may consist of homemaker services or private duty nursing services, based on the member's needs
- Services include assisting with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation and eating), enhancing self-help skills and providing opportunities for leisure, play and other recreational activities, and allowing community integration opportunities

Skilled Therapy Services for Adults

Skilled therapy services for adults include PT, OT and SLT services. (Children receive these services through the Medicaid EPSDT program.)

PT promotes gross or fine motor skills, facilitates independent functioning or prevents progressive disabilities. Specific services may include:

- Consulting or collaborating with other service providers or family members, as directed by the member
- Designing, modifying and monitoring use of related activities supportive to the ISP goals and objectives
- Designing, modifying or monitoring use of related environmental modifications
- Professional assessment(s), evaluations and monitoring for therapeutic purposes
- PT treatment interventions
- Training regarding PT activities
- Use of equipment and technologies or any other aspect of the member's PT services

PT services must be provided in accordance with all applicable federal, state and waiver program regulations, policies and procedures, and ALTSD/EDSD CoLTS "c" waiver service standards.

OT promotes fine motor skills, coordination and sensory integration; facilitates the use of adaptive equipment or other assistive technology; facilitates independent functioning; and prevents progressive disabilities. Specific services may include:

- Consulting or collaborating with other service providers or family members, as directed by the member
- Designing, fabricating or applying selected orthotic or prosthetic devices or selecting adaptive equipment
- Designing, fabricating or modifying assistive technology or adaptive devices
- Developing perceptual motor skills and sensory integrative functioning
- Providing assistive technology services
- Teaching daily living skills
- Training regarding OT activities
- Using specifically designed crafts and exercise to enhance function

OT services must be provided in accordance with all applicable federal, state and waiver program regulations, policies and procedures, and ALTSD/EDSD CoLTS "c" waiver service standards.

SLT preserves abilities for independent function in communication, facilitates oral motor and swallowing function, facilitates use of assistive technology and prevents progressive disabilities. Specific services may include:

- Adapting the member's environment to meet his needs
- Consulting or collaborating with other service providers or family members, as directed by the member
- Designing, fabricating or modifying assistive technology or adaptive devices
- Developing eating or swallowing plans and monitoring their effectiveness
- Identifying communicative or oropharyngeal disorders and delays in the development of communication skills
- Preventing communicative or oropharyngeal disorders and delays in the development of communication skills
- Providing assistive technology services
- Training regarding SLT activities
- Using specifically designed equipment, tools and exercises to enhance function

SLT services must be provided in accordance with all applicable federal, state and waiver program regulations, policies and procedures, and ALTSD/EDSD CoLTS "c" waiver service standards.

Mi Via Home- and Community-based Services Waiver

Amerigroup covers and supports the coordination of medical services only.

Member Rights and Responsibilities

Members have rights and responsibilities when participating with a MCO. Our Member Services Representatives serve as advocates for members. The following lists the rights and responsibilities of members:

Members have the right to:

- Be treated with respect and with due consideration for their dignity and privacy
- Receive health care services in a nondiscriminatory fashion
- Receive any information in an alternative format in compliance with the Americans with Disabilities Act
- Participate with their health care providers in decision making in all aspects of their health care, including the course of treatment development, acceptable treatments and the right to refuse treatment
- Informed consent
- Choose a surrogate decision-maker to be involved, as appropriate, to assist with care decisions
- Seek a second opinion from a qualified health care professional within the Amerigroup network, or Amerigroup will arrange for the member to obtain a second opinion outside the network at no cost to the member; a second opinion may be requested when the member or member's legal guardian needs additional information regarding recommended treatment or believes the provider is not authorizing requested care
- Voice grievances about the care provided by Amerigroup and to make use of the Amerigroup grievance process and the Human Services Department (HSD) fair hearings process without fear of retaliation
- Choose from among the available providers within the limits of the plan network and its referral and precertification requirements
- Make their wishes known through advance directives regarding health care decisions (e.g., living wills, right to die directives, do not resuscitate orders, etc.) consistent with federal and state laws and regulations
- Access their medical records in accordance with the applicable federal and state laws and regulations
- Receive information about: Amerigroup, our health care services, how to access those services and Amerigroup network providers
- Be free from harassment by Amerigroup or our network providers in regard to contractual disputes between Amerigroup and providers
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal or state of New Mexico regulations on the use of restraints and seclusion
- Select an MCO and exercise switch enrollment rights without threats or harassment
- Receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent
- Be notified that oral interpretation is available and how to access those services

- As potential members, to receive information about the basic features of managed care, which populations may or may not enroll in the program and the MCO's responsibilities for coordination of care in a timely manner in order to make an informed choice
- Receive a complete description of disenrollment rights at least annually
- Receive notice of any significant changes in the Benefits Package at least 30 days before the intended effective date of the change
- Receive information on the grievance, appeal and fair hearing procedures
- Receive the policy on referrals for specialty care and other benefits not provided by the members' PCP
- Have their privacy protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that they are applicable
- Participate in the decision-making about the health care services they receive
- Refuse health care (to the extent of the law) and understand the consequences of their refusal
- Decide ahead of time the kinds of care they want if they become sick, injured or seriously ill by making a living will
- Expect that their records (including medical and personal information) and communications will be treated confidentially
- If under age 18 and married, pregnant or with a child, be able to make decisions about themselves and/or their child's health care
- Choose their PCP or specialist(s) from the Amerigroup network of providers
- Have a candid discussion of appropriate clinically or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Receive information about Amerigroup, our services, our practitioners and providers and member rights and responsibilities
- Receive information on the Notice of Privacy Practices as required by HIPAA
- Get a current Member Handbook and a Directory of Health Care Providers within the Amerigroup network
- Choose any Amerigroup network specialist after getting a referral from their PCP; some services do not require a referral, such as family planning
- 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 symptoms meet the definition of an emergency medical condition
- In certain circumstances, get poststabilization services following an emergency medical condition
- Call our Nurse HelpLine toll free 24 hours a day, 7 days a week
- Call our Member Services staff toll free from 8:00 a.m. to 5:00 p.m. Mountain Time Monday through Friday
- Know what payment methodology Amerigroup utilizes with health care providers
- 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
- Continue to receive benefits pending the outcome of appeal or fair hearing under certain circumstances

- Only be responsible for cost-sharing as defined in the Cost-Sharing Information section of this manual
- Make recommendations regarding the organization's member rights and responsibilities policies

Members have the responsibility to:

- Provide, whenever possible, information that Amerigroup and providers need in order to care for them
- Understand thier health problems and to participate in developing mutually agreed upon treatment goals
- Follow the plans and instructions for care that they have agreed upon with their providers
- Keep, reschedule or cancel an appointment rather than to simply not show up
- 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 health care
- Tell their PCP and/or their treating physician about their symptoms and problems, and ask questions
- Get information and understand their health problems and consider treatments to participate in developing mutually agreed upon treatment goals before services 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
- Secure referrals from their PCP when specifically required before going to another health care provider unless they have a medical emergency
- Call Amerigroup and change their PCP before seeing the new PCP
- Make and keep appointments and be on time; members should always call if they need to cancel an appointment, change an appointment time or if they will be late
- Discuss grievances, 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 the member enrolls
- Become involved in their health care and cooperate with their doctor about recommended treatment and care that they have agreed on with their doctor
- Know the correct way to take their medications
- Show their ID cards to each provider
- Tell Amerigroup about any doctors they are currently seeing
- 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

Member Grievance Resolution

Amerigroup will provide members with a grievance resolution process. The member, legal guardian of the member if a minor or incapacitated adult, or a representative of the member as designated in writing to Amerigroup, has the right to file a grievance on behalf of the member. A provider acting on behalf of the member, with the member's written consent, may also file a grievance.

Member grievances do not relate to medical management actions or interpretation of medically necessary benefits. A grievance regarding an adverse action taken by Amerigroup to deny, reduce, terminate, delay or suspend a covered service, as well as any other acts or omissions of Amerigroup which impair the quality, timeliness or availability of such benefits, will be considered an appeal.

Definitions:

Action: The denial or limited authorization of a requested service, including:
- The type and level of service
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or in part, of payment of service
- The failure to provide services in a timely manner
- The failure of Amerigroup to act within certain time frames
- For a resident of a rural area with only one MCO, the denial of a Medicaid member's request to exercise his or her right, under 42 C.F.R. Section 438.52(b)(2)(ii), to obtain services outside the network

Appeal is a request for review by Amerigroup of an Amerigroup action.

Grievance: A verbal or written statement by a member expressing dissatisfaction regarding any aspect of the Amerigroup administration of CoLTS or its operations that is not an action.

Resolution: The final decision made by Amerigroup and communicated to the member.

When processing grievances, Amerigroup will determine whether a particular grievance involves a utilization management determination resulting in a denial, termination or other limitation of covered health care services. In those instances where Amerigroup is uncertain whether a particular grievance involves a utilization management determination, Amerigroup will process the grievance as one involving a utilization management determination (i.e., an appeal).

Amerigroup will not take punitive or retaliatory action against a member or a provider that files a grievance or a provider that support a member's grievance.

Information about how to file a grievance is available in writing in English and Spanish. This information includes the toll-free telephone number for the Member Services hotline and the appropriate mailing address. Other assistance is provided as needed, including other language translations, formats

accessible to the visually impaired, TDD and TTY lines for the deaf, explanation of the grievance process, and assistance with completion of forms if necessary.

The member or person acting on behalf of a member (and with the member's consent) may file a grievance by phone, fax, mail, e-mail or in person within 90 calendar days of the date that the member became aware of the issue. Any supporting documentation will accompany the grievance. A member representative must have the member's written consent to file a grievance on the member's behalf. Grievances can be filed in writing by mail or verbally using the following sources:

Amerigroup Community Care of New Mexico, Inc.
6565 Americas Parkway NE, Suite 110
Albuquerque, NM 87110
1-800-600-4441

When a member notifies Amerigroup of a grievance (either verbally or in writing), an Acknowledgment Letter will be sent to the member within 5 business days of receipt of the grievance. The Acknowledgment Letter acknowledges the date of the Amerigroup receipt of the grievance and provides the member with an expected resolution date.

In those instances when a member initially makes a verbal grievance and expresses interest in pursuing a written grievance, Amerigroup will assist the member in making a written grievance.

Amerigroup fully investigates each grievance and documents the substance of the grievance. Amerigroup will assume that every statement of dissatisfaction constitutes a grievance until the following is confirmed:

- The subject matter of the grievance may be resolved without processing through the grievance process
- The grievant does not wish to pursue a grievance

The Amerigroup total time for acknowledgment, investigation and resolution of the grievances will be 30 calendar days or less from the date Amerigroup receives the initial grievance from the complainant.

If delays are outside of the control of Amerigroup (e.g., the result of a third party's failure to provide documentation in a timely fashion or awaiting response from the complainant for additional information) Amerigroup may request a 14-calendar-day extension from HSD/MAD/ALTSD for all appeals and grievances. Amerigroup will notify the member in writing of the cause for the approved extension within 2 days.

The member will be notified in writing of the resolution of Amerigroup within 5 days after Amerigroup has arrived at a disposition and no more than 30 calendars days from the date of the grievance. The resolution letter will include:

- All information considered in investigating the grievance
- Findings and conclusions based upon the investigation
- The disposition of the grievance

The member can contact the following state agency if he or she is not satisfied with the resolution of their grievance:

New Mexico Human Services Department
Medical Assistance Division, Client Services Bureau
P.O. Box 2348
Santa Fe, New Mexico 87504
1-888-997-2583 or 505-827-3100

Tracking and Reporting

Grievances will be tracked and trended by our Quality Management Department. Records will include, at a minimum:

- Date grievance filed
- Date and outcome of all actions and findings
- All letters and documentation submitted regarding the grievance

Our Quality Management Department will maintain grievance records and keep them readily available for state inspection.

First Line of Defense Against Fraud and Abuse

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 commitment of Amerigroup 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 the 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.

The Amerigroup policy on Fraud, Waste and Abuse Prevention and Detection is part of the Amerigroup Corporate Compliance Program. Electronic copies of this policy and the Amerigroup Code of Business Conduct and Ethics are available at www.amerigroupcorp.com/corporate.

Amerigroup maintains several ways to report suspected fraud, waste and abuse. As an Amerigroup provider and a participant in federally or state sponsored health care, each of you are obligated to report suspected fraud, waste and abuse. These reports can be made anonymously at http://amerigroup.silentwhistle.com. In addition to anonymous reporting, suspected fraud, waste and abuse may also be sent via e-mail to corpinvest@amerigroupcorp.com. Suspected fraud may also be reported by calling our Customer Service at 1-800-600-4441, leaving a message on our anonymous Compliance Hotline at 1-877-660-7890 or reaching out directly to the Amerigroup Corporation Chief Compliance Officer Georgia Dodds Foley at 757-473-2711 or via e-mail to georgia.foley@amerigroup.com.

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 provider staff members or contractors who work with Amerigroup. If you have questions or would like to have more details concerning the Amerigroup fraud, waste and abuse detection, prevention and mitigation program, please contact the Amerigroup Chief Compliance Officer.

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 crack down on 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 and detect member and provider fraud and abuse, so you can be the first line of defense.

There are many types of fraud and abuse, such as:

Provider Fraud, Waste and Abuse

- Billing for services not rendered
- Billing for services that were not medically necessary
- Double billing
- Unbundling
- Upcoding

Providers can help prevent fraud, waste and abuse by ensuring that the services rendered are medically necessary, accurately documented in the medical records and billed according to AMA guidelines.

Member Fraud, Waste and Abuse

- Benefit sharing
- Collusion
- Drug trafficking
- Forgery
- Illicit drug seeking
- Impersonation fraud
- Misinformation/misrepresentation
- Subrogation/third-party liability fraud
- Transportation fraud

To help prevent member fraud, waste and abuse, providers can educate members and be observant. 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 identification card. Providers should take measure to ensure the cardholder is the person named on the card.

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

We believe 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 identification card 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 1-800-600-4441, our Compliance Hotline at 757-518-3633 or online at www.amerigroupcorp.com. No individual who reports violations or suspected fraud, waste or abuse will be retaliated against; and Amerigroup will make every effort to maintain anonymity and confidentiality.

Amerigroup will immediately report to the State any activity giving rise to a reasonable suspicion of fraud, waste and abuse, including aberrant utilization derived from provider profiling. Amerigroup will promptly conduct a preliminary investigation and report the results of the investigation to the State. A formal investigation may not be conducted by Amerigroup, but the full cooperation of Amerigroup as mutually agreed to in writing between the parties during the formal investigation will be required.

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. Contracted providers must implement procedures to demonstrate compliance with the HIPAA privacy regulations.

Amerigroup recognizes our responsibility under the HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Similarly, 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 e-mail (unless encrypted) should not be used to transfer files containing member information to Amerigroup (e.g., Excel spreadsheets with claim information). Such information should be mailed or faxed.

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

Health Promotion

Amerigroup strives to improve healthy behaviors, reduce illness and improve the 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 our network providers. Additionally, on-the-ground resources will conduct face-to-face classes with members.

Amerigroup manages projects that offer our members education and information regarding their health. Ongoing projects include:

- An annual member newsletter
- Creation and distribution of AMERITIPS, the Amerigroup health education tool used to inform members of health promotion issues and topics
- Health Tips on Hold (educational telephone messages while the member is on hold)
- A monthly calendar of health education resources available to members
- Development of health education curricula and procurement of other health education tools
- Relationship development with community-based organizations to enhance opportunities for members

Service Coordination

Service coordination is designed to proactively support members' strengths and challenges and to facilitate needed care and services. All PCO, CoLTS "c" waiver and nursing facility members will receive an initial and at least an annual face-to-face assessment. Through our face-to-face assessments, service coordination helps to identify services and goals that support the member's highest level of independence.

A provider, on behalf of the member, may request participation in the program. The Service Coordinator will work with the member and providers to identify the necessary:

- Services to help improve a member's functionality

- Appropriate least restrictive setting where care or services may be delivered
- Equipment and/or supplies
- Communication (e.g., between member and PCP)

Case Management Program

The purpose of complex case management is to prospectively identify members and ensure that there are appropriate treatment resources available to address the treatment of complex conditions that reflects social condition, mental health and physical health involvement. Any practitioner can refer a member by calling 1-877-269-5660 and talking to a service coordinator or case specialist.

Disease Management Centralized Care Unit

The Amerigroup Disease Management Centralized Care Unit (DMCCU) is based on a system of coordinated care management interventions and communications designed to assist physicians and other health care professionals in managing members with chronic conditions. DMCCU services include a holistic, member-centric care management approach that allows Care Managers to focus on the multiple needs of members.

Amerigroup received initial NCQA Patient and Practitioner Oriented Accreditation in 2006 and 3 year reaccreditation in 2009 for the following DMCCU programs:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Diabetes

In addition, the Amerigroup collaborative Maternal and Child Health program provides outreach services to assists low-, moderate- and high-risk pregnant members.

Program Features - Based on NCQA Disease Management Definition:

- Proactive population identification processes
- Evidence-based national practice guidelines
- Collaborative practice models to include physician and support-service providers in treatment planning for members
- Continuous patient self-management education, including primary prevention, behavior modification programs and compliance/surveillance, as well as service coordination for high-risk members
- Ongoing process and outcomes measurement, evaluation and management
- Ongoing communication with providers regarding patient status

All Amerigroup programs are based on nationally approved clinical practice guidelines located at providers.amerigroup.com or upon request by contacting our National Customer Care Department at 1-800-454-3730.

Who Is Eligible?
All members with diagnoses of the above conditions are eligible for DMCCU services. Members are identified through continuous case finding efforts including but not be limited to welcome calls, claims mining and referrals. As a valued provider, you may also refer patients who can benefit from additional education and care management support.

Members identified for participation in any of the programs are assessed and risk-stratified based on the severity of their disease. Once enrolled in a program, they are provided with continuous education on self-management concepts which include primary prevention, behavior modification and compliance/surveillance, as well as case/care management for high-risk members. Program evaluation, outcome measurement and process improvement are built into all the programs. Providers are given updates regarding patient status and progress.

Disease Management Centralized Care Unit Provider Rights and Responsibilities
The provider has the right to:

- Obtain information about Amerigroup, including the programs and services provided, our staff and our staff qualifications, as well as any contractual relationships
- Decline to participate in or work with the Amerigroup programs and services for their patients, if contractually possible
- Be informed of how Amerigroup coordinates our DMCCU interventions with treatment plans for individual patients
- Know how to contact the person responsible for managing and communicating with the provider's patients
- Be supported by the organization to make decisions interactively with patients regarding their health care
- Receive courteous and respectful treatment from Amerigroup staff
- Communicate grievances regarding DMCCU as outlined in the Amerigroup Provider grievance procedure

Hours of Operation
Amerigroup Care Managers are Licensed Nurses/Social Workers and are available from 8:00 a.m. to 5:00 p.m. Mountain Time, Monday through Friday. However, confidential voicemail is available 24 hours a day. The Nurse HelpLine is available 24 hours a day, 7 days a week for our members at 1-800-600-4441.

Contact Information
Please call 1-888-830-4300 to reach an Amerigroup Care Manager. Additional information about DMCCU can be obtained by visiting providers.amerigroup.com. Members can obtain information about our DMCCU program by visiting www.myamerigroup.com or calling 1-888-830-4300.

6 PROVIDER RESPONSIBILITIES

Medical Home

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

Amerigroup promotes the medical home concept to all of our members. The PCP is the member's and family's initial contact point when accessing health care. The PCP's relationship with the member and family, together with the health care providers within the medical home and the extended network of consultants and specialists with whom the medical home works, have 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 or specialty/hospital services or health and health-related services by the PCP 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 with the PCP who receives them into the medical home for continuing primary medical care and preventive health services.

Additionally, CoLTS members will make use of HCBS and other community services that may require support from the PCP. Service Coordinators will support the PCP in this process.

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 by referral to the appropriate provider of care within the network. FQHCs and RHCs may be included as PCPs. Below are highlights of the PCP's responsibilities.

The PCP will:

- 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); provide coordination necessary for referrals to specialists and FFS providers (both in and out-of-network); and maintain a medical record of all services rendered by the PCP and other providers
- Provide 24 hours-a-day, 7 days-a-week coverage. Regular hours of operation should be clearly defined and communicated to members
- 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 the Amerigroup grievance procedures. Amerigroup will notify the PCP of any member grievance
- Not balance bill members. However, the PCP is entitled to collect applicable copayments 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 service 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 our 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 to members 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 will be clearly contrasted with entries regarding the provision of nonresearch related care

- Coordinate care, consistent with appropriate confidentiality and consent procedures, with all relevant specialty providers involved in a member's care
- Screen all members for behavioral health disorders (validated screening tools are available on our website at providers.amerigroup.com/NM

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. Health care services provided through Amerigroup must be accessible to all members.

