Amerigroup

Provider Manual

Amerigroup Community Care

800-454-3730

https://provider.amerigroup.com/TN

TNAGP-CD-PM-025890-23

How to apply for participation
If you are interested in applying for participation with Amerigroup Community Care, please visit **provider.amerigroup.com/tn** or call Provider Services at **800-454-3730**.

Amerigroup Community Care complies with the applicable federal and state civil rights laws, rules, and regulations and does not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age, or disability. If a member or a participant needs language, communication, or disability assistance or to report a discrimination complaint, call 800-454-3730. Information about the civil rights laws can be found at **tn.gov/tenncare/members-applicants/civil-rights-compliance.html**.
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1 INTRODUCTION

Welcome to the Amerigroup Community Care network provider family! Incorporated as Amerigroup Tennessee, Inc., we are pleased that you have joined our Tennessee network, which consists of some of the finest health care providers in the state.

The Division of TennCare administers the TennCare℠ program, which includes TennCare Medicaid, TennCare Standard and CoverKids. TennCare Medicaid covers all Medicaid mandatory eligibility groups as well as various optional categorically needy and medically needy groups including children, pregnant women, the aged and individuals with disabilities. CoverKids is TennCare's Children's Health Insurance Plan (CHIP) program and it provides both maternity and medical benefits for children under age 19 years and pregnant women 19 years and over. There is a special section of this manual to find CoverKids information — see chapter 21 for specific details.

We believe 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 **800-454-3730** with any suggestions, comments or questions that you may have. Together, we can arrange for and provide an integrated system of quality, coordinated and efficient care for our members and your patients.

Throughout the manual, references to the CRA are references to the MCO statewide contract available on the TennCare website at **tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf**.

Division of TennCare required language — provider agreements
The Division of TennCare requires specific language in TennCare provider agreements. As noted in the provider agreement, TennCare-required language and state of Tennessee mandates regarding the TennCare program can be updated by inclusion in this provider manual.

For ease of provider review, we've included certain required language and TennCare program mandates in a document titled "TennCare Regulatory Appendix, Division of TennCare Required Language — Provider Agreements," which is routinely appended to Amerigroup TennCare provider agreements. The latest version of this Appendix is also in **Appendix C** of this provider manual.

When Amerigroup amends your provider agreement to comply with federal and state regulatory requirements, most of these changes may be made within the body of this manual; however, in certain circumstances, those regulatory requirements may require Amerigroup to make changes to confidential portions of your provider agreement, such as the payment provisions. When this type of change is required, Amerigroup may provide you with a separate confidential notice of the regulatory changes to your provider agreement. If the payment provisions are impacted, we will send you a new fee schedule or payment appendix for your records. If we provide you notice of changes in

accordance with this paragraph, Amerigroup will limit such changes to those required to comply with the change in regulatory requirements.

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

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

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

2 Overview

Who is Amerigroup?
Amerigroup Tennessee, Inc., doing business as Amerigroup Community Care, is a leader in managed healthcare services for the public sector; the Amerigroup subsidiary health plans provide health care coverage exclusively to low-income families, children, pregnant women and Medicare Advantage Special Needs Plans.

Our mission
The Amerigroup mission is to provide real solutions for members who need a little help by making the health care system work better while keeping it more affordable for taxpayers.

Our vision
Amerigroup will be a different kind of health insurance company — a company that does well by doing good.

Our values
The Amerigroup values include:

- **Compassion** — We understand the importance of acting with empathy and developing meaningful relationships that will positively influence our associates and members' lives.
- **Quality** — We provide outstanding products, quality and unsurpassed service that, together, deliver premium value to our stakeholders.
- **Integrity** — We uphold the highest standards in all our actions.
- **Teamwork** — We work together across boundaries and in partnership to meet the needs of our customers and to help the company achieve its goals.
- **Respect for people** — We value our associates and their diversity, encourage their development and reward their performance.
- **Good citizenship** — We seek to find ways in which to engage and support the communities in which we live and work through volunteerism, political involvement and leading by example.
- **Personal accountability** — We keep our commitments to one another and to those we serve through accepting ownership for the quality of the work we produce. We have a strong desire to win in the marketplace and in every aspect of our business, and each associate accepts personal responsibility for achieving organizational success.

Strategy
The Amerigroup strategy is to:

- Improve access to preventive primary care services by ensuring the selection of a PCP who will serve as provider, care manager and coordinator for all basic medical services.
- Improve the health status and outcomes of the 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 processes that actively involve providers in re-engineering health care delivery.
- Encourage a customer service orientation with regular measurement of member and provider satisfaction.

Summary
In a world of escalating health care costs, Amerigroup works to educate our members about the appropriate use of our managed care system and their involvement in all aspects of their health care.

3 Quick reference information

Amerigroup website

Our provider website, **provider.amerigroup.com/tn**, offers you a full complement of online tools including:

- Enhanced account management tools.
- Detailed eligibility lookup tool with downloadable panel listing.
- More comprehensive downloadable member listing tool.
- Easier authorization submission tool.
- New provider data, termination and roster tools

Amerigroup phone numbers

Please have your Amerigroup provider ID number and NPI number available when you call. Listen carefully and follow the appropriate prompts.

Provider Services telephone	**800-454-3730**
Provider Services fax	**800-964-3627**
TRS users	**711**
Automated provider inquiry line for member eligibility	**800-454-3730**
24-hour NurseLine	**800-600-4441**
Member Services	**800-600-4441**
Behavioral Health Services	**800-454-3730**
Behavioral Health Inpatient Authorization	**Should be submitted electronically via provider.amerigroup.com/tn.** **If you prefer to paper fax, forms are available on the provider website: provider.amerigroup.com/tn**
Behavioral Health Outpatient Services fax	**866-920-6006**
Behavioral Health Neuro-Psych fax	**Should be submitted electronically via provider.amerigroup.com/tn.** **If you prefer to paper fax, forms are available on the provider website: provider.amerigroup.com/tn**
After Hour Missed Visit Non-LTSS	**844 385 5244**
Amerigroup services for injectable and home infusion drug (prior authorizations only)	**800-454-3730**
Electronic Data Interchange (EDI)	Contact Availity Client Services **800-Availity (282-4548)**.
Durable Medical Equipment and Medical Supply Referrals — Amerigroup Utilization Management (UM)	**800-454-3730**
TennCare online services **tcmisweb.tenncare.tn.gov/tcmis/tennessee/Security/logon.asp** Providers and trading partners can: • Verify TennCare eligibility. • Upload or download *HIPAA* transactions. • Submit or inquire about pre-admission evaluation status.	**800-852-2683** (toll free) **615-741-6669** (Nashville local)

• Use the TennCare messaging system. Providers and partners who wish to use this online service must be a TN.gov subscriber. If you cannot verify an enrollee's eligibility via this online system, you should contact the enrollee's TennCare MCO. You may also contact TennCare Provider Services at the phone numbers to the right.	
TennCare phone numbers	
Dental Services: DentaQuest is TennCare's dental benefits manager	**855-418-1622**
TennCare Pharmacy	
OptumRx (toll free) for questions related to the pharmacy program and general prior authorization. Also, see the TennCare Pharmacy website: **tn.gov/tenncare/providers/managed-care-contractors/pharmacy-benefits-manager.html**	**866-434-5524**
TennCare Solutions Unit (for medical appeals) See also: **tn.gov/tenncare/members-applicants/how-to-file-a-medical-appeal.html**	**800-878-3192**
Mobile Crisis Services (behavioral health) operates 24 hours a day, 7 days a week and is open to anyone who needs mental health crisis services.	
Adults aged 18 and older	**855-CRISIS1 or 855-274-7471**
Children under the age of 18, please call Youth Villages:	
Memphis region: Rural West TN: Rural Middle TN: Nashville region: Upper Cumberland: Southeast TN: Knoxville region: Northeast TN:	**866-791-9226** **866-791-9227** **866-791-9222** **866-791-9221** **866-791-9223** **866-791-9225** **866-791-9224** **866-791-9228**
TennCare Connect	**855-259-0701**
Fraud, Waste, and Abuse Reporting To report TennCare member fraud or abuse: To report TennCare provider fraud or abuse:	Member Fraud and Abuse: **800-433-3928 or email at** TennCare.Fraud@tn.gov Provider Fraud and Abuse: **833-687-9611** or email at Program.Integrity.TennCare@tn.gov Or TBI Medicaid Fraud Control Division at **800-433-5454 or** email at: TBI.MedicaidFraudTips@tn.gov
Tennessee Carriers	**800-680-0633**

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 Provider Services at **800-454-3730**.
Precertification/ notification	• May be telephoned or faxed to Amerigroup: ○ Telephone: **800-454-3730** ○ Fax: 8**00-964-3627** Behavioral Health Inpatient Fax: **844-452-8071** Behavioral Health Outpatient Fax: **866-920-6006** Behavioral Health Neuro-Psych Testing **844-451-2827**
Precertification/ notification	• Data required for complete precertification/notification: ○ Member ID number ○ Legible name of referring licensed provider ○ Legible name of individual referred to provider ○ Number of visits/services ○ Date(s) of service ○ Diagnosis • In addition, clinical information is required for precertification Precertification forms are located at: **provider.amerigroup.com/tennessee-provider/resources/forms**
Become a Tennessee Medicaid provider	You may access this information on the web. Go to **tn.gov/tenncare/section/providers**
National Provider Identifier (NPI)	**NPI:** The *Health Insurance Portability and Accountability Act* (*HIPAA*) of 1996 requires the adoption of a standard unique provider identifier for health care providers. All Amerigroup participating providers must have an NPI number. NPI is a 10-digit intelligence-free numeric identifier. Intelligence-free means that the numbers do not carry information about health care providers such as the state in which they practice or their specialty. Providers can apply for an NPI by: • Completing the application online at **nppes.cms.hhs.gov** (estimated time to complete the NPI application is 20 minutes) • Completing a paper copy by downloading it at **nppes.cms.hhs.gov** • Calling **800-465-3203** and requesting an application
Claims information	• Submit paper claims to: TN Claims P.O. Box 61010 Virginia Beach, VA 23466-1010 • Your organization can submit and receive the following transactions through Availity's EDI gateway: ○ 837 — institutional claims

	○ 837 — professional claims ○ 837 — dental claims ○ 835 — electronic remittance advice (ERA) ○ 276/277 — claim status ○ 270/271 — eligibility request • **Get started with Availity:** ○ If you wish to submit directly to Availity, setup is easy. Go to the Availity Welcome Application and begin the process of connecting to the Availity EDI Gateway for your EDI transmissions. ○ If you wish to use another clearinghouse or billing company, please work with them to ensure connectivity. • For more information about Availity such as how to register, training opportunities and more, visit **Availity.com** or call **800-AVAILITY** (**800-282-4548**). • Timely filing is within 120 days of the date of service 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. For cases of retroactive eligibility, the time frames for filing a claim will begin on the date that Amerigroup receives notification from TennCare of the member's eligibility/enrollment. • A corrected claim or replacement claim may be submitted within 120 calendar days of payment notification (paid or denied). Corrections to a claim should only be submitted if the original claim information was wrong or incomplete. • For other claims (vision and pharmacy injectables), refer to the Services NOT Covered by Amerigroup section. (Noninjectable pharmacy benefits are covered by a Pharmacy Benefits Manager [PBM] contracted by TennCare.) • Amerigroup provides access to an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status and referral authorization status. Visit **providers.amerigroup.com**. • If you are unable to access the internet, you may receive claims, eligibility and referral authorization status over the telephone at any time by calling the toll-free automated Provider Inquiry Line at **800-454-3730**.
Medical appeal information	• Member appeals are managed by TennCare.

	• Members have the right to file appeals regarding adverse benefit determinations taken by Amerigroup. For purposes of this requirement, appeal means a member's right to contest, verbally or in writing, any adverse benefit determinations taken by Amerigroup to deny, reduce, terminate, delay or suspend a covered service; and any other acts or omissions of Amerigroup that impair the quality, timeliness or availability of such benefits. An appeal may be filed by the member or by a person authorized by the member to do so, including a provider with the member's written consent. Complaint means a member's right to contest any other action taken by Amerigroup or service provider other than those that meet the definition of an adverse benefit determinations. Amerigroup will inform members of their complaint and appeal rights in the member handbook. Amerigroup has internal complaint and appeal procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees and court orders governing the appeals process. • You may call Amerigroup at **800-600-4441** to speak to someone who is knowledgeable of appeal procedures and will facilitate all appeals as appropriate, whether the appeal is verbal or the member chooses to file in writing to TennCare. • Should a member choose to appeal in writing, the member will be instructed to file via mail or fax to the designated TennCare P.O. Box or fax number for medical appeals: TennCare Member Medical Appeals or CoverKids Member Medical Appeals P.O. Box 593 Nashville, TN 37202-0593 Fax (toll free) **888-345-5575** See also: **tn.gov/tenncare/members-applicants/how-to-file-a-medical-appeal.html**

Payment dispute process	We have several options when filing a claim payment dispute. They are described below: • Website (reconsideration and claim payment appeal): Amerigroup can receive reconsiderations and claim payment appeals via the secure Provider Availity Payment Appeal Tool at **Availity.com**. Supporting documentation can be uploaded to Availity.com. You will receive immediate acknowledgement of your submission. Locate the claim you want to dispute on Availity using **Claim Status** from the **Claims & Payments** menu. If available, select **Dispute Claim** to initiate the dispute. Go to **Request**" to navigate directly to the initiated dispute in the appeals dashboard add the documentation and submit. • Written (reconsideration and claim payment appeal): Written reconsiderations and claim payment appeals should be mailed along with the *Claim Payment Appeal Form* or the *Reconsideration Form* to: Provider Payment Disputes P.O. Box 61599 Virginia Beach, VA 23466-1599 • You may only submit one reconsideration and one appeal per claim. Multiple reconsiderations or appeals will not be accepted. • Verbal (reconsideration only): Verbal submissions may be submitted by calling Provider Services at **800-454-3730**. Submit reconsiderations on the *Reconsideration Form* located at: **provider.amerigroup.com/tn**. Submit written claim payment appeals on the *Claim Payment Appeal* form located at: **provider.amerigroup.com/tn**.
Member complaints	The member (or a provider on behalf of the member if the issue is treatment/benefits) may file a complaint by phone by contacting Amerigroup at **800-600-4441** or the Division of TennCare at **855-286-9085**. The member may file a complaint regarding allegations of discrimination by contacting Amerigroup at **800-600-4441**.
Provider complaints	Amerigroup has a system for nonpayment-related complaints for network and non-network providers. See Section 20, Provider Complaint Procedures. **File a provider complaint to:** Amerigroup Community Care Attention: Operations Department – Provider Complaint 22 Century Boulevard, Suite 220 Nashville, TN 37214 As a participant in a program receiving federal funds, you should not be subjected to discrimination because of your race, color, national origin, disability, age, sex, conscience and religious freedom, or other statuses protected by federal and/or state law. A provider may file a complaint regarding allegations of discrimination online at: **tn.gov/tenncare/members-applicants/civil-rights-compliance.html**.

Case managers	• Amerigroup case managers are available during normal business hours from 8 a.m. to 5 p.m. Central time. • For urgent issues at all other times, call **800-454-3730**.
Provider demographic updates	• Go online to: **provider.amerigroup.com/tn** • Fax updates on letterhead to **877-423-9973** or mail to: Operations Department Amerigroup Community Care 22 Century Blvd, Suite 220 Nashville, TN 37214 • Contact the Tennessee Network Data Support at by email at tnnwksup@amerigroup.com or fax to **877-423-9973**
Community Resource Referrals	Milena Novotny: **615-761-7212**
Provider Experience Team	**800-454-3730**
Provider Service representatives	For more information or for hard copies of the guidelines and polices listed below, contact Provider Services at **800-454-3730**.
Clinical Practice Guidelines	**provider.amerigroup.com/tn** See Resources > Policies, Guidelines and Manuals
Medical policies	**provider.amerigroup.com/tennessee-provider/resources/policies-guidelines-and-manuals/medical-policies**
Clinical UM Guidelines	**provider.amerigroup.com/tennessee-provider/resources/policies-guidelines-and-manuals/medical-policies**
Availity Web Portal client services	• Available Monday through Friday, 5 a.m. to 4 p.m. Pacific time at 800-Availity (**800-282-4548**), excluding holidays • Email questions to support@availity.com

4 Credentialing

Amerigroup uses the current National Committee for Quality Assurance (NCQA) Health Plan Accreditation Requirements for the credentialing and recredentialing of licensed independent providers with whom it contracts and who fall within its scope of authority and action.

Amerigroup will completely process credentialing applications within 30 calendar days of receipt of a completed credentialing application including all necessary documentation, attachments and a signed provider agreement. Completely process means that Amerigroup will review, approve and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not included in the Amerigroup provider network.

Credentialing
Each provider agrees to submit for verification all requested information necessary to credential or recredential providers who provide 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 and procedures.

Credentialing requirements
Each provider must 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 provider will complete the Amerigroup application form upon request by Amerigroup. Effective January 1, 2018, use of the Council for Affordable Quality Healthcare's (CAQH) ProView will be required for initial credentialing and recredentialing with Amerigroup. ProView is a free online service that allows health care providers to fill out **one** application to meet the credentialing data needs of multiple organizations.

All providers applying for initial or continuing participation will be required to complete and submit their credentialing and recredentialing applications through CAQH ProView by accessing the CAQH website. Below are some helpful hints and things to remember when using ProView.

To join CAQH ProView:

1. Go to **proview.caqh.org/pr**.
2. Select **Register Now** on the bottom right and follow the instructions.

If you already participate with CAQH and have completed your online application, ensure you authorized Amerigroup access to your credentialing information.

Note: If you have selected **Global Authorization**, Amerigroup will already have access to your data.

To authorize Amerigroup:

1. Go to **proview.caqh.org/pr** and enter your username and password.
2. Select the cog wheel in the upper right and then select **Authorize**.
3. Scroll down, locate *Amerigroup* and check the box beside *Amerigroup*.
4. Select **Save** to submit your changes.

For questions about ProView, call the CAQH help desk at **888-599-1771** or email providerhelp@proview.CAQH.org.

Each provider will 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
- Doctors of chiropractic
- Physician assistants
- Optometrists
- Dentists
- Nurse practitioners
- Certified nurse midwives
- Licensed professional counselors/social workers
- Psychologists
- Licensed psychological and senior psychological examiners
- Physical/occupational therapists
- Speech/language therapists
- Allied services (ancillary) providers
- Applied behavioral analysts

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

Amerigroup established a credentialing committee and a Medical Advisory Committee (MAC) for credentialing decisions. The credentialing committee will make decisions regarding participation of initial applicants at the time of credentialing and their continued participation at the time of recredentialing. The oversight rests with the MAC.

The Amerigroup credentialing policy is revised periodically based on input from several sources including:

- The health plan credentialing committees.
- The health plan medical directors.
- The Amerigroup chief medical officer.
- State and federal requirements.
- NCQA standards.

The policy will be reviewed and approved annually and as otherwise needed.

The provider application contains the provider's signature in attestation of the credentials summarized on and included with the application. The provider's signature also serves as a release for Amerigroup to obtain external information to verify credentials. 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 the provider's compliance with the Amerigroup managed care policies and procedures.

Each provider has the right to inquire about the application status. The applicant may do so by telephone, facsimile or contact through the provider's Provider Relations representative. Additionally, the applicant may call the local Credentialing Operations line at **615-316-2400, ext. 106-126-0704** to check status.

As an applicant for participation with Amerigroup, each provider has the right to review information obtained from primary verification sources during the credentialing process. Upon request from Amerigroup, the provider shall explain information obtained that may vary substantially from that submitted by the provider, and the provider shall submit proposed 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 by the credentialing committee.

Following verifications of all submitted documentation as more specifically described below, the practitioner file will be administratively deemed complete and be submitted to the health plan medical director or credentialing committee for review and approval. To the extent allowed under applicable law or state agency requirements and in accordance with NCQA Standards and Guidelines, the credentialing committee may delegate the authority to review and approve complete files to the medical director. Any file rejected by the medical director will be presented to the credentialing committee for a final determination on Plan 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. Verification of enrollment. If group enrollment, verification that the provider is linked appropriately to the group and that the provider is enrolled at the appropriate service locations.
2. Board certification. Amerigroup verifies board certification. Board certification is verified by referencing the American Medical Association (AMA) Provider Profile, American Osteopathic Association (AOA), the American Board of Medical Specialties (ABMS), American Board of Podiatric Surgery (ABPS), American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM).
3. Verification of education and training. Verification by referencing board certification or the appropriate state-licensing agency.
4. Verification of work history. For individual practitioners, an application or curriculum vitae documenting a minimum of the most recent five years of relevant work history must be submitted. Relevant experience includes work as a health professional. The application or CV must include the beginning and ending month and year for each position in the practitioner's employment experience. Any gaps in work history greater than six months must be explained in writing and be specifically reviewed by the medical director and/or credentialing committee.
5. 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 under applicable state law or state agency requirements, hospital admitting privileges in good standing are administratively verified for the practitioner by obtaining verification 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 network hospital are documented.
6. 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 contact or the internet access. For providers practicing under the supervision of a physician (for example, a physician assistant), Amerigroup will require the name of the supervising physician.
7. DEA number. Verification of the Drug Enforcement Administration (DEA) number to ensure that the practitioner is currently eligible to prescribe controlled substances. Amerigroup verifies this information via the National Technical Information Service (NTIS) database. 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.
8. Professional liability coverage. To the extent allowed under applicable law or state agency requirements, verification of professional liability insurance coverage may be accomplished by the use of an attestation signed by the provider indicating the name of the carrier, policy number, coverage limits, the effective date and expiration date of such insurance coverage. If attestation is not acceptable, the practitioner’s professional liability insurance information is verified by obtaining a copy of the professional liability insurance face sheet from the practitioner or from the insurance carrier. Practitioners are required under applicable law to maintain professional liability insurance in specified amounts. The application form must include specific questions regarding the dates and amount of a practitioner’s current malpractice insurance.

NCQA requires practitioners to attest to the dates and amount of their current malpractice coverage, even if the amount is $0.

9. 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 gives careful consideration to the medical facts of each case, the total number and frequency of claims during the past five years, and the financial settlements and/or legal judgments.
10. CMS sanctions. Verification that the practitioner's record is clear of any sanctions by Medicare/Medicaid. This information is verified by accessing the NPDB and OIG database.
11. Disclosures. The Amerigroup Provider Application will require completion of the following:
    - Reasons for the inability to perform the essential functions of the position with or without accommodation
    - History or current problems with chemical dependency, alcohol or substance use disorder
    - History of license revocation, 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 complaints 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

    You must also provide an:
    - Attestation of the correctness and completeness of the application.
    - Explanation in writing of any identified issues; these explanations are presented with the provider's application to the medical director and credentialing committee.
12. Other queries. The NPDB is queried for all applicants. The NPDB will provide 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 Federation of State Medical Boards for Doctors of Medicine (MDs), Doctors of Osteopathy (DOs) and Physician Assistants (PAs) is queried to verify any restrictions/sanctions made against the practitioner's license. The appropriate state-licensing agency is queried for all other providers. All sanctions are investigated and documented, including the health plan's decision to accept or deny the applicant's participation in the network.
13. Recredentialing. The provider must formally recredential its practitioners at least every 36 months. At the time of recredentialing, information for PCPs from quality improvement activities and member complaints is presented for credentialing committee review. The NPDB is queried for all Amerigroup-contracted providers subject to recredentialing. The resulting NPDB reports are shared with the medical director and the credentialing committee for review and action as appropriate. The Federation of State Medical Boards' MDs, DOs and PAs are queried to verify any restrictions/sanctions made against the practitioner's license. The appropriate state-licensing agency is queried for all other providers. All sanctions are investigated and documented, including the health plan's decision to accept the Amerigroup-contracted provider's participation in the network or to terminate the Amerigroup contract with the provider.

The provider will be notified by telephone or in writing if any information obtained in support of the credentialing or recredentialing process varies substantially from the information submitted by the provider. The provider has 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 the provider by submitting a written explanation or by appearing before the credentialing committee, if requested.

Amerigroup will completely process credentialing applications within 30 calendar days of receipt of a completed credentialing application, including all necessary documentation, attachments and a signed provider agreement. "Completely process" means that Amerigroup will review, approve and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not included for participation. The 30 calendar days will be calculated from the date of receipt of the last document, attachment or application element from the provider.

Credentialing — organizational providers

The organizational provider application contains the signature of the provider's authorized representative that serves as an attestation that the health care facility agrees to the assessment requirements. Organizational providers requiring assessments are hospitals, home health agencies, skilled nursing facilities, nursing homes, ambulatory surgical centers, FQHCs and RHCs, home- and community-based service providers, and behavioral health facilities providing mental health or substance use disorder services in an inpatient, residential, or ambulatory setting. The responsible officer of the organizational provider also agrees by signature on the application to a release of information for external credentials verification.

Following verification of all submitted documentation as more specifically described below, the organizational provider file will be deemed complete and be submitted to the medical director/credentialing committee for review and approval.

In addition to the submission of an application and the execution of a Network Provider Agreement, state licensure of the organizational provider 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 (TJC), Healthcare Facilities Accreditation Program (HFAP) or the American Osteopathic Association (AOA). The Commission on Accreditation of Rehabilitation Facilities (CARF) may accredit rehabilitation facilities. Home health agencies should be accredited by TJC or the Community Health Accreditation Program (CHAP). Nursing homes should be accredited by TJC. TJC or the Accreditation Association for Ambulatory Health Care (AAAHC) should accredit ambulatory surgical centers. Psychiatric inpatient facilities must be accredited by TJC and accept voluntary and involuntary admissions. Psychiatric residential facilities should be accredited by TJC, CARF or COA. If facilities, ancillaries or hospitals are not accredited, Amerigroup will accept a copy of a recent state or CMS review in lieu of performing an onsite review. If an accreditation review is unavailable, an onsite review will be performed. This does not apply to nonaccredited nursing facilities, for which Amerigroup must conduct an onsite review.

During the onsite review:

- A copy of the professional liability insurance face sheet is required. Organizational providers are required to maintain professional liability insurance in the amounts specified in the Network Provider Agreement consistent with state law requirements and Amerigroup policy.
- The Office of Inspector General (OIG) report is reviewed to ensure the organizational provider is free from Medicare/Medicaid sanctions. If sanctions are identified, the organizational provider is denied participation.
- Amerigroup will track an organizational provider's reassessment date and reassess every 36 or 12 months as applicable. Responsibilities for the facility/ancillary vendor are the same for reassessment as they are for the initial assessment.

- NCQA requires a site visit for unaccredited facilities that includes a process for ensuring that the provider credentials its practitioners.

The decision to continue participation or to terminate an organization's participation will be communicated in writing.

The organizational provider will be 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 organizational provider.

Organizational providers have the right to review the information submitted in support of the assessment process and to correct any errors in the documentation. This will be accomplished by the organizational provider submitting a written explanation or by appearing before the credentialing committee if requested.

Peer review

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

- Participate in the implementation of the established peer review system.
- Review and make recommendations regarding individual provider peer review cases.

Should investigation of a member complaint or other potential quality of care issue result in concern regarding a provider's compliance with community standards of care or service, all elements of peer review will be followed.

Peer review includes investigation of provider actions by or at the discretion of the medical director. The medical director takes action based on the quality issue and level of severity, invites the cooperation of the provider, and consults the peer review committee as appropriate. The medical director informs the provider of the peer review committee 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 policy is available upon request.

5 Primary care providers

Medical home
As a PCP, you serve as the entry point into the health care system for the member. You are the foundation of the collaborative concept known as a medical home. We promote this concept to all of our members.

The medical home has an ongoing and collaborative relationship that consists of the:

- PCP.
- Member.
- Member's family.
- Health care providers within the medical home.
- Extended network of consultants, treating providers and specialists with whom the members of the medical home works.

Providers in the medical home know the special, health-related social and educational needs of the members and their families and are connected to necessary resources in the community that can assist in meeting those needs.

Primary care providers
The PCP is a network provider who has the responsibility for the complete care of his or her patient, our member. This practice holds true whether functioning as provider of that care or by referral to the appropriate provider within the network.

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

- Family practitioner
- General practitioner
- General pediatrician
- General internist
- Geriatricians
- Nurse practitioners certified as specialists in family practice or pediatrics
- Federally qualified health centers and rural health centers
- Local health departments

A provider cannot be both a specialist and a PCP; you must choose one or the other.

To participate in a TennCare managed care organization (MCO), the provider must have a Tennessee Medicaid provider number and be a licensed provider by the state before signing a contract with Amerigroup.

The provider must be enrolled in the TennCare Medicaid program at the service location where he or she wishes to practice as a PCP before contracting with Amerigroup.

With the exception of members dually eligible for Medicare and TennCare, Amerigroup ensures that each member has an identified PCP who is responsible for coordinating the covered services provided to the member.

My PCP Connection
If a member is not dually eligible for Medicare and TennCare, Amerigroup will assign a PCP. The assigned PCP is responsible for providing care to their members and will not be reimbursed for services unless provided to a member assigned to themselves or their group. Amerigroup provides the member with an opportunity to change his or her PCP upon receipt of notice of PCP assignment. A member is issued an Amerigroup member identification card displaying the name of the member's PCP.

If a provider is contacted by a member who is either assigned to another PCP or who does not yet have an assigned PCP, the provider should have the member contact our Member Services department at **800-600-4441** to request a PCP change or to be assigned a PCP. The member may complete a *PCP Change Request* form and fax it to us at **866-840-4993**. The effective date of the new PCP assignment shall be based on the date of the member's signature on the PCP Change Form, or parent's or guardian's signature if the member is a child, when the form is received within three (3) business days of the date of signature on the PCP Change Form. In cases where the PCP Change Form is not received within three (3) business days of the date of the signature on the form, the effective date shall be the PCP Change Form date of receipt.

Responsibilities of the primary care provider

The PCP is a network provider who has the responsibility for the complete care of his or her patients, our members, whether providing it himself/herself or by referral to the appropriate provider of care within the network. Federally Qualified Health Clinics (FQHCs), health departments and Rural Health Clinics (RHCs) may be included as PCPs. Below are highlights of the PCP's responsibilities.

The PCP shall:

- Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers; provide coordination necessary for referrals to specialists, including behavioral health providers and fee-for-service providers (both in and out-of-network); and maintain a medical record of all services rendered by the PCP and other providers.
- Provide 24-hour-a-day, 7-day-a-week coverage and maintain regular hours of operation that are clearly defined and communicated to members.
- Provide services ethically and legally and in a culturally competent manner, meeting the unique needs of members with special health care needs.
- Ensure no person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin or any other classifications protected under federal or state laws shall be excluded from participation in, except as specified in Section A 2.3.5 of the CRA, or be denied benefits of, or be otherwise subjected to discrimination in the performance of provider's obligation under its agreement with Amerigroup or in the employment practices of the provider. Ensure notices of nondiscrimination are posted in conspicuous places available to all employees and enrollees.
- Participate in the systems established by Amerigroup that facilitate the sharing of records, subject to applicable confidentiality and *HIPAA* requirements.
- Implement policies and procedures for the provision of language assistance to members and/or the member's representative. Language assistance services include interpretation and translation services and effective communication assistance in alternative formats such as auxiliary aids to any member and/or the member's representative who needs such services including but not limited to members with limited English proficiency, members who are hearing impaired and individuals with disabilities. Such services will be provided free of charge and be available in the form of in-person interpreters, sign language or access to telephonic assistance (e.g., the TTY universal line). Providers will also employ appropriate auxiliary aids and services free of charge.
- Cooperate with Amerigroup and TennCare during discrimination complaint investigations and to report discrimination complaints and allegations to Amerigroup including allegations of discrimination set forth in Section A.2.12.21.1 and A.2.15.7.6.3.2.7 of the CRA.
- Assist TennCare members and/or member representatives in obtaining discrimination complaint forms and contact information for the Amerigroup nondiscrimination compliance office.
- Participate and cooperate with Amerigroup in any reasonable internal or external quality assurance, utilization review, continuing education, training, technical assistance or other similar program established by Amerigroup.

- Make reasonable efforts to communicate, coordinate and collaborate with specialty providers including behavioral health providers involved in delivering care and services to consumers.
- Participate in and cooperate with the Amerigroup complaint and grievance procedures when notified by Amerigroup of a member grievance.
- Not balance bill members, although PCPs are entitled to collect applicable copayments services.
- Continue care in progress during and after termination of his or her contract for up to 90 days until a continuity of care plan is in place to transition the member to another provider or to transition a pregnant member through postpartum care for pregnant members in their second and third trimester in accordance with TennCare requirements.
- 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.
- Meet the federal and state physical and web accessibility standards and those defined in the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973 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 the release of such records as allowed under applicable laws and regulations.
- Provide to members complete information concerning their diagnosis, evaluation, treatment and prognosis.
- 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.
- 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.
- Comply with the Tennessee Prescription Safety Act of 2012.
- Ensure the member is assigned to the provider's panel of members to provide services. This change can be made via fax (use *PCP Change* form) or by calling the NCC at **800-454-3730**. Failure to follow this process/requirement will impact claim payment.

Note: Amerigroup does **not** cover the use of any experimental procedures or experimental medications except under certain precertified circumstances.

Provider obligations

Amerigroup monitors the quality of services delivered under the provider agreement and initiates corrective action when necessary to improve quality of care. Services must be provided in accordance with either the level of medical,

behavioral health or long-term care recognized as the acceptable professional standard of care in the respective community in which the provider practices and/or the standards established by TennCare.

Amerigroup will only pay providers for services provided:

- In accordance with the requirements of the Provider Agreement, Amerigroup policies and procedures, and state and federal law.
- To TennCare enrollees who are enrolled with Amerigroup.

Providers are obligated to:

- Maintain documentation necessary to demonstrate that covered services were provided in compliance with state and federal requirements.
- Ensure that any applicable authorization requirements are met.
- Verify that a person is eligible for TennCare on the date of service.
- Assist a member by providing appeal forms and contact information that include the appropriate address, telephone number and/or fax number for submitting appeals for state-level review.
- Coordinate with other TennCare contractors or Amerigroup subcontractors as may be requested by TennCare or Amerigroup.
- Conduct background checks on employees in accordance with Tennessee law, and such background checks should include at a minimum a check of the Tennessee Abuse Registry, Tennessee Felony Registry, National and Tennessee Sex Offender Registry, the Social Security Master Death File, the Excluded Parties List System (EPLS), and the HHS-OIG List of Excluded Individuals/Entities (LEIE).
- Maintain documentation verifying that the employee's name does not appear on the State Abuse Registry, State Felony Registry, the State and National Sexual Offender Registry, Social Security Master Death File, the EPLS, or LEIE. Individuals who do appear on one of the listed registries are excluded from participating in Medicaid, Medicare and other federal health care programs.
- All providers treating members with opioid use disorder must either provide medication assisted treatment (MAT) or have a policy for referral to a MAT provider for those members wishing to access MAT.
- Maintain all records as described in the Code of Federal Regulations Section 438.3(u) for a period not less than 10 years.

Providers who are compensated via a capitation arrangement are obligated to:

- Notify both Amerigroup and TennCare by certified mail, return receipt requested, if they become aware for any reason that they are not entitled to a capitation payment for a particular enrollee (e.g., a patient dies).
- Submit utilization or encounter data to ensure the ability of Amerigroup to submit encounter data to TennCare that meets the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims.
- Submit utilization or encounter data in a timely manner to support the individual services provided for obstetric care.
- Comply with fraud, waste and abuse requirements.
- Report suspected abuse, neglect and exploitation of adults in accordance with TCA 71-6-103.
- Report suspected brutality, abuse or neglect of children in accordance with TCA 37-1-403 and TCA 37-1-605.
- Adhere to CareMore operational guidelines for designated Shelby County PCPs only. These guidelines are available in the TennCare CHOICES Long-Term Services & Supports (CHOICES) or Employment and Community First CHOICES (ECF CHOICES) Provider Manual Supplement link on our website, **provider.amerigroup.com/tn**, under the *Resources* heading.

Amerigroup may suspend, deny, and refuse to renew or terminate any provider agreement in accordance with the terms of the Amerigroup Agreement with TennCare and applicable law and regulation.

Both parties recognize that in the event of termination of the Agreement between Amerigroup and TennCare, providers will immediately make available to Amerigroup, TennCare, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the Amerigroup/provider agreement. The provision of such records will be at no expense to TennCare.

The TennCare Provider Independent Review of Disputed Claims process is available to providers to resolve claims denied in whole or in part by Amerigroup as provided at TCA 56-32-126(b).

PCP access and availability
All providers are expected to meet the federal and state physical and web accessibility standards and those defined in the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

Health care services provided through Amerigroup must be accessible to all members. Amerigroup is dedicated to ensuring that:

- The PCP or another physician/nurse practitioner is available to provide medically necessary services.
- Covering physicians follow the referral/precertification guidelines.
- The automatic direction of a member to the emergency room when the PCP is **not** available never occurs.

We encourage our PCPs to offer after-hours office care in the evenings and on weekends.

PCPs or extenders are required to adhere to the following access standards:

- Patient Load: 2,500 or less for physicians; half of physician extenders
- Appointment/wait times: usual and customary practice, not to exceed three weeks from date of a patient's request for regular appointments and 48 hours for urgent care; wait times shall not exceed 45 minutes

To ensure continuous 24-hour coverage, PCPs must maintain one of the following arrangements for their members to contact the PCP after normal business hours:

- Have the office telephone answered after-hours by an answering service that can contact the PCP or another designated network medical practitioner. All calls answered by an answering service must be returned within 60 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 60 minutes.
- An automated answering machine that directs the member to the practitioner or appropriate covering practitioner.

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.
- Returning after-hours calls outside of 60 minutes.

PCP transfers
In order to maintain continuity of care, Amerigroup encourages members to remain with their PCP. However, a member may request to change his or her PCP for any reason by contacting our National Customer Care department at **800-600-4441**. The effective date of the PCP change will be the date of the request, unless the member has seen

another assigned PCP on the same date. In this case, the effective date will be the next business day. The member may also complete a PCP Change Request Form and fax the request to **866-840-4993**. The effective date of the PCP change request for all received faxes will be the date the fax is received, unless the member has seen another assigned PCP on the same date. In this case, the effective date will be the next business day. Members can request a PCP change any day of the month. Members will receive a new ID card within 10 days.

Covering physicians/providers

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.

6 Specialty care providers

Specialty care providers
To participate in a TennCare MCO, the provider must have a Tennessee Medicaid provider number and be a licensed provider by the state before signing a contract with Amerigroup.

The provider must be enrolled in the TennCare Medicaid program at the service location where he or she wishes to practice as a specialist before contracting 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 provider who has the responsibility for providing the specialized care for members, usually upon appropriate referral from a PCP within the network (see Roles and Responsibilities 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.
- Community behavioral health (e.g., mental health and substance use disorder) services.
- Cardiology services.
- Clinical nurse specialists, psychologists, clinical social workers — behavioral health.
- Critical care medical services.
- Dermatology services.
- Chiropractic
- Endocrinology services.
- Gastroenterology services.
- General surgery.
- Hematology/oncology services.
- Neonatal services.
- Nephrology services.
- Neurology services.
- Neurosurgery services.
- OB/GYN services.
- Ophthalmology services.
- Orthopedic surgery services.
- Otolaryngology services.
- Perinatal services.
- Pediatric services.
- Psychiatry (adult) services
- Psychiatry (child and adolescent) services
- Trauma services
- Urology services

Role and responsibility of the specialty care providers
Specialist providers will only treat members who have been referred to them by network PCPs (with the exception of mental health and substance use disorder 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 the following:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program
- Accepting all members referred to them
- 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 comorbidities or co-occurring mental health and substance use disorder disorders
- Ensuring that no person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws shall be excluded from participation

in, except as specified in Section A.2.3.5 of the CRA, or be denied benefits of, or be otherwise subjected to discrimination in the performance of provider's obligation under its agreement with Amerigroup or in the employment practices of the provider

- Implementing policies and procedures for the provision of language assistance to members and/or the member representatives; language assistance services include interpretation and translation services and effective communication assistance in alternative formats such as auxiliary aids to any member and/or the member's representative who needs such services including but not limited to members with limited English proficiency, members who are hearing impaired, and individuals with disabilities; such services will be provided free of charge and be available in the form of in-person interpreters, sign language or access to telephonic assistance (e.g., the ATT universal line); providers will also employ appropriate auxiliary aids and services free of charge
- Cooperate with Amerigroup and TennCare during discrimination complaint investigations and report discrimination complaints and allegations to Amerigroup including allegations of discrimination set forth in Section A.2.12.21.1 and A.2.15.7.6.3.2.7 of the CRA available on the TennCare website at **tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf**.
- Assist TennCare members and/or the member representatives in obtaining discrimination complaint forms and contact information for the Amerigroup nondiscrimination compliance office. Members and/or their representatives may be referred to TennCare's Civil Rights Compliance webpage for more information about civil rights compliance, complaint forms, policies, and notices at: **tn.gov/tenncare/members-applicants/civil-rights-compliance.html**.

The specialist shall also adhere to the requirements stated in the Responsibilities of the PCP section.

Specialty care provider 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/she has a provider agreement with Amerigroup to provide specialty services to members.

Access to specialty care
Amerigroup will ensure access to specialty providers (specialists) for the provision of covered services.

Availability of specialty care
Specialty care and emergency care
Referral appointments to specialists (e.g., specialty provider services, hospice care, home health care, substance use disorder treatment, rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate at the nearest facility available regardless of contract. Wait times shall not exceed 45 minutes.

General optometry services
Appointment/wait times: Usual and customary not to exceed three weeks for regular appointments and 48 hours for urgent care. Wait times shall not exceed 45 minutes.

OB/prenatal care
Appointments for OB/prenatal care visits must not exceed three weeks.

All other services not specified here will meet the usual and customary standards for the community.

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 provider or other health care provider to request an extended authorization.

The provider can request an extended referral 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 specialist provider may renew the authorization by submitting a new request to the PCP. Additionally, Amerigroup requires the specialist provider or other health care provider to provide regular updates to the member's PCP. Should the need arise for a secondary referral, the specialist provider 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 shall request authorization from Amerigroup for services outside the network. Access will be approved to a qualified non-network health care provider within a reasonable distance and travel time at no additional cost if 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 TennCare appeals 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 shall 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 its 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.

7 Covered health services

Amerigroup coordinates with the other managed care organizations (MCOs) for members who have Medicaid with Amerigroup and another MCO for Medicare. Information regarding inpatient admissions and discharge planning as well as special requests for collaborative assistance is shared between the insurance companies. Members who have both Medicaid and Medicare (Amerivantage) with Amerigroup are managed seamlessly at the health plan. Providers will continue to follow their current process for requesting prior authorization for services under Amerivantage; requests will be processed for both Medicare coverage and Medicaid coverage as needed at the health plan.

Medically necessary services — medical necessity
Amerigroup uses these terms interchangeably. Medically necessary is defined by Tennessee Code Annotated, Section 71-5-144, and applies to TennCare enrollees. Implementation of the term “medically necessary” is provided for in TennCare Regulations at Chapter 1200-13-16-.05. The regulations are consistent with the statutory provisions and control in case of ambiguity. No enrollee is entitled to receive, and TennCare is not required to pay for any items or services that fail to fully satisfy all criteria of medically necessary items or services, as defined either in the statute or in the medical necessity regulations at Sections 1200-13-13-.01(79), 1200-13-14-.01(84) and 1200-13-16-.05.

1. To be determined to be medically necessary or a medical necessity, a medical item or service must be recommended by a licensed physician who is treating the enrollee or other licensed health care provider practicing within the scope of his or her license who is treating the enrollee and must satisfy each of the following criteria:
    a. It must be recommended by a licensed physician who is treating the enrollee or other licensed health care provider practicing within the scope of his or her license who is treating the enrollee.
    b. It must be required in order to diagnose or treat an enrollee’s medical condition.
    c. It must be safe and effective.
    d. It must not be experimental or investigational.
    e. It must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee’s medical condition.
2. The convenience of an enrollee, the enrollee's family, the enrollee’s caregiver or a provider shall not be a factor or justification in determining that a medical item or service is medically necessary.
3. Services required to diagnose an enrollee’s medical condition:
    a. Provided that all the other medical necessity criteria are satisfied, services required to diagnose an enrollee’s medical condition may include screening services as appropriate.
    b. Screening services are appropriate if they meet one of the following three categories:
        i. Services required to achieve compliance with federal statutory or regulatory mandates under the EPSDT program
        ii. Newborn testing for metabolic/genetic defects as set forth in the Tennessee Code Annotated, Section 68-5-401
        iii. Pap smears, mammograms, prostate cancer screenings, colorectal cancer screenings, and screening for tuberculosis and sexually transmitted diseases including HIV, in accordance with nationally accepted clinical guidelines adopted by the Division of TennCare
    c. Unless specifically provided for herein, other screening services are appropriate only if they satisfy each of the following criteria:
        i. The Division of TennCare, a managed care contractor, or a state agency performing the functions of a managed care contractor determines the screening services are cost effective.
        ii. The screening must have a significant probability of detecting the disease.
        iii. The disease for which the screening is conducted must have a significant detrimental effect on the health status of the affected person.
        iv. Tests must be available at a reasonable cost.

v. Evidence-based methods of treatment must be available for treating the disease at the disease stage which the screening is designed to detect.
vi. Treatment in the asymptomatic phase must yield a therapeutic result.

d. Services required to diagnose an enrollee's medical condition include diagnostic services mandated by EPSDT requirements.

4. Services required to treat an enrollee's medical condition:
   a. Provided that all other elements of medical necessity are satisfied, treatment of an enrollee's medical condition may only include:
      i. Medical care that is essential in order to treat a diagnosed medical condition, the symptoms of a diagnosed medical condition, or the effects of a diagnosed medical condition and which, if not provided, would have a significant and demonstrable adverse impact on quality or length of life
      ii. Medical care that is essential in order to treat the significant side effects of another medically necessary treatment (e.g., nausea medications for side effects of chemotherapy)
      iii. Medical care that is essential, based on an individualized determination of a particular patient's medical condition, to avoid the onset of significant health problems or significant complications that, with reasonable medical probability, will arise from that medical condition in the absence of such care

Home health services

1. **Prior Authorization for Home Health Nurse, Home Health Aide, and Private Duty Nursing Services must be obtained in order to establish the medical necessity of all requested services.**
   - **The following information must be provided when requesting authorization**
     i. Name of physician prescribing the service(s);
     ii. Specific information regarding the member's medical condition and any associated disability that creates the need for the requested service(s); and
     iii. A letter of medical necessity must be provided with specific information regarding the service(s) the nurse or aide is expected to perform, including the frequency with which each service must be performed (e.g., tube feeding patient 7:00 a.m., 12:00 p.m., and 5:00 p.m. daily; bathe patient once per day; administer medications three (3) times per day; catheterize patient as needed from 8:00 a.m. to 5:00 p.m. Monday through Friday; change dressing on wound three (3) times per week). This information should also include the total period of time that the services are anticipated to be medically necessary by the treating physician (e.g., total number of weeks or months).
   - **Updated orders must be obtained when there is a change in services and at least annually.**

2. **Adult: Part-time or intermittent nursing services**

   - Nursing services must be provided at no more than ONE visit per day, with each visit lasting less than **eight (8**) hours, and no more than **27** total hours of nursing care may be provided per week.
   - Nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week.
   - On a case-by-case basis, the weekly total for nursing services may be increased to 30 hours, and the weekly total for nursing services and home health aide services combined may be increased to 40 hours for members qualifying for Level 2 skilled nursing care.
   - Part-time or intermittent nursing services are not covered if the only skilled nursing function needed is administration of medications PRN (as needed) basis.

- Nursing services may include medication administration; however, a nursing visit will not be extended in order to administer medication or perform other skilled nursing functions at more than one point during the day, unless skilled nursing services are medically necessary throughout the intervening period.

3. Pediatric: Part-time or Intermittent Nursing Services

- Nursing services must be provided at no more than ONE visit per day, with each visit lasting less than **eight (8**) hours.
- Part-time or intermittent nursing services are not covered if the only skilled nursing function needed is administration of medications PRN (as needed) basis.
- Nursing services may include medication administration; however, a nursing visit will not be extended in order to administer medication or perform other skilled nursing functions at more than one point during the day, unless skilled nursing services are medically necessary throughout the intervening period.
- **Limits for children may be exceeded when medically necessary.**

4. Adult and Pediatric: More than One Member Receiving Services in the Same Home

- If there is more than one person in a household who is determined to require TennCare-reimbursed home health nursing services, it is not necessary to have multiple nurses providing the services. A single nurse may provide services to multiple members in the same home and during the same hours, as long as he can provide these services safely and appropriately to each member.