Amerigroup is dedicated to arranging access to care for our members. Our 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
Urgent, nonemergency visits	Within 24 hours
Routine visits	Within 30 calendar days
Prenatal care	Within 3 weeks of (+) pregnancy test
Walk-in patients (nonurgent)	Seen if possible or scheduled, consistent with standards
Walk-in patients (urgent)	Within 24 hours

Provider Type	Appointment Type	Standard
Primary care	Routine appointments	30 days
Primary dental care	Routine appointments	Community norm
Primary care and primary dental care	Nonurgent, routine, symptomatic	14 days
Behavioral health	Nonurgent	14 days
Primary care, primary dental and behavioral health	Urgent	24 hours
Specialty	Outpatient referral/consultation	Consistent with clinical urgency, not more than 21 days
Primary care and specialty	Outpatient scheduled	45-minute wait time to be seen
Outpatient lab and diagnostic	Walk-in	Wait time must be consistent with severity of clinical need
Outpatient lab and diagnostic	Nonurgent routine	14 days
Outpatient lab and diagnostic	Urgent scheduled visits	Consistent with clinical urgency, not more than 48 hours
Pharmacy	In-person prescription fill	40 minutes

Pharmacy	Provider call-in prescription	90 minutes
All providers	Follow-up appointments	Consistent with clinical need
Pharmacy	Provision of pharmaceutical agents	Consistent with clinical need

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

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, which can contact the PCP or another designated network medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
- 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, directing 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, who can return the call within 30 minutes.

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 which directs members to go to an emergency room for any services needed
- Returning after-hours calls outside of 30 minutes

Member Missed Appointments

Members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. Amerigroup encourages providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling the appointment. The contact should be by telephone and should be designed to educate the member about the importance of keeping appointments and to encourage the member to reschedule the appointment. Service Coordinators will also assist the provider with this task as directed.

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. In these cases, please call Provider Services at 1-800-454-3730 to address the situation. Amerigroup staff will contact the member and provide more extensive education and/or service coordination as appropriate. Our

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 Members

Amerigroup recognizes that providers may need help in managing nonadherent members. If you have an issue with a member regarding behavior, treatment cooperation and/or completion of treatment, and/or making or appearing for appointments, please contact our National Customer Care Department at 1-800-454-3730.

The Service Coordinator, Service Specialist or Member Advocate will contact the member by telephone, or a Member Advocate will visit the member to provide the education and counseling to address the situation and will report to you the outcome of any counseling efforts.

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 our National Customer Care Department at 1-800-600-4441. The member's name will be provided to the PCP on the membership roster.

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 10 days.

Covering Physicians

During a provider's absence or unavailability, the provider needs to arrange for 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 members 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 members in question. In addition, the covering provider will agree to the terms and conditions of the Network Provider Agreement, including without limitation 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.

Specialist as a PCP

Under certain circumstances, when a member requires the regular care of the specialist, a specialist may be approved by Amerigroup to serve as a member's PCP. The criteria for a specialist to serve as a member's PCP include the member having 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 of arranging for care exceed the capacity of the nonspecialist 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 Service Coordination Department and complete a Specialist as PCP Request Form. An Amerigroup Service Coordinator 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 outlining the reason(s) for the denial of the request within 1 day of the decision. 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 Address and/or Practice Status

Any status changes are to be reported to:

Amerigroup Community Care of New Mexico, Inc.
Provider Relations
Two Park Square
6565 Americas Parkway N.E., Suite 110
Albuquerque, NM 87110

Specialty Referrals

In order to reduce the administrative burden on the provider's office staff, 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 the member's PCP. The provider must supply the necessary clinical information that will be reviewed by the PCP 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 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 the PCP. Additionally, Amerigroup requires the specialist physician or other health care provider to provide regular updates to the member's PCP (unless acting also as the designated PCP for the member). Should the need arise for a secondary referral, the specialist physician or other health care provider must contact Amerigroup for a coverage determination.

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 will 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 medical necessity is met.

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, parent and/or legally appointed representative, or the member's PCP may request a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition. The second opinion will be provided at no cost to the member.

The second opinion must be obtained from a network provider (see 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 own discretion. This may occur under the following circumstances:

- 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, Amerigroup will make the necessary arrangements for the appointment, payment and reporting. Amerigroup will inform the member and the PCP of the results of the second opinion and the consulting provider's conclusion and recommendation(s) regarding further action.

Specialty Care Providers

To participate in the CoLTS program, the provider must qualify for enrollment in the New Mexico Medicaid program and have all applicable licenses required by the State for the specific services to be provided to CoLTS members before signing a contract with Amerigroup.

Amerigroup contracts with a network of provider specialty types to meet the medical specialty needs of members and provide all medically necessary covered services. The specialty care provider is a network physician who has the responsibility for providing the specialized care for members, usually upon appropriate referral from a PCP within the network (See Role and Responsibility of the Specialty Care Provider). In addition to sharing many of the same responsibilities to members as the PCP (See Responsibilities of the PCP), the specialty care provider provides services that include:

- Allergy and immunology services
- Burn services
- Cardiology services
- Critical care medical services
- Dermatology services
- Endocrinology services
- Gastroenterology services
- General surgery
- Geriatrics
- Hematology/oncology services
- Neonatal services
- Nephrology services
- Neurology services
- Neurosurgery services
- Ophthalmology services
- Orthopedic surgery services
- Otolaryngology services
- Perinatal services
- Pediatric services (other than primary care)
- Pulmonology
- Rheumatology services
- Surgical services
- Trauma services
- Urology services

Role and Responsibility of the Specialty Care Providers

Specialty care 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 include, but are not limited to, the following:

- Complying with all applicable statutory and regulatory requirements of 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 precertification 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 scheduling any procedure requiring the PCP's approval
- Coordinating care, as appropriate, with other providers involved in providing care for members especially in cases where there are medical and behavioral health co-morbidities or co-occurring mental health and substance abuse disorders

The specialist will:

- Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers, including those engaged on a fee-for-service (FFS) basis; provide coordination necessary for referrals to other specialists and FFS providers (both in and out-of-network); and maintain a medical record of all services rendered by the specialist and other providers
- Provide 24 hours-a-day, 7 days-a-week coverage and maintain regular hours of operation that are clearly defined and communicated to members
- Provide services ethically and legally in a culturally competent manner and meet the unique needs of members with special health care requirements
- Participate in the systems established by Amerigroup that facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements
- Participate and cooperate with Amerigroup in any reasonable internal or external quality assurance, utilization review, continuing education or other similar programs established by Amerigroup
- Make reasonable efforts to communicate, coordinate and collaborate with other specialty care providers, including behavioral health providers, involved in delivering care and services to consumers
- Participate in and cooperate with the Amerigroup grievance processes and procedures. Amerigroup will notify the specialist of any member grievance brought against the specialist
- Not balance bill members
- Continue care in progress during and after termination of his or her contract for up to 60 days until a continuity of service 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 regarding blood-borne pathogens in compliance with Occupational Safety and Health Administration (OSHA) standards
- Make best efforts to fulfill the obligations under the Americans with Disabilities Act applicable to his or her practice location
- Support, cooperate and comply with the Amerigroup Quality Improvement Program initiatives and any related policies and procedures designed to provide quality care in a cost-effective and reasonable manner
- Inform Amerigroup if a member objects for religious reasons to the provision of any counseling, treatment or referral services
- 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 as allowed under applicable laws and regulations

- Provide to members 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 that 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 quality patient care
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention that is part of a clinical research study is clearly distinguished from entries pertaining to nonresearch related care

Specialty Care Providers Access and Availability

Amerigroup will maintain a specialty network to ensure access and availability to specialists for all members. A provider is considered a specialist if he or she has a provider agreement with Amerigroup to provide specialty services to members.

Specialist must adhere to the following access guidelines:

Service	Access Requirement
Urgent, nonemergency visits	Within 24 hours
Specialty outpatient referrals and consultation appointment	Within 21 days

Cultural Competency

Cultural competency is the integration of congruent behaviors, attitudes, structures, policies and procedures, that come together in a system, agency or among professionals to enable effective work effectively in cross-cultural situations. Cultural competency assists providers and members to:

- Acknowledge the importance of culture and language
- Assess cross-cultural relations
- Embrace cultural strengths with people and communities
- Strive to expand cultural knowledge
- Understand cultural and linguistic differences

The quality of the patient-provider interaction has a profound impact on the ability of a patient to communicate symptoms to his or her provider and to adhere to recommended treatment. Some of the reasons that justify a provider's need for cultural competency include, but are not limited to:

- The perception that illness and disease, and their causes, vary by culture
- The diversity of belief systems related to health, healing and wellness are very diverse
- The fact that culture influences help-seeking behaviors and attitudes toward health care providers
- The fact that individual preferences affect traditional and nontraditional approaches to health care
- The fact that patients must overcome their personal biases within health care systems
- The fact that health care providers from culturally and linguistically diverse groups are under-represented in the current service delivery system

Cultural barriers between the provider and member can impact the patient-provider relationship in many ways including, but not limited to:

- The member's level of comfort with the practitioner and the member's fear of what might be found upon examination
- The differences in understanding on the part of diverse consumers in the U.S. health care system
- A fear of rejection of personal health beliefs
- The member's expectation of the health care provider and of the treatment

To be culturally competent, Amerigroup expects providers serving members within this geographic location to demonstrate the following:

Cultural Awareness Needed:

- The ability to recognize the cultural factors (norms, values, communication patterns and world views), which shape personal and professional behavior
- The ability to modify one's own behavioral style to respond to the needs of others, while at the same time maintaining one's objectivity and identity

Knowledge Needed:

- Culture plays a crucial role in the formation of health or illness beliefs
- Culture is generally behind a person's rejection or acceptance of medical advice
- Different cultures have different attitudes about seeking help
- Feelings about disclosure are culturally unique
- There are differences in the acceptability and effectiveness of treatment modalities in various cultural and ethnic groups
- Verbal and nonverbal language, speech patterns and communication styles vary by culture and ethnic groups
- Resources, such as formally trained interpreters, should be offered to and utilized by members with behalf of various cultural and ethnic differences

Skills Needed:

- The ability to understand the basic similarities and differences between and among the cultures of the persons served
- The ability to recognize the values and strengths of different cultures

- The ability to interpret diverse cultural and nonverbal behavior
- The ability to develop perceptions and understanding of other's needs, values and preferred means of having those needs met
- The ability to identify and integrate the critical cultural elements of a situation to make culturally consistent inferences and to demonstrate consistency in actions
- The ability to recognize the importance of time and the use of group process to develop and enhance cross-cultural knowledge and understanding
- The ability to withhold judgment, action or speech in the absence of information about a person's culture
- The ability to listen with respect
- The ability to formulate culturally competent treatment plans
- The ability to utilize culturally appropriate community resources
- The ability to know when and how to use interpreters and to understand the limitations of using interpreters
- The ability to treat each person uniquely
- The ability to recognize racial and ethnic differences and know when to respond to culturally-based cues
- The ability to seek out information
- The ability to use agency resources
- The capacity to respond flexibly to a range of possible solutions
- Acceptance of ethnic differences among people and an understanding of how these differences affect the treatment process
- A willingness to work with clients of various ethnic minority groups

Member Records

Utilizing 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 will be maintained at the primary care site for every member and be available to the PCP and other providers. Medical records must be kept in accordance with Amerigroup and state standards as follows:

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. Grievance or 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 will, 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. The record must include: date of birth, sex, mailing address and residential address, employer (if applicable), race and ethnicity (if available), home, school and work telephone numbers, marital status, emergency contacts, consent forms, and guardianship information.
3. Date and corroboration. All entries must be dated and author identified. Records also include date of encounter.
4. Legibility. 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 two or more times). Past medical history must be easily identified including, to the extent possible, reports of emergency care, serious accidents, operations, illnesses, hospital admissions and discharge summaries. For children and adolescents (18 years and younger), the history must include prenatal care of the mother and birth.
7. Status of preventive services. At least those specified by HSD must be summarized in auditable form (a single sheet) within 6 months of enrollment. Preventive screening and services will be offered in accordance with the Amerigroup clinical practice guidelines.
8. Immunizations. For pediatric records age 13 and under, a completed immunization record or a notation of prior immunization must be recorded including vaccines and their dates of administration when possible. Providers are encouraged to verify and document all administered immunizations for children and adults in the New Mexico Statewide Immunization Information System (SIIS).
9. Diagnostic information.
10. Medication information. Medication history will include what has been effective, and what has not and why.
11. Problem list. Containing significant illnesses and medical conditions.
12. Identification of current problems. Significant illnesses, medical and behavioral health conditions and health maintenance concerns must be identified in the medical record.
13. Working diagnoses. Are consistent with findings.

14. Treatment plans. Are consistent with diagnoses.
15. Instructions. Record must include evidence that the patient was provided with basic teaching/instructions regarding physical and/or behavioral health condition.
16. 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.
17. Consultations, referrals and specialist reports. Notes from any referrals and consultations must be in the record. Consultation, lab and X-ray reports filed in the chart must 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.
18. 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 to the extent possible.
19. Hospital discharge summaries. Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the patient is enrolled and for prior admissions, as appropriate. Prior admissions pertaining to admissions that may have occurred prior to the patient being enrolled may be pertinent to the patient's current medical condition.
20. Advance directive. 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 that directs health care decision-making for individuals who are incapacitated.
21. Security. Provider must maintain a written policy is required to ensure that medical records are safeguarded against loss, destruction or unauthorized use.
22. Release of information. Written procedures are required for the release of information and obtaining consent for treatment.
23. Multidisciplinary teams. Documentation is required of the team members involved in the multidisciplinary team of a patient needing specialty care.
24. 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 which 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
    - At least quarterly (or more often if clinically indicated), a summary of the status/progress from the behavioral health provider to the PCP
    - A written release of information that will permit 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

- HCBS or social services necessary to support the member in his or her desired residence

In addition, Amerigroup will retain all member medical records, social service records, collected data and other information subject to the State and Federal reporting or monitoring requirements for 10 years after the contract is terminated or 10 years after any pending audit is completed and resolved, whichever is later. These records will be subject to inspection by the State and/or the Department of Finance and Administration and/or any authorized State or Federal entity. The Health and Human Services (HHS) awarding agency, the U.S. Comptroller General or any representatives will have access to any books, documents, papers and records of Amerigroup which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions. This right also includes timely and reasonable access to our personnel for the purpose of interview and discussion related to such documents.

Providers will maintain medical, financial and administrative records concerning services provided to members in accordance with industry standards and regulatory requirements, including without limitation applicable law regarding confidentiality of member information. Records will be retained by providers for no less than 10 years from the date the service is rendered. Providers will provide state and federal agencies access to review records related to services provided hereunder in accordance with regulatory requirements. Providers will have available medical records for each clinical encounter. Providers will permit Amerigroup or its designated agent to review records directly related to services provided to members with respect to their medical records to permit Amerigroup access to such records. Providers will supply the records described above at no charge upon request.

Patient Visit Data

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

1. A history and physical exam for presenting complaints containing relevant psychological and social conditions affecting the patient's behavioral health, including mental health (psychiatric) and substance abuse status
2. A plan of treatment that includes activities/therapies and goals to be carried out
3. Evidence that diagnostic, laboratory tests, or other therapeutic interventions and studies are ordered as appropriate
4. Evidence of test results and PCP review
5. Evidence that working diagnoses are consistent with the results
6. Evidence that the treatment plan is consistent with the diagnoses
7. Drugs prescribed, including the strength, amount, directions for use and refills
8. Reports of therapies and other prescribed regimens and the results
9. Encounter forms or notes include information regarding follow-up care, calls or visits (including behavioral health); the specific time of return is noted in days, weeks, months or as needed
10. Consultations, referrals and the results with evidence of PCP review
11. Consultations, referrals, diagnostic reports and test results have explicit notation of follow-up plans
12. Any other significant aspect of the member's physical or behavioral health services
13. Unresolved issues from previous office visits are addressed in subsequent visits

Amerigroup will systematically review medical records to ensure compliance with these standards. Amerigroup 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, i.e., records must be retained for 10 years from the date of service. Records will be made accessible on request to agencies of the state of New Mexico and the federal government.

Clinical Practice Guidelines

Using nationally recognized standards of care, Amerigroup works with providers to develop clinical policies and guidelines for the care of our membership. The Medical Advisory Committee (MAC) oversees and directs Amerigroup in formulating, adopting and monitoring guidelines for preventive health care and management of chronic diseases.

Amerigroup will measure performance against at least two important aspects of three clinical practice guidelines annually. The guidelines must be reviewed and revised at least every 2 years or whenever the guidelines change.

Clinical practice guidelines are located on our website at providers.amerigroup.com/NM. A copy of the guidelines can be printed from the website, or you can contact Provider Services at the National Customer Care Department at 1-800-454-3730 to receive a printed copy. Appendix B contains a list of the guidelines. Providers will be notified when guidelines have been updated.

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 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 over age 18 and emancipated minors are able to make an advance directive. Their 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.

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.

Amerigroup notes the presence of advance directives in the medical records when conducting medical record reviews. A living will and durable power of attorney are located in Appendix A – Forms.

7 MEDICAL MANAGEMENT

Medical Review Criteria

Amerigroup uses nationally recognized Standards of Care as guidelines in medical decision making. These standards are available upon request by the provider. Amerigroup works with network providers to develop clinical guidelines of care for our membership. The Medical Advisory Committee assists Amerigroup in formalizing and monitoring guidelines.

If Amerigroup utilizes 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 of criteria, the process used in such development, and when and how often the criteria will be evaluated and updated

Clinical Criteria

Amerigroup uses nationally recognized Standards of Care for clinical decision support for medical management coverage decisions. The criteria provides 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
- Home care
- Imaging studies and X-rays
- Rehabilitation
- Subacute care
- Surgery and procedures

Amerigroup utilization reviewers use these criteria as part of the precertification 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 to make clinical determinations are available upon request by contacting Amerigroup at 1-800-454-3730. Requests for the criteria may also be submitted in writing to:

Amerigroup Community Care of New Mexico, Inc.
Attn: Provider Relations
Two Park Square
6565 Americas Parkway NE Suite 110
Albuquerque, NM 87110

Precertification/Notification Process

Amerigroup may require members to seek a referral from their PCP prior to accessing nonemergency specialty physical health services. **Precertification** is defined as: 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. **Notification** is defined as: prior to rendering covered medical services to a member, the provider must notify Amerigroup by telephone or fax of the intent to do so. However, member eligibility and provider status (network and non-network) are verified. Additionally, primary care physicians must coordinate all specialist referrals in accordance with managed care principles. Members may self-refer for obstetrical, gynecological, family planning and outpatient behavioral health services (mental health and substance abuse) without PCP coordination or precertification. Participating specialists are not required to submit referral forms with claims. See Precertification/Notification Coverage Guidelines in Section 9.

Amerigroup staff is available 24 hours a day, 7 days a week by calling 1-800-454-3730 toll free for any questions regarding the UM process.

Medical Necessity Appeal Process and Procedures

Amerigroup has established and maintains a system for the resolution of dissatisfaction of actions filed by a member or a provider acting on behalf of a member with respect to the denial or limitation of coverage of health care services.

An **appeal** is a request for review by Amerigroup of an Amerigroup action.

An **action** is defined as the denial or limited authorization of a requested service, including:

- The type and level of service
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or in part, of payment of service
- The failure to provide services in a timely manner
- The failure of Amerigroup to act within certain time frames
- For a resident of a rural area with only one MCO, the denial of a Medicaid members request to exercise his or her right, under 42 C.F.R. Section 438.52(b)(2)(ii), to obtain services outside the network

An untimely service authorization constitutes a denial and is thus considered an action.

Notice of an Amerigroup Action

Amerigroup will not arbitrarily deny services or procedures, or reduce by amount, duration, or scope solely because of diagnosis, type of illness, or the member's condition. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, will be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease. Such health care professionals will include the Plan's Medical

Director, a board-certified consultant or a physician under the clinical direction of the Plan's Medical Director. Denials of claims that may result in member financial liability require immediate member notification.