5. Adult and Pediatric: Home Health Aide

- Home health aide services must be provided as no more than two visits per day with care provided less than or equal to eight (8) hours per day.
- If there is more than one person in a household who is determined to require TennCare-reimbursed home health aide services, it is not necessary to have multiple home health aides providing the services. A single home health aide may provide services to multiple enrollees in the same home and during the same hours, as long as he can provide these services safely and appropriately to each enrollee.
- **Limits for children may be exceeded when medically necessary.**
- Home health aide services will not be approved to provide childcare services, prepare meals, perform housework, or generally supervise patients. Examples of appropriate home health aide services include, but are not limited to, patient transfers and bathing.

6. Adult: Home Health Aide

- Nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care.

7. **Adult and Pediatric: Private Duty Nursing Services**

- These are nursing services for members who require eight (8) or more hours of continuous skilled nursing care during a 24-hour period.
- A member who needs intermittent skilled nursing functions at specified intervals, but who does not require continuous skilled nursing care throughout the period between each interval, shall not be determined to need continuous skilled nursing care.
- If there is more than one member in a household who is determined to require TennCare-reimbursed private duty nursing services, it is not necessary to have multiple nurses providing the services. A

single nurse may provide services to multiple members in the same home and during the same hours, as long as he can provide these services safely and appropriately to each member.

- Non-skilled services may be provided by a nurse rather than a home health aide. However, it is the total number of hours of skilled nursing services, not the number of hours that the nurse is in the home, that determines whether the nursing services are continuous or intermittent.

8. Adult: Private Duty Nursing Services

- Private duty nursing services are covered for adults aged 21 and older only when medically necessary to support the use of ventilator equipment or other life-sustaining medical technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required.
- An adult is using ventilator equipment or other life-sustaining medical technology if he:
    i. Is ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula); or
    ii. Is ventilator dependent with a progressive neuromuscular disorder or spinal cord injury, and is ventilated using noninvasive positive pressure ventilation (NIPPV) by mask or mouthpiece for at least 12 hours each day to avoid or delay tracheostomy (requires medical review); or
    iii. Has a functioning tracheostomy:
        a. Requiring suctioning; and
        b. Oxygen supplementation; and
        c. Receiving nebulizer treatments or requiring the use of Cough Assist/in-exsufflator devices; and
        d. In addition, at least one subitem from each of the following items (I and II) must be met:
            i. Medication:
                - Receiving medication via a gastrostomy tube (G-tube); or
                - Receiving medication via a Peripherally Inserted Central Catheter (PICC) line or central port; and

            ii. Nutrition:
                - Receiving bolus or continuous feedings via a permanent access such as a G-tube, Mickey Button, or Gastrojejunostomy tube (G-J tube); or
                - Receiving total parenteral nutrition.

9. Home health nurses and aides and private duty nurses will never be authorized to personally transport a member. Home health nurses and aides delivering prior approved home health care services may accompany an enrollee outside the home in accordance with T.C.A. § 71-5-107(a)(12).

10. Private duty nursing services are limited to services provided in the member's own home, with the following two exceptions:
    - A member age twenty-one (21) or older who requires eight (8) or more hours of skilled nursing care in a 24-hour period and is authorized to receive private duty nursing services in the home setting may make use of the approved hours outside of that setting in order for the nurse to accompany the recipient to:
        i. Outpatient health care services (including services delivered through a TennCare home and community-based services waiver program);
        ii. Public or private secondary school or credit classes at an accredited vocational or technical school or institute of higher education; or,
        iii. Work at his place of employment.

11. Members under the age of twenty-one (21) who requires eight (8) or more hours of continuous skilled nursing care in a 24-hour period and is authorized to receive those services in the home setting may make use of the approved hours outside of that setting when normal life activities temporarily take him outside of that setting. Normal life activity for a child under the age of twenty-one (21) means routine work (including work in supported or sheltered work settings); licensed childcare; school and school-related activities; religious services and related activities; and outpatient health care services (including services delivered through a TennCare home and community based services waiver program). Normal life activities do not include non-routine or extended home absences.

12. Private Duty Nursing and Caregivers

- Private duty nursing services include services to teach and train the member and the member's family or other caregivers how to manage the treatment regimen.
- Having a caregiver willing to learn the tasks necessary to provide a safe environment and quality in home care is essential to assuring the member is properly attended to when a nurse or other paid caregiver is not present, including those times when the member chooses to attend community activities, and the above rules don't permit the private duty nurse or other paid caregiver to accompany the patient.
- To ensure the health, safety, and welfare of the member, and to receive private duty nursing services the member must have family or caregivers who:
    - **i.** Have a demonstrated understanding, ability, and commitment in the care of the member related to ventilator management, support of other life-sustaining technology, medication administration and feeding, or in the case of children, other medically necessary skilled nursing functions, as applicable; and
    - **ii.** Are trained and willing to meet the recipient's nursing needs during the hours when paid nursing care is not provided, and to provide backup in the event of an emergency; and
    - **iii.** Are willing and available as needed to meet the recipient's non-nursing support needs.
    - **iv.** In the case of children under the age of 18, the parent or guardian will be expected to fill this role. In the case of an adult age 18 and older, if the health, safety, and welfare of the individual cannot be assured because the recipient does not have such family or caregiver, private duty nursing services may be denied, subject to items (I) and (II) below. However, it shall be the responsibility of the MCO to:
        a. Arrange for the appropriate level of care, which may include nursing facility care, if applicable; and
        b. In the case of a person currently receiving private duty nursing services, facilitate transition to such appropriate level of care prior to termination of the private duty nursing service.

Electronic Visit Verification (EVV) System

EVV requirements of the 21st Century Cures Act, will begin July 1, 2023. Amerigroup will begin denying claims for private duty nursing, hourly home health nursing, and hourly home health aide services where the home health agency treating any Amerigroup member is not using an Electronic Visit Verification (EVV) system.

This includes the following services and procedure codes:

Service	Procedure Code
Private Duty Nursing	T1000
Hourly Home Health Nurse	S9123/S9124

Service	Procedure Code
Hourly Home Health Aide	S9122

It is the Home Health Agency's responsibility to use CareBridge Health or implement a Third-Party EVV System with a data aggregator that interfaces with CareBridge Health. The EVV systems, at minimum, are required to track the following data elements per the Federal 21st Century Cures Act requirements:

- Type of service performed
- Individual receiving services
- Date of service
- Location of service
- Individual providing the service
- Time the service begins and ends

Intermittent Services **do not apply to the above claim deadline. Implementation of EVV for Intermittent Services will not be require until 2024.** Beginning July 1, 2023 CareBridge Health EVV systems will be able to process the following procedure codes for intermittent services also:

Service	Procedure Code
Intermittent Home Health Social Work Visit	S9127
Intermittent Home Health Occupational Therapy	S9129
Intermittent Home Health Physical Therapy Visit	S9131
Home Health Enterostomal Therapy Visit By A Registered Nurse Certified In Enterostomal Therapy	S9474
Intermittent Home Health Skilled Nursing Visit	G0299/G0300
Intermittent Home Health Aide Visit	G0156
Intermittent Home Health Physical Therapy Visit	G0151
Intermittent Home Health Occupational Therapy Visit	G0152
Intermittent Home Health Speech Therapy Visit	G0153
Intermittent Home Health Social Worker Visit	G0155
Intermittent Home Health Physical Therapy Assistant Visit	G0157
Intermittent Home Health Occupational Therapy Assistant Visit	G0158
Intermittent Home Health Physical Therapy Visit	G0159
Intermittent Home Health Occupational Therapy Visit	G0160
Intermittent Home Health RN Visit	G0162
Intermittent Home Health RN Visit	G0299
Intermittent Home Health LPN Visit	G0300
Intermittent Home Health RN Visit	G0493
Intermittent Home Health LPN Visit	G0494
Intermittent Home Health RN Visit	G0495

Intermittent Home Health LPN Visit	G0496

Amerigroup EVV Vendor Contact Information

Tennessee EVV — CareBridge
(carebridgehealth.com)
carebridgehealth.com/tnevv

Amerigroup Vendor — CareBridge

Customer Support email:
tnevv@carebridgehealth.com
Customer Support: **844-482-0256**
Caregiver IVR: **844-383-1678**

Personal care services

1. Personal care services are necessary to treat an enrollee's medical condition only if such services are ordered by the treating physician pursuant to a plan of care to address a medical condition identified because of an EPSDT

screening. Personal care services must be supervised by a registered nurse and delivered by a home health aide. In addition, the services must:

a. Be of a type that the enrollee cannot perform for himself or herself.
b. Be of a type for which there is no caregiver able to provide the services.
c. Consist of hands-on care of the enrollee.

2. Services that do not meet these requirements, such as general childcare services, cleaning services or preparation of meals, are not required to treat an enrollee's medical condition and will not be provided. For this reason, to the extent that personal care services are provided to a person under 18 years of age, a responsible adult (other than the home health aide) must be always present during provision of personal care services.
    a. The following preventive services:
        i. Prenatal and maternity care delivered in accordance with standards endorsed by the American College of Obstetrics and Gynecology
        ii. Family planning services
        iii. Age-appropriate childhood immunizations delivered according to guidelines developed by the Advisory Committee on Immunization Practices
        iv. Health education services for TennCare-eligible children under age 21 in accordance with 42 U.S.C. Section 1396d
        v. Other preventive services that are required to achieve compliance with federal statutory or regulatory mandates under the EPSDT program
        vi. Other preventive services that have been endorsed by the Division of TennCare or a particular managed care contractor as representing a cost-effective approach to meeting the medically necessary health care needs of an individual enrollee or group of enrollees
3. The Division of TennCare may make limited special exceptions to the medical necessity requirements described at TennCare Rule 1200-13-16-.05(1) for particular items or services such as long-term care, or such as may be required for compliance with federal law.
4. Transportation services that meet the requirements described at rule 1200-13-13-.04 and 1200-13-14-.04 shall be deemed medically necessary if provided in connection with medically necessary items or services.

* Note: Please reference the CHOICES or ECF CHOICES Provider Manual Supplement for information regarding personal care services provided under the CHOICES or ECF CHOICES program.

Amerigroup covered services

Physical health benefits chart

Service	Benefit limit
Abortions	Amerigroup will cover abortions only if the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. • We ensure a *Certification of Medical Necessity for* Abortion form, which is available on TennCare's website, **tn.gov/tenncare/providers/tenncare-provider-news-notices-forms/miscellaneous-provider-forms.html** is completed. Medical records will be required for all abortion procedures. Should the claim be submitted for an abortion procedure without medical records, your claim will be denied.

Chiropractic services	**Medicaid/Standard eligible, age 21 and older:** Amerigroup will cover for(for spine manipulation only) by a chiropractor without requiring authorization. **Medicaid/Standard eligible, under age 21:** Covered as medically necessary in accordance with TennCare Kids requirements.
Chlamydia screenings	As medically necessary.
Dental services	**Dental services will be provided to members by the Dental Benefits Manager (DBM).** The facility, transportation, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall be covered services provided by the CONTRACTOR (Amerigroup) when the dental service is covered by the Dental Benefits Manager (DentaQuest) or through an HCBS waiver. For information on dental benefits, visit **=tn.gov/tenncare/providers/dental-benefits-manager.html** or call **1-855-259-0701**.
Diabetic services	As medically necessary.
Durable medical equipment	As medically necessary. Specified DME and medical supplies will be covered/noncovered in accordance with TennCare rules and regulations. DME is provided by Amerigroup Utilization Management (UM). Call **800-454-3730,** submit fax referrals at **877-423-9958,** or through the digital authorization application which is accessible through Availity Essentials.
Emergency air and ground ambulance transportation	As medically necessary.
Home Health Care	Covered as medically necessary as outlined in the home health section.
Hospice care program	As medically necessary. Must be provided by a Medicare-certified hospice agency.
Hysterectomies	Amerigroup will cover hysterectomies only if the following requirements are met: • The hysterectomy is medically necessary. • The member or her authorized representative, if any, has been informed orally and in writing that the hysterectomy will render the member permanently incapable of reproducing. • The member or her authorized representative, if any, has signed and dated a *Hysterectomy Acknowledgement* form, which is available on TennCare's website, **tn.gov/tenncare/providers/tenncare-provider-news-notices-forms/miscellaneous-provider-forms.html**, prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age in accordance with federal requirements. The form will be available in English and Spanish. Assistance must be provided in completing the form when an alternative form of communication is necessary. Refer to the instructions on the *Hysterectomy Acknowledgement* form for additional guidance and exceptions. Amerigroup will not cover a hysterectomy under the following circumstances:

	• If it is performed solely for the purpose of rendering an individual permanently incapable of reproducing. • If there is more than one purpose for performing the hysterectomy, but the primary purpose is to render the individual permanently incapable of reproducing. • It is performed for the purpose of cancer prophylaxis.
Inpatient hospital services	**Medicaid eligible, age 21 and older:** As medically necessary. Inpatient rehabilitation hospital facility services may be covered for adults as a cost-effective alternative at the sole discretionary authority of Amerigroup. **Medicaid/Standard eligible, under age 21:** As medically necessary, including rehabilitation hospital facility.
Lab and x-ray services	As medically necessary. **Compliance with the *Clinical Laboratory Improvement Act* (*CLIA*) of 1988:** Amerigroup will require that all laboratory testing sites providing services have either a current *CLIA* certificate of waiver or a certificate of registration along with a *CLIA* identification number. Those laboratories with certificates of waiver will provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests. Amerigroup will comply with the provisions of *CLIA*. If the provider performs laboratory services, the provider is required to meet all applicable requirements of *CLIA*. **Please note that only LabCorp and Quest will be paid. OON's lab will require prior authorization before payment can be made.**
Medical supplies	As medically necessary. Specified medical supplies will be covered/noncovered in accordance with TennCare rules and regulations. Requests for medical supplies are sent to Amerigroup Utilization Management (UM). Call **800-454-3730** or fax referrals to **877-423-9958**.
Nonemergency transportation (including nonemergency ambulance transportation)	As necessary to get a member to and from covered services, dental services (provided by the DBM) and pharmacy services (provided through the PBM) for enrollees not having access to transportation. If Amerigroup is unable to meet the access standards for a member, transportation must be provided regardless of whether the member has access to transportation. If the member is a child, transportation must be provided in accordance with TennCare Kids requirements. As with any denial, all notices and actions must be in accordance with the requirements of the TennCare CRA. Amerigroup may require advance notice of the need for transportation to timely arrange transportation. Transportation must be coordinated through Tennessee Carriers at **866-680-0633**.
Occupational therapy	**Medicaid/standard eligible, age 21 and older:** Covered as medically necessary when provided by a licensed occupational therapist to restore, improve, or stabilize impaired functions.

	Medicaid/standard eligible, under age 21: Covered as medically necessary in accordance with TennCare Kids requirements.
Organ and tissue transplant and donor organ procurement	**Medicaid eligible, age 21 and older:** All medically necessary organ and tissue transplants, as covered by Medicare, are covered. Experimental or investigational transplants are not covered. Those covered include: • Bone marrow/stem cell. • Cornea. • Heart. • Heart/Lung. • Kidney. • Kidney/pancreas. • Liver. • Lung. • Pancreas. • Small bowel/multi-visceral. **Medicaid/standard eligible, under age 21:** Covered as medically necessary in accordance with TennCare Kids requirements. Experimental or investigational transplants are not covered.
Orthodontic services	Medicaid/standard eligible, under age 21 Orthodontic services must be prior authorized by the Dental Benefits Manager (DBM). Orthodontic services are only covered for individuals under age 21. Effective October 1, 2013, TennCare reimbursement for orthodontic treatment approved and begun before age 21 will end on the individual's 21st birthday. For individuals receiving treatment prior to October 1, 2013, such treatment may continue until completion as long as the enrollee remains eligible for TennCare. Orthodontic treatment is not covered unless it is medically necessary to treat a handicapping malocclusion. Cleft palate, hemifacial microsomia, or mandibulofacial dysostosis shall be considered handicapping malocclusions. A TennCare-approved Malocclusion Severity Assessment (MSA) will be conducted to measure the severity of the malocclusion. An MSA score of 28 or higher, as determined by the DBM's dentist reviewer(s), will be used for making orthodontic treatment determinations of medical necessity. However, an MSA score alone cannot be used to deny orthodontic treatment. Orthodontic treatment will not be authorized for cosmetic purposes. Orthodontic treatment will be paid for by TennCare only as long as the individual remains eligible for TennCare. The MCO is responsible for the provision of transportation to and from covered dental services, as well as the medical and anesthesia services related to the covered dental services.
Outpatient hospital services	As medically necessary.
Pharmacy services	**Pharmacy services will be provided by the TennCare PBM unless otherwise described below.** Amerigroup is responsible for reimbursement of specific covered injectable drugs administered in an office/clinic setting and for reimbursing providers providing both covered home infusion services and the drugs and biologics. Amerigroup requires that all claims for medications contain NDC coding and unit information to be considered for payment. Services reimbursed by Amerigroup will not include any pharmacy benefits otherwise covered by TennCare for pharmacy services.

<table>
<tr><td>Physical therapy</td><td>Medicaid eligible, age 21 and older: Covered as medically necessary when provided by a licensed physical therapist to restore, improve, or stabilize impaired functions.

Medicaid/standard eligible, under age 21: Covered as medically necessary in accordance with TennCare Kids requirements.</td></tr>
<tr><td>Physician inpatient Services</td><td>As medically necessary.</td></tr>
<tr><td>Physician outpatient services/community health clinic services/other clinic services</td><td>As medically necessary.</td></tr>
<tr><td>Preventive care services</td><td>Preventive services include initial and periodic evaluations, family planning services, prenatal care, laboratory services and immunizations in accordance with TennCare rules and regulations. These services shall be exempt from TennCare cost sharing responsibilities.

The following preventive medical services (identified by applicable CPT® procedure codes) are covered subject to any limitations described below, within the scope of standard medical practice and are exempt from any deductibles and copayments.

Dental services and laboratory services not specifically listed below, which are required pursuant to the TennCare Kids program for persons under age 21, shall be provided in accordance with the TennCare periodicity schedule for such services.

Office visits
1. New patient
99381 — Initial evaluation
99382 — Age 1 through 4 years
99383 — Age 5 through 11 years
99384 — Age 12 through 17 years
99385 — Age 18 through 39 years
99386 — Age 40 through 64 years
99387 — Age 65 years and over

2. Established patient
99391 — Periodic reevaluation
99392 — Age 1 through 4 years
99393 — Age 5 through 11 years
99394 — Age 12 through 17 years
99395 — Age 18 through 39 years
99396 — Age 40 through 64 years
99397 — Age 65 years and over

Counseling and risk factor reduction intervention
3. Individual
99401 — Approximately 15 minutes
99402 — Approximately 30 minutes
99403 — Approximately 45 minutes
99404 — Approximately 60 minutes

4. Group
99411 — Approximately 30 minutes
99412 — Approximately 60 minutes

Family planning services, if not part of a preventive services office visit, should be billed using the codes above.

Prenatal/postpartum care
59400 — Routine obstetric care, including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care
59410 — Vaginal delivery only (with or without episiotomy and/or forceps), including postpartum care</td></tr>
</table>

	59430 — Postpartum care only (separate procedure) 59510 — Routine obstetric care, including antepartum care, cesarean delivery and postpartum care 59515 — Cesarean delivery only, including postpartum care **Other preventive services** 96160 through 96161— Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal) 90619 through 90750— Immunizations 92551 — Screening test, pure tone, air only (audiologic function) 96110 — Developmental screening 99173 — Visual screening Any laboratory test or procedure listed in the preventive services periodicity schedule when the service CPT code is one of the above preventive medicine codes. This includes mammography screening (77057) as indicated in the US Preventive Services schedule.
Private duty nursing **For children under the age of 21 — Private duty nursing**	Covered as medically necessary as outlined in the home health section above.
Prosthetics and orthotics	As medically necessary. Specified prosthetics and orthotics will be covered/noncovered in accordance with TennCare rules and regulations.
Reconstructive breast surgery	Coverage for all stages of reconstructive breast surgery on a diseased breast because of a mastectomy, as well as surgical procedures on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five years of the date the reconstructive breast surgery was performed on a diseased breast.
Renal dialysis Services	As medically necessary. Generally limited to the beginning 90-day period prior to the enrollee's becoming eligible for coverage by the Medicare program.
Speech Therapy	**Medicaid eligible, age 21 and older:** Covered as medically necessary by a licensed speech therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder. **Medicaid/standard eligible, under age 21:** Covered as medically necessary in accordance with TennCare Kids requirements.
Sterilizations	Sterilization means any medical procedure, treatment or operation done for the purpose of rendering a member permanently incapable of reproducing. Amerigroup will cover sterilizations only if the following requirements are met: • The member has given informed consent no less than 30 full calendar days (or no less than 72 hours in the case of premature delivery or emergency abdominal surgery) but no more than 180 calendar days before the date of the sterilization. The member may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since the member

	gave informed consent for the sterilization. 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 member is at least 21 years old at the time consent is obtained. • The member is mentally competent. • The member is not institutionalized (i.e., not involuntarily confined or detained under a civil or criminal status in a correctional or rehabilitative facility or confined in a mental hospital or other facility for the care and treatment of mental illness, whether voluntarily or involuntarily committed). • The member has voluntarily given informed consent on the approved *Sterilization Consent* form, which is available at **tn.gov/tenncare/providers/tenncare-provider-news-notices-forms/miscellaneous-provider-forms.html** • The form will be available in English and Spanish. Amerigroup will provide assistance in completing the form when an alternative form of communication is necessary.
TennCare Kids services	**Medicaid eligibles, age 21 and older:** Not covered. **Medicaid/standard eligibles, under age 21:** Covered as medically necessary, except that the screenings do not have to be medically necessary. Children may also receive screenings in-between regular checkups if a parent or caregiver believes there is a problem. Periodic screenings, interperiodic screenings, diagnostic and follow-up treatment services as medically necessary in accordance with federal and state requirements.
Vision services	**Medicaid eligible, age 21 and older:** Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), will be covered as medically necessary. This includes coverage for annual retinal eye examination to screen for diabetic retinopathy. Routine periodic assessment, evaluation or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery. **Medicaid/standard eligible, under age 21:** Preventive, diagnostic and treatments services (including eyeglasses) are covered as medically necessary in accordance with TennCare Kids requirements. Providers may contact EyeQuest at **800-526-9202** for more information.

Services not covered by Amerigroup

For more information about services **not** covered by Amerigroup or TennCare Medicaid/Standard, please call Provider Services at **800-454-3730**.

Refer to TennCare's benefit exclusions in the Exclusions section of the TennCare Rules:

- TennCare Medicaid at **publications.tnsosfiles.com/rules/1200/1200-13/1200-13-13.20220517.pdf**, Find 1200-13-13-.10

- TennCare Standard at **publications.tnsosfiles.com/rules/1200/1200-13/1200-13-14.20220517.pdf**, Find 1200-13-14-.10

The services, products and supplies listed in the exclusion rules are excluded from coverage unless the rules require a medical necessity review for persons younger than 21 years. Some of the services may be covered under the CHOICES or ECF CHOICES programs or an HCBS waiver when provided as part of an approved plan of care in accordance with the appropriate TennCare HCBS rule.

Amerigroup has discretionary authority to offer medically appropriate cost-effective alternative services that are not covered under the mandatory benefit package on a case-by-case basis. Amerigroup may offer the medical care that Amerigroup and the health care provider deem appropriate in each individual case from a preapproved list of alternative services. An example of a cost-effective alternative service includes the use of a nursing home as a step-down alternative to continued acute care hospitalization. Amerigroup will follow all procedures in instances where it chooses to consider a cost-effective alternative service option.

Weight management
Members ages 10 and older who have a body mass index (BMI) ≥ 25 or who wish to make lifestyle changes that focus on healthy eating, behavioral management and increasing physical activity can be referred to the Population Health's Condition Care Program. The program is designed to encourage personal responsibility by actively engaging individuals in the management of their weight.