1. Amerigroup will make available a physician reviewer to discuss, by telephone, denial decisions based on medical necessity to a requesting provider. Providers may call 505-875-4320 to request a peer-to-peer discussion with the physician reviewer.
2. The Plan's Medical Director or his physician designee will be available to make decisions in urgent cases and on an as-needed basis for all other cases, as required by the medical situation.
3. Amerigroup will provide written notification to the requesting provider and to the member of any decision to deny a service authorization request or to authorize a service in the amount, duration or scope that is less than requested.
4. At the time of denial notification, both members and providers will be notified of how to initiate an expedited appeal.
5. For nonurgent preservice decisions (standard authorization) of care, a decision will be made within 14 calendar days of receipt of request for service and the provider/member will be notified within 1 business day; however, notification must be made within 15 calendar days of the recipt of request.
6. For nonurgent concurrent reviews (e.g., ongoing long term services), a decision will be made within 10 working days and the provider/member will be notified within 1 working day.
7. For urgent concurrent review, a decision/notification will be made within 24 hours of the request.
8. For urgent preservice (expedited authorization of care), a decision and notification to member/provider will be made within 3 calendar days of receipt of request for service.
9. The failure to complete the authorization request in a timely manner will constitute a denial and will be considered an action by Amerigroup.
    a) Amerigroup will notify the member and the provider within 15 business days of the date of the action.
    b) Denials of claims that may result in member financial liability require immediate notification.
10. All written notifications of denial will include the following:
    a) Notice that a physician reviewer (or other appropriate practitioner) is available to discuss the UM denial decision and how to contact the reviewer.
    b) The action Amerigroup has taken or intends to take.
    c) The reasons for the action based upon the applicable medical necessity or benefit criteria.
    d) Notification that a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decisions was based is available upon request.
    e) The member's or the provider's right, as applicable, to file an appeal of the Amerigroup action through amerigroup.
    f) An explanation of the appeal process that includes the right to submit written comments, documents or other information relevant to the appeal; and the right to member representation by anyone of their choosing; and timeframes for deciding appeals.
    g) The member's right to request an HSD/MAD fair hearing and what the process would be.
    h) The procedures for exercising the rights specified.

i) The circumstances under which expedited resolution of an appeal is available and how to request it.

j) The member's right to have benefits continue pending resolution of an appeal or fair hearing, how to request the continuation of benefits, and the circumstances under which the member may be required to pay the costs of continuing these benefits.

Exceptions to the notification requirements above include the following:

- The period of advance notice is shortened to 5 business days if recipient fraud has been verified
- The period of advance notice is the lesser of the notification requirements listed above or by the date of the action for the following:
  - The death of a member
  - A signed written statement from the member requesting service termination or giving information requiring termination or reduction of covered services (where the member understands that this must be the result of supplying that information)
  - The member's admission to an institution where he is ineligible for further services
  - The member's address is unknown and mail directed to the member has no forwarding address
  - The member has been accepted for Medicaid services in another jurisdiction
  - The member's physician prescribes the change in level of medical care
  - An adverse determination made with regard to preadmission screening requirements for nursing facility admissions on or after January 1, 1989
  - The safety and health of individuals in the facility would be endangered, the member's health improves significantly to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or a member has not resided in the nursing facility for 30 calendar days (which applies only to adverse actions for nursing facility transfers)

Medical Necessity Appeal Process

A member may file an appeal of an action within 90 calendar days of receiving our Notice of Action. The following have the right to file an appeal of an action on behalf of the member:

- The legal guardian of the member, if a minor
- A representative of the member as designated in writing to Amerigroup, if a incapacitated adult
- A provider acting on behalf of the member with the member's written consent

Amerigroup will consider the member, representative or estate representative of a deceased member as parties to the appeal.

Amerigroup has 30 calendar days from the date the initial oral or written appeal is received by Amerigroup to resolve the appeal.

Amerigroup has a process in place that ensures that an oral or written inquiry from a member seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). An oral appeal must be followed by a written appeal that is signed by the member within 10 calendar days. Amerigroup will use its best efforts to assist members as needed with the written appeal.

Within 5 working days of receipt of the appeal, Amerigroup will provide the member with written notice that the appeal has been received and the expected date of its resolution. Amerigroup will confirm in writing receipt of oral appeals, unless the member or the provider requests an expedited resolution.

Amerigroup may request an extension from HSD/MAD of up to 14 days if the member requests the extension, or Amerigroup demonstrates to HSD/MAD that there is need for additional information, and the extension is in the member's best interest. For any extension not requested by the member, Amerigroup will give the member written notice of the extension and the reason for the extension within 2 business days of the decision to extend the time frame.

Amerigroup will provide the member and/or the member's representative a reasonable opportunity to present evidence and allegations of the fact or law in person as well as in writing.

Amerigroup will provide the member and/or the member's representative the opportunity, before and during the appeals process, to examine the member's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. The member and his or her representative or the legal representative of a deceased member's estate will be included as parties to the appeal.

For all appeals, Amerigroup will provide written notice within 30 calendar days of the appeal resolution to the member and the provider, if the provider filed the appeal on the member's behalf. The written notice of the appeal resolution in the member's favor must include, but is not limited to, the following:

- The result(s) of the appeal resolution
- The date it was completed

The written notice of the appeal resolution for appeals not resolved wholly in favor of the member will include, but not be limited to, the following information:

- The right to request a HSD/MAD Fair Hearing and instructions on how to file for a Fair Hearing
- The right to request receipt of benefits while the Fair Hearing is pending and how to make the request
- That the member may be held liable for the cost of continuing benefits if the Fair Hearing decision upholds the Amerigroup action
- The specific reasons for the appeal decision, in easily understandable language
- A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based
- Notification that the member can obtain, upon request, a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based
- Notification that the member is entitled to receive, upon request, reasonable access to and copies of all documents relevant to the appeal. Relevant documents include documents or records relied upon and documents and records submitted in the course of making the appeal decision
- A list of titles and qualifications of each individual participating in the appeal review, including specialty (as appropriate)

Amerigroup may continue covered services and other benefits while the appeal and/or the HSD/MAD Fair Hearing process is pending. Amerigroup will continue the member's covered services and other benefits if all of the following are met:

- The member or the provider files a timely appeal of the action and/or asks for a fair hearing within 13 days from the date on the notice of action
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment; this does not include a new annual authorization for services which may be lower than provided in the previous year
- The services were ordered by an authorized provider
- The time period covered by the original authorization has not expired
- The member requests an extension of the benefits

Amerigroup will provide covered service and other benefits until one of the following occurs:

- The member withdraws the appeal
- Thirteen calendar days have passed since the date Amerigroup mailed the resolution letter, provided the resolution of the appeal was against the member and the member has taken no further action
- HSD/MAD issues a hearing decision adverse to the member
- The time period or service limits of a previously authorized service has expired

If the final resolution of the appeal is adverse to the member, that is, the Amerigroup action is upheld, Amerigroup may recover the cost of the services furnished to the member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 C.F.R. §431.230(b).

If Amerigroup or HSD/MAD reverses a decision to deny, limit or delay services and these services were not furnished while the appeal was pending, Amerigroup will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

If Amerigroup or HSD/MAD reverses a decision to deny, limit or delay services and the member received the disputed services while the appeal was pending, Amerigroup will pay for these services.

Expedited Resolution of Appeals

An expedited resolution of an appeal is an expedited review by Amerigroup of an action. Amerigroup has established and maintains an expedited review process for appeals when Amerigroup determines that allowing the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. Such a determination is based on:

- A request from the member
- A provider's support of the member's request
- A provider's request on behalf of the member
- The independent determination of Amerigroup

Amerigroup ensures that the expedited review process is convenient and efficient for the member.

Amerigroup will resolve the appeal within 72 hours of receipt of the request for an expedited appeal, if the request meets the definition of an expedited appeal. In addition to written resolution notice, Amerigroup will provide verbal notification to the involved practitioner, who is acting as the member's authorized representative, followed by written notification to the member and involved practitioner(s) within 3 calendar days after the initial verbal notification.

Amerigroup may extend the time frame by up to 14 calendar days if the member requests the extension or Amerigroup demonstrates to HSD/MAD that there is need for additional information and the extension is in the member's best interest. For any extension not requested by the member, Amerigroup will make reasonable efforts to give the member prompt verbal notification and follow-up with a written notice within 2 business days.

Amerigroup will:

- Ensure that punitive action is not taken against a member or a provider who requests an expedited resolution or supports a member's expedited appeal.
- Provide an expedited resolution of an appeal, if the request meets the definition of an expedited appeal, in response to an oral or written request from the member or provider on behalf of the member.
- Inform the member of the limited time available to present evidence and allegations in fact or law.

If Amerigroup denies a request for an expedited resolution of an appeal, Amerigroup will:

- Transfer the appeal to the 30-day time frame for standard resolution, in which the 30-day period begins on the date Amerigroup received the original request for appeal
- Make reasonable efforts to give the member prompt oral notice of the denial and follow up with a written notice within 2 business days
- Inform the member in the written notice of the right to file an appeal and/or request an HSD/MAD Fair Hearing if the member is dissatisfied with our decision to deny an expedited resolution

Amerigroup will document in writing all oral requests for expedited resolution and will maintain the documentation in the case file.

Special Rule for Certain Expedited Service Authorization Decisions

In the case of expedited service authorization decisions that deny or limit services, Amerigroup will, within 72 hours of receipt of the request for service, automatically file an appeal on behalf of the member and use its best effort to give the member oral notice of the decision on the automatic appeal and to resolve the appeal. For purpose of this section, an expedited service authorization is a certification requesting urgently needed care or services.

Note: Medical necessity appeals do not apply to nonmedical issues. Nonmedical concerns are classified as grievances and are addressed in the member grievance resolution policy and procedure. (See Section 5 – Member Grievance Resolution)

Continuation of Benefits

Members may request a continuation of their benefits during the medical appeal process by contacting the Care Coordination line at 1-877-269-5660. To ensure continuation of currently authorized services, the member or person acting on behalf of the member must file a medical appeal on or before the later of 13 calendar days following our mailing of the Notice of Action or the intended effective date of the Action.

Amerigroup will continue the member's coverage of benefits if the following conditions are met:

- The member or the provider files the appeal timely (as defined above)
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment or service
- The services were ordered by an authorized provider
- The original period covered by the original authorization has not expired
- The member requests extension of benefits

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

- The member withdraws the medical appeal or request for the State Fair hearing
- 13 calendar days pass after Amerigroup mails the medical appeal determination letter, unless the member has, within the 13 calendar days, requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached
- The time period or service limits of a previously authorized service has been met

It is important that the member understands that he or she is responsible for the continued benefits if the final determination of the medical appeal is not in the member's favor. If the final determination is NOT in the member's favor, the member will need to pay for the disputed services. If the final determination of the medical 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.

8 HOSPITAL AND ELECTIVE ADMISSION MANAGEMENT

Amerigroup requires precertification of all inpatient elective admissions. The referring primary care or specialist physician is responsible for precertification.

The referring physician identifies the need to schedule a hospital admission and must submit the request to our Medical Management Department.

Requests for precertification with all supporting documentation should be submitted immediately upon identifying the inpatient request or at least 72 hours prior to the scheduled admission. This will allow Amerigroup to verify benefits and process the precertification request. For services that require precertification, Amerigroup makes case by case determinations that consider the individuals' health care needs and medical history, in conjunction with nationally recognized standards of care.

The hospital can confirm that an authorization is on file by calling the Amerigroup automated Provider Inquiry Line at 1-800-454-3730 (see Section 12 for instructions on use of the Provider Inquiry Line). If coverage of an admission has not been approved, the facility should call Amerigroup at 1-800-454-3730. Amerigroup will contact the referring physician directly to resolve the issue.

Amerigroup is available 24 hours a day, 7 days a week to accept precertification requests. When a request is received from the physician via telephone or fax for medical services, the care specialist will verify eligibility and benefits. This information will be forwarded to the precertification nurse.

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

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with nationally recognized standards of care, an Amerigroup reference number will be issued to the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

If medical necessity criteria for the admission are not met on the initial review, the Medical Director will contact the requesting physician to discuss the case.

If the precertification documentation is incomplete or inadequate, the precertification nurse will not approve coverage of the request but will notify the referring provider of the required time frame to submit the additional necessary documentation. Determinations are made within the required time frames regardless of whether the necessary information is present to make the determination.

If the Medical Director denies coverage of the request, the appropriate denial letter (including the member's appeal rights) will be mailed to the requesting provider, member's PCP and member.

Emergent Admission Notification Requirements

Amerigroup prefers immediate notification by network hospitals of emergent admissions. Network hospitals must notify Amerigroup of emergent admissions within 1 business day. Amerigroup Medical Management staff will verify eligibility and determine benefit coverage.

Amerigroup is available 24 hours a day, 7 days a week to accept emergent admission notification at our National Customer Care Department at 1-800-454-3730.

If the notification documentation provided is incomplete or inadequate, Amerigroup will not approve coverage of the request but will notify the hospital of the required time frame to submit the additional necessary documentation. Determinations are made within the required time frame regardless of whether the necessary information is present to make the determination.

If the Medical Director denies coverage of the request, the appropriate denial letter will be mailed to the hospital, member's PCP and member. **Note:** Amerigroup does not require notice or precertification to treat an emergency medical condition.

Nonemergent Outpatient and Ancillary Services – Precertification and Notification Requirements

Amerigroup requires precertification for coverage of selected nonemergent outpatient and ancillary services (see chart below). To ensure timeliness of the authorization, the expectation of the facility and/or provider is that the following must be provided:

- Member name and ID
- Name, telephone number and fax number of physician performing the elective service
- Name of the facility and telephone number where the service is to be performed
- Date of service
- Member diagnosis
- Name of elective procedure to be performed with CPT-4 code
- Medical information to support requested services (medical information includes current signs/symptoms, past and current treatment plans, response to treatment plans and medications)

The table below contains precertification and notification requirement guidelines:

Precertification/Notification Coverage Guidelines		
Service	**Requirement**	**Comments**
Adaptive Aids	Precertification	Precertification is required for adaptive aids
Adult Day Care/Day Health Services	Precertification	Precertification required for coverage of all services.
Behavioral Health/ Substance Abuse Assessments	Referral to OptumHealth New Mexico, Statewide Entity	
Chemotherapy	See comments	No precertification is required for coverage of chemotherapy procedures

Precertification/Notification Coverage Guidelines		
Service	**Requirement**	**Comments**
		when performed in an outpatient setting by a participating facility, provider: office, outpatient hospital or ambulatory surgery center. For information on coverage of chemotherapy drugs, please see the Pharmacy section. **Note:** Precertification is required for coverage of inpatient services.
Dental	See comments	Precertification is required for oral maxillofacial and dental services related to accidental injury to teeth.
Dermatology Services	See comments	No precertification required for network provider for E&M, testing and procedures. Services considered cosmetic in nature are not covered. Services related to previous cosmetic procedures are not covered. See Diagnostic Testing.
Diagnostic Testing	See comments	No precertification is required for routine diagnostic testing. Precertification is required for coverage of MRA, MRI, CAT scans, nuclear cardiac, PET scans and video EEG.
Durable Medical Equipment (DME)	Precertification and Certificate of Medical Necessity	• No precertification is required for coverage of glucometers and nebulizers, dialysis and ESRD equipment, gradient pressure aids, infant photo/light therapy, UV light therapy, sphygmomanometers, walkers and orthotics for arch support, heels, lifts, shoe inserts and wedges by network provider. • Precertification is required for coverage of certain prosthetics, orthotics and DME. For code-specific precertification requirements for DME, Prosthetics and orthotics ordered by network provider or network facility, please refer to providers.amerigroup.com and click on Precertification Look-up Tool. • See Medical Supplies for guidelines relating to disposable medical supplies. • Precertification may be requested by completing a Certificate of Medical Necessity (CMN) — available at providers.amerigroup.com — 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 (CPAP) devices, lymphedema pumps, osteogenesis stimulators, transcutaneous electrical nerve stimulator (TENS) units, seat lift mechanisms, power operated vehicles (POVs), external infusion pumps, parenteral nutrition, enteral nutrition and oxygen. Amerigroup and provider must agree on HCPCS and/or other codes for billing covered services. All custom wheelchair precertifications require Medical Director's review. • All DME billed with an RR modifier (rental) requires precertification.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Visit	Self-referral	Utilize EPSDT schedule and **document** visits. For those providers participating in Vaccine For Children (VFC) Program, vaccines should be delivered by VFC. For those providers **not** participating in VFC, please provide the appropriate immunizations and bill Amerigroup.

Precertification/Notification Coverage Guidelines		
Service	**Requirement**	**Comments**
EPSDT-Personal Care	Precertification	Precertification is required for coverage of medically necessary basic personal care services, cognitive assistance and assistance with eating and other nutritional activities provided to recipients under 21 years of age.
EPSDT-Private Duty Nursing	Precertification	Precertification is required for coverage of services provided to recipients under 21 years of age at home and medically necessary skilled nursing services for attending school and provided to the recipient in the school setting.
EPSDT-Rehabilitation Services	Precertification	Precertification is required for coverage of speech therapy, physical therapy and occupational therapy services for recipients under 21 years of age. Specifically covered are evaluations, individual therapy and group therapy in an outpatient setting. Services must be medically necessary and provided for the purpose of diagnostic study or treatment. Services must be designed to improve, restore or maintain the recipient's condition including controlling symptoms and maintaining the functional level to avoid further deterioration.
Educational Consultation	See comments	No notification or precertification required.
Emergency Room	No precertification required	Emergency care in the ER does not require prior notification. If emergency care results in an observation or admission, notification to Amerigroup is required within 24 hours or the next business day.
ENT Services (Otolaryngology)	See comments	No precertification required for network provider E&M, testing and procedures. Precertification required for tonsillectomy and/or adenoidectomy 12 years and older, nasal/sinus surgery, and cochlear implant surgery and services. See Diagnostic Testing.
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 (e.g., IUD). • Infertility services and treatment are not covered.
Gastroenterology Services	See comments	No precertification is required for network provider for E&M, testing and procedures. See Diagnostic Testing.
Gynecology	See comments	Self-referral to network provider. No precertification is required for E&M, testing and procedures. Precertification is required for coverage of an elective surgery.
Hearing Aids	See comments	Precertification is required for all types of hearing aids. There does need to be an invoice submitted in situations where there is no allowable attached to it.
Hearing Screening	See comments	No notification or precertification is required by network provider for coverage of diagnostic and screening tests, hearing aid evaluations and counseling.
Home Health Care	Precertification	Precertification is required. Covered services include skilled nursing, home health aide, physical, occupational and speech therapy services and physician-ordered supplies. Skilled nursing and home health aide require precertification. See also Rehabilitation Therapy. Drugs and DME

Precertification/Notification Coverage Guidelines		
Service	**Requirement**	**Comments**
		require separate precertification.
Hospital Admission	Precertification	• Elective admissions require precertification for coverage. • Emergency admissions require notification within 24 hours or the next business day. • To be covered, preadmission testing must be performed by an Amerigroup preferred lab vendor or network facility outpatient department. See Provider Referral Directory for a complete listing of participating vendors. • Same-day admission is required for surgery. • No coverage for rest cures, personal comfort and convenience items, services and supplies not directly related to the care of the patient (such as telephone charges, take-home supplies and similar costs).
Indian Health Services (IHS) and Tribal Health Centers	No precertification	No precertification is required for coverage of Native Americans who seek care from any IHS or Tribal 638 provider.
Laboratory Services (Outpatient)	Precertification is required for genetic testing	• All laboratory services furnished by non-network providers require precertification 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 one of our preferred lab vendors. See Provider Referral Directory for a complete listing of participating vendors.
Local Department of Health Offices	Self-referral	Covered services include: • Sexually transmitted disease services, including screening, diagnosis, treatment, follow-up and contact investigations • HIV prevention counseling, testing, and early intervention • Tuberculosis screening, diagnosis and treatment • Disease outbreak prevention and management, including reporting according to New Mexico law and regulations, responding to epidemiology requests for information and coordination with epidemiology investigations and studies • Referral and coordination to ensure maximum participation in the Supplemental Food Program for Women, Infants and Children (WIC) • Health education services for individuals and families with a particular focus on injury prevention including car seat use, domestic violence, and lifestyle issues, including tobacco use, exercise, nutrition and substance use • Development and support for family support programs, such as home visiting programs for families of newborns and other at-risk families and parenting education • Participation and support for local health councils to create healthier and safer communities with a focus on coordination of efforts, such as DWI councils, maternal and child health councils, tobacco coalitions, safety counsel, safe kids, and others.