The member will be connected with a nurse who will partner with the member in achieving his or her weight loss goals. The case manager works closely with the member to assist in consulting with his or her physician to explore weight loss options and to determine the safest recommended approach to weight loss. The nurse will work collaboratively with the member and provider to develop a care plan and strategy to help the member be successful. The nurse will provide assistance to locate facilities and programs in the area that are available to support the member's decision to lose weight. Ongoing education about diet and exercise are provided over the phone and by mail. Monitoring the member's progress is an ongoing part of the service the nurses provide along with support and encouragement.

Members can be referred to Population Health's Condition Care program for weight loss by calling Member Services at **800-600-4441**.

Mid Cumberland region — nutritionist available by appointment
Dickson: **615-446-2839**
Humphreys: **931-296-2231**
Williamson: **615-794-1542**
Rutherford: **615-898-7880**
Stewart: **931-232-5329**
Montgomery: **931-648-5747**
Davidson: Matthew Walker Comprehensive Health Center: **615-327-9400** United Neighborhood Health Services: **615-620-8647**

Pharmacy
Amerigroup is not responsible for the provision and payment of pharmacy benefits except as described below. TennCare contracts with a Pharmacy Benefits Manager (PBM) to provide these services. However, we coordinate with the PBM as necessary to ensure members receive appropriate pharmacy services without interruption. We monitor and manage both our contract providers' prescribing patterns and our members' utilization of prescription

drugs. Providers identified as noncompliant as it relates to adherence to the PDL and/or generic prescribing patterns will be contacted by Amerigroup via letter, phone call and/or face-to-face visit. Amerigroup is responsible for reimbursement of specified injectable drugs administered in an office/clinic setting and to providers providing home infusion service. Providers must obtain precertification of these drugs by contacting the Amerigroup pharmacy department at **800-454-3730**.

For all J-codes billed and all other codes representing billing for drugs, NDC code and drug pricing information (NDC quantity, unit price and unit of measurement) are required. Exceptions are:

- Vaccines for children which are paid as an administrative fee.
- Inpatient administered drugs.
- Radiopharmaceuticals unless the drug is billed separately from the procedure.

Additional information is located in Section 16, Claim Submission and Adjudication Procedures.

Services reimbursed by Amerigroup are not included in any pharmacy benefit limits established by TennCare for pharmacy services.

We require providers to inform all members being considered for prescription of psychotropic medications of the benefits, risks and side effects of the medication, alternate medications, and other forms of treatment.

All providers should seek precertification/prior authorization from the pharmacy benefits manager when they feel they cannot order a drug on the TennCare Preferred Drug List (PDL), as well as take the initiative to seek precertification or change or cancel the prescription when contacted by a member or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication).

TennCare's PBM is OptumRx. You can reference PDL information online at **provider.amerigroup.com/tn**.

Drugs deemed self-injectable should be obtained through the TennCare pharmacy program. There are several drug products that are administered by intramuscular (IM) or intravenous (IV) route that, due to established channels of distribution, should be obtained through the designated specialty pharmacy. There may be instances where an emergency exists, the provider does not have access to the needed drug or a caregiver has been trained to administer the drug. In these situations, an override may be requested by calling or faxing OptumRx. The drug can be administered in the provider's office or another clinical setting.

For a list of drugs considered self-injectable available through the TennCare pharmacy program, please visit **optumrx.com/oe_tenncare/landing**.

Drugs that cannot be self-administered should be billed as a medical benefit to Amerigroup only after receiving precertification. Drugs given intravenously are considered nonself-administered by the patient. Drugs given by intramuscular injection may be presumed to be nonself-administered by the patient. Additionally, products whose package literature does not list or support self-administration are considered nonself-administered.

Amerigroup precertification requirements by procedure code are searchable through our Precertification Look-up Tool online at: **provider.amerigroup.com/tn/Pages/PLUTO.aspx**.

Pharmacy copays

Pharmacy copays applies to all **TennCare Standard** members as well as noninstitutionalized Medicaid adults who are eligible to receive pharmacy services in the TennCare program. Medicaid eligibles are exempt from nonpharmacy copays. These copays are administered by the PBM, who should be contacted directly for related questions or issues.

The pharmacy copay amounts are as follows:
Generic $1.50
Brand name $3.00

Pharmacy copayments do not apply to family planning services, pregnant women, enrollees in long-term care institutions (including HCBS) or members receiving hospice care. Members who are pregnant or receiving hospice care must self-declare at the pharmacy prior to obtaining any medications in order for the copay to be waived.

There are no annual out-of-pocket maximums.

The TennCare pharmacy manual
To help prescribers provide appropriate and timely drug treatment therapy, TennCare and OptumRx have written their own pharmacy manual. We strongly encourage you to regularly review this document online at https://www.optumrx.com/oe_tenncare/landing for the appropriate and current information concerning:

- Preferred drug list
- Clinical criteria for prior authorizations
- ICD-10 prior authorization bypass codes
- Prior authorization drug forms
- TennCare's auto-exemption list
- TennCare's prescriber attestation list
- Drug titration override list
- Covered over-the-counter medications
- Emergency supply medication list

Durable medical equipment and medical supplies
All DME and medical supplies that require precertification are reviewed and managed by the Amerigroup Utilization Management (UM) Department. Requests should be submitted to the health plan for review via:

- The digital authorization application), which is accessible through Availity Essentials
- Fax to **877-423-9958**.
- Phone at **800-454-3730**.

Providers are encouraged to use the Precertification Lookup Tool to determine whether the item or procedure requires precertification. This feature can be found under the *Resources* tab on the provider self-service login page at **provider.amerigroup.com/tn/Pages/PLUTO.aspx**.

Medical necessity is required for all services. All precertification requests must contain, at a minimum, the following information:

- First and last name of the patient
- Address where the service is to be rendered
- Patient or caregiver's phone number with area code
- Patient's date of birth and gender
- Current and clear physician orders
- Ordering physician's name and phone number
- Diagnosis and documentation to support the medical necessity of the requested service(s) or equipment (e.g., oxygen saturation levels for home O2)
- Allergies, disability status, height, weight or diabetic status
- Desired date of service
- Services or equipment required including size, quantity, frequency, brand, etc.

- Details and description regarding the requested service or equipment including brand name, size, quantity, frequency and expected duration, etc.
- Amerigroup subscriber ID

Retroactive reviews or requests are not accepted by the health plan for review. If the code is a notification only code the provider may submit a retro request for authorization up to 120 days from date of service. If Amerigroup receives a claim for DME or medical supplies that normally require authorization and there is not a corresponding authorization on file, the claim will be denied.

If Amerigroup receives claims for DME or medical supplies, the claims will be denied.

Vision
Vision benefits are administered through EyeQuest. Providers may contact EyeQuest at **800-526-9202**, Monday through Friday, 7 a.m. to 5 p.m. CT, for more information.

Providers must have a separate contract with EyeQuest to perform vision services. If Amerigroup receives claims for vision services that are not associated with a medical diagnosis, the claims will be denied, and the *EOP* will direct the provider to submit the claim to EyeQuest for services to be reimbursed.

Amerigroup offers vision coverage for:

- **Medicaid eligible, age 21 and older:** Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), will be covered as medically necessary. This includes coverage for annual retinal eye examination to screen for diabetic retinopathy. Routine periodic assessment, evaluation or screening of normal eyes, and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.
- **Medicaid/standard eligible, under age 21:** Preventive, diagnostic and treatment services (including eyeglasses) are covered as medically necessary in accordance with TennCare Kids requirements.

Nonemergency medical transportation
Nonemergency medical transportation benefits are administered through Tennessee Carriers. Providers may contact Tennessee Carriers at **866-680-0633** for more information.

Transporters must have a separate contract with Tennessee Carriers to perform nonemergency medical transportation services. If Amerigroup receives claims for nonemergency transportation services that are not coordinated through Tennessee Carriers, the claims will be denied and the *Explanation of Payment* (*EOP*) will direct the provider to submit the claim to Tennessee Carriers for services to be reimbursed.

Ethical or religious directives
If you are not providing the care or treatment a TennCare member needs or wants due to your ethical or religious directives please, provide us with a list of the TennCare covered services that you or your organization does not deliver due to ethical or religious directives. If and the TennCare member needs help finding a provider, please call us at **800-600-4441**. We can help the member find the care or treatment needed.
Please, inform the member that Amerigroup has additional information on providers and procedures that are covered by TennCare, and you are not required to make specific recommendations or referrals for that member.

8 TennCare Kids program

TennCare Kids mission
TennCare Kids is the name for Tennessee's Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) program. Tennessee has made a commitment to promoting good health in children from birth until age 21. TennCare Kids is a full program of health checkups and health care services for children with TennCare. These services make sure babies, children, teens, and young adults receive health care they need.

Providers are required to:

- Provide TennCare Kids services.
- Make appropriate TennCare Kids referrals and document the referrals in the member's medical record.
- Make arrangements for necessary follow-up when all of the components of screening cannot be completed in a single visit.
- Have a process for documenting services declined by a parent or legal representative that specifies the particular service that was declined.

Amerigroup will educate providers about proper coding and encourage them to submit the appropriate diagnosis codes identified by TennCare in conjunction with the evaluation and management (E&M) procedure codes for TennCare Kids services.

A child age 14 through 17 is presumed to be competent to seek his or her own medical care, to consent to release medical records, and to obtain transportation to and from medical services without the knowledge and consent of his or her parents or legal custodians. The child must be counseled by the provider to determine that the child actually is competent, and the record must reflect such determination by the provider. Release of medical records by an individual age 14 through 17 must be signed by the child. If it is determined that the child is incompetent, the services should not be provided without consent of the legal guardian or parent.

This determination of competency is essentially the same as an adult providing informed consent to receive health care services.

A child age 7 through 13 is presumed to be incompetent to seek his or her own medical care, etc. However, if counseling of the child shows the child is competent, the medical services may be provided. The child's medical record must reflect such counseling and determination.

A child under the age of seven is incompetent to seek his or her own medical care. No care can be provided without the consent of the parent or legal custodian.

Examples:

- Practitioners may treat juvenile drug abusers without prior legal guardian or parent consent.
- Practitioners should use their own discretion in determining whether to notify the child's legal guardian or parent.
- A practitioner may diagnose, examine and treat a minor without knowledge or consent of the legal guardian or parent for purposes of providing prenatal care.
- Contraceptive supplies and information may be supplied to a minor without consent of the legal guardian or parent.
- The practitioner may diagnose and treat STDs without the knowledge or consent of the parent or legal guardian. Legal reporting requirements to the Department of Health still exist.

To comply with the TennCare Kids requirements, transportation for a minor child may not be denied pursuant to any policy that poses a blanket restriction due to the member's age or lack of an accompanying adult. Any decision to

deny transportation of a minor child due to a member's age or lack of an accompanying adult shall be made on a case-by-case basis and shall be based on the individual facts surrounding the request and state of Tennessee law.

For members under 16 years of age seeking behavioral health TennCare Kids services and the member's parent or legal guardian is unable to accompany the member to the examination, providers must

- Contact the member's parents or legal guardian to discuss the findings
- Inform the family of any other necessary health care, diagnostic services, treatment or other measures recommended for the member
- Notify Amerigroup to contact the parent(s) or legally appointed guardian with the results

Referrals are not required for TennCare Kids members to access behavioral health providers. Members and their parents or guardians can request names of behavioral health providers from their PCPs.

TennCare Kids early and periodic screening

Amerigroup joins TennCare in this screening requirement. These early and periodic screening services are provided to members without cost. These screens will include periodic and interperiodic screens and be provided at intervals that meet reasonable standards of medical, behavioral and dental practice. Reasonable standards of medical and dental practice are those standards set forth in the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care for medical practice and American Academy of Pediatric Dentistry (AAPD) guidelines for dental practice. Tools used for screening will be consistent with the screening guidelines recommended by the state, which are available at **tn.gov/tenncare/tenncare-kids.html**.

These include recommended screening guidelines for developmental/behavioral surveillance and screening, hearing screenings and vision screenings. *Preventive Visit* forms, *EPSDT and TennCare Kids Encounter Documentation* forms, and the *Tennessee Chapter of the American Academy of Pediatrics EPSDT/TennCare Kids* manual are also available on the following websites:

- **tnaap.org/programs/epsdt-coding/epsdt-well-child-visits**
- **tnaap.org/programs/epsdt-coding/coding-resources**
- **tnaap.org/resources/developmental-behavioral-health-screening-tools**
- **tnaap.org/programs/epsdt-coding/oral-health**

The screens include:

- Comprehensive health (physical and mental) and developmental history.
    - Initial and interval history
    - Developmental/behavioral assessment
- Comprehensive unclothed physical exam.
- Vision screening.
- Hearing screening.
- Laboratory tests.
- Immunizations.
- Health education/anticipatory guidance.

Providers must notify Amerigroup if a screening reveals the need for other health care services and if the provider is unable to make an appropriate referral for those services. In these cases, Amerigroup will make an appropriate referral and contact the member to offer scheduling assistance and transportation for members who lack access to transportation.

Amerigroup does not require precertification for periodic and interperiodic screens conducted by PCPs. Amerigroup will cover all medically necessary covered services regardless of whether the need for the services was identified by a provider who had received precertification from Amerigroup or a network provider.

Providers are encouraged to refer children to dentists by the time the first tooth appears in the mouth and no later than the first birthday.

TennCare Kids checkups can be provided by a child's PCP or local health department and include the following:

- Comprehensive health and developmental history
  - Physical
  - Behavioral/developmental
  - Dental
- Complete physical exam (unclothed)
  - Compare child's physical growth against what is considered normal for child's age
- Vision screening
  - Includes age-appropriate vision assessment. Tools used for screenings shall be consistent with the screening guidelines
- Hearing screening
  - Includes an age-appropriate hearing assessment. Tools used for hearing screenings shall be consistent with the screening guidelines
- Lab tests
  - Blood lead test should be performed at 12 and 24 months; assessed at each visit beginning at 6 months. Children 36-72 months of age shall receive a screening blood lead test if they have not been previously screened for lead poisoning.
- Immunizations
  - Age-appropriate and current status of shots in accordance with the most current Advisory Committee on Immunization Practices (ACIP) schedule
- Health education
  - Anticipatory guidance (e.g., car seat safety, sex education, smoking, etc.)
  - Counseling parents and child regarding child's development

The periodicity schedule is recommended by the American Academy of Pediatrics. It indicates when screenings should be scheduled. Members are encouraged to contact their physician within the first 90 days of enrollment to schedule a checkup and within 24 hours after the birth of a newborn.

Infants/toddlers should have 12 TennCare Kids checkups before their third birthdays:

- Newborn
- 3-5 days of age
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months

Children 3-20 years of age should get a TennCare Kids checkup every year.

Tools recommended for use in TennCare Kids screenings

Measure	Age range	Description	Scoring	Accuracy	Time frame
Child Development Inventories (formerly Minnesota Child Development Inventories) (1992) Behavior Science Systems, Box 580274, Minneapolis, MN 55458 Phone: **612-929-6220**	Birth to 72 months	Sixty yes/no descriptions with separate forms for 0-18 months, 18-36 months and 3-6 years. Can be mailed to families, completed in waiting rooms, administered by interview or by direct elicitation.	A single cutoff tied to 1.5 standard deviations below the mean	Sensitivity[1] was 75 percent or greater across studies and specificity[2] was 70 percent	About 10 minutes (if interview needed)
Parents' Evaluations of Developmental Status (PEDS) (1997) Ellsworth & Vandemeer Press, Ltd., P.O. Box 68164, Nashville, TN 37206 Phone: **615-226-4460**; fax: **615-227-0411** **pedstest.com**	Birth to 9 years	Ten questions eliciting parents' concerns. Can be administered in waiting rooms or by interview. Available in Spanish. Written at the 5th grade level. Normed in teaching hospitals and private practice.	Categorizes patients into those needing referrals, screening, counseling, reassurance, extra monitoring	Sensitivity ranged from 74 percent to 79 percent and specificity ranged from 70 percent to 80 percent	About two minutes (if interview needed)
Pediatric Symptom Checklist Jellinek MS, Murphy JM, Robinson J. et al. Pediatric Symptom Checklist: Screening School age children for psychosocial dysfunction. Journal of Pediatrics, 1988; 112:201-209 (the test is included in the article and in the PEDS manual)	6 to 16	Thirty-five short statements of problem behaviors to which parents respond with never, sometimes or often. The PSC screens for academic and emotional/behavioral difficulties.	Single refer/ nonrefer score	Sensitivity ranged from 80 percent to 95 percent; specificity in all but one study was 70 percent to 100 percent	About seven minutes (if interview needed)

[1]Sensitivity = percentage of children with disabilities identified as probably delayed by a screening test.
[2]Specificity = percentage of children without disabilities identified as probably normal by a screening test.

Tools recommended for secondary screening involving direct testing of children

Measure	Age range	Description	Scoring	Accuracy	Time frame
Brigance Screens Billerica, MA: Curriculum Associates, Inc. (1985) 153 Rangeway Road, N. Billerica, MA 01862 **800-225-0248**	21 to 90 months	Seven separate forms, one for each 12-month age range. Taps speech-language, motor, readiness and general knowledge at younger ages and also reading and math at older ages. Uses direct elicitation and observation.	Cutoff and age equivalent scores	Sensitivity and specificity to giftedness and to developmental and academic problems was 70 percent to 82 percent	10 minutes (direct testing only)

Individual education plans

TennCare, is committed to the coordination of school-based, medically necessary services. TennCare worked closely with the Department of Education (DOE) and managed care organizations (MCOs), including Amerigroup, to ensure coordination of care and the delivery of medically necessary services to TennCare-enrolled school age children. For any medically necessary service provided in the school setting, TennCare continues to require an individual education plan (IEP) with the service included and confirmation a parental consent form was obtained. Timely filing for IEP services was effective 7/1/21 and IHP 7/1/22. Timely filing is 365 days from the date of service.

We do not require schools to send eligible students' IEPs to us before paying for the covered, medically necessary services. Instead, we audit IEPs as we do with other services, which means each school must prepare and maintain updated IEPs for each eligible student and then provide any requested IEP to us upon request. At a minimum, we are required to conduct regular post-payment sample audits of IEPs and all other documentation to support the medical necessity of the school-based services reimbursed by us.
When we require a copy of an IEP, the provider must also include a copy of the appropriate parental consent and physician's order for the identified services. TennCare has updated the authorization forms, which can be found at **tn.gov/tenncare/tenncare-kids/school-based-services.html**. The school can coordinate with Amerigroup to arrange for services to be provided during school or outside of a school setting. Effective July 1, 2022, the IEP may be ordered by student's PCP or treating provider OR the ordering/referring PT, ST, OT or Audiologist.

Guidelines for obtaining TennCare Medicaid reimbursement for medically necessary covered school nursing services as required by the IEP and as allowable by TennCare through the Individual Health Plan (IHP):

1. The billable services below are performed by the school nurse and shall be ordered by the primary care provider (PCP) or the child's treating provider. In addition to the supervision required for the performing school nurse, as described in section 4a (ii) below, the school nursing program shall have a physician to clinically supervise the physician assistant or nurse practitioner in accordance with the Tennessee Board of Nursing Rules and Regulations and T.C.A., Title 63.

2. The school nurse will meet the clinical and licensing requirements, as required by the Tennessee Department of Health, as well as the training required to perform these services in the school setting.

3. The school will maintain policies and procedures for the provision and documentation of the services listed in the table below.

4. The following are the guidelines for billing:
    a. Use 99211 with POS (Place of Service) 03 as the daily billable CPT code, to include a global fee.
        i. School nursing services eligible for reimbursement, as denoted by (Y) in the table below, are restricted to medically necessary covered services included in the IEP or IHP, as applicable.
        ii. Medically necessary, covered services in the IEP or IHP that are ordered by the PCP or treating provider may be reimbursed. The IEP or IHP alone does not satisfy requirements for Medicaid reimbursement. Services are performed by the school nurse, under the clinical supervision of an in-network Physician, Physician's Assistant, or Nurse Practitioner licensed through the Tennessee Department of Health. Clinical supervision does not require the continuous and constant presence of the clinical supervisor; however, the clinical supervisor must always be available for consultation or shall arrange for a substitute provider to be available. Services are performed pursuant to the student's primary care provider's (PCP) or the child's treating provider's order.

iii. The supervising Physician, Physician's Assistant, or Nurse Practitioner shall serve as the rendering provider on the claim, as the school nurse is not credentialed and cannot contract with the MCOs as a network provider.

iv. Administrative services are not billable services

b. The billable items in the table below include the code to be used for the services.

c. TennCare MCOs will contract with any school district(s) that seek(s) to contract with the MCOs, based on the MCOs' standard reimbursement rates, to receive reimbursement for medically necessary, covered services in the IEP or IHP that are ordered by the PCP or treating provider and provided in a school setting.

d. The MCOs will monitor claims and will retrospectively audit claims for appropriate claims billing and the presence of a valid Provider order to ensure school-based providers are submitting claims appropriately.

	Billable (Y)/Non-Billable(N)
Assessment and Treatment of acute and chronic illnesses	Y
Blood glucose monitoring and testing	Y
Vital sign monitoring	N
Tracheostomy care and suctioning	Y
Colostomy care	Y
Catherization	Y
Administration of oral medication – per tube	Y
O2 saturation monitoring (pulmonary and/or cardiac disease)	Y
G-Tube feeding	Y
Wound care	Y
Nebulizer treatment	Y
Postural drainage	N
Medication administration for medically fragile students as identified in IEP or IHP	Y
Development, implementation of Individual Health Plan (IHP)	N
Evaluation of Nursing service in the Individualized Education Program (IEP)	N

As a reminder, failure to abide by the requirements and our requests may subject the school to recoupments and, potentially, other penalties.

Vaccines for Children program

The Vaccines for Children (VFC) program was established by Congress in 1993. The VFC program is an entitlement program (a right granted by law) for eligible children age 18 years and younger. VFC helps families of children who may not otherwise have access to vaccines by providing free vaccines to doctors who serve them. VFC is administered at the national level by the CDC that contracts with vaccine manufacturers to buy vaccines at reduced rates. Tennessee enrolls physicians in the VFC program who serve eligible children and provide routine immunizations. More than 600 private physicians, health department clinics, Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) participate in VFC in Tennessee.

Children from birth through 18 years of age who meet at least one of the following criteria are eligible to receive VFC services:

- TennCare eligible: A child who is eligible for Medicaid or enrolled in the TennCare program

- Uninsured: A child who has no health insurance coverage
- American Indian or Alaska Native: As defined by the Indian Health Care Improvement Act (25 U.S.C. 1603)
- Underinsured: A child who has commercial (private) health insurance but the coverage does not include vaccines, a child whose insurance covers only selected vaccines (VFC-eligible for noncovered vaccines only), or a child whose insurance caps vaccine coverage at a certain dollar amount. Once that coverage amount is reached, the child is categorized as underinsured. In Tennessee, underinsured children are eligible to receive VFC services only through an FQHC, RHC or local health department.

Children whose health insurance covers the cost of vaccinations are not eligible for VFC services, even when a claim for the cost of the vaccine and its administration would be denied for payment by the insurance carrier because the plan's deductible had not been met.

VFC enrollment and re-enrollment is managed through the Tennessee Immunization Information System web portal, known as TennIIS. To enroll or re-enroll please go to **tennesseeiis.gov/tnsiis** and select the **Register to use TennIIS** heading and follow the instructions provided. If you have questions about the enrollment process, please contact the VFC program at **VFC.Enrollment@tn.gov**.

Providers interested in joining the VFC program may contact the Tennessee Immunization Program at **800-404-3006** for enrollment information or visit **tennesseeiis.gov/tnsiis**.

Lead toxicity screening program

All children are considered at risk and must be screened for lead poisoning. TennCare requires the use of the blood lead test when screening children for lead poisoning. Physicians should use each office visit as an opportunity for anticipatory guidance and risk assessment for lead poisoning. Appropriate laboratory tests (including lead toxicity screening appropriate for age and risk factors). All children shall receive a screening blood lead test at twelve (12) and twenty-four (24) months of age. Children between the ages of thirty-six and twenty-four (36-24) months and seventy-two (72) months of age shall receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test shall be used when screening Medicaid-eligible children. A blood lead test equal to or greater than three point five (3.5) ug/dL obtained by capillary specimen (finger stick) shall be confirmed by using a venous blood sample. Any additional diagnostic and treatment services determined to be medically necessary must also be provided to a child diagnosed with an elevated blood lead level (BLL).