Precertification/Notification Coverage Guidelines		
Service	**Requirement**	**Comments**
Medical Supplies	See comment	No precertification is required for coverage of disposable medical supplies. Disposable medical supplies are disposed of after use by a single individual.
Neurology	No precertification required for network provider in office for E&M.	Precertification is required for neurosurgery, spinal fusion and artificial intervertebral disc surgery. See Diagnostic Testing.
Nursing Facilities (NF)	Precertification	Precertification is required for all admissions and changes in LOC. Amerigroup pays for Low NF and High NF level of care for short-term or indefinite lengths of stay. Services may include skilled nursing and therapy or may be custodial in nature. Member must meet State of New Mexico level of care requirements.
Observation	See comments	• No precertification or notification is required for in-network observation. If billed with CPT/HCPCS code, authorization requirement should follow the requirement of the CPT/HCPCS code. If observation results in admission, notification to Amerigroup is required within 24 hours or the next business day. • **Note:** Precertification is required for Behavioral Health diagnosis.
Obstetrical Care	See comments	• No precertification is required for coverage of obstetrical services including obstetrical visits, diagnostic tests and laboratory services when performed by a participating provider. • Notification to Amerigroup is required at the FIRST prenatal visit. No precertification is required for coverage of labor, delivery and circumcision for newborns up to 12 weeks in age. • No precertification is required for the ordering physician for OB diagnostic testing for the coverage of ultrasounds, Biophysical Profile (BPP), Non-Stress Test (NST) and amniocentesis (Codes: 59000, 59001, 59012, 59015). • Notification of delivery is required within 24 hours with newborn information. OB case management programs are available. • See Diagnostic Testing.
Ophthalmology	No precertification required for network provider in office for E&M, testing and procedures	Precertification is required for repair of eyelid defects. Services considered cosmetic in nature are not covered. See Diagnostic Testing.
Otolaryngology (ENT) Services	See comment	See ENT Services (Otolaryngology)

Precertification/Notification Coverage Guidelines		
Service	**Requirement**	**Comments**
Out-of-Area/Out-of-Network Care	Precertification	Precertification is required for nonparticipating providers. Amerigroup will have contracts with certain providers outside of the State of New Mexico. For these contracted providers, applicable precertification rules will apply. For non-network out-of-area providers, precertification is required except for emergency and OB delivery.
Outpatient/ Ambulatory Surgery	See comments	Precertification and plan of care are required for the coverage of elective outpatient and ambulatory surgery.
Pain Management/ Physiatry/Physical Medicine and Rehabilitation	Precertification	Non-E&M level testing and procedures require precertification for coverage.
Personal Care Option (PCO) Services	Precertification	Precertification is required for coverage of Medicaid-eligible individuals 21 years of age or older who have been determined by the State of New Mexico for PCO services. Coverage includes individualized bowel and bladder services, meal preparation and assistance, support services, hygiene/grooming, minor maintenance of assistive device(s), mobility assistance, eating, assisting with self-administered medication, skin care, cognitive assistance and household services.
Pharmacy	See comments	The pharmacy benefit covers medically necessary prescription and over-the-counter (OTC) medications prescribed by a licensed provider. Exceptions and restrictions exist as the benefit is provided under a closed formulary/preferred drug list (PDL). Please refer to the PDL for the preferred products within therapeutic categories as well as requirements around generics, Prior Authorization (PA), Step Therapy, Quantity Edits and the prior authorization process. The formulary and PDL are available by going to providers.amerigroup.com and clicking on Quick Tools. Changes to the formulary/PDL or prior authorization procedures are updated via the website. Paper copies are available upon request by contacting the Amerigroup National Customer Care Department at 1-800-454-3730. Most self-injectable drugs are available through Caremark Specialty pharmacy and require prior authorization. Please call Caremark at 1-800-237-2767. For a complete list of drugs available through Caremark Specialty, please visit the Pharmacy section of our website. The following injectable drugs and their counterparts in the same therapeutic class require precertification by Amerigroup at 1-800-454-3730 when administered from a provider's supply: Epogen, Procrit, Aranesp, Neupogen, Neulasta, Leukine, IVIG, Enbrel, Remicade, Kineret, Amevive, Raptiva, Synvisc, Hyalgan, Erbitux,

Precertification/Notification Coverage Guidelines		
Service	**Requirement**	**Comments**
		Avastin, Rituxan, Camptosar, Eloxatin, Gemzar, Ixempra, Tasigna, Taxol, Taxotere and Growth Hormone.
Plastic/Cosmetic/ Reconstructive Surgery (including Oral Maxillofacial Services)	See comments	• No precertification is required for coverage of E&M codes. • All other services require precertification for coverage. Services considered cosmetic in nature are not covered. Services related to previous cosmetic procedures are not covered. Reduction mammoplasty requires Medical Director's review. • No precertification is required for coverage of oral maxillofacial E&M services. • Precertification is required for coverage of trauma to the teeth and oral maxillofacial medical and surgical conditions including TMJ. See Diagnostic Testing.
Podiatry	See comment	No precertification for coverage of E&M, testing, and procedures when provided by a participating podiatrist. Precertification is required for coverage of all elective surgical procedures.
PCP Services	Self referral	• PCP services include addressing the member's health needs, coordinating the member's health care, disease prevention, promotion and maintenance of health (including coverage of seasonal inoculations), treatment of illness or injury, maintaining member's health records and availability 24/7. • **EPSDT Tot-to-Teen Health Checks** include coverage of screening services that are provided to eligible recipients under 21 years of age. 20 screens are allowed at the following intervals: ○ **Under age 1: 6 screening/examination visits: (1, 2, 4, 6, 9 and 12 mos.)** ○ **Ages 1 – 5: 6 screening/examination visits: (15, 18 and 24 mos., 3, 4 and 5 yrs.)** ○ **Ages 6 – 14: 5 screening/examination visits: (6, 8, 10, 12 and 14 yrs.)** ○ **Ages 15 – 20: 3 screening/examination visits: (16, 18 and 20 yrs.)**
Radiology	See comments	See Diagnostic Testing.
Rehabilitation Therapy (Short Term): OT, PT, RT and ST	Precertification	Precertification is required for Rehabilitation Therapy Services beyond the initial evaluation.
Respite Services	Precertification	Precertification is required for Respite Services
Sterilization	See comments	• No precertification required for network providers when performed in an outpatient setting. If the procedure is performed during an inpatient admission, authorization is required for the admission. • **Sterilization consent form is required for claims submission.** • Reversal of sterilization is <u>not</u> a covered benefit.
Transportation	See comments	• For nonemergent transportation, no precertification required for

Precertification/Notification Coverage Guidelines		
Service	**Requirement**	**Comments**
		network providers with the exception of fixed wing (commercial airline) aircraft billed with procedure code A0140. • Precertification is required for all nonpar services. • No precertification required for emergency services.
Transitional Services	Precertification	Precertification is required for Transitional Services
Urgent Care Center	Self-referral	No notification or precertification is required for participating facility.
Vision	Self referral	
Well-Woman Exam	Self-referral	Well-woman exams are covered one per calendar year when performed by PCP or in-network GYN. Includes examination, routine lab work, STD screening, mammograms for members age 35 or older, and Pap smear.
Revenue (RV) Codes	See comments	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 through 0249 – All-inclusive Ancillary Psychiatric • 0250 – Pharmacy General • 0632 – Pharmacy Multiple Source • 3101 through 3109 – Adult day care and foster care

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 precertification requests. When a request for services is received from a provider via fax, the precertification assistant will verify eligibility and benefits which will then be forwarded to the nurse reviewer.

The Service Coordinator 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 or community services as supported by the Medical Director.

When the information received meets medical necessity criteria, an Amerigroup reference number will be issued to the referring physician.

If the request is a Stat/Urgent request (expedited service authorizations), the decision will be made within 24 hours.

To expedite requests, we encourage the documentation to be complete so that our Service Coordinators can turn around requests as quickly as possible. Determinations are made within the required time frame regardless of whether the necessary information is present to make the 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 physician, the facility and the member.

Inpatient Reviews

Inpatient Admission Reviews

All inpatient hospital admissions, including urgent and emergent admissions, will be reviewed within 1 business day. The Amerigroup Utilization Review Clinician 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.

Inpatient Concurrent Review

Each network hospital will have an assigned utilization management (UM) clinician. Each UM clinician will conduct a concurrent review of the hospital medical record at the hospital or by telephone to determine the authorization of coverage for a continued stay.

When an Amerigroup UM clinician reviews the medical record at the hospital, he or she also attempts to meet with the member and family to discuss any discharge planning needs and verify that the member or family is aware of the member's PCP's name, address and telephone number. The UM clinician will conduct continued stay reviews daily 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 the clinical information received meets medical necessity criteria, approved days and bed level coverage will be communicated to the hospital for the continued stay.

If the discharge is approved, the Amerigroup UM clinician will help coordinate discharge planning needs with the hospital utilizations 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. In the case of a behavioral health discharge, the attending physician is responsible for ensuring that the consumer has secured an appointment for a follow-up visit with a behavioral health provider to occur within 7 calendar days of discharge.

Amerigroup will authorize covered length of stay 1 day at a time based on the clinical information that supports the continued stay. Exceptions to the one-day length of stay authorization 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 confinement and/or treatment include the following: 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 action will be mailed to the hospital, member's PCP and member.

Discharge Planning

Discharge planning is designed to assist the provider in the coordination of the member 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 services
- Nursing facility
- Home health care program (i.e., home I.V. antibiotics)
- HCBS

When the member and family together with the provider identifies medically necessary and appropriate services for the member, a Service Coordinator will assist the discharge planner in providing a timely and effective plan that meets the member's needs and goals.

Confidentiality of Information

Utilization management, service coordinator services, disease management, discharge planning, quality management and claims payment activities are designed to ensure that patient-specific information, particularly protected health information (PHI) obtained during review, is kept confidential in accordance with applicable laws, including HIPAA. Information is used 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 hours a day, 7 days a week Nurse HelpLine service with clinical staff to provide triage advice and referral and, if necessary, to make arrangements 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 precertification. Any hospital or provider calling for an authorization for emergency services will be granted one immediately upon request. Emergency services coverage includes services that are needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

Emergency Medical Condition: A physical or behavioral 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 to result in the following: (1) placing the health of the individual (or, with respect to a

pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part.

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 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. The physician or other appropriate personnel will indicate in the member's chart the results of the emergency medical screening examination. Amerigroup will compensate the provider for the screening evaluations and examination that are reasonable and calculated to assist the health care provider determine whether or not the patient's condition is an emergency medical condition.

If there is concern surrounding the transfer of a patient (i.e., 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.

Post-Stabilization Care Services

Post-stabilization care services are covered services related to an emergency condition that are provided after a patient is stabilized to maintain the stabilized condition or improve or resolve the patient's condition. Amerigroup will adjudicate emergency and post-stabilization care services that are medically necessary until the emergency condition is stabilized and maintained.

Nonemergency Services

For routine, asymptomatic, recipient-initiated, outpatient appointments for primary preventive medical care, the request-to-appointment time must be no greater than 14 days, unless the member requests a later time. For routine, symptomatic, recipient-initiated, outpatient appointments for nonurgent primary medical care, the request-to-appointment time must be no greater than 4 – 6 weeks, unless the member requests a later time. Primary medical, including dental care outpatient appointments for urgent conditions, must be available within 24 hours. Specialty outpatient referral and/or consultation appointments, including the request-to-appointment time, must be consistent with the clinical urgency but no greater than 21 days, unless the member requests a later time. For outpatient scheduled appointments the time the member is seen must not be more than 45 minutes

after the scheduled time unless the member is late. For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time must be consistent with the clinical urgency but no greater than 14 days unless the member requests a later time. For urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability will be consistent with the clinical urgency but no greater than 48 hours. The timing of scheduled follow-up outpatient visits with practitioners must be consistent with the clinical need.

Urgent Care

Amerigroup requires its members to contact their PCP in situations in which urgent, unscheduled care is necessary. Precertification with Amerigroup is not required for a member to access a participating urgent care center.

9 QUALITY MANAGEMENT

Quality Management Program

Overview

Amerigroup maintains a comprehensive quality management program 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. Members and providers have opportunities to make recommendations for areas of improvement. The Quality Management Program goals and outcomes are available, upon request, to providers and members. 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 our specific population occurs on an annual basis. This includes not only age/sex 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 define areas that are high-volume or that are problem-prone.

Annual evaluation of care and services will be performed utilizing Health Care Effectiveness Data and Information Set (HEDIS) measures and the Consumer Assessment of Health Care Providers and Systems (CAHPS) survey and HSD/MAD defined measures. The Quality Management (QM) Program will develop interventions and implement actions to achieve improvements in care and services. Information about the QM Program will be available at anytime by calling Amerigroup at 505-875-4320.

There is a comprehensive committee structure in place with oversight from the governing body of Amerigroup. Not only are the traditional Medical Advisory Committee (MAC) and Credentialing Committee in place, but a Consumer Advisory Board is also an integral component of the Quality Management Committee structure.

Quality of Care

All physicians, Advanced Registered Nurse Practitioners and Physician Assistants (PA) are evaluated for compliance with pre-established standards as described in the Amerigroup credentialing program.

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

Reviews are accomplished by QM coordinators 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.

Our quality program includes review of quality of care issues identified for all care settings. Quality Management staff use member grievances, reported adverse events and other information to evaluate the quality of service and care provided to our members.

Quality Management Committee

The Quality Management Committee (QMC) maintains 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 quality management program
- Establish processes and structure that ensures accreditation compliance
- Analyze, review and make recommendations regarding the planning, implementation, measurement and outcomes of clinical/service quality improvement studies
- Coordinate communication of quality management activities throughout the Plan
- Review HEDIS® and CAHPS® data and action plans for improvement
- Review, monitor and evaluate program compliance against Amerigroup, State, Federal and accreditation standards
- Review and approve the annual quality management program description and work plan
- Provide oversight and review of delegated services
- Provide oversight and review of operational indicators as they relate to member care and service outcomes
- Assure inter-departmental collaboration, coordination and communication of quality improvement activities
- Measure compliance to medical practice guidelines
- Monitor continuity of care between medical and behavioral health services
- Monitor accessibility and availability with cultural assessment
- Publicly make information available to members and practitioners about our network hospitals actions to improve patient safety
- Make information available about our QI program to members and practitioners
- Assure practitioner involvement through direct input from our Medical Advisory Committee, Consumer Advisory Board, or other mechanisms that allow member and practitioner involvement

Medical Advisory Committee

The Medical Advisory Committee (MAC) has multiple purposes. The MAC assesses levels and quality of care provided to members and recommends, evaluates and monitors standards of care. The MAC 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 Subcommittee which employs a peer review process for systematic monitoring of quality and the appropriateness of care. The MAC conducts a systematic process for network maintenance through the credentialing/recredentialing process. The MAC advises the health plan administration in any aspect of the health plan policy or operation affecting network providers or members. The MAC approves and provides oversight of the peer review process, the Quality Management Program and the Utilization Review Program. It oversees and makes recommendations regarding clinical quality improvement studies and health promotion activities.

The MAC's responsibilities are to:

- Use ongoing peer review system to assess levels of care and quality of care provided
- Monitor practice patterns in order to identify appropriateness of care and for improvement/risk prevention activities
- Review and provide input, based on the characteristics of the local delivery system, and approve evidenced-based clinical protocols/guidelines to facilitate the delivery of quality care and appropriate resource utilization
- Review clinical study design and results
- Develop and approve action plans/recommendations regarding clinical quality improvement studies
- Consider/act in regard to physician sanctions
- Approve recommendations from the Credentialing Sub-Committee to credential/recredential providers for participation in the Plan
- Review and provide feedback regarding new technologies
- Oversee compliance of delegated services

Consumer Advisory Board

The Consumer Advisory Board (Board) consists of regional representation including members, advocates and providers. The Board advises Amerigroup on issues concerning service delivery and quality, member rights and responsibilities, the process for resolving member grievances and the needs of the groups they represent pertaining to Medicaid or CoLTS managed care. The Board meets at least quarterly and informs HSD/MAD in writing 10 days in advance. Minutes are taken and made available to HSD/MAD upon request. Amerigroup conducts outreach activities to ensure member input. Amerigroup representatives attend at least two statewide consumer meetings to ensure member issues are heard and addressed.

Credentialing

The state of New Mexico requires that MCOs credential each provider that applies to become a participating provider. Therefore, each applicant must agree to submit for verification all requested information necessary to credential or recredential practitioners providing services in accordance with the standards established by Amerigroup. Additionally, each provider must cooperate with Amerigroup, as necessary, to conduct credentialing and recredentialing pursuant to Amerigroup policies, procedures and rules. At the request of Amerigroup, the provider will authorize and release to Amerigroup any and all information compiled, maintained or otherwise assembled by a network hospital for the credentialing or recredentialing of the provider by Amerigroup.

Each provider agrees to submit for verification all requested information necessary to credential or recredential practitioners providing services in accordance with the standards established by Amerigroup. Each provider will cooperate with Amerigroup as necessary to conduct credentialing and recredentialing pursuant to Amerigroup policies, procedures and rules.

Credentialing Requirements
Each practitioner/organizational provider (i.e., hospital, facility/ancillary service) will remain in full compliance with the Amerigroup credentialing criteria as set forth in its credentialing policies and procedures and all applicable laws and regulations. Each practitioner/organizational provider (i.e., hospital, facility/ancillary service), completes an Amerigroup application form upon request by Amerigroup. Each provider is required to comply with other such credentialing criteria as may be established by Amerigroup.

Credentialing Procedures
Amerigroup is committed to operating an effective, high-quality credentialing program. Amerigroup credentials the following provider types: medical doctors, doctors of osteopathy, doctors of dental surgery, doctors of dental medicine, doctors of podiatric medicine, physician assistants, optometrists, dentists, nurse practitioners, certified nurse midwives, licensed professional counselors/social workers, psychologists, physical/occupational therapists, speech/language therapists and other applicable or appropriate mid-level providers, as well as hospitals, facilities and ancillary providers.

During recredentialing, each provider must show evidence of satisfying the Amerigroup policy requirements and must have satisfactory results relative to the Amerigroup measures of quality of health care and service.

Amerigroup has an established Credentialing Committee and a Medical Advisory Committee for the formal determination of recommendations regarding credentialing decisions. The Credentialing Committee will make decisions regarding participation of initial applicants and their continued participation at the time of recredentialing. The oversight rests with the Medical Advisory Committee.

The Amerigroup credentialing policy is revised periodically based on input from several sources, including but not limited to the Credentialing Committee, the Health Plan Medical Director, the Amerigroup Chief Medical Officer and state and federal requirements. The policy is reviewed and approved as needed, but at a minimum annually.

The provider application contains the provider's actual signature that serves as an attestation of the credentials summarized on and included with the application. The provider's signature also serves as a release of information to verify credentials externally. Amerigroup is responsible for externally verifying specific items attested to on the application. Any discrepancies between information included with the application and information obtained by Amerigroup during the external verification process will be investigated and documented and may be grounds for refusal of acceptance into the network or termination of an existing provider relationship. The signed agreement documents compliance with the Amerigroup managed care policies and procedures.

Each provider has the right to inquire about the status of their application. They may do so by the following methods: (1) telephone; (2) facsimile; (3) contact through their Provider Relations Representative; or (4) in writing.

As an applicant for participation with Amerigroup, each provider has the right to review information obtained from primary verification sources during the credentialing process in accordance with local, state and Federal regulations. Upon notification from Amerigroup, the provider has the right to explain

information obtained that may vary substantially from that provided and to provide corrections to any erroneous information submitted by another party. The provider must submit a written explanation or may appear before the Credentialing Committee if deemed necessary.

Currently, the following verifications are completed, as applicable prior to final submission of a practitioner file to the Health Plan Medical Director or Credentialing Committee. To the extent allowed under applicable law or state agency requirements, per NCQA Standards and Guidelines, the Medical Director has authority to approve clean files without input from the Credentialing Committee. All files not designated as a clean file are presented to the Credentialing Committee for review and decision regarding participation.

In addition to the submission of an application and the execution of a Participating Provider Agreement, the following must be reviewed and approved by the Credentialing Committee or the Medical Director.

1. Board Certification. Verification by referencing the American Medical Association (AMA) Provider Profile, American Osteopathic Association (AOA), the American Board of Medical Specialties, American Board of Podiatric Surgery and/or American Board of Podiatric Orthopedics and Primary Podiatric Medicine.
2. Verification of Education and Training. Verification by referencing board certification, the appropriate state-licensing agency, or the medical/professional school/residency program.
3. Verification of Work History. The practitioner must submit a curriculum vitae documenting work history for the past 5 years. Any gaps in work history greater than 6 months must be explained in written format and brought to the attention of the Medical Director and Credentialing Committee, as applicable.
4. Hospital Affiliations and Privileges. To the extent allowed under applicable law or state agency requirements, verification of clinical privileges in good standing at an Amerigroup network hospital may be accomplished by the use of an attestation signed by the provider. If attestation is not acceptable, hospital admitting privileges in good standing are verified for the practitioner. This information is obtained in the form of a written letter from the hospital, roster format (multiple practitioners), Internet access or by telephone contact. The date and name of the person spoken to at the hospital are documented.
5. State Licensure or Certification. Verification of state license information to ensure that the practitioner maintains a current legal license or certification to practice in the state. This information can be verified by referencing data provided to Amerigroup by the state via roster, telephone or the Internet.
6. DEA Number. Verification of the Drug Enforcement Administration (DEA) number to ensure that the practitioner is currently eligible to prescribe controlled substances. This information is verified by obtaining a copy of the DEA certificate or by referencing the National Technical Information Service (NTIS) data. If the practitioner is not required to possess a DEA Certificate but does hold a state controlled substance certificate, the Controlled Dangerous Substance (CDS) certificate is verified to ensure the practitioner is currently eligible to prescribe controlled substances. This information is verified by obtaining a copy of the CDS certificate or by referencing CDS online or Internet data if applicable.
7. Professional Liability Coverage. To the extent allowed under applicable law or state agency requirements, verification of malpractice coverage information is verified by obtaining a copy of

the professional liability insurance face sheet from the practitioner or from the malpractice insurance carrier. Practitioners are required to maintain professional liability insurance in specified amounts.