Once the initial BLL screen is performed, further testing may be required. See below:

If the capillary blood lead level is ≥ 3.5 µg/dL, follow the recommended schedule for a confirmatory venous sample	
Screening test result (µg/dL)	**Time to confirmation testing**
5-9	3months
10-19	1 - 3 months*
20-24	1 – 3 months
25-44	2 weeks – 1 month
≥ 45	As soon as possible

*The higher the BLL on the screening test, the more urgent the need for confirmatory testing.

The child's medical record must contain a laboratory report of test results. Diagnosis, treatment, education and follow-up should also be documented in the medical record.

Amerigroup is required to track and follow up with members that have an elevated BLL (blood lead result with a level equal to or higher than 3.5 µg/dL (or the most current level of concern for blood lead prescribed by CDC). Providers should complete the *Elevated Blood Lead Level* form located in Appendix A and fax it to the designated number within one week of receipt of the test results from the laboratory.

TennCare Kids visits reminder program
Amerigroup has a minimum of six outreach contacts per member per calendar year in which Amerigroup provides information about TennCare Kids to members. The minimum outreach contacts include one member handbook, four quarterly member newsletters and one reminder notice issued before a screening is due. The reminder notice will include an offer of transportation and scheduling assistance.

Amerigroup has a mechanism for systematically notifying families when TennCare Kids screens are due and mails the family a postcard reminder 45-90 days prior to the due date for screening.

Amerigroup has a process in place to follow up with members who do not get their screenings on a timely basis. This process includes provisions for documenting all outreach attempts and maintaining records of efforts made to reach out to members who have missed screening appointments or who have failed to receive regular check-ups. Amerigroup will make at least two outreach attempts in excess of the six outreach attempts to get the member in for a screening. The efforts are in different forms. The member receives a text message on a monthly basis as well as a 90-day overdue postcard reminder.

Amerigroup will determine if a member who is eligible for TennCare Kids has used no services within a year and will make two reasonable attempts to renotify such members about TennCare Kids. Amerigroup sends a one-year overdue text message, interactive voice response (IVR) call reminder, and letter which all encourage members to schedule a well-child exam with their PCP.

Local health departments
The provider agreement with a local health department must meet the minimum requirements and must also specify for the purpose of TennCare Kids screening services that:

- The local health department agrees to submit encounter data timely to Amerigroup.
- Amerigroup agrees to timely process claims for services.
- The local health department may terminate the agreement for cause with 30 days advance notice.
- Amerigroup agrees precertification will not be required for the provision of TennCare Kids screening services.

Amerigroup will reimburse contracted local health departments for TennCare Kids screenings to members under age 21 at no less than the following rates, unless specified otherwise by TennCare. Although the codes include preventive visits for individuals 21 and older, this section only requires Amerigroup to pay local health departments for the specified visits for members under age 21.

Preventive visits	85 percent of 2001 Medicare
99381 New pt. Up to 1 year	$80.33
99382 New pt. 1-4 years	$88.06
99383 New pt. 5-11 years	$86.60
99384 New pt. 12-17 years	$95.39
99385 New pt. 18-39 years	$93.93
99391 Estab. pt. Up to 1 year	$63.04
99392 Estab. pt. 1-4 years	$71.55
99393 Estab. pt. 5-11 years	$70.96
99394 Estab. pt. 12-17 years	$79.57
99395 Estab. pt. 18-39 years	$78.99

TennCare may conduct an audit of the Amerigroup reimbursement methodology and related processes on an annual basis to verify compliance with this requirement. In addition, the local health department may initiate the

independent review procedure at any time it believes the Amerigroup payment is less than the required minimum reimbursement rate.

9 Behavioral health services

Behavioral health services

Amerigroup provides behavioral health services in accordance with best practice guidelines, rules and regulations, and policies and procedures set forth by TennCare. This includes mental health services such as psychiatric inpatient hospital services, 24-hour psychiatric residential treatment services, outpatient mental health services, intensive community based treatment, Tennessee Health Link, psychiatric rehabilitation services and behavioral health crisis services. All behavioral health services referenced in this area are in accordance with TennCare's Contractor Risk Agreement.

Amerigroup also provides substance use disorder treatment through inpatient, residential and outpatient services. Detoxification services can be rendered as part of inpatient, residential or outpatient services as clinically appropriate. All member detoxifications are supervised by Tennessee licensed physicians with a minimum daily re-evaluation by a physician or registered nurse.

Providers are required to inform children and adolescents for whom residential treatment is being considered, their parent(s) or legally appointed guardian, and adults for whom voluntary inpatient treatment is being considered of:

- All of their options for residential and/or inpatient placement.
- Alternatives to residential and/or inpatient treatment.
- Benefits, risks and limitations of each so that they can provide informed consent.

Providers must inform all members being considered for prescription of psychotropic medications of the benefits, risks and side effects of the medication, alternate medications, and other forms of treatment.

Behavioral health services chart

Service[1]	Benefit limit
Psychiatric Inpatient Hospital Services (including physician services)	As medically necessary
24-hour Psychiatric Residential Treatment	**Medicaid/standard eligible, age 21 and older**: As medically necessary **Medicaid/standard eligible, under age 21:** As medically necessary
Outpatient Mental Health Services (including physician services)	As medically necessary
Inpatient, Residential and Outpatient Substance Use Disorder Benefits[2]	**Medicaid/standard eligible, age 21 and older**: As medically necessary **Medicaid/standard eligible, under age 21:** As medically necessary
Behavioral Health Intensive Community Based Treatment	As medically necessary
Psychiatric-Rehabilitation Services	As medically necessary
Behavioral Health Crisis Services	As medically necessary
Lab and X-ray Services	As medically necessary
Nonemergency Transportation (including Nonemergency Ambulance Transportation)	Same as for physical health (see Physical Health Benefits)
I/DD Behavioral Health Stabilization Systems of Support (SOS)	Time-limited, based on the needs of each member

1 Behavioral health access standards are in the **Behavioral Health Access Standards** section of this manual.

2 When medically appropriate, services in a licensed substance use disorder residential treatment facility may be substituted for inpatient substance use disorder services.

Behavioral health specialized service descriptions

Behavioral Health Intensive Community Based Treatment (ICBT)

Behavioral Health Intensive Community Based Treatment (ICBT) Services provide frequent and comprehensive support to individuals with a focus on recovery and resilience. Amerigroup will ensure the provision of Behavioral Health Intensive Community Based Treatment Services to adults and youth with complex needs including individuals who are at high risk of future hospitalization or placement out of the home and require both community support and treatment interventions. Behavioral Health Intensive Community Based Treatment Services shall be rendered through a team approach, which shall include a therapist and Care Coordinator who work under the direct clinical supervision of a licensed behavioral health professional. The primary goal of these services is to reach an appropriate point of therapeutic stabilization so the individual can be transitioned to less in home based services and be engaged in appropriate behavioral health office based services.

Intensive Community Based Treatment Services should include, at a minimum, the following elements and services as clinically appropriate:

- System Of Care principles
- Direct clinical supervision
- Evidenced-based comprehensive assessments and evaluations
- An average of one to two visits per week for individual therapy, family therapy or care coordination

Intensive Community Based Treatment Services shall be outcome-driven including but not limited to these treatment outcomes:

- Strengthened family engagement in treatment services
- Increased collaboration among formal and informal service providers to maximize therapeutic benefits
- Progress toward child and family goals
- Increased positive coping skills
- Increased family involvement in the community
- Developed skills to independently navigate the behavioral health system

Intensive Community Based Treatment Services include CTT, CCFT and PACT treatment models as described below:

Continuous Treatment Team (CTT)
CTT is a coordinated team of staff (to include physicians, nurses, case managers and other therapists as needed) who provide a range of intensive, care coordination, treatment and rehabilitation services to adults and children and youth. The intent is to provide intensive treatment to adults and families of children and youth with acute psychiatric problems in an effort to prevent removal from the home to a more restrictive level of care. An array of services are delivered in the home or in natural settings in the community and are provided through a strong partnership with the family and other community support systems. The program provides services including crisis intervention and stabilization, counseling, skills building, therapeutic intervention, advocacy, educational services, medication management as indicated, school-based counseling and consultation with teachers, and other behavioral health services deemed necessary and appropriate.

Comprehensive Child and Family Treatment (CCFT)
CCFT services are high intensity, time-limited, therapeutic services designed for children and youth to provide stabilization and deter from out-of-home placement. There is usually family instability and high-risk behaviors exhibited by the child/adolescent. CCFT services are concentrated on child, family and parental/guardian behaviors and interaction. CCFT services are more treatment oriented and situation specific with a focus on short-term stabilization goals.

Program of Assertive and Community Treatment (PACT)
PACT is a service delivery model for providing comprehensive community-based treatment to adults with severe and persistent mental illness. It involves the use of a multi-disciplinary team of mental health staff organized as an

accountable, mobile mental health agency or group of providers who function as a team interchangeably to provide the treatment, rehabilitation and support services persons with severe and/or persistent mental illnesses need to live successfully in the community. The service components of PACT include:

1. Services targeted to a specific group of individuals with severe mental illness
2. Treatment, support and rehabilitation services provided directly by the PACT team
3. Sharing of responsibility between team members and individuals served by the team
4. Small staff (all team staff including case managers) to individual ratios (approximately 1 to 10)
5. Comprehensive and flexible range of treatment and services
6. Interventions occurring in community settings rather than in hospitals or clinic settings
7. 24 hour a day availability of services
8. Engagement of individuals in treatment and recovery

Tennessee Health Link

Tennessee Health Link is a team of professionals associated with a mental health clinic or other behavioral health provider who provides whole-person, patient-centered, coordinated care for an assigned panel of members with behavioral health conditions. Members who would benefit from Tennessee Health Link will be identified based on diagnosis, health care utilization patterns or functional need. They will be identified through a combination of claims analysis and provider referral. Health Link professionals will use care coordination and patient engagement techniques to help members manage their healthcare across the domains of behavioral and physical health including:

- Comprehensive care management (e.g., creating care coordination and treatment plans).
- Care coordination (e.g., proactive outreach and follow up with primary care and behavioral health providers).
- Health promotion (e.g., educating the patient and his/her family on independent living skills).
- Transitional care (e.g., participating in the development of discharge plans).
- Patient and family support (e.g., supporting adherence to behavioral and physical health treatment).
- Referral to social supports (e.g., facilitating access to community supports including scheduling and follow through).

Psychiatric rehabilitation

Definition

Psychiatric rehabilitation is an array of consumer-centered recovery services designed to support the individual in the attainment or maintenance of his or her optimal level of functioning. These services are designed to capitalize on personal strengths, develop coping skills and strategies to deal with deficits and develop a supportive environment in which to function as independent as possible on the individual's recovery journey.

The service components included under psychiatric rehabilitation are as follows:

- Psychosocial Rehabilitation is a community-based program that promotes recovery, community integration and improved quality of life for members who have been diagnosed with a behavioral health condition that significantly impairs their ability to lead meaningful lives.
- The goal of Psychosocial Rehabilitation is to support individuals as active and productive members of their communities through interventions developed with a behavioral health professional or certified peer recovery specialist, in a nonresidential setting. These interventions are aimed at actively engaging the member in services and forming individualized service plan goals that will result in measurable outcomes in the areas of educational, vocational, recreational and social support, as well as developing structure and skills training related to activities of daily living. Such interventions are collaborative, person-centered, individualized and ultimately results in the member's wellness and recovery being sustainable within the community without requiring the support of Psychosocial Rehabilitation.

- Psychosocial Rehabilitation must meet medical necessity criteria and may be provided in conjunction with routine outpatient services.
- Psychosocial Rehabilitation services vary in intensity, frequency, and duration in order to resolve the member's ability to manage functional difficulties**.**

Supported employment
Supported employment consists of evidenced based practices (e.g., individual placement and support) to assist individuals to choose, prepare for, obtain and maintain gainful employment that is based on individuals' preferences, strengths and experiences. This service also includes support services to the individual, including side-by-side support on the job. These services may be integrated into a psychosocial rehabilitation center.

Peer recovery services
Peer recovery services are designed and delivered by people who have lived experience with behavioral health issues. A certified peer recovery specialist (CPRS) is someone who has self-identified as being in recovery from mental illness, substance use disorder, or co-occurring disorders of both mental illness and substance use disorder. In addition, a certified peer recovery specialist has completed specialized training recognized by the Tennessee Department of Mental Health and Substance Abuse Services on how to provide peer recovery services based on the principles of recovery and resiliency. Certified peer recovery specialists can provide support to others with mental illness, substance use disorder, or co-occurring disorder and help them achieve their personal recovery goals by promoting self-determination, personal responsibility and the empowerment inherent in self-directed recovery.

Under the direct clinical supervision of a licensed behavioral health professional, peer recovery services provided by a certified peer recovery specialist may include: assisting individuals in the development of a strengths-based, person-centered plan of care; serving as an advocate or mentor; developing community support; and providing information on how to successfully navigate the behavioral health care system. Activities which promote socialization, recovery, self-advocacy, development of natural supports and maintenance of community living skills are provided so individuals can educate and support each other in the acquisition of skills needed to manage their recovery and access resources within their communities. Services are often provided during the evening and weekend hours.

Family support services
Family support services are used to assist other caregivers of children or youth diagnosed with emotional, behavioral, or co-occurring disorders, and are provided by a certified family support specialist under the direct clinical supervision of a licensed behavioral health professional. A certified family support specialist is a person who has previously self-identified as the caregiver of a child or youth with an emotional, behavioral or co-occurring disorder and who has successfully navigated the child-serving systems to access treatment and resources necessary to build resiliency and foster success in the home, school and community. This individual has successfully completed and passed training recognized by the Tennessee Department of Mental Health and Substance Abuse Services on how to assist other caregivers in fostering resiliency in their child based on the principles of resiliency and recovery and has received certification from the Tennessee Department of Mental Health and Substance Abuse Services as a certified family support specialist.
These services include assisting caregivers in managing their child's illness and fostering resiliency and hope in the recovery process. These direct caregiver-to-caregiver support services include, but are not limited to, developing formal and informal supports, assisting in the development of strengths-based family and individual goals, serving as an advocate, mentor, or facilitator for resolution of issues that a caregiver is unable to resolve on his or her own, or providing education on system navigation and skills necessary to maintain a child with emotional, behavioral or co-occurring disorders in their home environment.

Illness management and recovery

Illness management and recovery services refer to a series of weekly sessions with trained mental health practitioners for the purpose of assisting individuals in developing personal strategies for coping with mental illness and promoting recovery. Illness management and recovery is not limited to one curriculum but is open to all evidenced-based and/or best practice classes and programs such as WRAP (Wellness Recovery Action Plan).

Support housing
Supported housing services refer to transitional services rendered at facilities that provide behavioral health staff supports for individuals who require treatment services in a highly structured, safe and secure setting. Supported housing services are for TennCare Priority Enrollees and are intended to prepare individuals to live independently in a community setting. At a minimum, supported housing services include coordinated and structured personal care services to address the individuals' behavioral and physical health needs in addition to 15 hours per week of psychosocial rehabilitation services to assist individuals in achieving recovery and resiliency based goals and developing the life skills necessary to live independently in a community setting. The required 15 hours per week of psychosocial rehabilitation is not inclusive of the psychosocial rehabilitation services received in day programs. Supported housing services do not include the payment of room and board.

I/DD behavioral health stabilization systems of support (SOS)
Amerigroup provides I/DD behavioral health stabilization SOS services according to I/DD behavioral health stabilization SOS standards set by TennCare. I/DD behavioral health stabilization SOS is a comprehensive, person-centered approach to the delivery of behavioral health crisis prevention, intervention and stabilization services for individual with intellectual and developmental disabilities (I/DD) who experience challenging behaviors that place themselves and others at risk of harm. The system is designed to provide a full array of necessary behavioral services and supports for individuals with I/DD and co-occurring mental health and/or behavioral disorder including behavioral health crisis prevention, intervention, stabilization and when necessary, inpatient services.

This proactive model is designed to improve quality of life by promoting behavioral crisis planning and prevention. Behavioral health crisis prevention includes person-centered assessment and planning and will require the development of an individualized crisis plan that includes linkage, coordination and collaboration with current state crisis teams.

The contracted I/DD systems of support provider will be the first point of contact in crisis events for members that have been enrolled into the systems of support program. The provider will assess the member for the purpose of stabilization in the individual's environment; however, should the member need further assessment for potential hospitalization, the provider will collaborate with our state crisis service teams.

Procedures for requesting psychological or neuropsychological testing
Providers are encouraged to utilize the electronic request as our preferred method of receipt. This is available at www.provider.amerigroup/tn.com. If you prefer to paper fax, you may request psychological or neuropsychological testing, providers must complete the *Request for Authorization-Psychological Testing Authorization* form or the *Behavioral Health Neuropsychological Testing* form (see Appendix A — Forms). All sections of the forms must be completed in full as may not be able to process incomplete requests.

The completed form should be faxed to **844-451-2827** or mailed to:

Behavioral Health Department
Amerigroup Community Care
P.O. Box 62509
Virginia Beach, VA 23466-2509

Providers will be notified of the disposition of the request within the time standards for completing noncurrent preservice requests.

Behavioral health access standards

Service type	Geographic access requirement	Maximum time for admission/appointment
Psychiatric inpatient hospital services	Transport access ≤ 90 miles travel distance and ≤ 120 minutes travel time for all child and adult members.	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24-hour psychiatric residential treatment	Not subject to geographic access standards.	Within 30 calendar days
Outpatient (non-MD services)	Transport access ≤ 30 miles travel distance and ≤ 45 minutes travel time for at least 75% of child and adult members and ≤ 60 miles travel distance and ≤ 60 minutes travel time for all child and adult members.	Within 10 business days; if urgent, within 48 hours
Intensive outpatient (may include day treatment (adult), intensive day treatment (children and adolescent) or partial hospitalization)	Transport access ≤ 90 miles travel distance and ≤90 minutes travel time for 75% of child and adult members and ≤ 120 miles travel distance and≤ 120 minutes travel time for-all child and adult members.	Within 10 business days; if urgent, within 48 hours
Inpatient facility services (substance use disorder)	Transport access ≤ 90 miles travel distance and ≤ 120 minutes travel time for all child and adult members.	Within two calendar days; for detoxification — within four hours in an emergency and 24 hours for nonemergency
24-hour residential treatment services (substance use disorder)*	Not subject to geographic access standards.	Within 10 business days
Outpatient treatment services (substance use disorder)	Transport access ≤ 30 miles travel distance and ≤ 30 minutes travel time for 75% of child and adult members and ≤ 45 miles travel distance and ≤ 45 minutes travel time for all child and adult members.	Within 10 business days; for detoxification — within 24 hours
Opioid Use Disorder (OUD) treatment providers (providers treating with Buprenorphine)	Transport access ≤ 45 miles travel distance and ≤ 45 minutes travel time for at least 75% of non-dual members and ≤ 60 miles travel distance and ≤ 60 minutes travel time for ALL non-dual members	Within 10 business days
Intensive community based treatment services	Not subject to geographic access standards.	Within seven calendar days
Tennessee Health Link services	Not subject to geographic access standards	Within 30 calendar days

Service type	Geographic access requirement	Maximum time for admission/appointment
Psychosocial rehabilitation (may include supported employment, illness management and recovery, peer recovery services or family support)	Not subject to geographic access standards.	Within 10 business days
Supported housing	Not subject to geographic access standards.	Within 30 calendar days
Crisis services (mobile)	Not subject to geographic access standards.	Face-to-face contact within two hours for emergency situations and four hours for urgent situations
Crisis stabilization	Not subject to geographic access standards.	Within four hours of referral

*24-hour residential treatment substance use disorder services may be provided by facilities licensed by TDMHSAS as Halfway House Treatment Facilities (TDMHSAS Rule Chapter 0940-05-41), Residential Detoxification Treatment Facilities (TDMHSAS Rule Chapter 0940-05-44) or Residential Rehabilitation Treatment Facilities (TDMHSAS Rule Chapter 0940-05-45).

Coordination of behavioral health

Amerigroup network providers are required to notify a member's PCP when the member first enters behavioral health care and anytime there is a significant change in care, treatment or need for medical services, provided that the behavioral health provider has secured the necessary release of information. The minimum elements to be included in such correspondence are:

- Patient demographics
- Date of initial or most recent behavioral health evaluation
- Recommendation to see PCP if medical condition identified or need for evaluation by a medical practitioner has been determined for the enrollee (e.g., EPSDT screen, complaint of physical ailments)
- Diagnosis and/or presenting behavioral health problem(s)
- Prescribed medication(s)
- Behavioral health clinician's name and contact information

Amerigroup puts special emphasis on the coordination and integration of physical and behavioral health services, wherever possible. Key elements of the Amerigroup model of coordinated care include:

- Ongoing communication and coordination between PCPs and specialty providers including behavioral health (mental health and substance use disorder) providers.
- Screening for co-occurring disorders including:
    - Behavioral health screening by PCPs.
    - Medical screening by behavioral health providers.
    - Screening of mental health patients for co-occurring substance use disorder disorders.
    - Screening of consumers in substance use disorder treatment for co-occurring mental health and/or medical disorders.
- Screening tools for PCPs and behavioral health providers that can be located at **provider.amerigroup.com/tn.**
- Referrals to PCPs or specialty providers, including behavioral health providers, for assessment and/or treatment for consumers with co-occurring disorders.
- Development of individualized treatment plans for each consumer and coordinating those plans with the PCP and/or other active specialty providers.
- Case management and population health programs to support the coordination and integration of care between providers.

- Consultation for providers wishing assistance in coordinating care for consumers with co-occurring disorders through the Amerigroup Provider Services line.

Recovery and resiliency

All behavioral health services shall be rendered in a manner that supports the recovery of persons experiencing mental illness and enhance the development of resiliency of children and families who are impacted by mental illness, serious emotional disturbance and/or substance use disorder issues. Recovery is a consumer-driven process in which consumers are able to work, learn and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life with a disability. The Substance use disorder and Mental Health Services Administration (SAMHSA) has released a consensus statement on mental health recovery. The components listed in this consensus statement are reflective of TDMHSAS's desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency.

The 10 fundamental components of recovery include:

1. Self-direction: Consumers lead, control, exercise choice over and determine their own path of recovery by optimizing autonomy, independence and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
2. Individualized and person-centered: There are multiple pathways to recovery based on an individual's unique strengths and resiliency, as well as his or her needs, preferences, experiences (including past trauma) and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result, as well as an overall paradigm for achieving wellness and optimal mental health.
3. Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions — including the allocation of resources — that will affect their lives and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
4. Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and health care treatment and services, complementary and naturalistic services (e.g., recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation and family supports as determined by the person. Families, providers, organizations, systems, communities and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
5. Nonlinear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
6. Strengths-based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, and employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
7. Peer support: Mutual support including the sharing of experiential knowledge and skills and social learning plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles and community.
8. Respect: Community, systems and societal acceptance and appreciation of consumers including protecting their rights and eliminating discrimination and stigma are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

9. Responsibility: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
10. Hope: Recovery provides the essential and motivating message of a better future- that people can and do overcome the barriers and obstacles that confront them. Hope is internalized but can be fostered by peers, families, friends, providers and others. Hope is the catalyst of the recovery process.

Resiliency is a dynamic developmental process for children and youth that encompasses positive adaptation and is manifested by traits of self-efficacy, high self-esteem, maintenance of hope and optimism within the context of significant adversity.

Services that are provided to children and youth with serious emotional disturbances and their families should be delivered based on the System of Care Values and Principles that are endorsed by the SAMHSA and the Center for Mental Health Services (CMHS). Services should be:

- Child centered and family focused with the needs of the child and family dictating the types and mix of services provided.
- Community based with the focus of services as well as management and decision making responsibility resting at the community level.
- Culturally competent with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.
- The guiding principles of a system of care include:
    - Children should have access to a comprehensive array of services that address the child's physical, emotional, social, educational and cultural needs.
    - Children should receive individualized services in accordance with their unique needs and potential, which is guided by an individualized service plan.
    - Children should receive services within the least restrictive, most normative environment that is clinically appropriate.
    - Children should receive services that are integrated, with linkages between child serving agencies and programs and mechanisms for planning, developing and coordinating services.
    - Children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated, therapeutic manner and adapted in accordance with the changing needs of the child and family.
    - Children should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics.