8. Professional Liability Claims History. Verification of an applicant's history of professional liability claims, if any, reviewed by the Health Plan Credentialing Committee to determine whether acceptable risk exposure exists. The review is based on information provided and attested to by the applicant and information available from the National Practitioner's Data Bank (NPDB). The Credentialing Committee's policy is designed to give careful consideration to the medical facts of the specific cases, total number and frequency of claims in the past 5 years and the amounts of settlements and/or judgments.
9. CMS Sanctions. Verification that the practitioner's record is clear of any sanctions by Medicare/Medicaid. This information is verified by accessing the NPDB or the Office of Inspector General List of Excluded Individuals/Entities (LEIE) Database.
10. Disclosures – Attestation and Release of Information. The Amerigroup Provider Application will require responses to the following:
    - Reasons for the inability to perform the essential functions of the position with or without accommodation
    - Any history or current problems with chemical dependency, alcohol or substance abuse
    - History of license revocations, suspension, voluntary relinquishment, probationary status or other licensure conditions or limitations
    - History of conviction of any criminal offense other than minor traffic violations
    - History of loss or limitation of privileges or disciplinary activity including denial, suspension, limitation, termination or nonrenewal of professional privileges
    - History of grievances or adverse action reports filed with a local, state or national professional society or licensing board
    - History of refusal or cancellation of professional liability insurance
    - History of suspension or revocation of a DEA or CDS certificate
    - History of any Medicare/Medicaid sanctions
    - Attestation by the applicant of the correctness and completeness of the application
    - Any issue identified must be explained in writing. These explanations are presented with the provider's application to the Credentialing Committee.
11. The NPDB is queried against applicants and the Amerigroup contracted providers. The NPDB provides a report for every practitioner queried. These reports are shared with the Medical Director and the Credentialing Committee for review and action as appropriate. The appropriate state-licensing agency is queried to verify any restrictions/sanctions made against the practitioner's license. All sanctions are investigated and documented, including the health plan's decision to accept or deny the applicant's participation in the network.
12. Office Location Review. At the time of initial credentialing, an Amerigroup representative will complete a site visit for each office location of all providers wanting to participate as a PCP and/or OB/GYN to determine whether the provider's office can accommodate the members and meets all requirements.
13. Recredentialing. At the time of recredentialing (every 3 years) information for providers from quality improvement activities and member grievances is presented for Credentialing Committee review.

The provider will be notified by telephone or in writing if any information obtained in support of the assessment or reassessment process varies substantially from the information submitted by the providers. Providers have the right to review the information submitted in support of the credentialing and recredentialing process and to correct any errors in the documentation. This will be accomplished by submission of a written explanation or by appearance before the Credentialing Committee, if so requested.

The decision to approve or deny initial participation is communicated in writing within 60 days of the Credentialing Committee's decision. To the extent allowed under applicable law or state agency requirements, per NCQA Standards and Guidelines, the Medical Director may render a decision regarding the approval of clean files without benefit of input from the Credentialing Committee. In the event the provider's continued participation is denied, the provider is notified by certified mail. If continued participation is denied, the provider is provided 30 days to appeal the decision.

Credentialing-Organizational Providers

The provider application contains the actual signature of the provider's authorized representative that serves as an attestation that the health care facility agrees to the assessment requirements. Providers requiring assessments are as follows: hospitals, home health agencies, skilled nursing facilities, nursing homes, ambulatory surgical centers, behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting, and all other ancillary providers. The provider's signature also serves as a release of information to verify credentials externally.

Currently, the following steps are completed in addition to the application and Network Provider Agreement before approval for participation of a hospital or organizational provider.

State licensure is verified by obtaining a current copy of the state license from the organization or by contacting the state licensing agency. Primary source verification is not required. Any restrictions to a license are investigated and documented, including the decision to accept or deny the organization's participation in the network.

Amerigroup contracts with facilities that meet the requirements of an unbiased and recognized authority. Hospitals (i.e., acute, transitional or rehabilitation) should be accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), Health Care Facilities Accreditation Program (HFAP) or the AOA. The Commission on Accreditation of Rehabilitation Facilities (CARF) may accredit rehabilitation facilities. Home health agencies should be accredited by JCAHO or the Community Health Accreditation Program (CHAP). JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC) should accredit ambulatory surgical centers. It is preferred that nursing homes be accredited by JCAHO. If facilities, ancillaries or hospitals are not accredited, and Amerigroup determines in its discretion that such providers' participation in our provider network is needed for network access, Amerigroup may accept a copy of a recent state or CMS review, or if a copy of a recent review is unavailable, perform an on-site review.

- A copy of the malpractice insurance face sheet is required. Organizations are required to maintain malpractice insurance in the amounts specified in the provider contract and according to Amerigroup policy.

- Amerigroup tracks the facility's/ancillary's reassessment date and reassess every 36 months as applicable. Requirement for recredentialing of organizational providers are the same for reassessment as they are for the initial assessment.

The organization is notified either by telephone or in writing if any information obtained in support of the assessment or reassessment process varies substantially from the information submitted by the organization.

Organizations have the right to review the information submitted in support of the assessment process and to correct any errors in the documentation. This is accomplished by submission of a written explanation or by appearance before the Credentialing Committee if so requested.

The decision to terminate an organization's participation is communicated in writing via certified mail.

Delegated Credentialing

Amerigroup ensures the quality of its credentialing program through direct verification and through delegation of credentialing functions to qualified provider organizations. Where a Provider Group (Group) is believed to have a strong credentialing program, Amerigroup may evaluate a delegation of credentialing and recredentialing. Group should have a minimum of 150 participating providers.

The Credentialing Department reviews the written credentialing policy of the Group for adequacy. Steps, if any, are identified where the Group's credentialing policy does not meet the standards of Amerigroup. Amerigroup will perform, or arrange for the Group to perform, the Amerigroup credentialing steps not addressed by the Group.

Amerigroup performs a predelegation audit of the Group's credentialing practices. A passing score is considered to be an overall average of 90 percent compliance. The Group is expected to submit an acceptable corrective action plan within 30 days of receipt of the audit results.

If there are serious deficiencies, Amerigroup may deny the delegation or restrict the level of delegation.

Amerigroup may, in its discretion, waive the need for the predelegation on-sight audit if the delegated entity's credentialing program is NCQA Certified to include all credentialing and recredentialing elements.

Amerigroup is responsible for oversight of any delegated credentialing arrangement and schedules appropriate reviews. The reviews are held at least annually.

Peer Review

The Peer Review process provides a systematic approach for monitoring the quality and appropriateness of care.

Peer Review responsibilities are:

- Utilize ongoing peer review system to assess levels of care and quality of care provided
- Recommend corrective action and/or sanctions as appropriate

- Review and update peer review policies and procedures
- Report to the Medical Advisory Committee physician corrective actions and sanctions imposed based upon peer review activity

Should investigation of a member grievance result in concern regarding a practitioner's compliance with community standards of care or service, all elements of peer review including appeal rights will be followed.

Dissatisfaction severity codes and levels of severity are applied to quality issues. The Medical Director assigns a level of severity to the grievance. Peer review includes investigation of physician actions by or at the discretion of the Medical Director. The Medical Director takes action based on the quality issue, the level of severity, invites the cooperation of the physician, consults and informs the Peer Review Committee, and reports peer review activity to the Medical Advisory Committee. The Medical Director informs the physician 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 which include the Quality Management Committee.

The Peer Review process and activity is a standing component of the Medical Advisory Committee agenda.

The Peer Review policy is available upon request.

The following provider types require additional credentialing criterion:

- **Adult Day Health Services** – Licensed by DOH pursuant to 7 NMAC 13.2, comply with ALTSD/EDSD requirements, compliance with Title II and III of American's Disability Act (ADA) of 1990.
- **Assisted Living Facilities** – Must be provided in the following facilities or environmental settings: Adult Residential Care facilities (including home-like) licensed by Licensing and Certification Bureau, Division of Health Improvement/Department of Health, comply with (ALTSD/EDSD) requirements, compliance with Title II and III of Americans Disability Act (ADA) of 1990, compliance with 7NMAC 26.6. Care may be provided in a home-like environment as outlined in the CoLTS "c" waiver service standards.
- **Emergency Response Services** – Must comply with all laws, rules and regulations of the NM State Corporation Commission for telecommunications and security systems, if applicable. Provider agency is required to have attended an orientation/training regarding the CoLTS "c" waiver program. The agency must have security bonding and comply with the ALTSD Elderly and Disability Services Division General Provider Requirements. The agency must meet the General Requirements for Documentation (7NMAC 26.6) and NM Aging and Long Term Services Department, Elderly and Disability Services Division, CoLTS "c" waiver program service standards.
- **Environmental Modifications** – Must comply with all New Mexico state laws, rules and regulations including applicable building codes. Must have a valid New Mexico Regulation and Licensing Department, Construction Industries Division GB02 Class Construction License pursuant to the Construction Industries Licensing Act NMSA 1978, Section 60-13-3. Provider must meet all service standards for environmental modifications outlined in the New Mexico Aging and Long Term

Services Department, Elderly and Disability Services Division, CoLTS "c" waiver program service standards.

- **Laboratory** – provider must maintain CLIA certification.
- **Nursing Facility/Home** – Provider must be licensed by the DOH as a nursing home and must comply with all Federal and state requirements and attest to their compliance with the Caregivers Criminal History Screening Requirements (Title 7, Chapter 1, Part 9 – 7.1.9 NMAC).
- **Respite Services** – Respite services may be provided by a Homemaker Agency, a Home Health Agency, A Registered Nurse (RN), or a Licensed Practical Nurse (LPN). Provider agency of Respite Services must meet all waiver program requirements, certifications and training standards set forth by the NM ALTSD to provide Homemaker and/or Private Duty Nursing service standards as outlined in NM Aging and Long Term Services Department, Elderly and Disability Services Division, CoLTS "c" waiver program service standards.
- **Rural Health Clinic/FQHC/Diagnostic Treatment Center** – Provider must be licensed by DOH and meet the 7 NMAC 11.2 requirements.
- Out of state providers are reviewed and credentialed on an as needed basis. The facility is required to meet New Mexico HSD requirements; hold appropriate licensing in the state services are rendered, and possess appropriate accreditation as outlined in the HSD/MAD policy manual.
- State owned or operated health care facilities, intermediate care facilities for the mentally retarded, general acute care hospitals, adult community residential facilities, adult limited diagnostic treatment centers, case management entities providing services to persons with respite, companion or personal care programs funded by the New Mexico Aging and Long Term Service Department, care providers funded through the New Mexico children youth and families department providing homemaker and adult care services, CoLTS "c" residential care providers providing services paid for in whole or in part by state funds, home health agencies, all residential habilitation service or respite service care providers authorized to be reimbursed in whole or in part by state funds or under any Medicaid or Medicaid waiver program, nursing home facilities, any other care provider entity which is licensed or Medicaid certified is required to attest to their compliance with the Caregivers Criminal History Screening Requirements (Title 7, Chapter 1, Part 9 – 7.1.9 NMAC).

All provider types requiring an initial and reassessment will be presented to the Amerigroup Credentialing Committee for review and consideration. Recredentialing of organizational providers will occur at least every 3 years following initial credentialing to confirm they are maintaining their credentials and Amerigroup standards.

Credentialing Requirements for Initial and Reassessment of Organizational Providers – all required information must be submitted prior to the Amerigroup Credentialing Committee review and approval. At a minimum, Amerigroup requires evidence of the following for all organizational providers requesting participation in the network:

- The provider must complete an organizational provider (ancillary/facility) application which contains the provider's actual signature attesting to comply with assessment
- The provider must be licensed by the state and be in good standing with state and federal regulatory bodies

The provider must be reviewed and approved by an industry-recognized accrediting body. Accepted Accrediting Organizations include but are not limited to:

- JCAHO: Joint Commission on Accreditation of Health Organizations
- AAAHC: Accreditation Association for Ambulatory Health Care
- AAASF: American Association of Ambulatory Surgical Facilities
- CARF: Commission on Accreditation of Rehabilitation Facilities
- CHAP: Community Health Accreditation Program
- CCAC: Continuing Care Accreditation Commission
- CAP: College of American Pathologists
- ACHC: Accreditation Commission for Home Care
- ACR: American College of Radiology

If not accredited Amerigroup may accept a copy of a recent state or CMS review, or if a copy of a recent review is unavailable, perform an on-site review.

Organizational providers will maintain compliance with all Amerigroup Credentialing and Recredentialing standards as a condition of participation — initial and ongoing. It is the responsibility of the participating organizational provider to continue to provide all required information as a requirement of continued participation. Failure to do so may be grounds for termination.

Requirements for an Organizational Provider Application — credentialing and recredentialing. Requirements for an application to be considered complete include:

- Completed application indicating provider type and compliance with the ADA accessibility for each office location
- Copy of current, unrestricted state license
- Evidence of liability insurance
- Evidence of current accreditation status
- Any documentation necessary to establish that credentialing/recredentialing standards are met
- Any documentation necessary to waive accreditation criteria are met (refer to Amerigroup Nonaccredited Provider Standards for further information on requirements)
- Signed release granting Amerigroup access to records for credentialing purposes of any licensing board, malpractice insurance carrier or any other entity which does or may maintain records regarding the applicant
- Signed attestation regarding the completeness or correctness of the application
- Primary source verification of Medicare and Medicaid suspensions, sanctions or exclusions

Amerigroup Nonaccredited Organizational Provider Standards — if the provider has not been reviewed and approved by an accepted accrediting body, and Amerigroup has a demonstrated need for that provider in its provider network, Amerigroup may require an onsite assessment including a medical record review audit and waive the accreditation standard for an organizational provider when all of the following criteria are met:

- The provider meets all other Amerigroup credentialing standards
- The provider either has chosen not to seek accreditation or is in the process of applying for accreditation but has not been denied accreditation or had accreditation revoked

- The provider has passed an onsite assessment. This standard may be met by:
  - Passing score on all federal or accrediting body requirements
  - Evidence and documentation of substantial compliance with Amerigroup review standards during onsite assessment:
    - The specific criteria for each provider type are identified in the Organizational Provider Credentialing Criteria Matrix
    - Medical Directors and/or Administrative Directors that provide direct care to Amerigroup beneficiaries/members must be credentialed by Amerigroup
  - An overall score of 80 percent or above

Onsite Assessments: Initial and Ongoing — onsite assessments including site reviews and medical record reviews for an organizational provider who has an issue(s) identified and/or is not accredited by an accepted accrediting body will be performed by our Provider Relations Representative using the Amerigroup site visit and file review assessment tools.

- Site visits must be scheduled prior to presenting the provider to the Amerigroup Credentialing Committee for review and consideration. It is the responsibility of the organizational provider to cooperate with Amerigroup during its onsite assessment process.
- Appropriate site visit forms are used to document the assessment findings. Accredited agency scores and site visit scores are maintained by Amerigroup in the provider's file. Refer to attachments for conducting site visits.

Credentialing/recredentialing applicants are evaluated with respect to the above Amerigroup criteria for organizational providers. The recredentialing process must include confirmation that the provider continues to be in good standing with state and federal regulatory bodies, and if applicable, accreditation is current. When accreditation is not applicable, Amerigroup reserves the right to conduct an onsite assessment process. A favorable passing score for the onsite assessment is required.

Presentation to Amerigroup Credentialing Committee for review and approval — applicants who receive a favorable review are submitted to Amerigroup.

For applicants who do not meet a favorable review (potential or accepted), the file is reviewed by the Amerigroup Credentialing Committee for the decision. The Amerigroup Credentialing Committee will recommend one of the following actions:

- Approve – unconditional
- Pend – for further review
- Deny application
  - All reports, studies, minutes and other committee documents prepared for the Amerigroup Credentialing Committee will be marked as privileged and confidential. All member/patient information will be coded or suppressed to protect confidentiality

Approval/Denial Policy – the decision to approve or deny an organizational provider is made by the Amerigroup Credentialing Committee, having been granted the authority by the Amerigroup Board of Directors and Medical Advisory Committee who has oversight of the Credentialing Committee.

Denial Decision – the denial decision is communicated in writing by the Medical Director to the organizational provider within 45 calendar days.

Corrective Action Plan – the organizational provider who has been pended for further review by the Amerigroup Credentialing Committee must submit an acceptable corrective action plan for all scores below 100 percent which addresses all identified deficiencies within 30 calendar days from the date of the letter. Evidence of implementation including revised policies and procedures must be submitted within 60 calendar days.

Committee Decision/Provider Notification Process – the Amerigroup Medical Director notifies the organizational provider of the Amerigroup Credentialing Committee's decision and date of decision. The provider will be notified in writing no later than 45 calendar days of the Credentialing Committee's decision. Correspondence will:

- Indicate rationale for the denial or the proposed termination or limitation
- Reiterate that the applicant had been given the right to review and correct information used in support of the application
- Initial Credentialing only: Explain the credentialing applicant's right to submit additional information in writing to the Amerigroup Credentialing Committee for reconsideration and the requirements for the submission of the information
- Recredentialing only: Explain the recredentialing provider's right to appeal the decision to the Fair Hearing Committee and the requirements for a valid appeal. Refer to provider appeal policy for further details.

Provider's Right to Review Credentialing Information — in the event that credentialing information obtained from other sources varies substantially from that attested to by the organizational provider and the discrepancy effects or is likely to adversely affect the credentialing or recredentialing decision, Amerigroup will notify the organizational provider of the discrepancy and the right to review information provided in support of their application and to correct erroneous information.

- Applicants may be notified by telephone or in writing of specific occurrences of discrepant information when such discrepancies are determined by the Amerigroup Medical Director, his or her designee or the Amerigroup Credentialing Committee to adversely affect the credentialing decision
- Examples for organizational providers include:
  - Malpractice claims history
  - Suspension of Medicare or Medicaid certification
  - Accreditation status
- The organizational provider will be given 30 calendar days to comment and correct erroneous information. No final credentialing determination is made until the applicant has responded within the allowed time frame or the time has elapsed

All organizational provider files and records will be considered confidential, stored in a secure environment and the documents scanned into MACESS or an agency-approved document imaging system.

- Information will be updated by the Corporate Health Services Provider Contract/Provider Data Management area to load/update provider's billing and demographic information

- Appropriate tracking systems are updated to reflect the decision and indicate the provider's participation status

Out of Network Providers

Out of network IHS and Tribal providers are credentialed in accordance with the Amerigroup credentialing program. Out of state organizational providers are required to be licensed by the New Mexico DOH, or maintain appropriate licensure within the state of operation and must meet the Amerigroup credentialing requirements.

10 PROVIDER GRIEVANCE PROCEDURES

Amerigroup has a formal grievance process for the handling of dissatisfaction pertaining to administrative issues and nonpayment related matters. Providers may access this process by filing a written grievance. Provider grievances will be resolved fairly and within 30 calendar days, consistent with Amerigroup policies and covered benefits.

Providers are not penalized for filing grievances. Any supporting documentation should accompany the grievance.

A provider can file a grievance in writing to:

Amerigroup Community Care of New Mexico, Inc.
P.O. Box 61599
Virginia Beach, VA 23466-1599

At no time will Amerigroup cease coverage of care pending a grievance investigation.

11 CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

Payments

Amerigroup has a comprehensive strategy for meeting timeliness standards in each of the states in which we do business. Timely and accurate payment of claims is critical to developing and maintaining positive relationships with our members and providers and are, therefore, a focus of our Operational Excellence program. We know that timely reimbursement can be even more critical to providers who serve the special needs of CoLTS members. Our processing goal for the CoLTS program is to adjudicate all clean claims as quickly as possible. Claims are processed upon arrival and payments are sent to providers twice per week. The turnaround of Amerigroup is typically well below the state standard for clean claims which is:

- Within 30 calendar days of receipt for clean claims submitted electronically and clean claims received by mail
- Within 14 calendar days of receipt for electronically submitted clean claims for home- and community-based providers

If a provider has more than one location, payments are made only to the location they indicated as their primary location.

Amerigroup receives electronic claims in a HIPAA-compliant 837 format. We offer providers a HIPAA-compliant electronic data interface for claims submission and status inquiries which reduces paperwork, speeds claims adjudication and increases accuracy. We actively market these services to providers. Each month, a report is created to identify providers who still submit a high volume of hard copy claims. Our Provider Representatives work closely with these providers to encourage and instruct them on converting to EDI claims submission. Our provider orientation sessions include a detailed fact sheet and step-by-step instructions for submitting electronic, HIPAA-compliant claims. Upon request, we will provide provider workshops and/or seminars on EDI claims processing; we also offer a CBT course on HIPAA compliance.

Drawing from our best practices in our other markets, Amerigroup has implemented the following process and technology solutions to ensure timely claims:

- CoLTS claims unit
- Electronic Data Interchange (EDI)
- High auto-adjudication rates and more frequent payments
- First In/First Out policy

CoLTS Claims Unit

Amerigroup understands and recognizes the unique needs of CoLTS providers such as nursing facilities, day activity health services and other community-based providers. Therefore, we use dedicated teams to process CoLTS claims, respond to written correspondence from the providers and answer claim questions from providers via a toll-free line.