Source: TDMHSAS

Training

Amerigroup must monitor and ensure all participating providers that deliver behavioral health services provide relevant staff with training in accordance with TDMHSAS requirements. As a contracted provider of Amerigroup, your organization is required to provide training to your staff as appropriate. Your organization is also responsible for complying with any updates in training requirements, which can be found on the TDMHSAS website at **tn.gov/behavioral-health/for-providers.html**. Additionally, Amerigroup will conduct audits to ensure compliance with training requirements.

Training topic	Staff to receive	Time frame to be provided
Consumer Rights and Responsibilities		

Training topic	Staff to receive	Time frame to be provided
Consumer rights and responsibilities, including (as appropriate) such topics as consumer advocacy and alternative decision making, educational rights, declarations for mental health treatment, durable power of attorney, guardianship and conservatorships*	Any staff member, licensed staff and those for whom a license is not required	• Initially within the first 90 days of employment either through training or assessment of competency • Every three years thereafter either through retraining or assessment of competency
Cultural Competence and Diversity		
Cultural competence — recognizing any unique aspects of members; these may include language, ~~dress~~, traditions, beliefs about modesty, eye contact, health values, help-seeking behaviors, work ethics, spiritual values, attitudes regarding treatment of mental illness and substance use disorder, concepts of status and issues of privacy and personal boundaries	Any staff member, licensed staff and those for whom a license is not required.	• Initially within the first 90 days of employment either through training or assessment of competency • Annually thereafter either through retraining or assessment of competency
Prevention/Intervention and Recovery/Resiliency Strategies		
Prevention and intervention techniques to address the management of potentially aggressive behavior	Any direct care staff member, licensed staff and those for whom a license is not required	• Initially within the first 90 days of employment either through training or assessment of competency • Every three years thereafter either through re-training or assessment of competency
Recovery and resiliency-based approaches to providing services*	Any direct care staff member, licensed staff and those for whom a license is not required	• Initially within the first 90 days of employment either through training or assessment of competency • Every three years thereafter either through re-training or assessment of competency
Behavioral Health/Substance Use Disorders and Associated Medical Conditions and Care		
Etiology, treatment and diagnostic categories of mental illness; serious emotional disturbance; substance use and/or abuse; physical and sexual abuse; suicidal ideation; developmental disabilities and mental retardation, as well as general health care practices and medical conditions that may be associated with mental illness, serious emotional disturbance, and/or substance use and/or abuse*	Any direct care staff member for whom a license is not required	• Initially within the first 90 days of employment either through training or assessment of competency • Every three years thereafter either through retraining or assessment of competency

Training topic	Staff to receive	Time frame to be provided
Research-based Practices		
Evidence-based practices identified and recognized by the CMHS such as: • Illness management and recovery skills • Supported employment • Family psychoeducation • Program of Assertive and Community Treatment (PACT) • Integrated co-occurring disorders treatment (substance use and mental illness)* Resource: **mentalhealth.gov** **samhsa.gov**	Any staff member for whom a license is required in the performance of his/her duties.	• Initially within the first 90 days of employment either through training or assessment of competency • Every three years thereafter either through retraining or assessment of competency
TDMHSAS Best Practice Guidelines – adult behavioral health services and behavioral health services for children and adolescents* Resource: **tn.gov/partnersforhealth/health-options/behavioral-health.html**	Any staff member for whom a license is required in the performance of his/her duties	• Initially within the first 90 days of employment either through training or assessment of competency • Every three years thereafter either through retraining or assessment of competency
Legal Issues and Mandates		
Legal issues and mandates regarding mental illness, serious emotional disturbance and substance use disorder such as mandatory outpatient treatment, confidentiality and involuntary commitment.*	Any staff member for whom a license is required in the performance of his/her duties	• Initially within the first 90 days of employment either through training or assessment of competency • Every three years thereafter either through retraining or assessment of competency
Psychopharmacology		
Psychopharmacology such as classes of medications, drug interactions, adverse drug reactions and medication use in pregnancy and lactation.*	Any staff member for whom a license is required in the performance of his/her duties. Persons in the following categories may be exempted: physicians, pharmacists, nurse practitioners and physician assistants	• Initially within the first 90 days of employment either through training or assessment of competency • Every three years thereafter either through retraining or assessment of competency
Treatment Considerations for Children and Adolescents		
System of care values and principles for the treatment of children and adolescents that are child-centered and family-focused, community-based, culturally competent and evaluated for effectiveness in addition to wraparound	Any staff member for whom a license is required that works directly with children and adolescents and their families	• Initially within the first 90 days of employment either through training or assessment of competency • Every three years thereafter either through retraining or assessment of competency

Training topic	Staff to receive	Time frame to be provided
supports tailored to fit the individual child and family unit Resource: **tn.gov/partnersforhealth/health-options/behavioral-health.html**		
Age appropriate developmental principles and EPSDT requirements for children and adolescents	Any staff member for whom a license is required that works directly with service recipients age 20 and under	• Within the first 90 days of employment either through training or assessment of competency
Tennessee Health Link		
Tennessee Health Link principles, assessment for treatment planning, intervention techniques, philosophy and facilitating access to community resources*	Tennessee Health Link staff and Tennessee-certified peer support specialists, as applicable	• Initially within the first 90 days of employment either through training or assessment of competency • Every three years thereafter either through retraining or assessment of competency
Crisis Services Curriculum		
Tennessee Department of Mental Health & Substance Abuse (TDMHSAS) — designated crisis services curriculum	Crisis services staff and Tennessee-certified peer support specialists as applicable	• Initially within the first 90 days of employment either through training or assessment of competency • Every three years thereafter either through retraining or assessment of competency
Psychiatric Rehabilitation Principles		
Principles of psychiatric rehabilitation and supports, including psychosocial rehabilitation, supported housing, supported employment, peer support and illness management and recovery	Staff at psychiatric rehabilitation facilities or facilities that implement psychiatric rehabilitation programs that work directly with service recipients, as well as Tennessee-certified peer support specialists	• Initially within the first 90 days of employment either through training or assessment of competency • Every three years thereafter either through retraining or assessment of competency

* Training should be appropriate to the type of staff and the population served.

Documentation of training and/or competency should be maintained by the agency in which staff members are employed.

- Documentation may take the form of:
    - Certificates.
    - Descriptions of training PLUS sign-in sheets.
    - Letters of confirmation.

Competence will be determined by the agency. One or more of the following tools might be used as documentation:

- Posttest results
- Supervisor check-off forms

Staff members currently employed with a provider will have one year after the effective date of a provider's contract with an MCC to receive any trainings listed above that they have not already successfully completed. Required

training may be obtained either through the agency/provider or through outside entities that offer continuing education unit (CEU) credits or contact hours. The agency/provider may accept comparable training completed within one year prior to employment if the employee has demonstrated competence in the area.

Member records and treatment planning

Member records must meet the following standards and contain the following elements, if applicable, to permit effective service provision and quality reviews:

1. Information related to the provision of appropriate services to a member must be included in his or her record to include documentation in a prominent place whether there is an executed declaration for mental health treatment.
2. For members in the priority population, a comprehensive assessment that provides a description of the consumer's physical and mental health status at the time of admission to services. This comprehensive assessment covers:
    - A psychiatric assessment which includes:
        - Description of the presenting problem.
        - Psychiatric history and history of the member's response to crisis situations.
        - Psychiatric symptoms.
        - Diagnosis using the most current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM).
        - Mental status exam.
        - History of alcohol and drug abuse.
    - A medical assessment that includes:
        - Screening for medical problems.
        - Medical history.
        - Present medications.
        - Medication history.
    - A substance use assessment that includes frequently used over-the-counter medications, alcohol and other drugs and history of prior alcohol and drug treatment episodes. The history should reflect impact of substance use in the domains of the community functioning assessment.
    - A community functioning assessment or an assessment of the member's functioning in the following domains:
        - Living arrangements, daily activities (vocational/educational)
        - Social support
        - Financial
        - Leisure/recreational
        - Physical health
        - Emotional/behavioral health
    - An assessment of the member's strengths, current life status, personal goals and needs.
3. An individualized treatment plan, which is based on the psychiatric, medical, substance use and community functioning assessments listed above, must be completed for any member who receives behavioral health services for 30 calendar days or longer.
    - The treatment plan must be completed within the first 30 days of admission to behavioral health services and updated every six months, or more frequently as necessary based on the member's progress towards goals or a significant change in psychiatric symptoms, medical condition and/or community functioning.
    - Provide documentation that the member and, as appropriate, his or her family members or legal guardian, participated in the development and subsequent reviews of the treatment plan.
    - For providers of multiple services, one comprehensive treatment plan is acceptable as long as at least one goal is written and updated as appropriate for each of the different services that are being provided to the member.

- The treatment plan must contain the following elements:
    - Identified problem(s) for which the member is seeking treatment
    - Member goals related to problem(s) identified
    - Measurable objectives to address the goals identified
    - Target dates for completion of objectives
    - Responsible parties for each objective
    - Specific measurable action steps to accomplish each objective
    - Individualized steps for prevention and/or resolution of crisis, which includes identification of crisis triggers (situations, signs and increased symptoms); active steps or self-help methods to prevent, de-escalate or defuse crisis situations; names and phone numbers of contacts that can assist the member in resolving crisis; and the member's preferred treatment options, to include psychopharmacology, in the event of a mental health crisis

4. Progress notes are written to document status related to goals and objectives indicated on the treatment plans.
5. Correspondence concerning the member's treatment and signed and dated notations of telephone calls concerning the member's treatment.
6. A brief discharge summary must be completed within seven calendar days following discharge from services or death.
7. Discharge summaries for psychiatric hospital and residential treatment facility admissions that occur while the member is receiving behavioral health services.

Behavioral health supervision for nonlicensed clinicians

Amerigroup expects ongoing supervision is provided by mental health/substance use disorder facilities/CMHC providers who employ nonlicensed clinical staff to complete clinical activities (such as clinical assessments and psychotherapy). The facility should ensure all nonlicensed clinicians are regularly supervised by a licensed clinician. The supervising clinician will have regular, in-person, one-on-one supervision with the noncredentialed clinician to review the treatment and services provided to members.

Under the supervision of an independently licensed clinician, nonlicensed master's level clinicians who render behavioral health professional services must receive clinical supervision specific to the rendered service. The supervision will include a minimum of direct supervision during service initiation, which may be followed by general supervision for the remainder of the service at the discretion of the supervisory practitioner.

- **Direct supervision** means the supervising provider must be immediately available (i.e., in person, by phone or through telehealth/video conferencing) to furnish assistance and direction throughout the rendered service and may include the supervisor's review and signing of the treatment plan during service initiation.
- **General supervision** means the service is performed under the supervisory clinician's overall direction and control but his or her presence is not required during the performance of the intervention.

Crisis services

Definition

Behavioral health crisis services shall be rendered to individuals with a mental health or substance use/abuse issue when there is a perception of a crisis by an individual, family member, law enforcement, hospital staff or others who have closely observed the individual experiencing the crisis. Crisis services are available 24 hours a day, 7 days a week. Crisis services include 24-hour toll-free telephone lines answered in real time by trained crisis specialists and face-to-face crisis services including but not limited to: prevention, triage, intervention, evaluation/referral for additional services/treatment, and follow-up services. Certified peer recovery specialists and/or certified family support specialists shall be utilized in conjunction with crisis specialists to assist adults and children in alleviating and stabilizing crises and promote the recovery process as appropriate. Behavioral health crisis service providers are not responsible for pre-authorizing emergency involuntary hospitalizations.

The Mental Health Crisis Response Services Community Face-to-Face Response Protocols provide guidance for calls that are the responsibility of a crisis response service to determine if a face-to-face evaluation is warranted and those that are not the responsibility of the crisis response service. These protocols were developed to ensure that consumers who are experiencing a behavioral health crisis and have no other resources receive prompt attention. All responses are first determined by clinical judgment.

Guidance for all calls

- For calls originating from an emergency department, telehealth is the preferred service delivery method for the crisis response service.
- After determining there is no immediate harm, ask the person if they can come to the closest walk-in center.
- If a Mandatory prescreening agent (MPA) not employed by a crisis response service is available, there may be no need for a crisis evaluation by mobile crisis.
- For all other calls, unless specified in the protocols, if a person with mental illness is experiencing the likelihood of immediate harm, then a response is indicated.

Mandatory prescreening agent

Tennessee law requires a face-to-face evaluation, known as prescreening, of each member in crisis to assess eligibility for emergency involuntary admission to a Regional Mental Health Institute (RMHI) and to determine whether all available, less drastic, alternative services and supports are unsuitable to meet the member's needs. An MPA is required to complete one of the certificates of need (CONs) prior to an emergency admission to a RMHI. Private hospitals that have been approved by TDMHSAS and accept the authority of an MPA may also accept CONs from an MPA for emergency involuntary admissions.

Behavioral health crisis respite

All behavioral health crisis service providers must provide access to crisis respite 24 hours a day, 7 days a week for all members meeting guidelines for this level of treatment including:

- Diagnosed or suspected mental illness.
- Mental status exam reveals no immediate intent to harm self or others.
- Respite is deemed a safe level of treatment.
- Respite would be an appropriate and beneficial level of treatment.

Behavioral health crisis respite services are intended to provide immediate shelter to those members with emotional/behavioral problems who are in need of emergency respite. These services involve short-term respite with overnight capacity for room and board, while meeting the member's crisis need(s). Trained crisis respite staff members typically provide crisis respite. However, others who are deemed appropriate by crisis staff members may render respite services. For children/youth, authorization must be given for the use of crisis respite services by the parent, legal guardian, legal custodian, legal caretaker or court with appropriate jurisdiction.

If a behavioral health crisis respite service provider is unable to obtain a current treatment plan, then the behavioral health crisis respite service provider will complete a respite plan that is developed and agreed upon in writing by the member, respite staff and family/care givers/support system as applicable. The plan should include actions to attain stabilization or alleviation of the crisis situation. Crisis respite must be rendered in a community location approved by the managed care company or a site licensed by TDMHSAS that can be facility-based, home-based or hospital-based in nature, depending on the need and availability.

Behavioral health crisis respite services will continue to be utilized by those members that continue to be serviced on the DIDDS (Department of Intellectual and Developmental Disabilities) waiver to provide immediate shelter to I/DD members with emotional/behavioral problems who are in need of emergency respite in the event that the member

cannot be stabilized in the current living environment. These services are delivered by contracted providers in community locations approved by the health plan.

Facility-Based Crisis Respite Services
Crisis respite services that use a placement in a facility with direct care from trained crisis respite staff in direct response to a consumer's acuity level based on the assessment of risk.

Home-Based Crisis Respite Services
Crisis respite services that use a placement in a home approved by the behavioral health crisis services provider with direct care from trained crisis respite staff or family members/significant others in direct response to a consumer's acuity level based on the assessment of risk.

Hospital-Based Crisis Respite Services
Crisis respite services that use hospital emergency rooms or other acute psychiatric services based on the assessment of risk to the member and/or the need for a medically supervised setting.

Crisis stabilization services
Crisis stabilization services are short-term supervised care services, accessed to prevent further increase in symptoms of a behavioral health illness or to prevent acute hospitalization. Crisis stabilization services are more intensive than regular crisis respite services in that they require more secure environments, highly trained staff and have typically longer stays. For adults, these services are provided in Crisis Stabilization Units licensed by TDMHSAS. Crisis stabilization services should include availability and utilization of the following types of services on a short-term basis as appropriate:

- Individual and/or family counseling/support
- Medication management/administration
- Stress management counseling
- Individualized treatment plan development that empowers the consumer
- Mental illness/substance use disorder awareness/education
- Identification and development of natural support systems

If a crisis stabilization service provider is not able to obtain a current treatment plan, then the crisis stabilization services provider shall complete a crisis stabilization plan that is developed and agreed upon in writing by the individual, staff and the individual's significant others if appropriate. This plan identifies services and assistance needed to achieve stabilization as well as the components needed for discharge or transition to a lower level of care. Discharge/transition plans are to address what criteria are needed for the individual to move safely to a less restrictive level of care. This plan may also detail what is needed to move an individual to a higher level of care if it is deemed appropriate.

Follow-up services
Follow-up services can be telephone call(s) or face-to-face assessment(s) between crisis staff and the member following crisis intervention, respite or stabilization to ensure the safety of the member until treatment is scheduled or treatment begins and/or the crisis is alleviated and/or stabilized. Follow-up services can include crisis services contacting the member only one time or can include several contacts a day for several days as deemed appropriate by crisis staff.

A follow-up contact with the member must be made within 12 hours of an MPA face-to-face assessment or anytime a physician or psychologist conducts a face-to-face assessment because an MPA was not available within two hours when it is determined that psychiatric inpatient criteria is not met. A follow-up contact with the member must be made within 24 hours of a crisis specialist face-to-face assessment that does not involve an MPA or a physician or psychologist acting in place of an MPA when it is determined that psychiatric inpatient criteria is not met. Should a

crisis specialist's face-to-face assessment result in psychiatric inpatient criteria being met, contact with the inpatient facility to verify admission must be completed within 24 hours.

Adverse occurrences
Adverse occurrence reports must be reported by each network provider to all appropriate agencies and Amerigroup as required by licensure and state and federal laws within the specified time frames required immediately following the event.

The applicable providers required to report are:

- Inpatient psychiatric hospitals.
- Psychiatric residential treatment centers.
- Substance use disorder inpatient psychiatric hospitals.
- Substance use disorder residential treatment centers.
- Crisis stabilization units.

The reportable categories of incidents are:

- Suicide death.
- Nonsuicide death.
- Death, cause unknown.
- Homicide.
- Homicide attempt with significant medical intervention.*
- Suicide attempt with significant medical intervention.*
- Accidental injury with significant medical intervention.*
- Use of restraints or seclusion (physical, chemical or mechanical) requiring significant medical intervention.*
- Treatment complications (medical errors and adverse medical reactions) requiring significant medical intervention.*
- Elopement (specific to inpatient and residential services only, as related to minors or involuntary admits for adults).
- Allegation of physical, sexual or verbal abuse or neglect, including peer-to-peer
- Medical emergency (e.g., heart attack, medically unstable, etc.).

* For purposes of behavioral health adverse occurrences, significant medical intervention is defined as requiring an ER visit or inpatient hospital stay.

Adverse occurrences should be reported within 24 hours of detection or notification. A form for reporting these incidents is included in the Forms section of this manual and on our provider website. Providers should complete all portions of the form and fax to **877-423-9976**. Any questions concerning this form may be directed to the Quality Management department at **615-316-2400**.

10 Member enrollment

Member enrollment process
The Division of TennCare will process all member enrollments. Enrollment will begin at 12:01 a.m. on the effective date of enrollment with Amerigroup and will end at midnight on the date that the enrollee is disenrolled from Amerigroup. After becoming eligible for TennCare and enrolling in Amerigroup (whether the result of selection by the enrollee or assignment by TennCare), enrollees will have one opportunity, anytime during the 90-day period immediately following the effective date of enrollment with Amerigroup or the date TennCare sends the member notice of enrollment in Amerigroup, whichever is later, to request to change MCOs. Children eligible for TennCare as a result of being eligible for SSI may request to enroll in another MCO or re-enroll with TennCare Select during this 90-day period.

TennCare will provide an opportunity for members to change MCOs (excluding TennCare Select) every 12 months. Children eligible for TennCare as a result of being eligible for SSI may request to enroll in another MCO or re-enroll with TennCare Select every 12 months.

Members who do not select another MCO will be deemed to have chosen to remain with their current MCO.

A member may request disenrollment or be disenrolled if:

- The member chooses another MCO during the 90-day change period after the member's enrollment is effective.
- The member chooses another MCO during the annual choice period.
- An appeal by the member to change MCOs based on hardship criteria (pursuant to TennCare rules and regulations) is decided by TennCare in favor of the member.
- The member is assigned incorrectly to the MCO by TennCare and requests enrollment in another MCO.
- The member moves outside the Amerigroup service area.
- During the appeal process, if TennCare determines it is in the best interest of the enrollee and TennCare.
- The member loses eligibility for TennCare.
- TennCare grants the member the right to terminate enrollment, and the member exercises that right.
- Amerigroup no longer participates in TennCare.

Unknown member assignment and retro-enrolled members
Because individuals can be retroactively eligible for TennCare, and the effective date of initial enrollment in an MCO is the effective date of eligibility, the effective date of enrollment may occur prior to the MCO or the individual being notified and enrollment of individuals in an MCO may occur without prior notice to the MCO or enrollee. The Tennessee Contractor Risk Agreement (CRA) language sets out the CRA provisions for payment of these claims.

Amerigroup will review claims for retro-enrolled/retro-assigned members ordinarily requiring authorization for medical necessity prior to payment. Claims payment determinations/adjudication approval overriding authorization requirements will only be given after the medical necessity review of submitted medical records.

Effective October 1, 2020, if you submit a claim for a retro-enrolled member (including sick newborns) for services that would have required prior authorization, you will need to submit medical records with the claim. Please do not request prior authorization for services already rendered. Claims submitted without medical records will be denied for medical record submission. If you receive a claim denial, you may file a first-level claims payment dispute to include the medical records within 365 days from the initial denial of the claim. Amerigroup will review the records received and issue a medical necessity determination on the claim.

Timely filing for claims submitted for our retro-enrolled/retro-assigned members will not change. A member claim must be filed prior to 120 days from the date the MCO is notified of the enrollment by the State. Timely filing

overrides will not be given if the claim is submitted after the 120-day timely filing limit from the MCO's receipt date of the eligibility file from the State.

Newborn enrollment process
TennCare-eligible newborns and their mothers, to the extent that the mother is eligible for TennCare, should be enrolled in the same MCO with the exception of newborns who are SSI eligible at birth. Newborns who are SSI eligible at birth will be assigned to TennCare Select, but the parent or guardian may choose to opt out of TennCare Select and choose Amerigroup as the baby's MCO.

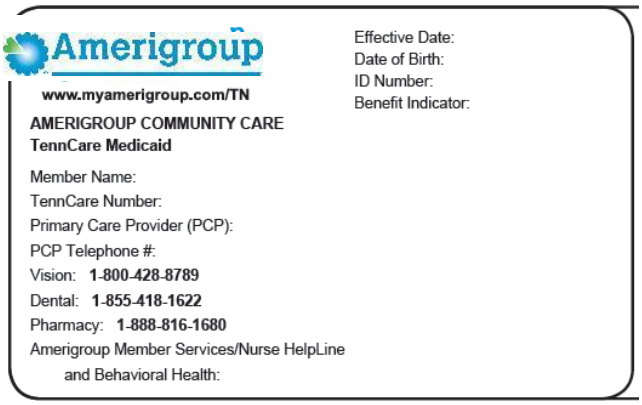
Member eligibility listing
The PCP may access a listing of his or her panel of assigned members online at **provider.amerigroup.com/tn**. If a member calls to change his or her PCP, the change will be effective as of the date of the request, unless the member has been seen by his or her assigned PCP on the same date of the request. If this is the case, the effective date will be the next business day. The PCP should verify that each Amerigroup member receiving treatment in his or her office is on the PCP's membership listing. For questions regarding a member's eligibility, providers may access **provider.amerigroup.com/tn** or call the automated provider inquiry line at **800-454-3730**.

Member identification cards
Each Amerigroup member will be provided an identification card, which identifies the member as a participant in the TennCare program within 30 calendar days of notification of enrollment into Amerigroup or prior to the member's enrollment effective date. The identification card will include:

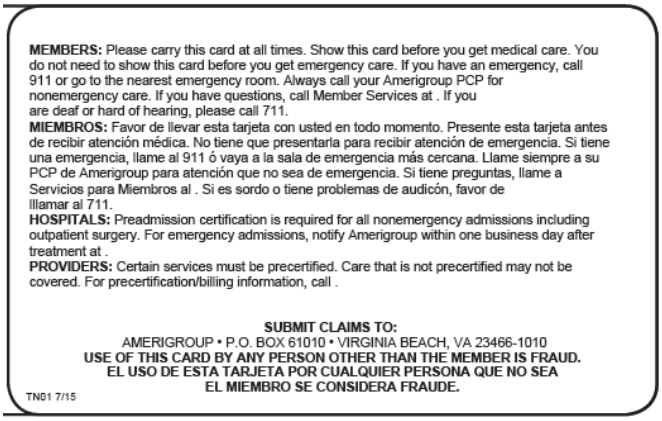
- The member's identification number.
- The member's name (first and last name and middle initial).
- The member's date of birth.
- The member's enrollment effective date.
- Phone numbers for information and/or authorizations including for behavioral health services.
- Descriptions of procedures to be followed for emergency or special services.
- Copay responsibility.
- The *HIPAA* adopted identifier.
- The words Medicaid or Standard based on eligibility.
- The appropriate Amerigroup address and telephone number.
- The PCP's name.