Electronic Data Interchange (EDI)
Amerigroup has extensive experience handling electronically submitted claims. We offer EDI interfaces for claims submission and status inquiries, reducing paperwork, shortening reimbursement cycles and increasing reimbursement accuracy. Our current EDI business vendors are Emdeon (formerly WebMD), Capario (formerly MedAvant) and Availity (also known as THIN). Electronic submissions are loaded into the claims system for batch adjudication daily and tracked by our dedicated EDI unit. EDI Specialists work with individual providers and our business vendors to ensure all submissions are properly received, acknowledged and processed.

First In/First Out
Our claims processing team members are assigned to queues based upon their experience and the volume of claims in the queue. Working pended claims in age-order enables us to achieve our overall processing goals. Supervisors review aging reports daily to prioritize work, identify abnormalities and ensure compliance with performance guarantees. Once a claim is resolved, it automatically posts to the next payment cycle.

Our claims adjudication processes are designed to comply with state and federal laws, rules and regulations, the Contract and the Uniform Managed Care Manual.

Electronic Submission

Amerigroup requires the submission of claims electronically through Electronic Data Interchange (EDI). Providers must submit claims within 90 days from the date of discharge for inpatient services or from the date of service for outpatient services. Electronic claims submission is available through:

- Emdeon (formerly WebMD) – Claim Payer ID 27514
- Capario (formerly MedAvant) – Claim Payer ID 28804
- Availity (formerly THIN) – Claim Payer ID 26375
- Amerigroup website

The advantages of electronic claims submission are as follows:

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

The guide for EDI claims submission is located at providers.amerigroup.com. The EDI claim submission guide includes additional information related to the EDI claim process.

To initiate the electronic claims submission process or obtain additional information, please contact our EDI Hotline at 1-800-590-5745.

Web Site Submission

Participating providers have the option to use the claim submission utilities available on our provider website. Providers will have the ability to enter claims data on a preformatted CMS-1500 (08-05) and UB-04 CMS-1450 claim template. Provider offices and facilities that are able to create HIPAA-compliant ANSI 837 4010A1 claim transactions will have the ability to upload the claims on the provider website. In order to take advantage of the direct submission of ANSI 837 claim files, please contact our EDI Hotline at 1-800-590-5745.

Paper Claims Submission

Providers also have the option of submitting paper claims. Amerigroup utilizes Optical Character Reading (OCR) technology as part of its front-end claims processing procedures. The benefits include the following:

- Claims status availability within five days of receipt
- Improved turn around time for claims adjudication compared to manual entry
- 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) laser printed or typed (not handwritten) in a large, dark font. Providers must submit a properly completed UB-04 CMS 1450 or CMS 1500 (08-05) within 90 days from the date of discharge for inpatient services or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. 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.

CMS-1500 (08-05) and UB-04 CMS-1450 forms are available from the Centers for Medicare and Medicaid Services at www.cms.hhs.gov.

CMS 1500 (08-05) or UB-04 CMS 1450 must include the following information (HIPAA compliant where applicable):

- Patient’s ID number
- Patient’s name
- Patient’s date of birth
- ICD-9 diagnosis code/revenue codes
- Date of service
- Place of service
- Description of services rendered CPT-4 codes/HCPC codes/DRGs
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- Amerigroup provider number
- NPI of billing provider when applicable

- State Medicaid ID number, as applicable
- COB/other insurance information
- Authorization/precertification number or copy of authorization/precertification
- Name of referring physician
- NPI of referring physician when applicable
- Any other State required data

Amerigroup cannot accept claims with alterations to billing information. Claims that have been altered will be returned to the provider with an explanation of the reason for the return. Amerigroup will not accept claims from those providers who submit entirely handwritten claims.

Paper claims must be submitted **within 90 days** of the date of service and submitted to the following address:

Amerigroup Community Care of New Mexico, Inc.
Attn: NM Claims
P.O. Box 61010
Virginia Beach, VA 23466-1010

Encounter Data

Amerigroup has 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 can be submitted through EDI submission methods or on a CMS-1500 (08-05) claim form unless other arrangements are approved by Amerigroup. Data will be submitted in a timely manner, per the requirement in the Provider Agreement or subsequent Amendments.

The encounter data will include the following:

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

Encounter data should be submitted to the following address:

Amerigroup Community Care of New Mexico, Inc.
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 (e.g., childhood immunization, mammography, Pap smears)
- Prenatal care (e.g., LBW, general first trimester care)
- Acute and chronic illness (e.g., ambulatory follow-up and hospitalization for major disorders)

Compliance is monitored by our utilization and quality management 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 could result in termination.

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-9 Manuals. Institutional claims should be submitted using EDI submission methods or an UB-04 CMS 1450 and provider services using the CMS 1500 (08-05).

Providers must use HIPAA-compliant billing codes when billing Amerigroup. This applies to both electronic and paper claims. When billing codes are updated, the provider is required to use appropriate replacement codes for submitted claims. Amerigroup will not pay any claims submitted using non-compliant billing codes.

Amerigroup reserves the right to use code-editing software to determine which services are considered part of, incidental to, or inclusive of the primary procedure.

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

- Submit clean claims within 90 days from the date the service is rendered or for inpatient claims filed by a hospital within 90 days from the date of discharge
- In the case of other insurance, submit the claim within 90 days 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 90 days from the date the eligibility is added and Amerigroup is notified of the eligibility/enrollment
- Claims submitted after the 90-day filing deadline will be denied
- Claims rejected by Amerigroup as unclean must be resubmitted within the 90 day filing deadline

After filing a clean claim with Amerigroup, review the explanation of payment (EOP). If the claim does not appear on an EOP within 30 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 at providers.amerigroup.com/NM or the telephonic Provider Inquiry Line at 1-800-454-3730**. If the claim is not on file with Amerigroup, resubmit your claim within 90 days 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 Payment

A clean claim means a manually or electronically submitted claim from a participating provider that contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside of the Amerigroup system. A clean claim may include errors originating in the State's system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. A clean claim is not materially deficient or improper, such as one that lacks substantiating documentation currently required by Amerigroup. A clean claim has no particular or unusual circumstances requiring special treatment that prevents payment from being made by Amerigroup within 30 days of the date of receipt if submitted electronically or 45 days if submitted manually.

A clean claim is a request for payment for a service rendered by a provider that:

- Is timely submitted by provider
- Is accurate
- Is submitted on a HIPAA compliant standard claim form including a CMS 1500 (08-05) or UB-04 CMS 1450 or successor forms thereto or the electronic equivalent of such claim form
- Requires no further information, adjustment or alteration by provider or by a third party in order to be processed and paid by Amerigroup

Clean claims are adjudicated within 30 days of the date of receipt if submitted electronically or 45 days if submitted manually. If Amerigroup does not adjudicate the clean claim within the time frames specified above, Amerigroup will pay all applicable interest as required by law.

Amerigroup produces and mails EOP's on a biweekly basis, which delineates for the provider the status of each claim that has been adjudicated during the previous week. Upon receipt of a clean claim and any additional information requested by Amerigroup from the provider, Amerigroup must complete processing of the clean claim within 30 days of the date of receipt if submitted electronically or 45 days if submitted manually.

Paper claims that are determined to be unclean will be returned to the billing provider along with a letter stating the reason for the rejection. Electronic claims (EDI) that are determined to be unclean will be returned to the Amerigroup contracted clearinghouse that submitted the claim.

In accordance with state requirements, Amerigroup will pay 90 percent of all clean claims from practitioners who have an individual or group practice, or who practice in shared health facilities within 30 calendar days of date of receipt, and will pay 99 percent of all such clean claims within 90 calendar days of receipt. The date of receipt is the date Amerigroup receives the claim, as indicated by its date stamp on the claim. Amerigroup has the right to request additional supporting documentation, such as medical records or itemized bills that are necessary to properly process the claim and the claim will not be considered clean until the requested documentation has been received. The date of receipt is the date Amerigroup receives the claim, as indicated by the date stamp on a paper claim or the date within

the file received from the provider or one of our contracted clearinghouses. The date of payment is the date of the check or other form of payment.

Claims Status

Providers should use our online resource located at providers.amerigroup.com/NM or call the automated Provider Inquiry Line at 1-800-454-3730 to check claims status.

Provider Reimbursement

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)
Amerigroup offers Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) with online viewing capability. Providers can elect to receive Amerigroup payments electronically through direct-deposit to their bank account. In addition, providers can select from a variety of remittance information options, including:

- Electronic remittance advice presented online and printed in your location
- HIPAA-compliant data file for download directly to your practice management or patient accounting system
- Paper remittance printed and mailed by Amerigroup

Some of the benefits providers may experience include:

- Faster receipt of payments from Amerigroup
- The ability to generate custom reports on both payment and claim information based on the criteria specified
- Online capability to search claims and remittance details across multiple remittances
- Elimination of the need for manual entry of remittance information and user errors
- Ability to perform faster secondary billing

To register for ERA/EFT, please visit our website at providers.amerigroup.com/NM.

PCP Reimbursement
Amerigroup reimburses PCPs according to their contractual arrangement.

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

Specialty care providers will obtain PCP and Amerigroup approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized by the PCP's referral or beyond the scope of self-referral permitted under this program.

Specialty care provider services will be covered only when there is documentation of appropriate notification or precertification, as appropriate, and receipt of the required claims and encounter information to Amerigroup.

Provider Payment Disputes

Providers may access a timely payment dispute resolution process. A payment dispute is any dispute between the healthcare provider and Amerigroup for reason(s) including, but not limited to:

- Denials for timely filing
- The failure to pay timely by Amerigroup
- Contractual payment issues
- Lost or incomplete claim forms or electronic submissions
- Requests for additional explanation as to services or treatment rendered by a provider
- Inappropriate or unapproved referrals initiated by providers (e.g., a provider payment dispute may arise if a provider was required to get authorization for a service, did not request the authorization, provided the service, and then submitted the claim)
- Provider appeals without member's consent
- Retrospective review after a claim denial or partial payment

Responses to itemized bill requests, submission of corrected claims, requests for supporting documentation and submission of coordination of benefits/third party liability information are not considered payment disputes. These are considered correspondence and should be addressed to Claims Correspondence.

No action is required by the member. **Payment disputes do <u>not</u> include medical appeals.**

Providers will not be penalized for filing a payment dispute. All information will be confidential. The Payment Dispute Unit (PDU) will receive, distribute and coordinate all payment disputes. To submit a payment dispute, please complete the Payment Dispute form located in Appendix A – Forms or online at providers.amerigroup.com, and submit to:

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

The network or non-network provider should file a payment dispute within 45 calendar days of the paid date of the EOP by submitting a written request with a written explanation of what is in dispute and why and attach any supporting documentation. Examples of appropriate supporting documentation include:

- Letter stating the reason(s) why the provider believes the claim reimbursement is incorrect
- Copy of the original claim
- Copy of the Amerigroup EOP
- EOP or EOB from another carrier
- Evidence of eligibility verification (i.e., copy of ID card, panel report, call log record with date and the name of the Amerigroup person the provider's staff spoke with when verifying eligibility)
- Medical records
- Approved referral and authorization forms from us indicating the authorization number
- Contract rate sheets indicating evidence of payment rates
- Evidence of previous appeal submission or timely filing
- Certified mail receipt with claim/dispute log if more than one claim/dispute was submitted

- Overnight mail receipt with claim/dispute log if more than one claim/dispute was submitted
- EDI claim transmission reports indicating that the claim was accepted by Amerigroup. Rejection reports are not accepted as proof of timely filing

The PDU will research and determine the current status of a payment dispute. A determination will be made based on the available documentation submitted with the dispute and a review of Amerigroup systems, policies and contracts. Any payment dispute received with supporting clinical documentation will be retrospectively reviewed by a licensed/registered nurse. Established clinical criteria will be applied to the payment dispute. After retrospective review, the payment dispute may be approved or forwarded to the Amerigroup Medical Director for further review and resolution.

A Level I determination letter will be sent to the provider within 30 calendar days from receipt of complete information. The PDU may request a 14 day extension from the provider if unable to respond within 30 days due to the need for additional information or delays in obtaining information necessary to make a determination. The provider may also require the PDU to take a 14 day extension to allow the provider more time to provide supporting documentation. Any dispute submitted without required supporting documentation will be denied. The response will include the following information:

- Provider name and Amerigroup ID number
- Date of initial filing of concern
- Written description of the concern
- Decision
- Further dispute options

If a provider is dissatisfied with the Level I administrative dispute resolution, the provider may file a Level II payment dispute. This must consist of a written dispute that is submitted within 30 calendar days of the date of the Level I determination letter.

If the provider expresses dissatisfaction with the Level I payment dispute, he or she can initiate a Level II payment dispute by mail. A Level II payment dispute will be reviewed by a senior PDU staff member who has not been involved with the original decision. A Level II Determination Letter will be sent to a provider within 30 calendar days of receipt of the request.

Payment Dispute Web Submission Tool

A new feature has been added to our provider website. As a participating provider you now have the ability to submit payment disputes online. When reviewing a claim status where there has been a partial or nonpayment of a claim, a dispute button will appear to the right of the claim. Once a provider clicks on the button a form will display to complete. Information will pre-populate from the claim being disputed. A provider also has the ability to attach supporting documents to the dispute. Once the provider has completed the remaining fields and attached any documentation they will click the submit button. If an email address has been provided, an email acknowledgement will go to the provider. Once the dispute has been submitted it will be routed to our Intake team for logging and then routed to the Payment Dispute Unit for review and determination. If it is found that no additional payment is warranted, a determination letter will be mailed to the provider. If additional payment is warranted, an EOP and check will be sent to the provider on the next check cycle.

Coordination of Benefits

State-specific guidelines will be followed when coordination of benefits (COB) procedures are necessary. Amerigroup agrees to utilize covered medical and hospital services whenever available or other public or private sources of payment for services rendered to members in the Amerigroup plan.

Amerigroup and its providers 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 a medical service, it 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 some time 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 trauma-related claims where third-party resources are identified prior to payment. Otherwise, Amerigroup will follow a pay and pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched post-payment to determine likely cases with multiple letters and phone calls being are made to document the appropriate details. The filing of liens and settlement negotiations are handled internally and externally via our subrogation vendor, ACS Recovery Services.

Amerigroup 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 1-800-454-3730.

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 services
- 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 to timely submit a claim, including claims not received by Amerigroup
- Failure to submit a claim to Amerigroup for initial processing within the 90-day filing deadline
- Failure to submit a corrected claim within the 90-day filing resubmission period
- Failure to appeal a claim within the 45-day administrative appeal period
- Failure to appeal a utilization review determination within 30 days of notification of coverage 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 a covered benefit **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 or that are not a covered benefit. I understand that AMERIGROUP has established the medical necessity standards for 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 to be inconsistent with the AMERIGROUP medically necessary standards for my care or not a covered benefit."

Service or items: _____

Cost: _____

Signature: _____

Date: _____

APPENDIX A – FORMS

Referral and Claim Submission Forms

The rest of this page intentionally left blank. Forms displayed on subsequent pages.

WIC Referral Form

The rest of this page intentionally left blank. Form displayed on subsequent pages.

WIC Referral Form

WIC

This is a referral to a **Women, Infant and Children (WIC)** provider agency. Medicaid recipients eligible for WIC benefits include the classifications listed below. Please check the category that most appropriately describes the individual that is being referred for services.

- ☐ Pregnant woman
- ☐ Woman who is breast feeding her infant(s) up to one year postpartum
- ☐ Woman who is non-breast feeding her infant(s) up to six months postpartum
- ☐ Infant under age one
- ☐ Child under age five

Name of individual being referred: _____

Address: _____

_____

Telephone Number: _____

I, the undersigned, give permission for my provider to give the WIC Program any required medical information.

_____

Signature of the patient being referred or, in the case of children and infants, signature and printed name of the parent/guardian.

Physician's Name: _____

Telephone Number: _____

Date of Referral: _____

Send completed form to:

Local WIC Program Center: _____

Address: _____

_____

Telephone Number: _____

Precertification – Maternity Delivery Only

The rest of this page intentionally left blank. Form displayed on subsequent pages.

Precertification – Maternity Delivery Only

Fax: 1-800-964-3627

- ❑ Incomplete forms will not be processed.
- ❑ This form should NOT be used to preauthorize emergency, urgent cases or services for high-risk OB conditions.
- ❑ All payments for approved procedures are subject to claims adjudication policies and member eligibility at the time service is rendered.
- ❑ You will receive a determination by facsimile within two business days.

TODAY'S DATE: **CONTACT PERSON:**

TELEPHONE #:

PATIENT INFORMATION

AMERIGROUP ID#: **MEDICAID ID#:**

MEMBER'S NAME: **DOB:**

PROVIDER INFORMATION

OB/PHYSICIAN GROUP NAME:

ID#: **NPI #:** **TELEPHONE #:**

DELIVERY INFORMATION

EDC: **GRAVIDA:** **PARA:**

HOSPITAL NAME: **CITY:**

PRENATAL CARE INFORMATION

DATE OF FIRST VISIT: **GESTATION AGE:**

HIGH-RISK CONDITION(S):

REFER TO: **NAME OF PROVIDER:**

❑ MEDICAL

❑ NUTRITION

❑ SOCIAL/PSYCHOLOGICAL

CHILD BIRTH CLASSES: ❑ YES ❑ NO **DATE STARTED:**

WIC REFERRAL: ❑ YES ❑ NO **DATE:**

CASE MANAGEMENT REQUESTED: ❑ YES ❑ NO **OUTREACH REQUIRED:** ❑ YES ❑ NO

FOR AMERIGROUP USE ONLY

CERTIFICATION #: **DATE RETURNED:**

COMMENTS:

Authorization Request Form

The rest of this page intentionally left blank. Form displayed on subsequent pages.

Precertification Request

Phone: 1-800-454-3730 ■ Fax: 1-800-964-3627
To avoid delay, please print clearly

Amerigroup RealSolutions in healthcare

TODAY'S DATE: **PROVIDER RETURN FAX #:**

MEMBER INFORMATION (Please verify eligibility prior to rendering service)

NAME: (Last Name, First Name)	AMERIGROUP #:	DOB:
ADDRESS:	CITY, STATE ZIP:	
MEDICAID #:	OTHER INSURANCE/WORKER'S COMP:	

REFERRING PROVIDER INFORMATION (Check the box where the referral should be faxed back)

NAME:		OFFICE CONTACT NAME:	
MEDICAID PROVIDER #:	AMERIGROUP #:	GROUP PRACTICE #:	NPI #:
PHONE #:	❑ FAX #:	OTHER PHONE #:	
PHONE #:	❑ FAX #:	OTHER PHONE #:	

SPECIALIST CONSULT

CONSULTANT: (Last Name, First Name, Provider Specialty)

AMERIGROUP PROVIDER#:	NPI #:	PHONE #:	FAX #:
ADDRESS:	CITY, STATE ZIP:		

ICD-9 CODE/DIAGNOSIS/REASON FOR REFERRAL:

PMH/PREVIOUS STUDIES/TREATMENT:

OF VISITS REQUIRED:

MATERNITY CARE

For initial notification of pregnancy, please use the Maternity Notification form.

For all other services related to pregnancy, please use this form (e.g., ultrasound, fetal nonstress test).

DIAGNOSTIC STUDY

FACILITY NAME: DOS:

DIAGNOSIS/REASON FOR REFERRAL:

PROCEDURE/CPT-4 CODE:

PMH/PREVIOUS STUDIES/TREATMENTS:

SURGERY REQUEST

SURGEON'S FULL NAME: (Last Name, First Name) DOS: ❑ Inpt ❑ Outpt ❑ Ext Stay

FACILITY NAME:

DIAGNOSIS/REASON FOR SURGERY:

PROCEDURE/CPT-4 CODE:

PMH/PREVIOUS STUDIES/TREATMENTS:

OTHER - CLINICAL INFORMATION NEEDED

❑ DME ❑ Home Health ❑ Hospice ❑ Other

REFERRED TO PROVIDER: (Last Name, First Name) AMERIGROUP PROVIDER #: NPI #:

DIAGNOSIS/REASON FOR REFERRAL:

PROCEDURE/CPT-4 CODE:

PMH/PREVIOUS STUDIES/TREATMENTS:

PLACE OF SERVICE: ❑ OFFICE ❑ HOME ❑ OUTPATIENT HOSPITAL ❑ INPATIENT HOSPITAL ❑ OTHER

** PLEASE ATTACH CLINICAL INFORMATION TO SUPPORT MEDICAL NECESSITY **

This referral is valid only for services authorized by this form. Only completed referrals will be processed. If the consultant/provider recommends another service or surgery, additional authorization is required. Certification does not guarantee that benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions.

To be completed by Amerigroup:	DATE APPROVED:	
DATE SPAN:	REFERENCE #:	INITIALS OF APPROVER:

Specialist as PCP Request Form

The rest of this page intentionally left blank. Form displayed on subsequent pages.

Specialist as PCP Request Form

Date: _____

Member's Name: _____

Member's ID #: _____

PCP's Name (if applicable): _____

Specialist/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 to the member access 24 hours a day, 7 days a week.

Specialist's Signature: _____ Date: _____

Medical Director's Signature: _____ Date: _____

Member's Signature: _____ Date: _____

CMS 1500 (08-05) Claim Form

This form is also available from the Centers for Medicare and Medicaid Services at www.cms.hhs.gov.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 2. 3. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If Item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., Items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURE(S): Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDIC AID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

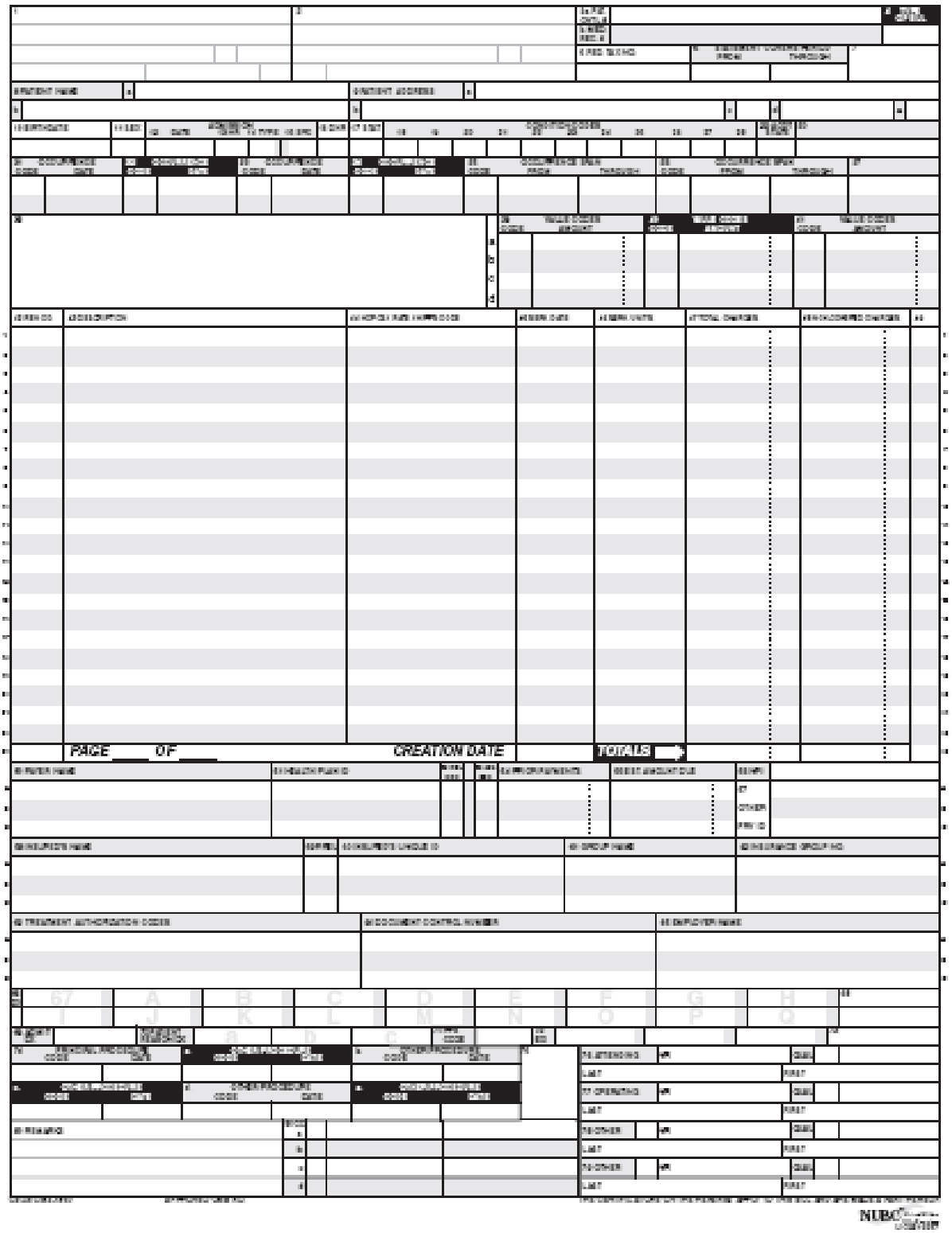
SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

UB-04 CMS 1450 Claim Form

This form is also available from the Centers for Medicare and Medicaid Services at www.cms.hhs.gov.



UB-04 CMS 1450 Claim Form Instructions

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically and appropriate for the health of the patient;
   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
   (g) Based on 42 United States Code 1395cc(a)(1)(J) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care a participating provider.

Excluded/Debarred Provider of Emergency Services/Items Form

The rest of this page intentionally left blank. Form displayed on subsequent pages.

Excluded/Debarred Provider of Emergency Services/Items Form

(PLEASE COMPLETE THE FOLLOWING INFORMATION)

Provider Name _____

Provider Number _____

Date of Provider Exclusion/Debarment _____

Phone Number: _____ (Direct phone number)

Date of Service _____ Claim Number (if known) _____

Member Name _____

Member ID Number _____

Sworn Statement

I attest that that I am a provider who is excluded/debarred from participation in the Medicaid, Medicare and/or other federal health care programs.

I seek reimbursement for the attached claim(s) in accordance with 42 CFR 1001.1901(5).

I affirm that I am neither employed nor under any contract or other arrangement to routinely provide emergency health care services or items.

I seek reimbursement for the following emergency services and/or items furnished by me or at my medical direction or on prescription by me or another authorized individual during the period of my exclusion:

_____
_____
_____
_____

The emergency services and/or items were furnished by me instead of by an eligible provider because of the following emergency circumstances:

_____
_____
_____
_____

I attest under penalty of perjury that the foregoing statements and the claim(s) attached hereto are true and correct.

Signature: _____ Date: _____

In witness whereof he has hereto set his hand and seal.

_____

(SEAL)

_____
(Title)

I, _____, a Notary Public of the County and State aforesaid, hereby certify that _____ personally known to me to be the affiant in the foregoing affidavit, personally appeared before me this day and having been by me duly sworn deposes and says that the facts set forth in the above affidavit are true and correct.

Witness my hand and official seal this the _____ day of _____, _____.

(SEAL) _____
Notary Public

My Commission expires:

____ / ____ / _____.

Medical Record Forms

The rest of this page intentionally left blank. Form displayed on subsequent pages.

Clinical Information Form

_____

Patient Name

PATIENT DIAGNOSES	DATE DIAGNOSED

HEALTH SCREENS	DATE PERFORMED				
RECTAL EXAM					
PSA					
CHEST X-RAY					
SIGMOIDOSCOPY					
EKG					

SURGICAL HISTORY	HABITS
	PHARMACY/TELEPHONE

Problem List 1 Form

The rest of this page intentionally left blank. Form displayed on subsequent pages.

Problem List 1 Form

Problem Number	Date	Active Problem/Diagnosis	Date Resolved

Addressograph

MEMBER NAME: _____

DOB _____ EFF DATE _____

ID # _____ SSN # _____

Problem List 2 Form

The rest of this page intentionally left blank. Form displayed on subsequent pages.

Problem List 2 Form

NAME: _____

DOB: _____

TELEPHONE: _____

MEMBER ID #:_____

PROBLEM LIST

Code	Active	Inactive
	1.	1.
	2.	2.
	3.	3.
	4.	4.
	5.	5.
	6.	6.
	7.	7.
	8.	8.
	9.	9.

MEDICATION

	Start	Stop		Start	Stop
1.			1.		
2.			2.		
3.			3.		
4.			4.		
5.			5.		
6.			6.		
7.			7.		

ALLERGIES

Patient Drug Profile Form

The rest of this page intentionally left blank. Form displayed on subsequent pages.

Patient Drug Profile Form

Addressograph

Change in dosage requires new medication entry.

			REFILL			**REFILL**			**REFILL**		
Start date	MD's initials	Medication/dosage frequency	Date	# refill	MD nurse	Date	# refill	MD nurse	Date	# refill	MD nurse

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

HIV Antibody Blood Forms

The rest of this page intentionally left blank. Form(s) displayed on subsequent pages.

Counsel for HIV Antibody Blood Test Form

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 Form

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 they really don't — this is a false positive test. The test may also fail to show that a person has antibodies to the virus when they really do — 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 Signature Patient's/Guardian's Printed Name

_____

Physician Signature

Amerigroup recognizes the need for strict confidentiality guidelines.

Results of the HIV Antibody Blood Test Form

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 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

Hysterectomy and Sterilization Forms

The rest of this page intentionally left blank. Form(s) displayed on subsequent pages.

New Mexico Sterilization Consent Form

The required MAD 345 Sterilization Consent form is available on the New Mexico Human Services Department website at http://www.hsd.state.nm.us/mad/pdf_files/Forms/MAD-345.pdf.

Acknowledgement of Receipt of Hysterectomy Information

PART 1 - (MUST BE COMPLETED)

Recipient Name: _____

Recipient Identification #: _____

Physician Name: _____

PART II - ACKNOWLEDGMENT

It has been explained to _____ and her representative, if any, orally and in writing that the hysterectomy to be performed on her will render her permanently incapable of reproducing.

_____

Recipient or Representative Signature Date

_____

(If required, Interpreter Signature) Date

PART III - PHYSICIAN STATEMENT

In my professional judgment, the hysterectomy is not being performed solely to accomplish sterilization; it is being performed for other medically necessary reasons.

_____

Physician Signature Date

PART IV - EXCEPTION REQUEST

☐ Exception 1 - I certify that the above named individual was already sterile at the time of the hysterectomy. The cause of the sterility was

_____.

☐ Exception 2 - I certify that the hysterectomy performed on the above named individual was performed under a life threatening emergency situation, i.e.,

_____ in which I determined prior acknowledgment of receipt of hysterectomy information was not possible. I have attached a copy of the hospital operative records or other written explanation of the nature of the emergency.

☐ Exception 3 - The above named individual had a hysterectomy performed during a period of retroactive Medicaid eligibility. Date of Surgery _____. I certify that she was informed prior to the operation that the hysterectomy would render her permanently incapable of reproducing; or that Exception 1 ( ) or Exception 2 ( ), as certified above, made such explanation unnecessary or impossible.

_____

Physician signature Date

Abortion Statement Form

This certification meets Financial Fair Play (FFP) requirements and must include all of the aforementioned criteria.

Patient's Name: _____

Patient's Medicaid ID#: _____

Patient's Address: _____

_____

Physician Certification Statement

I, _____, certify that it was necessary to terminate the pregnancy of _____ for the following reason:

( ) A. Physical disorder, injury or illness (including a life-endangering condition caused or arising from pregnancy) placed the patient in danger of death unless abortion was preformed. Name of condition: _____

( ) B. The patient has certified to me the pregnancy was a result of rape or incest, and the police report is attached.

( ) C. The patient has certified to me the pregnancy was a result of rape or incest, and the patient is unable for physiological or psychological reasons to comply with the reporting requirements.

_____ _____

Physician's Signature Date

The patient's certification statement is only required in cases of rape or incest.

Patient's Certification Statement

I, _____, certify that my pregnancy was the result of an act of rape or incest.

_____ _____

Patient's Signature Date

Both the completed Abortion Statement and appropriate medical records must be submitted with the claim form.

INSTRUCTIONS FOR COMPLETING THE ABORTION STATEMENT FORM

1. Patient's Name: The name of the patient can by typed or handwritten.
2. Patient's Medicaid ID #: The patient's Medicaid identification number can be typed or handwritten.
3. Patient Address: Patient's complete address. This can be typed or handwritten.
4. Name of Physician: The physician who performed the abortion procedure. This can be typed or handwritten.
5. Patient's Name: This can be typed or handwritten.
6. Reason: Check the box that indicates the necessity to terminate the pregnancy.
7. Name of Condition: The diagnosis or name of medical condition which makes abortion necessary.
8. Physician Signature: The physician must sign his or her name and date in his or her own handwriting.
9. Patient's Certification Statement: Complete this section only in cases of rape or incest.
10. Patient's Name: This can be typed or handwritten.
11. Patient's Signature: Patient must sign his or her name and date in his or her own handwriting.

Practitioner Evaluation and Audit Tools

The rest of this page intentionally left blank. Form(s) displayed on subsequent pages.

Practitioner Office Site Evaluation Form

PRACTITIONER OFFICE SITE EVALUATION - ALL PLANS

INFORMATION BELOW MUST BE DOCUMENTED AT TOP OF EACH PAGE OF SITE VISIT FORM! ALL QUESTIONS MUST BE ANSWERED.

Physician/Practitioner Name(s):

_____ _____
Last First

_____ _____
Last First

_____ _____
Last First

_____ _____
Last First

Office Manager: _____ _____
Last First

Physician/Practitioner Name(s):

_____ _____
Last First

_____ _____
Last First

_____ _____
Last First

Office Address _____

Specialty(ies) _____ **Date** _____ **Reviewer Name** _____ _____
Last First

	Point Value	Y	N	N/A	Point Score
A. Physical Accessibility:	10				
1 Is there accessibility for people with disabilities? (First floor access, ramps or elevator access) If not, does staff have an alternative plan of action? Access throughout the office including bathroom(s)?	2				
2 Is accessible parking clearly marked? (Sign/painted symbol on pavement) Only applies to off-street parking; N/A is parking is street-side only.	2				
3 Are doorways and stairways that provide access free from obstructions at all times and allow easy access by wheelchair or stretcher?	2				
4 Are exits clearly marked and is there emergency lighting in instances of power failure?	2				
5 Are building and office suite clearly identifiable (clearly marked office sign)?	2				
B. Physical Appearance:	10				
1 Is the office clean and well kept? (Neat appearance, no trash on floor, furniture in good repair, no significant spills on floors / furnishings)	2				
2 Is treatment area clean and well kept? (No significant spills on floors, counters or furnishings, no trash on floor)	2				
3 Does office have smoke detector(s)?	2				
4 Easy access to a clean, supplied bathroom? (Soap, toilet paper, hand towels and hand washing instructions)	2				
5 Fire extinguishers clearly present and fully charged and recently inspected (even if office has sprinkler system)?	2				
C. Adequacy of Waiting and Examining Room Space:	8				
1 Is there adequate seating in the waiting area (based on number of physicians/practitioners)? *	1				
2 Does the staff provide extra seating when the waiting room is full?	1				
3 Is there a minimum of 2 exam rooms per scheduled provider? (2 consultation rooms for Behavioral Health (BH) Providers)	1				
4 Is there privacy of exam/consultation rooms? (Doors or curtain closures; rooms cannot be visualized from waiting room)	1				
5 Are exam/consultation rooms reasonably sound proof? (Conversations cannot be heard from waiting room or other exam rooms)	1				
6 An otoscope, ophthalmoscope, blood pressure cuff and scale readily accessible? N/A for BH Providers	1				
7 For OB/GYNs only or any physician/practitioner providing OB Care: Does the office have the following readily accessible: (If not OB/GYN, check N/A)					
7a - A fetalscope (DeLee and/or Dopler) and a measuring tape for fundal height measurement?	1				
7b - Supplies for dipstick urine analysis (glucose, protein)?	1				
D. Adequacy of Medical Records:	20				
1 Are there individual patient records?	2				
2 Are records stored in a manner which ensures confidentiality - are they kept in an area not accessible by patients?	2				
3 Are all items secured in the chart?	2				
4 Are medical records readily available? (Within 15 minutes of request) Ask them if they are.	2				
5 Medical Recordkeeping practices:					
5a Is there a place to document allergies?	2				
5b Is there a place to document current medication list?	2				
5c Is there a place to document current chronic problems list?	2				
5d Is there an immunization record on pediatric charts? N/A for BH Providers	2				
5e Is there a growth chart on pediatric charts? N/A for BH Providers	2				
5f Is there a place to document presence/absence and discussion of a patient self-determination / advance directive? (If not appropriate, check N/A)	2				

* 1 Provider = 6 seats, 2 Providers = 8 seats, 3 Providers = 11 seats, 4 Providers = 14 seats, 5 Providers = 17 seats

PRACTITIONER OFFICE SITE EVALUATION - ALL PLANS

INFORMATION BELOW MUST BE DOCUMENTED AT TOP OF EACH PAGE OF SITE VISIT FORM! ALL QUESTIONS MUST BE ANSWERED.

Physician/Practitioner Name(s):

_____ Last _____ First

_____ Last _____ First

_____ Last _____ First

_____ Last _____ First

Office Manager: _____ Last _____ First

Physician/Practitioner Name(s):

_____ Last _____ First

_____ Last _____ First

_____ Last _____ First

Office Address _____

Specialty(ies) _____ **Date** _____ **Reviewer Name** _____ Last _____ First

	Point Value	Y	N	N/A	Point Score
E. Appointment Availability: Is the physician/practitioner available:	15				
1 Routinely within a wait time of 45 minutes or less? (Ask office manager)	1				
2 At least 4 days or 20 hours per week? **NY:** At least 16 hours per week at this office location or has waiver been granted?	1				
3 **IL Only-All other Plans N/A:** Maximum number of intermediate/limited encounters is 6 per hour?	1				
4 **IL Only-All other Plans N/A:** Serious care (not a medical emergency) within the same day of the date of the request?	1				
5 **GA Only-All other Plans N/A:** PCP adult sick visits w/n 72 hrs. and/or PCP pediatric sick visits w/n 24 hrs.?	1				
6 **GA Only-All other Plans N/A:** Specialist visits w/n 30 calendar days of request?	1				
7 **GA Only-All other Plans N/A:** Mental Health Providers w/n 14 calendar days of request?	1				
8 **GA Only-All other Plans N/A:** Initial visit for pregnant women w/n 14days of request?	1				
9 24 hour call coverage for emergencies? (By themselves or by covering provider) Crisis Hotline **Yes/No (BH Providers only)**	1				
10 Urgent care within 24 hours?	1				
11 Routine/problem care within 2 weeks **FL, NM, NY, OH, SC, TN,TX;** 10 days-**VA, MD/DC** ; 3 weeks-**GA, IL;** 28 days-**NJ,** of appt. request	1				
[All except GA - including first visit after pregnancy determination (excludes home pregnancy test)]? **Please circle appropriate Health Plan**					
12 Are phone lines adequate to handle volume of total patient population?	1				
13 Physical/wellness exams for adults within 30 days-**VA, MD/DC, FL, SC, NM, NY, OH,** TN; 10 weeks **TX;** 5 weeks-**IL;** baseline	1				
physical for new members w/n 180 days of enrollment-**NJ? Please circle appropriate Health Plan - N/A for BH Providers**					
14 Physical/wellness exams for children within 30 days-**VA, MD/DC, FL, SC, GA, NM, NY, OH,** TN; 2 months.-**TX and NJ;** from the	1				
date of contact/request? **Please circle appropriate Health Plan - N/A for BH Providers**					
15 **NJ Only:** Baseline physicals for new child members/adult members of DDD w/n 90 days of enrollment or according to EPSDT	1				
guidelines? **- N/A for BH Providers and for all Plans except NJ**					
F. Documentation Evaluation: Does the office have the following:	17				
1 No-show follow-up procedure/policy? (If not written, can the staff verbally explain the process?)	2				
2 A chaperone policy? (If provider does not have written chaperone policy, office must provide statement on letterhead indicating chaperone	2				
will be in exam room.) **THIS ELEMENT IS A MUST HAVE TO PASS SITE VISIT & PARTICIPATE**					
3 Is the Patient Bill of Rights posted?	1				
4 Is Medical License/Occupational License displayed?	1				
5 **TX and FL only:** Is there a posted notice of member complaint process?	1				
6 **FL Only:** Is the HMO hotline number posted?	1				
6 **FL Only:** If Provider does not carry malpractice insurance, is required patient notification statement posted in prominent place in	1				
reception area?					
7 Is there a written policy for hand washing, gloved procedures, and disposal of sharps, etc.? May not be applicable for BH Providers	2				
in private practice setting.					
8 Is there a written OSHA Exposure Control Plan which includes Universal Precautions & Blood Born Pathogen exposure	2				
procedures for staff? May not be applicable for BH Providers					
9 **FL & TX Only:** Posted copy of CLIA Certificate or Certificate of Waiver, if applicable? **(Attach a copy to site evaluation tool)**	1				
TX Only: PCPs providing TX HealthSteps services MUST have CLIA, CLIA Waiver or lab services on site within same bldg.					
10 **FL & TX Only:** Posted copy of current radiology services certification or licensure, if applicable? **(Attach a copy to site evaluation tool)**	1				
11 If Provider employs NPs, PAs or other mid-level providers that will asseses health care needs of members, do they have written policies that	2				
describe duties and supervision of such providers?					
G. HIPAA Requirements/Regulations	8				
1 Is there a written P & P addressing permitted uses/disclosures and required disclosures of patient PHI/IIHI?	2				
2 Does Provider have authorization forms available to designate Personal Representative(s) to which PHI/IIHI may be	2				
released and/or disclosed?					
3 Are there physical safeguards in place to protect the privacy of patient PHI/IIHI?	2				
4 Is there a designated Compliance & Privacy person? **Name:**_____	2				

PRACTITIONER OFFICE SITE EVALUATION - ALL PLANS

INFORMATION BELOW MUST BE DOCUMENTED AT TOP OF EACH PAGE OF SITE VISIT FORM! ALL QUESTIONS MUST BE ANSWERED.