Amerigroup member identification card sample:

Front



Back



MEMBERS: Please carry this card at all times. Show this card before you get medical care. You do not need to show this card before you get emergency care. If you have an emergency, call 911 or go to the nearest emergency room. Always call your Amerigroup PCP for nonemergency care. If you have questions, call Member Services at . If you are deaf or hard of hearing, please call 711.

MIEMBROS: Favor de llevar esta tarjeta con usted en todo momento. Presente esta tarjeta antes de recibir atención médica. No tiene que presentarla para recibir atención de emergencia. Si tiene una emergencia, llame al 911 ó vaya a la sala de emergencia más cercana. Llame siempre a su PCP de Amerigroup para atención que no sea de emergencia. Si tiene preguntas, llame a Servicios para Miembros al . Si es sordo o tiene problemas de audicón, favor de llamar al 711.

HOSPITALS: Preadmission certification is required for all nonemergency admissions including outpatient surgery. For emergency admissions, notify Amerigroup within one business day after treatment at .

PROVIDERS: Certain services must be precertified. Care that is not precertified may not be covered. For precertification/billing information, call .

SUBMIT CLAIMS TO:
AMERIGROUP • P.O. BOX 61010 • VIRGINIA BEACH, VA 23466-1010
USE OF THIS CARD BY ANY PERSON OTHER THAN THE MEMBER IS FRAUD.
EL USO DE ESTA TARJETA POR CUALQUIER PERSONA QUE NO SEA EL MIEMBRO SE CONSIDERA FRAUDE.

TN01 7/15

11 Member management support

Welcome call
As part of our member management strategy, Amerigroup offers a welcome call to new members. Additionally, Member Services representatives offer to assist the member with any current needs such as scheduling an initial checkup and transportation to the appointment if needed.

Appointment scheduling
Amerigroup, through its participating providers, ensures that members have access to primary care services for routine, urgent and emergency services and to specialty care services for chronic and complex care. Providers will respond to an Amerigroup member's needs and requests in a timely manner. The PCP must schedule members for appointments using the guidelines outlined in the section of this manual entitled PCP Access and Availability.

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 requires providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling the appointment. The contact must 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.

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 **800-454-3730** to address the situation. Amerigroup staff will contact the member and provide more extensive education and/or case management as appropriate. The goal of Amerigroup is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCP. Providers may not bill members for missed appointments.

Nonadherent 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 Provider Services at **800-454-3730**.

A member/provider services representative will contact the member by telephone, or a member advocate will visit the member to provide education and counseling to address the situation and will report to you the outcome of any counseling efforts.

Member dismissal
The provider may determine that the member should be dismissed from his or her panel. The provider must send a certified letter to the member or head of household indicating that the member must select a new PCP within 30 days of the notice. The provider must continue to provide care until the effective date for assignment to the new PCP. A copy of the letter must be mailed to the National Customer Care department at:

National Customer Care
Amerigroup Community Care
22 Century Boulevard, Suite 220
Nashville, TN 37214

24-hour Nurse HelpLine
The 24-hour Nurse HelpLine provides triage services and helps direct members to appropriate levels of care. The 24-hour Nurse HelpLine telephone number is **800-600-4441** and is listed on the member's ID card. This ensures that members have an additional avenue of access to health care information when needed. Available 24 hours a day, 7

days a week, the Nurse HelpLine is a service designed to support the provider by offering information and education to members after normal physician practice hours about medical conditions, health care and prevention. The 24-hour Nurse HelpLine includes:

- Information based upon nationally recognized and accepted guidelines.
- Free translation services for 170 different languages and for members with difficulty hearing, use of a TDD line.
- Education for members about appropriate alternatives for handling nonemergent medical conditions.

A member's assessment report will be faxed to the member's provider office within 24 hours of receipt of a call to the 24-hour Nurse HelpLine.

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 community organizations and network providers that are contracted with Amerigroup.

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

- A quarterly member newsletter.
- The creation and distribution of Ameritips, a health education tool used to inform members of health promotion issues and topics.
- The development of health education curricula and procurement of other health education tools (e.g., breast self-exam cards).
- Partnering with providers to focused efforts promoting the patient/physician relationship and closure of care gaps.
- Providing various member and provider incentives aimed at improving clinical outcomes.
- Relationship development with community-based organizations to enhance opportunities for members.

Population Health

Our Population Health program is part of an integrated and comprehensive Healthcare Management Services model that is based upon risk stratification of the entire population. The Population Health Model touches members across the entire care continuum, promoting healthy behaviors and disease self-management as well as providing care coordination and intense care management as needed and supported by evidence-based medicine and national best practices.

The Population Health model evaluates the entire member population and identify members for specific cohorts, according to risk rather than disease specific categories. Amerigroup utilizes a combination of predictive modeling utilizing claims data, CSMD data, pharmacy data, and laboratory results, supplemented by referrals, UM data, and/ or health risk assessment results to stratify the member population into cohorts. Amerigroup re-stratifies the entire member population monthly. Activities, interventions, and education objectives appropriate for members will vary for each cohort, with increasing engagement and intensity as level of risk increases. The Population Health risk level programs ranging from no risk to high risk are as follows:

No Risk (Wellness/Prevention)

Members identified as eligible for our Wellness program receive quarterly member newsletters that address specific topics focused on health promotion and disease prevention.

Low Risk Case Management
Members will be put into cohorts designed to manage members with rising risks and chronic care needs.
The goal of the cohorts is to improve the quality of life, health status and utilization of services, of members with multiple chronic conditions, by providing intense self-management education and support.

Low-Risk Maternity and High-Risk Maternity
Taking Care of Baby and Me® is a proactive case management program for all expectant mothers and their newborns that uses extensive methods to identify pregnant women as early in their pregnancy as possible through review of state enrollment files, claims data, hospital census reports, Availity and notification of pregnancy forms as well as provider and member self-referrals. Once pregnant members are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care and case management services to mitigate risk.

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

When it comes to our pregnant members, we are committed to keeping both mom and baby healthy.
That's why we encourage all of our moms-to-be to take part in our Taking Care of Baby and Me® program — a comprehensive case management and care coordination program offering:

- Individualized, one-on-one case management support for women at the highest risk
- Care coordination for moms who may need a little extra support
- Educational materials and information on community resources
- Incentives to keep up with prenatal and postpartum checkups

As part of the Taking Care of Baby and Me® program, members are offered the My Advocate® program. This program provides pregnant women proactive, culturally appropriate outreach and education through Interactive Voice Response (IVR). Eligible members receive regular phone calls with tailored content from a voice personality (Mary Beth), or they may choose to access the program via a smartphone application or website. This program does not replace the high-touch case management approach for high-risk pregnant women. However, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high-risk, to facilitate connections between them and our case managers and improve member and baby outcomes. For more information on My Advocate visit **myadvocatehelps.com**.

Amerigroup requires notification of pregnancy after the first prenatal visit and notification of delivery following birth. You must complete the Maternity Care Management Notification Form and fax it to Amerigroup at **866-495-5788**. The notification of delivery form may be completed online or faxed to **800-964-3627**.

Amerigroup also encourages you to complete the Maternity form on Availity Essentials:

- Perform an Eligibility and Benefits (E&B) request on the desired member.
- Choose one of the following benefit service types: maternity, obstetrical, gynecological, or obstetrical/gynecological.
- Before the benefit results screen, you will be asked if the member is pregnant. Choose "Yes", if applicable. If you indicate "Yes" you may provide the estimated due date, if it is known, or leave it blank if the due date is unknown.
- After submitting your answer, the E&B will display. If the member was identified as pregnant, a Maternity form will be generated. You may access the form by navigating to the "Applications" tab and selecting the "Maternity" link.

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

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

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

Our case managers are here to help you. If you have a member in your care that would benefit from OB or NICU case management, please call us at **800-454-3730.** Members can also call our 24-hour Nurse Helpline at 800-864-2544 available 24 hours a day, 7 days a week..

Care coordination
Members from any Population Health program are eligible at any time for care coordination enrollment. Members may benefit from care coordination services when they have short-term, immediate, targeted needs and do not require complex case management services. Additionally, members who have more intensive needs and are appropriate for complex case management but refuse those services may be appropriate for care coordination services. Members engaged in care coordination may receive various interventions including:

- Assistance with resources such as transportation and pharmacy benefits.
- Arranging PCP appointments.
- Telephonic contact for coaching.
- Mailings of disease-specific educational materials.
- Information regarding Amerigroup On Call (24-hour Nurse HelpLine).

Enhanced Care Coordination
Care Coordination for members with an identified unmet social need.

High-Risk Case Management
We administer an initial health risk assessment to members who are identified for and agree to enroll in the Complex Case Management program. The case manager assesses the member's total health care needs in a holistic manner including physical, behavioral, functional, cognitive and social factors. As part of the assessment process, the case manager completes a gap analysis to determine health care needs and prioritize goals. Upon identification of health care needs, the case manager will work with the member, his or her health care providers, and the member's family and caregivers to develop interventions to support the achievement of the identified health goals. Interventions may include:

- Health education.
- Interpretation of benefits.
- Community resource referrals.
- Post-discharge service authorizations and member outreach (e.g., DME, home health services and coordination of physician appointments).
- Service coordination.

- Medication reconciliation review.
- Assistance in developing a self-management plan.
- Community-based services (e.g., home or hospital visits).
- Provider-based intensive case management (behavioral health).
- Special needs program interventions.
- Ongoing assessment of barriers to meeting goals or complying with the care plan.
- Interventions to address those barriers.

Program features:

- Proactive population identification processes
- Program content is based on 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
- Ongoing communication with primary and ancillary providers regarding patient status
- Nine of our Population Health Condition Care programs are National Committee for Quality Assurance accredited and incorporate outreach, education, care coordination and follow-up to improve treatment compliance and enhance self-care.

Additionally, all Amerigroup programs are based on nationally approved Clinical Practice Guidelines located at **provider.amerigroup.com/tn**. Under *Resources*, select **Provider Manuals and Guides**. A copy of the guidelines can be printed from the website or upon request by contacting Provider Services at **800-454-3730**.

Who is eligible?

All Amerigroup members are enrolled in the Population Health's Condition Care program. Members may choose to opt out of the program. Members are stratified within the Population Health program based on overall clinical risk, which considers their age, gender, diagnosis history, service utilization history and self-reported risk factors. We derive this information through continuous case finding efforts, welcome calls and referrals from both internal and external sources.

The Population Health services are provided whether members are well, have an ongoing health problem or have a health episode. Population Health's Condition Care services are available to members depending on individual health risks and need for the service and may include but are not limited to the following:

- Asthma
- Hypertension
- Bipolar disorder
- Major depressive disorder - Adult
- Major depressive disorder – Children and adolescent
- Chronic obstructive pulmonary disease (COPD)
- Obesity/weight management
- Congestive heart failure (CHF)
- Schizophrenia
- Coronary artery disease (CAD)
- Smoking cessation
- Diabetes
- Substance use disorder
- HIV/AIDS

You can refer patients who can benefit from additional education and care management support. Our case managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the cohorts are assessed and stratified based on the severity of their disease. Once enrolled in a cohort, they are provided with continuous education on self-management concepts, which include primary prevention, coaching related by healthy behaviors and compliance/monitoring, as well as case/care management for high-risk members. Providers are given telephonic and/or written updates regarding patient status and progress.

Provider rights and responsibilities
The provider has the right to:

- Obtain information about us on our programs and services, our staff and their qualifications, and any contractual relationships.
- Decline participation in our Population Health program and services for his or her patients.
- Be informed of how we coordinate our population health-related interventions with your patient treatment plans.
- 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 our staff.
- Communicate complaints about population health programs as outlined in our Provider Complaint and Grievance Procedure.

Hours of operation
Our case managers are registered nurses who are available from 8:30 a.m.- 5:30 p.m. local time, Monday-Friday. We also have confidential voicemail available 24 hours a day. The 24-hour Nurse HelpLine is available for our members 24 hours a day, 7 days a week at **800-600-4441**.

Contact information
Please call **800-454-3730** to reach a case manager. Find more information about Population Health's Condition Care by visiting **provider.amerigroup.com/tn**. Members can get information about our Population Health's Condition Care program by visiting **myamerigroup.com/tn** or calling **888-830-4300**.

Submitting provider demographic data requests and roster submissions through roster automation

Use the Provider Data Management (PDM) application on Availity Essentials to verify and initiate care provider demographic change requests for all professional and facility care providers*. Going forward, the PDM application is now the preferred intake tool for care providers to submit demographic change requests, including submitting **roster**

uploads. If preferred, Providers may continue to utilize the Provider Enrollment application in Availity Essentials to submit requests to add new practitioners under existing groups for available provider types.

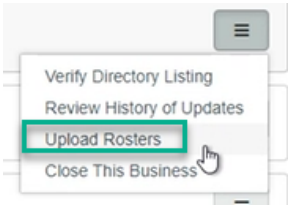
Within the PDM application, Providers have the choice and flexibility to request data updates via the standard PDM experience or by submitting a spreadsheet via a roster upload.

Roster Automation is our new technology solution designed to streamline and automate provider data additions, changes, and terminations that are submitted using a standardized Microsoft Excel document. Any provider, whether an individual provider/practitioner, group, or facility, can use Roster Automation today:**

The resources for this process are listed below and available on our website. Visit **providers.amerigroup.com/TN,** then under For Providers, select Forms and Guides. The Roster Automation Rules of Engagement and Roster Automation Standard Template appear under the Digital Tools category.

- Roster Automation Rules of Engagement: Is a reference document, available to ensure error-free submissions, driving accurate and more timely updates through automation.
- Roster Automation Standard Template: Use this template to submit your information. More detailed instructions on formatting and submission requirements can also be found on the first tab of the Roster Automation Standard Template (*User Reference Guide*).
- Upload your completed roster via the Availity PDM application.

Accessing PDM Application:
Log onto **Availity.com** and select My Providers > Provider Data Management to begin the attestation process. If submitting a roster, find the TIN/business name for which you want to verify and update information. Before you select the TIN/business name, select the three-bar menu option on the right side of the window, and select Upload Rosters (see screen shot below) and follow the prompts.



Availity Administrators will automatically be granted access to PDM. Additional staff may be given access to Provider Data Management by an administrator. To find your administrator, go to My Account Dashboard > My Account > Organization(s) > Administrator Information.

* Exclusions: Any specific state mandates or requirements for provider demographic updates
** If any roster data updates require credentialing, your submission will be routed appropriately for further action.

WIC program
WIC provides specific nutritious supplemental food and nutrition education at no cost to low-income pregnant, postpartum, breastfeeding women, infants and children up to their 5th birthday. They must meet income guidelines, a state residency requirement, and be individually determined to be at nutritional risk by a health professional such as a physician, nutritionist or nurse. WIC serves as an adjunct to good health care. Many TennCare families are WIC recipients. More information about the WIC program is available at **tn.gov/health/health-program-areas/fhw/wic.html**.

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. An example of this could include loss of license. In the case of a mandatory disenrollment of a PCP, members will be auto-assigned to another PCP to ensure that members have continuous access to the TennCare covered services, as appropriate. Amerigroup will notify members of any termination for PCPs or other providers from whom they receive ongoing care.

Amerigroup 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 their 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.

Amerigroup is responsible for submitting notification of all provider disenrollments to the Division of TennCare.

Reporting changes in address and/or practice status
Any status changes are to be reported to:

Provider Relations Department
Amerigroup Community Care
22 Century Blvd., Suite 220
Nashville, TN 37214

12 Member rights and responsibilities

Member rights and responsibilities
Members have rights and responsibilities when participating with an MCO. Our Member Services representatives are advocates for our members. The following lists the rights and responsibilities of members:

Members have the right to:

- Be treated with respect with due consideration for dignity and privacy.
- Participate in Amerigroup without being discriminated against on the basis of handicap and/or disability, age, race, color, religion, sex, national origin, or any other classification protected under applicable federal and state laws.
- Privacy during a visit with their doctor.
- Talk about their medical record with their PCP and ask for a summary of that record and request to amend or correct the record as appropriate.
- Be properly educated about and helped to understand their illnesses and the available health care options.
- Have a candid discussion with their provider of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Participate in 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.
- Be free from any form of restraint or seclusion as a means of coercion, discipline, inconvenience or retaliation as specified in other federal regulations on the use of restraints and seclusion.
- Decide ahead of time the kinds of care they want if they become sick, injured or seriously ill by executing an advance directive.
- Expect that their records (including medical and personal information) and communications will be treated confidentially.
- If under age 18 and married, pregnant or have a child, be able to make decisions about themselves and/or their child's health care.
- Choose their PCP from the Amerigroup network of providers.
- Have information about Amerigroup, its services, 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 provider referral directory.
- Choose any Amerigroup network specialist after getting a referral from their PCPs; 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 PCPs or backups 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 post-stabilization services following an emergency medical condition.
- Call the 24-hour Nurse HelpLine toll free 24 hours a day, 7 days a week at **800-600-4441**.
- Call the Amerigroup Member Services staff toll free from 7 a.m. to 7 p.m. Central time Monday through Friday at **800-600-4441**.
- Know what payment methodology Amerigroup uses with health care providers.
- File a medical appeal with TennCare.
- Freely exercise the right to file a complaint or an appeal without adversely affecting the way members are treated.
- Receive notification to present supporting documentation for their complaints.
- 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 section of this manual.
- Make recommendations regarding the organization's member rights and responsibilities policies.

Members have the responsibility to:

- Treat their doctors, their doctors' staff and Amerigroup employees with respect and dignity.
- Not be disruptive in their doctor's offices.
- 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 doctors and help their doctor complete new medical records as necessary.
- Respect the privacy of other people waiting in doctors' offices.
- Secure referrals from their PCPs, when specifically required, before going to another health care provider unless they have a medical emergency.
- Call Amerigroup to change their PCPs before seeing any new PCPs.
- Make and keep appointments and be on time; members should always call if they need to cancel appointments, change appointment times or if they will be late.
- Discuss complaints, concerns and opinions in an appropriate and courteous way.
- Tell their doctor who they want to receive their health information.
- Obtain medical services from their PCPs.
- Learn and follow the Amerigroup policies outlined in the member handbook.
- Read the member handbook to understand how Amerigroup works.
- Notify TennCare if a family member who is enrolled in Amerigroup has died.
- Notify TennCare if addresses and/or status change.
- Give TennCare proper identification when they enroll.
- 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.
- Carry their Amerigroup ID card at all times and report any lost or stolen cards to Amerigroup quickly; members should contact TennCare of the Tennessee Department of Human Services if there are changes to their name, address or marital status.
- Show their ID cards to each provider.
- Tell Amerigroup about any doctors they are currently seeing.
- Notify their PCPs as soon as possible after they receive emergency services.
- Go to the emergency room when they have an emergency.
- Report suspected fraud, waste and abuse.

Member rights under Title VI of the Civil Rights Act of 1964

Title VI of the Civil Rights Act of 1964 is a federal law that protects members and participants like providers from discrimination based on their race, color or national origin in programs and activities that receive federal financial assistance. If members are eligible for Medicaid, other health care or human services, he/she cannot be denied assistance because of race, color or national origin. The Office for Civil Rights in the U.S. Department of Health and Human Services (DHHS) enforces Title VI as well as other civil rights laws.

Some of the institutions or programs that may be covered by Title VI are:

- Extended care facilities.
- Mental health centers.
- Public assistance programs.
- Senior citizen centers.

- Nursing homes.
- Adoption agencies.
- Hospitals.
- Day care centers.
- Medicaid and Medicare.
- Family health centers and clinics.
- Alcohol and drug treatment centers.

Under federal and state regulations of Title VI of the Civil Rights Act of 1964 and Section 1557 of the Patient Protection and Affordable Care Act, translation or interpretation services needed to effectively communicate with a Limited English Proficiency (LEP) individual are to be provided by the entity at the level at which the request for service is received. The financial responsibility for the provision of the requested language assistance is that of the entity that provides the service. Charges for these services should not be billed to **TennCare[SM]** and it is not permissible to charge a member for these services. The U.S. Department of Health and Human Services issued guidance on preventing discrimination against LEP individuals at: **federalregister.gov/documents/2003/08/08/03-20179/guidance-to-federal-financial-assistance-recipients-regarding-title-vi-prohibition-against-national**.

Providers can find more resources for effectively communicating with individuals and civil rights compliance information at TennCare's Provider Civil Rights Information webpage at:
tn.gov/tenncare/providers/programs-and-facilities/civil-rights-information.html

The U.S. Department of Health and Human Services has health literacy and communication tools and resources at:

- **health.gov/our-work/national-health-initiatives/health-literacy**
- **health.gov/our-work/national-health-initiatives/health-literacy/consumer-health-content/myhealthfinder**

And can also recommend resources for use when LEP services are needed at:
hhs.gov/civil-rights/for-providers/index.html

Prohibited discriminatory acts

There are many forms of illegal discrimination based on a person's status or perceived characteristics like race, , disability, age, or sex that frequently limit the opportunities of individuals to gain equal access to services and health care. Beneficiaries like members and participants like providers of a program receiving federal financial assistance may not, based on status protected under federal and state civil rights laws:

- Be denied services or other benefits provided as a part of health or human service programs.
- Be provided a different service or other benefit or be provided with services in a different manner from those provided to others under the program.
- Be segregated or separately treat members in any matter related to the receipt of any service, financial aid or other benefit.

For information on how to file a complaint of discrimination or to obtain information regarding civil rights in the TennCare program, you may contact:

- Amerigroup: **800-600-4441**
- TennCare Office of Civil Rights Compliance
  More information about civil rights compliance, including forms, policies, and notices can be found online at:
  tn.gov/tenncare/members-applicants/civil-rights-compliance.html
  and **tn.gov/tenncare/providers/programs-and-facilities/civil-rights-**
- Phone: **615-507-6474** or for free at **855-857-1673 (TRS Dial 711)**
  Email: HCFA.fairtreatment@tn.gov
- ¿Habla español y necesita ayuda con esta carta? Llámenos gratis al **855-857-1673**
  U.S. Department of Health & Human Services — Office of Civil Rights
  You can file a complaint online at: **ocrportal.hhs.gov/ocr/portal/lobby.jsf**
  Or find more information at: at **hhs.gov/ocr**

- Call: **800-368-1019** (toll free)
- TDD: **800-537-7697**

The TennCare Discrimination Complaint form in English, Arabic, and Spanish is located in Appendix A.

Member rights under the Nondiscrimination in Health Programs and Activities Final Rule
Amerigroup does not engage in, aid or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color, national origin, disability, age or sex in providing aid, benefits or services to beneficiaries. Amerigroup does not utilize or administer criteria having the effect of discriminatory practices on the basis of a person's status protected under the applicable federal and state civil rights laws.. Amerigroup does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of or subjecting them to discrimination on the basis of on the basis of a person's status protected under the applicable federal and state civil rights laws.. In addition, in compliance with the Age Act, Amerigroup may not discriminate against any person on the basis of age, or aid or perpetuate age discrimination by providing significant assistance to any agency, organization or person that discriminates on the basis of age. Amerigroup provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of sex, race, color, age, religion, national origin, physical or mental disability, other protected statuses, or type of illness or condition.

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when an Amerigroup representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and is assisted in doing so, if the member requests assistance. We document, track and trend all alleged acts of discrimination.

Members are also advised to file a civil rights complaint with TennCare's Office of Civil Rights Compliance ("OCRC"). For more information or to file a complaint with OCRC see:
tn.gov/tenncare/members-applicants/civil-rights-compliance.html
310 Great Circle Road, 3W; Nashville, Tennessee 37243
Email: **HCFA.Fairtreatment@tn.gov** Phone: 855-857-1673 (TRS 711)

Also, information about preventing discrimination is available from the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Through the OCR complaint portal at **ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201
- By phone at: **800-368-1019** (TTY/TTD: **800-537-7697**)

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

Amerigroup provides free tools and services to people with disabilities to communicate effectively with us. Amerigroup also provides free language services to people whose primary language isn't English (e.g., qualified interpreters and information written in other languages). These services can be obtained by calling the customer service number on their member ID card.