Physician/Practitioner Name(s):

_____ _____
Last First

_____ _____
Last First

_____ _____
Last First

_____ _____
Last First

Office Manager: _____ _____
Last First

Physician/Practitioner Name(s):

_____ _____
Last First

_____ _____
Last First

_____ _____
Last First

_____ _____
Last First

Office Address _____

Specialty(ies) _____ **Date** _____ **Reviewer Name** _____ _____
Last First

		Point Value	Y	N	N/A	Point Score
H.	**Office Evaluation**	12				
1	Is there an approved process for bio-hazardous disposal?	2				
2	Are pharmaceutical supplies and medication stored in a locked area that is not readily accessible to patients?	2				
3	Is there a plan/procedures for narcotic inventory, control and disposal?	2				
4	Are vaccines and other biologicals refrigerated, as appropriate?	2				
5	Observe 2-3 office staff interactions: Are they professional and helpful?	2				
6	Is emergency equipment available (an oral airway and ambu bag)? If not, note how staff accommodates emergency situations.	2				

To complete the form, answer every question, then total the number of points and record here. **100** **TOTAL** ☐

A copy of this complete profile was received by:

_____ Office Manager / Physician/Practitioner **(please circle one)**
Office Manager/Physician/Practitioner Signature

REMINDER - DO NOT DEDUCT POINTS FOR THOSE QUESTIONS THAT ARE ANSWERED N/A
INCLUDE THOSE POINTS FOR N/A ANSWERS IN TOTAL SCORE

REMINDER - IF PROVIDER HAS A CLIA CERTIFICATE/CERTIFICATE OF WAIVER AND/OR RADIOLOGY LICENSURE
YOU MUST ATTACH A COPY OF THE DOCUMENTS TO THIS SITE VISIT FORM

Practitioner Clinical Medical Record Audit Form

Physician Name: _____ Office Manager: _____

Office Address: _____

Specialty: _____ Date: _____ Reviewer Name: _____

Patient Name: _____Chart/Member #: _____

Note: Reference to specific sections in NMAC 8.307.8.17.A (Standards for Medical Records) are noted in brackets. Additional Amerigroup standards are noted as [AGP].

Minimum Document Standards [2]	Point Value	Y	N	Point Score
1. Is chart accessible?*	6			
2. Do all pages contain patient ID (name/ID #)?* [2a]	6			
3. Is there personal/biographical data to include DOB, race, ethnicity, marital status, employer, emergency contact information, phone numbers, home address or consent form? [2b]	4			
4. Are all entries dated? [2c]	4			
5. Is the provider (author) identified on each entry? [2d]	3			
6. Are allergies and adverse reactions to medications prominently displayed or, if patient has no known allergies or history of adverse reaction, is this appropriately noted in the record?* [2e] Are all entries dated?	6			
7. Is there an appropriate past medical history in the record for patients seen two or more times? [2f]	5			
8. Has the member had appropriate preventive care and screenings, and has the status of that preventive care and screening been summarized in a format that is easy to audit within 6 months of enrollment? [2g]	3			
9. Is diagnostic information documented? [2h]	3			
10. Is there a list of current medications as well as a medication history to include what medication has been effective and what has not and why? * [2i]	6			
11. Is the record legible (to at least a peer of the author)?	6			
12. Is the chief complaint documented? * [AGP] Are significant illnesses and medical conditions indicated on the problem list or, if patient has not know allergies or history of adverse reaction, is this appropriately noted in the record? *	3			

Minimum Document Standards [2]	Point Value	Y	N	Point Score
13. Is there a current problem list? [2j] Are allergies and adverse reactions to medications prominently displayed or, if patient has no known allergies or history of adverse reaction, is this appropriately noted in the record? *	3			
14. Are allergies and adverse reactions to medications prominently displayed or, if patient has no known allergies or history of adverse reaction, is this appropriately noted in the record?* Is there an appropriate past medical history in the record (for patients seen three or more times) which includes serious accidents, operations or illnesses, emergency care and discharge summaries? Age 18 and under should include prenatal care, birth, operations and childhood illnesses.*	3			
15. Is there an appropriate past medical history in the record for patients seen two or more times? Documentation of smoking habits and history of alcohol or substance abuse (age 12 and over)?	1			
16. Is there documentation of smoking habits and history of alcohol or substance use and abuse (age 12 and over)? [2k] Is there a pertinent history and physical exam?	2			
17. If applicable, are there reports of consultations and referrals, labs and diagnostic imaging studies and do results reflect PCP review? [2l]	3			
18. If applicable, in regards to the current/last visit, are lists of therapies and other prescribed regimens and the results documented? [4e]	6			
19. Are advance directives present on the chart (21 and older)? [2n]	3			
20. Is the record legible? (to at least a peer of the author) [2o]	3			
Standards for Individual Clinical Encounters [4]				
21. Are labs and other studies ordered, as appropriate, and reflect PCP review? Is there a history and physical exam for presenting complaints containing relevant psychological and social conditions affecting the patient's behavioral health, including mental health and substance abuse status?* [4a]	6			
22. Is there a treatment plan? [4b]	3			
23. Are diagnostic tests and their results documented? [4c]	3			
24. Are working diagnoses consistent with findings? * [AGP]	3			
25. Do plans of action/treatments appear consistent with diagnosis(es)? * Is there a treatment plan and it is consistent with diagnoses?	3			
26. Is the treatment plan consistent with diagnoses? [AGP]	3			
27. In regards to the current/last visit, were the drugs prescribed documented, including the strength, amount, directions for use and refills? [4d]	3			
28. If applicable, in regards to the current/last visit, are lists of therapies and other prescribed regimens and the results documented? [4e]	3			
29. Is there a date for a return visit or other follow-up plan for each encounter? [4f]	3			
30. If applicable, in regards to the current/last visit, are consultations and	3			

Minimum Document Standards [2]	Point Value	Y	N	Point Score
referrals and the results documented? [4g] Are problems from previous visits addressed? If applicable, Is there a list of therapies and other prescribed regimens and the results?				
31. Is there evidence of appropriate use of consultants? If applicable, are there reports of consultations and referrals, labs and diagnostic imaging studies and do results reflect PCP review?	3			
32. Is there evidence of continuity and coordination of care between primary and specialty physicians? Has the member had appropriate preventive care and screenings within 6 months of enrollment, and has the status of that preventive care and screening been summarized in a format that is easy to audit?	4			
33. Do consultant summaries, lab and imaging study results reflect PCP review? Are advance directives present on the chart (21 and older)?	3			
34. Does the care appear to be medically appropriate? (There is no evidence that patient was placed at inappropriate risk by diagnostic or therapeutic procedure.) * Is there a list of current medications as well as a medication history to include what medication has been effective and what has not and why? *	4			
35. Is there a completed immunization record (ages 13 and under)? Are copies of any emergency treatment and/or hospital admission present in the chart to the extent possible?	1			
36. Are preventive services appropriately used? In regards to the current/last visit, what drugs were prescribed, to include the strength, amount, directions for use and refills?	3			
37. Are advance directives present on the chart (21 and older)?	3			
38. Does pediatric documentation include: (4 points total)				
– Growth chart (1.5 pts.)	1.5			
– Head circumference chart (1 pt.)	1			
– Developmental milestones (1.5 pts.)	1.5			
Is there a list of current medications?	4			
Are copies of any emergency treatment and/or hospital admission present in the chart?	1			
If a mental health problem is noted, was a referral made, or did the PCP perform treatment?	3			
If a substance abuse problem is noted, was a referral made, or was treatment or education noted?	3			
If smoking is noted, was patient advised to quit (age 12 and older)?	1			
Is there evidence of blood lead risk assessment (verbal assessment or blood lead test, age 6 months to 6 years)?	1			
TOTAL	100			
***These critical elements must be met, in addition to receiving an average score of 80 percent to achieve an acceptable rating on the Clinical**				

Minimum Document Standards [2]	Point Value	Y	N	Point Score
Medical Record Review.				

Reference: NMAC 8.307.8.17 A

Practitioner Clinical Medical Record Audit Form

Physician Name: _____ Office Manager: _____

Office Address: _____

Specialty: _____ Date: _____ Reviewer Name: _____

Patient Name: _____Chart/Member #: _____

Note: Reference to specific sections in NMAC 8.307.8.17.A (Standards for Medical Records) are noted in brackets. Additional Amerigroup standards are noted as [AGP].

Minimum Document Standards [2]	Point Value	Y	N	Point Score
1. Is chart accessible?*	6			
2. Do all pages contain patient ID (name/ID #)?* [2a]	6			
3. Is there personal/biographical data to include DOB, race, ethnicity, marital status, employer, emergency contact information, phone numbers, home address or consent form? [2b]	4			
4. Are all entries dated? [2c]	4			
5. Is the provider (author) identified on each entry? [2d]	4			
6. Are allergies and adverse reactions to medications prominently displayed or, if patient has no known allergies or history of adverse reaction, is this appropriately noted in the record?* [2e] Are all entries dated?	6			
7. Is there an appropriate past medical history in the record for patients seen two or more times? [2f]	5			
8. Has the member had appropriate preventive care and screenings, and has the status of that preventive care and screening been summarized in a format that is easy to audit within 6 months of enrollment? [2g]	3			
9. Is diagnostic information documented? [2h]	3			
10. Is there a list of current medications as well as a medication history to include what medication has been effective and what has not and why? * [2i]	6			
11. Is the record legible? (to at least a peer of the author)	4			
12. Is the chief complaint documented? * [AGP] Are significant illnesses and medical conditions indicated on the problem list or, if patient has not know allergies or history of adverse reaction, is this appropriately noted in the record? *	6			
13. Is there a current problem list? [2j] Are allergies and adverse	3			

Minimum Document Standards [2]	Point Value	Y	N	Point Score
reactions to medications prominently displayed or, if patient has no known allergies or history of adverse reaction, is this appropriately noted in the record? *				
14. Are allergies and adverse reactions to medications prominently displayed or, if patient has no known allergies or history of adverse reaction, is this appropriately noted in the record?* Is there an appropriate past medical history in the record (for patients seen three or more times) which includes serious accidents, operations or illnesses, emergency care and discharge summaries? Age 18 and under should include prenatal care, birth, operations and childhood illnesses. *	4			
15. Is there an appropriate past medical history in the record for patients seen two or more times? Documentation of smoking habits and history of alcohol or substance abuse (age 12 and over)?	3			
16. Is there documentation of smoking habits and history of alcohol or substance use and abuse (age 12 and over)? [2k] Is there a pertinent history and physical exam?	4			
17. If applicable, are there reports of consultations and referrals, labs and diagnostic imaging studies and do results reflect PCP review? [2l]	3			
18. If applicable, in regards to the current/last visit, are lists of therapies and other prescribed regimens and the results documented? [4e]	1			
19. Are advance directives present on the chart (21 and older)? [2n]	2			
20. Is the record legible? (to at least a peer of the author) [2o]	3			
Standards for Individual Clinical Encounters [4]				
21. Are labs and other studies ordered, as appropriate, and reflect PCP review?Is there a history and physical exam for presenting complaints containing relevant psychological and social conditions affecting the patient's behavioral health, including mental health and substance abuse status?* [4a]	4			
22. Is there a treatment plan? [4b]	3			
23. Are diagnostic tests and their results documented? [4c]	3			
24. Are working diagnoses consistent with findings? * [AGP]	4			
25. Do plans of action/treatments appear consistent with diagnosis(es)? * Is there a treatment plan and it is consistent with diagnoses?	4			
26. Is the treatment plan consistent with diagnoses? [AGP]	3			
27. In regards to the current/last visit, were the drugs prescribed documented, including the strength, amount, directions for use and refills? [4d]	3			
28. If applicable, in regards to the current/last visit, are lists of therapies and other prescribed regimens and the results documented? [4e]	3			
29. Is there a date for a return visit or other follow-up plan for each	3			

Minimum Document Standards [2]	Point Value	Y	N	Point Score
encounter? [4f]				
30. If applicable, in regards to the current/last visit, are consultations and referrals and the results documented? [4g] Are problems from previous visits addressed? If applicable, is there a list of therapies and other prescribed regimens and the results?	3			
31. Is there evidence of appropriate use of consultants? If applicable, are there reports of consultations and referrals, labs and diagnostic imaging studies and do results reflect PCP review?	3			
32. Is there evidence of continuity and coordination of care between primary and specialty physicians? Has the member had appropriate preventive care and screenings within 6 months of enrollment, and has the status of that preventive care and screening been summarized in a format that is easy to audit?	4			
33. Do consultant summaries, lab and imaging study results reflect PCP review? Are advance directives present on the chart (21 and older)?	2			
34. Does the care appear to be medically appropriate? (There is no evidence that patient was placed at inappropriate risk by diagnostic or therapeutic procedure.) * Is there a list of current medications as well as a medication history to include what medication has been effective and what has not and why? *	4			
35. Is there a completed immunization record (ages 13 and under)? Are copies of any emergency treatment and/or hospital admission present in the chart to the extent possible?	1			
36. Are preventive services appropriately used? In regards to the current/last visit, what drugs were prescribed, to include the strength, amount, directions for use and refills?	3			
37. Are advance directives present on the chart (21 and older)?	3			
38. Does pediatric documentation include: (4 points total)				
– Growth chart (1.5 pts.)	1.5			
– Head circumference chart (1 pt.)	1			
– Developmental milestones (1.5 pts.)	1.5			
Is there a list of current medications?	4			
Are copies of any emergency treatment and/or hospital admission present in the chart?	1			
If a mental health problem is noted, was a referral made, or did the PCP perform treatment?	3			
If a substance abuse problem is noted, was a referral made, or was treatment or education noted?	3			
If smoking is noted, was patient advised to quit (age 12 and older)?	1			
Is there evidence of blood lead risk assessment (verbal assessment or blood lead test, age 6 months to 6 years)?	1			
TOTAL	100			

Minimum Document Standards [2]	Point Value	Y	N	Point Score
***These critical elements must be met, in addition to receiving an average score of 80 percent to achieve an acceptable rating on the Clinical Medical Record Review.**				

Reference: NMAC 8.307.8.17 A

Advance Directives

The rest of this page intentionally left blank. Form(s) displayed on subsequent pages.

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 1-800-600-4441.

I name *(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 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 initials 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 my 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 1-800-600-4441.

I, (Print your Name Here) _____, am of sound mind. I want to have what I say here followed. I am writing this for when 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 <u>NOT</u> WANT. I do not want (put your initials by the services you do not want):

_____ Cardiac resuscitation (start my heart pumping after it has stopped)
_____ Mechanical respiration (machine breathing for me if my lungs have stopped)
_____ Tube feeding (a tube in my nose or stomach that will feed me)
_____ Antibiotics (drugs that kill germs)
_____ Hydration (water and other fluids)
_____ Other (indicate what it is here)

TREATMENT I DO WANT. I want (put your initial by the services you do want):

_____ Medical services
_____ Pain relief
_____ All treatment to keep me alive as long as possible
_____ Other (indicate what it is here)

What I indicate here will happen, unless I decide to change it or decide not to have a living will at all. I can change my living will anytime I wish. I just have to let my doctor know I want to change it or forgo a living will entirely.

SIGNATURE: **DATE:**

ADDRESS:

Behavioral Health Form

Authorization for Release of Information

I, _____, authorize/do not authorize

(Member's Name) (Circle one)

_____

(PCP's Name)

to release an initial summary and progress notes to my behavioral health provider for continuity of care purposes and to release information to above-named behavioral health provider and Amerigroup or its designee as may be necessary for the administration and provision of my health care coverage. The information released may include information on mental health care, substance abuse treatment or other medical or clinical information.

I understand that this consent shall remain in effect for one year or throughout this course of treatment, whichever is longer. I understand that I may revoke this authorization at anytime by written notice to the above-named treatment provider and Amerigroup.

_____ _____

Signature (if minor, signature of parent or guardian) (Date)

_____ _____

(Witness) (Date

Disease Management Forms

The rest of this page intentionally left blank. Form(s) displayed on subsequent pages.

Coronary Artery Disease (CAD) Treatment Plan

Name: _____ Amerigroup #: _____

Member's Telephone #: _____

Practitioner Name: _____

Date Member Diagnosed with CAD: _____

Comments: _____

_____

MEDICATIONS

Medication	Dosage

Aspirin Prescribed, Not Prescribed (Medical Reasons*)
Beta Blocker Therapy Prescribed, Not Prescribed (Medical Reason*)
LDL-C Lowering Therapy (When Indicated) Prescribed, Not Prescribed (Medical Reason*) Current LDL-C mg/dl
*Specify Medical Reason (e.g., Allergy, Contraindication)
Desire Weight Management Interventions? (circle one) Yes No Wt: _____ Ht: _____ BMI: _____
Desire Tobacco Cessation Interventions? (circle one) Yes No
Flu Shot Date: _____

Most Recent Values	Result	Date
Blood Pressure		
LDL		
HDL		
Triglycerides		
Total Cholesterol		

EKG/ECHO/Stress Test/Cath Date and Results: _____

_____

Smoker: Y or N **Interventions: Y or N** **Counseling Y or N** **Pharmacologic: Y or N**

REFERRALS (SPECIALISTS and COMMUNITY)

Date	Resource	Reason for Referral

Other Diagnosis: _____

_____

For additional assistance, please call 1-800-454-3730 and ask to speak to the CAD disease management care manager.

Physician's Signature: _____ Date: _____

PLEASE FAX TO 757-321-2614

Chronic Obstructive Pulmonary Disease (COPD) Treatment Plan

Name: _____ Amerigroup #: _____

Member's Telephone #: _____

Practitioner Name: _____

Date Member Diagnosed with COPD: _____

Comments: _____

_____

MEDICATIONS

Medication	Dosage

STEP-WISE THERAPY

Many Physicians Use a Step-Wise Approach in the Care of Patients with COPD.
Step 1 - Regular or PRN Use of Ipratropium Bromide
Step 2 - PRN Use of a β2-adrenergic Inhaler for Rescue
Step 3 - Long-Acting Theophylline
Step 4 - Corticosteroids: Oral, Inhaled
Step 5 - As Indicated: Oxygen, Diuretics, Antibiotics, Long-Acting β2- Adrenergics

Is Member on Oxygen? Yes ____ No ____	If Yes, How Many L/min? _____
Spirometry Performed? Yes ____ No ____	If Yes, Date and Result _____
Is Member a Smoker? Yes ____ No ____	
Desire Tobacco Cessation Interventions? Yes ____ No ____ Has Member Attended Smoking Cessation Classes? Yes ____ No ____	If Yes, Where and When? _____ _____ _____
Desire Weight Management Interventions? Yes ____ No ____	Wt: _____ Ht:_____ BMI:_____
Flu Shot Date: _____	

REFERRALS (SPECIALISTS and COMMUNITY)

Date	Resource	Reason for Referral

Other Diagnosis: _____

_____

For additional assistance, please call 1-800-454-3730 and ask to speak to the COPD Disease Management Care Manager.

Physician's Signature: _____ Date: _____

PLEASE FAX TO 757-321-2614

Diabetes Treatment Plan

Name: _____ Amerigroup #: _____

Member's Telephone #: _____ Practitioner Name: _____

Date Member Diagnosed with Diabetes (Duration of Illness): _____

Any Diabetes-Related Complications? _____
_____

Comments: _____
_____

MEDICATIONS

Medication	Dosage

Most Recent Lab Values	Level	Date
Average Glucose Level		
Hemoglobin A1c		
Blood Pressure		
LDL		
HDL		
Triglycerides		
Creatinine (Blood)		
Urine Microalbumin		

Desire Weight Management Interventions? (circle one) Yes No Wt: _____ Ht: _____ BMI: _____

Desire Tobacco Cessation Interventions? (circle one) Yes No

Flu Shot Date: _____

Date of Most Recent Diabetic Foot Exam by Physician: _____

Date of Most Recent Diabetic Eye Exam: _____

REFERRALS (SPECIALISTS and COMMUNITY)

Date	Resource	Reason for Referral

Other Diagnosis: _____
_____

For additional assistance, please call 1-800-454-3730 and ask to speak to the Diabetes Disease Management Care Manager.

Physician's Signature: _____ Date: _____

PLEASE FAX TO 757-321-2614

APPENDIX B – CLINICAL PRACTICE GUIDELINES

The following clinical practice guidelines are located on our website at providers.amerigroup.com/NM:

1. Pediatric Preventive Health
2. Child Immunization (0 – 6)
3. Adolescent Immunization Schedule (7 – 18)
4. Adult Immunization Schedule (over 18)
5. Congestive Heart Failure
6. Asthma
7. Human Immune Deficiency Virus
8. Adult Preventive Health
9. Adult Hypertension
10. Chronic Kidney Disease
11. Coronary Artery Disease
12. Chronic Obstructive Pulmonary Disease
13. Adult Obesity
14. Diabetes Mellitus
15. Child and Adolescent Hypertension

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