If you or your patient believe that Amerigroup has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our nondiscrimination coordinator via:

- Mail: 22 Century Blvd., Suite 220, Nashville, TN 37214
- Phone: **615-316-2400, ext. 22529**
- Email: tn.nondiscrimination@amerigroup.com

Equal program access on the basis of sex
Amerigroup provides individuals with equal access to health programs and activities without discriminating on the basis of sex. Amerigroup must also treat individuals in a manner that is consistent with their gender identity and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association with, a member of a protected class (i.e., race, color, national origin, sex, gender, gender identity, age or disability).

Amerigroup may not deny or limit health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that a different gender was assigned at birth, or because the sex or gender recorded is different from the one in which health services are ordinarily or exclusively available.

Disability Nondiscrimination Laws and their Requirements
Amerigroup policies and procedures are designed to promote compliance with Sections 504 and 508 of the Rehabilitation Act of 1973, Section 1557 of the Patient Protection and Affordable Care Act, and Title II and Title III of the Americans with Disabilities Act of 1990 in the provision services and activities for members and participants with disabilities.. 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:

- Street-level access.
- Elevator or accessible ramp into facilities.
- Access to lavatory that accommodates a wheelchair.
- Access to examination room that accommodates a wheelchair.
- Handicap parking clearly marked unless there is street-side parking.
- The provision of communication assistance in alternative formats, or
- The provision of other mitigating measures like a reasonable accommodation/modification or auxiliary aids and services.

Auxiliary aids or services to ensure effective communication
The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with the method of communication used by the member and/or the member's representative; the nature, length, and complexity of the communication involved; and the context in which the communication is taking place. In determining what types of auxiliary aids and services are necessary, providers shall give primary consideration to the requests of members with disabilities, and/or the member's representative, in accordance with 28 C.F.R. § 35.160 and 28 C.F.R. § 36.303. In order to be effective, auxiliary aids and services must be provided in accessible formats, in a timely manner, and in such a way as to protect the privacy and independence of the individual with a disability. If a member and/or the member's representative requests an auxiliary aid or service that the provider can demonstrate would result in a fundamental alteration in the nature of its services or result in an undue financial and administrative burden, the provider does not have to provide the requested auxiliary aid or service to the member and/or the member's representative. However, if available, the provider shall provide the member and/or the member's representative with another form of an auxiliary aid or service that would achieve effective communication with the member and/or the member's representative and not result in a fundamental alteration in the nature of the provider's services or result in an undue financial and administrative burden.

For more guidance see:

- **ada.gov**
- **ada.gov/taman3.html**
- **hhs.gov/ocr/civilrights/resources/laws/index.html**

Specifications for member materials
All written materials shall be printed with the notice of nondiscrimination and taglines as required by TennCare and set forth in TennCare's tagline template. In addition to any other requirements specified in Section A.2.17 of the CRA, Amerigroup may also provide required member materials/information electronically or on its website pursuant to the specifications set forth in section 2.28.10, TennCare's tagline template, and the following requirements: 1) the material/information must be placed on the Amerigroup website in a location that is prominent and readily accessible for applicants and members to link to from the Amerigroup home page; 2) the material/information must be provided in a format that can be electronically saved and printed; and 3) if a member or applicant requests that Amerigroup mail them a copy of the material/information, Amerigroup must mail free of charge the material/information to them within five days of that request. To the extent that Amerigroup and its providers and/or subcontractors are using electronic and information technology to fulfill its obligations under this contract, the entities shall comply with section 2.28.10.

Non-discrimination training
In compliance with Section 2.28 of the CRA, Amerigroup providers are required to make available nondiscrimination training available to its staff.

Cost-sharing information

Copays
There are no copays or cost-sharing for TennCare enrollees. Copays are due at the time of service and are collected by the health care provider.

For adults who have Medicaid from TennCare and Medicare, Medicare pays first for health care. Then, TennCare Medicaid will pay the part of the service not paid for by Medicare so long as the service is medically necessary and is a TennCare covered service.

Copays for TennCare Standard enrollees with incomes at or above 100 percent of poverty level are similar to commercial copays. To encourage good preventive health habits, there will be no copays for preventive care visits such as:

- Well-child visits
- Immunizations
- Checkups
- Pap smears
- Prostate examinations
- Mammograms
- Family planning services
- Prenatal services

There are no deductibles or annual out-of-pocket (OOP) maximums, which apply to persons with copay obligations.

Members do not have cost sharing responsibilities for TennCare coverage and covered services, except that TennCare Medicaid adults (age 21 and older) who receive pharmacy services have nominal copays for these services. The copays are $3.00 for each branded drug and $1.50 for each covered generic drug. Generic drugs that exceed the limit of five prescriptions or refills per member per month are not covered. Family planning drugs and emergency services are exempt from copays. Members may not be denied a service for inability to pay a copayment. There is no OOP maximum on copays. Copays are administered by the PBM. Please contact the PDM directly for related questions or issues.

The following adult groups are exempt from copays:

- Members receiving hospice services who provide verbal notification of such to the pharmacy provider at the point of service
- Members who are pregnant who provide verbal notification of such to the pharmacy provider at the point of service

- Members who are receiving services in a nursing facility, an intermediate care facility for the mentally retarded or based on a home- and community-based services waiver

Nonpharmacy copay schedule (unless otherwise directed by TennCare)

Poverty level	Copay amounts
0 percent-99 percent	$0.00
100 percent-199 percent	$10.00 Hospital Emergency Room (waived if admitted) $5.00 PCP and Community Mental Health Agency Services Other Than Preventive Care* $5.00 Physician Specialists (including psychiatrists) $5.00 Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode)
200 percent and above	$50.00 Hospital Emergency Room (waived if admitted) $15.00 PCP and Community Mental Health Agency Services Other Than Preventive Care* $20.00 Physician Specialists (including psychiatrists) $100.00 Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode)

** The copay amounts at the community mental health agencies exclude Tennessee Health Link and Intensive Community Based Treatment Services (e.g., CTT, CCFT, PACT).*

Member complaints

TennCare member complaint and appeals processes are compliant with all applicable federal and state laws and regulations. In addition, TennCare operates under a number of federal court orders and consent decrees, certain of which modify and/or enhance federal requirements regarding notice and hearing rights.

Members may file a complaint for causes other than adverse benefit determination taken by Amerigroup to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of Amerigroup that impair the quality, timeliness or availability of such benefits. A member has the option of filing an appeal at every step of the complaint process (see Chapter 13, Adverse Actions/Appeals). For complaints related to allegations of discrimination, see the Prohibited Discriminatory Acts section of this chapter.

When a complainant member notifies Amerigroup in writing or orally of a complaint, Amerigroup fully investigates each complaint and documents the substance of the complaint, including any aspect of clinical care involved. The Amerigroup member complaint specialist oversees and coordinates the member complaint process. Amerigroup has educated its staff concerning the importance of the complaint procedure, the rights of the member and the time frames, including clinically urgent situations in which action must be taken by Amerigroup regarding the handling and disposition of a complaint.

The complainant member, within five business days of Amerigroup receipt of a complaint, is sent an acknowledgement letter, which includes any requests for additional information necessary to investigate the complaint. The total time for an Amerigroup investigation and resolution of the complaint will be within 90 calendar days from the date Amerigroup receives the initial complaint from the complainant member. A clinically urgent complaint will be handled in 72 hours. If delays are outside of the control of Amerigroup (e.g., the result of the third party's failure to provide documentation in a timely fashion or awaiting response from the complainant for additional information), Amerigroup may extend the time to respond for up to an additional 14 calendar days if within the

original time frame, Amerigroup demonstrates in writing to the complainant reasonable cause for the delay beyond its control and provides a written progress report.

Amerigroup ensures that a complaint is resolved by individuals who are not directly or indirectly involved in the action or inaction, which gave rise to the complaint. After Amerigroup investigates the complaint, Amerigroup issues a resolution letter to the complainant member explaining the Amerigroup resolution. The letter will include:

- A statement of the specific contractual reasons for the resolution.
- The facts established in relation to the complaint.
- The actions, if any, that Amerigroup has taken or will take in response to the complaint.

A copy of the resolution letter will be provided to:

- Any provider identified in the complaint upon request.
- The TennCare Administration or ombudsman program representative if Amerigroup received the complaint from the state.

Complaint tracking and reporting

Upon receipt of a member complaint, Amerigroup will track the complaint through its system including tracking of all materials/records requested and received, communications with applicable parties, and all required correspondence. Complaint trending data will be reported on a quarterly and annual basis to the Quality Management Committee to identify trends and patterns for intervention. The report provides a written summary analyzing the categories of complaints, brief statements of the problem, resolution and resulting corrective actions as required.

Records will include:

- Date complaint filed.
- Date and outcome of all actions and findings.
- Date and decision of any complaint proceedings.
- Date and proceedings of any litigation.
- All letters and documentation submitted regarding the complaint.

Amerigroup maintains a complaint log categorized by cause and disposition and including length of time for resolution of each complaint. Amerigroup compiles information from the complaint log for use by the Quality Management Committee.

Complaints will be categorized by cause (according to NCQA-required reporting categories) including:

- Billing and financial or plan administration (e.g., marketing, EOBs sent to members, policy holder service or similar administrative functions, member balance billing).
- Attitude and service issues with the treating physician or provider care (e.g., lack of courteous treatment).
- Access (e.g., participating provider lacked available appointments).
- Quality of care concerns.
- Quality of provider office site (e.g., lack of wheelchair accessibility, office and/or exam rooms are dirty, office is cluttered and unorganized, etc.).

Documentation for all complaints and actions taken are maintained for a period of 10 years from the date of the receipt of the complaint. The member has a right to a copy of the complaint record within 30 calendar days of the request.

The Quality Management department will maintain complaint records and keep them readily available for state inspection.

Member appeals
Please see Adverse Action section in Section 13, Medical Management.

13 MEDICAL MANAGEMENT

Medical review criteria
Effective May 1, 2013, Amerigroup medical policies, which are publicly accessible from its subsidiary website, became the primary benefit plan policies for determining whether services are a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive for Amerigroup subsidiaries. The website is: **medicalpolicies.amerigroup.com/wps/portal/agpculdesac?content_path=amerigroup/noapplication/f1/s0/t0/pw_e216383.htm&na=onlinepolicies&rootLevel=0&label=Overview**.

Amerigroup utilizes the following criteria for behavioral health and medical health services:

Behavioral health services	Criteria
All requests: outpatient, inpatient, and concurrent reviews	MCG Care Guidelines
Medical health services	**Criteria**
Outpatient	Amerigroup Medical Policies and Clinical Utilization Management Guidelines and Carelon Medical Benefits Management, Inc. Clinical Guidelines
Inpatient site of service	MCG Care Guidelines
Inpatient concurrent reviews	MCG Care Guidelines Long-Term Acute Care, Acute Inpatient Rehabilitation and Sub/Acute Skilled Nursing Facility MCG Care Guidelines — Acute Inpatient
Outpatient health home care	Amerigroup Medical Policies and Clinical Utilization Management;
Outpatient rehabilitation and chiropractic	Amerigroup Medical Policies and Clinical Utilization Management Guidelines, Carelon Medical Benefits Management Clinical Guidelines, CMS guideline LCD L37254 Local Coverage Determination for Chiropractic Services

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

MCG Care Guidelines are used for non-behavioral acute in-patient concurrent and continued stay review determinations. MCG Care Guidelines, in addition to the Amerigroup Medical Policies and Clinical Utilization Management Guidelines are also used by the Utilization Management clinicians to determine clinical appropriateness and medical necessity for the pre-certification of scheduled and elective admissions. MCG Care Guidelines is used for all Long-Term Acute Care, Acute Inpatient Rehabilitation and Sub/Acute Skilled Nursing Facility initial and concurrent reviews.

Amerigroup also works with network providers to develop clinical guidelines of care for its membership. The Medical Advisory Committee (MAC) assists Amerigroup in formalizing and monitoring guidelines.

Determinations of medical necessity are made on a case-by-case basis in accordance with the TennCare Program definition of medical necessity. Tenn. Code Ann. §71-5-144 and Tenn. Comp. R. & Regs. 1200-13-16-.05 To be determined to be medically necessary or a medical necessity, a medical item or service must be recommended by a physician who is treating the member or other licensed health care provider practicing within the scope of the physician's license who is treating the member and must satisfy each of the criteria outlined in the Medically

Necessary Services — Medical Necessity section of this manual. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

Amerigroup may deny services that are noncovered except as otherwise required by TennCare Kids or unless otherwise directed to provide by TennCare.

All medically necessary services will be covered for members less than 21 years of age in accordance with TennCare Kids requirements.

If precertification of a service is granted by Amerigroup, payment for the precertified service will not be denied based on the lack of medical necessity, assuming that the member is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances, which were described at the time that precertification was granted.

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

Practitioners may obtain Utilization Management (UM) criteria upon request. If a medical necessity decision results in an adverse determination, practitioners may discuss the denial decision with an Amerigroup medical director by contacting Provider Services at **800-454-3730**.

It is the policy of Amerigroup to make available to treating practitioners a physician-to-physician (P2P) review to discuss by telephone determinations based on medical appropriateness. A physician-to- physician discussion can be arranged by calling Utilization Management at **615-232-2121** Monday-Friday from 7 a.m.-5 p.m. CT. Provider office staff should only initiate a physician-to-physician discussion with one of our medical directors when the attending or ordering physician requests. A Physician Assistant or Nurse Practitioner is allowed to speak on behalf of the doctor that is treating the member.

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

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 request. "Prospective" means that the service request occurred prior to the provision of the service being provided. "Notification" is the telephonic, facsimile, or electronic communication received from a provider informing Amerigroup of the intent to render covered medical services to a member prior to the rendering of such services. There is no review against medical necessity criteria. However, member eligibility and provider status (network and non-network) are verified. The purpose of notification is to identify members who may benefit from case management such as members who require high-risk obstetrics.

If Amerigroup requires members to obtain PCP referral, Amerigroup may exempt certain services identified in the Amerigroup member handbook from PCP referral.

If a service requires precertification/notification, the provider must contact Amerigroup via phone, facsimile, or electronic communication to either obtain approval or provide the notification prior to the rendering of services. All relevant clinical information needed to determine medical necessity must be included in the request for prior authorization for a decision to be made. See Section 14 for more detailed information regarding utilization management processes for hospital and elective admission processes.

Please refer to the Precertification Lookup Tool (PLUTO) on our website for information on coverage and precertification requirements. If no precertification is required per PLUTO for In-Network providers Amerigroup will not review for medical necessity**. Note:** Out of network, in-patient admissions, and/or procedures done in an in-patient setting, require precertification or authorization.

For members determined to need a course of treatment or regular care monitoring, Amerigroup allows members to directly access a specialist via PCP referral/extended referral as appropriate for the members' condition and identified needs.

Amerigroup will not require that a woman go in for an office visit with her PCP to obtain the referral for prenatal care.

Referral provider listing
Amerigroup provides all PCPs with a current hard copy listing of referral providers, including behavioral health providers at least 30 calendar days prior to the start date of operations. Thereafter, Amerigroup will mail PCPs an updated version of the listing on a quarterly basis. Amerigroup will also maintain an updated electronic, web-accessible version of the referral provider listing.

Exceptions to precertification and/or referrals

Other health insurance
If Member has Other Health Insurance (OHI) excluding Dual members that have Medicare and Medicaid with Amerigroup, no authorization should be built as the member's OHI insurance is primary and responsible for payment. Home Health Care is also Excluded from the (OHI) Exception.

Emergency and Post-Stabilization Care Services
Amerigroup provides emergency services without requiring precertification or PCP referral regardless of whether these services are provided by a contract or noncontract provider. Amerigroup provides post-stabilization care services.

TennCare Kids
Amerigroup does not require precertification or PCP referral for the provision of TennCare Kids screening services.

Access to women's health specialists
Amerigroup will allow female members direct access (without requiring a referral) to a women's health specialist who is a contract provider for covered services necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

Behavioral health services

Amerigroup does not require a PCP referral for members to access a behavioral health provider.

Transition of new members
Amerigroup provides for the continuation of medically necessary covered services regardless of precertification or referral requirements. However, in certain circumstances, Amerigroup may require precertification for continuation of services beyond the initial 30 days.

Clinical practice guidelines
Using nationally recognized standards of care, Amerigroup works with providers to develop clinical policies and guidelines for the care of its membership. The Medical Advisory Committee (MAC) oversees and directs Amerigroup in formulating, adopting, and monitoring guidelines.

Clinical guideline forms are located online at **provider.amerigroup.com/tn**. Amerigroup selects at least four evidence-based clinical practice guidelines that are relevant to the member population. Amerigroup will measure performance against at least two important aspects of each of the four clinical practice guidelines annually.

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 any medical or surgical means or procedures calculated to prolong his or her life either provided, withheld, or withdrawn. 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 Tennessee Health Care Decisions Act, Tenn. Code Ann. Sections 68-11-1801 *et. seq*., and the Tennessee Right to Natural Death Act, Tenn. Code Ann. Sections 32-11-101 *et. seq.* and maintains written policies and procedures regarding advance directives. Advance directives are documents signed by competent persons giving direction to health care providers about treatment choices under certain circumstances. An advance directive, an Appointment of Health Care Agent or other instrument signed by the individual complying with the terms of Tenn. Code Ann. Sections 32-11-101 *et. seq.*, or a durable power of attorney for health care complying with the terms of Tenn. Code Ann. Sections 34-6-part 2, will be given effect and interpreted in accord with those respective acts. Any advance directive that does not evidence an intent to be given effect under those acts but that complies with Tenn. Code Ann. Section 68-11-1803 may be treated as an advance directive under the law. See also https://www.tn.gov/health/health-program-areas/health-professional-boards/hcf-board/hcf-board/advance-directives.html.

Member Services and outreach associates encourage members at their first appointment with their PCP to request an *Advance Directive* form and to seek education on advance directives.

Amerigroup will provide its policies and procedures to all members 18 years of age and older and will educate members about their ability to direct their care using this mechanism. Amerigroup will designate staff members and/or providers responsible for providing this education. Neither Amerigroup nor its providers will discriminate or retaliate based on whether a member has or has not executed an advance directive.

Amerigroup, for behavioral health services, will provide its policies and procedures to all members 16 years of age and older and will educate members about their ability to direct their care using advance directives including the use of Declarations for Mental Health Treatment. Amerigroup will designate staff members and/or providers responsible for providing this education.

While each member has the right, without condition, to execute an advance directive, a facility or an individual physician may conscientiously object to an advance directive under certain limited circumstances.

Member services and outreach associates will answer questions about advance directives. No associate of Amerigroup may give legal advice or serve as witness to an advance directive or as a member's designated agent or representative.

A *Living Will* form is in Appendix A along with educational member information and forms for an Advanced Care Plan and an Appointment of a Health Care Agent.

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

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

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

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

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

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

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

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

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

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

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

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

Patient safety

Amerigroup promotes patient safety in all aspects of care and treatment and believes that communication is a powerful tool in improving patient safety. Providers are encouraged to educate themselves and their members on actions that can be taken to improve safety. Providers can take some of the following actions to support patient safety:

- Use approved Clinical Practice Guidelines to ensure safe and appropriate care and treatment
- Identify at-risk members and use available screening tools to intervene appropriately
- Update and review members' medications including over the counter medications at each health care encounter
- Communicate legibly and clearly when writing prescriptions and when using telephonic prescribing; completely spell the medications and clearly state the prescribing instructions; adhere to The Joint Commission's official Do Not Use list of abbreviations and symbols: **jointcommission.org/facts_about_do_not_use_list**
- Keep legible and organized medical records and follow Amerigroup documentation and Medical Record Keeping Standards
- Review lab, radiology, and other diagnostic tests when they are received and notify members of the results in a timely manner
- Encourage members to be actively involved in their care, to ask questions and share any concerns they have about following prescribed treatments
- Communicate effectively with other providers with whom you are involved in concurrently treating members

- Keep informed about the quality performance of contracted hospitals within your network by reviewing the comparison data compiled by the Leapfrog Group's Hospital Quality and Safety Survey: **leapfroggroup.org**
- Report quality of care concerns at **State of Tennessee website for reporting safety issues – Health Care Facility Section**

Notices of adverse benefit determinations/benefit appeals

Adverse benefit determinations

The Amerigroup medical director or designee, a licensed physician, will make all decisions for adverse benefit determinations. The reviewer must have appropriate clinical expertise in treating the member's condition or disease.

The decision regarding an authorization request for service must be made within 14 calendar days for standard request or 72 hours for expedited. TennCare may approve an extension for a standard authorization up to 14 additional days (48 additional hours for an expedited authorization request) if the extension is in the best interest of the member.

For adverse benefit determinations, both the use of explicit medical criteria and the process of daily review by an Amerigroup medical director assure consistency in the determination of medical necessity.

Notification of adverse benefit determination
If the decision is to deny, delay, reduce, suspend, or terminate services, a notification to the member must be made in writing. The notification is based on the TennCare approved templates and includes:

- Service type and amount.
- Identity of prescriber.
- Reason(s) for the proposed action, including specific facts personal to the beneficiary.
- Plan and concise statement of cited legal or policy basis that is consistent with federal law, the TennCare waiver, rules, and contract provisions.
- Official legal citation.
- Member appeal rights.
- When the decision is deemed medically necessary, identity of the consulting clinician, medical records used to make the determination, unmet medical necessity criteria and explanation regarding the evidentiary weight given the treating physician's opinion.
- Readable explanation of discharge plan or description of specific arrangements in place to provide for continuing care (if applicable).

The attending physician and/or other ordering health care provider, the facility rendering service, and the member will be notified 10 business days prior to an adverse benefit determination by Amerigroup that reduces, suspends, or terminates ongoing services (except for inpatient hospital treatment). In instances of Amerigroup-initiated reduction, termination or suspension of psychiatric inpatient hospital treatment, the notice must be provided to a member at least two business days in advance of the proposed action.

In instances of any provider-initiated reduction, termination or suspension of the following services, the notice must be issued by said provider to a member at least two business days in advance of the proposed action:

- Any behavioral health service for a severely and/or persistently mentally ill (SPMI) adult member or seriously emotionally disturbed (SED) child
- Any inpatient psychiatric 24-hour or psychiatric residential service
- Any service being provided to treat a patient's chronic condition across a continuum of services when the next appropriate level of medical service is not immediately available
- Home health services

How to submit a request for generating a Provider Initiated Notice (PIN) to Amerigroup?
Log in to our secure provider website and download a copy of the *PIN Request* form. Access it by selecting the **Downloadable Forms** link in the *Office Support* drop-down menu.

Fill in the form and submit it via one of the following options:
Fax to **877-579-6674**
Email to tn1pin@amerigroupcorp.com or tn1pin@amerigroup.com

Once we receive the completed *PIN Request* form, Amerigroup will generate the appropriate letter and PIN waiver. The Provider Initiated Notice and the Waiver are faxed to the provider to hand deliver to the member. If the member has been discharged, the Provider Initiated Notice and the Waiver are mailed to the member at the address of record. The provider should review the Provider Initiated Notice and Waiver with the member. The provider is responsible for ensuring the member receives the letter and the waiver if inpatient. If the member chooses to waive the Grier days, the provider shall submit the signed waiver to Amerigroup. Providers should not generate a generic wavier in lieu of a PIN form.

Benefit appeal — reconsideration
Members have the right to file benefit appeals regarding adverse benefit determinations taken by Amerigroup. Appeal means a member's right to contest, verbally or in writing, any adverse benefit determinations taken by Amerigroup to deny, reduce, terminate, delay, or suspend a covered service and any other acts or omissions of Amerigroup that impair the quality, timeliness or availability of such benefits.

Amerigroup ensures that punitive action is not taken against a provider who files an appeal on behalf of a member with the member's written consent, supports a member's appeal, or certifies that a member's appeal is an emergency appeal and requires an expedited resolution in accordance with TennCare policies and procedures.

Amerigroup will include a clear and understandable description of the method to appeal an adverse benefit determination in member handbooks, in provider manuals and through **provider.amerigroup.com/tn**.

Upon request, Amerigroup will provide members a TennCare approved appeal form(s).

Amerigroup will provide reasonable assistance to all appellants during the appeal process.

Members and their representative(s), including a member's provider, have 60 calendar days from receipt of the adverse benefit determination in which to file an appeal. The member may use the TennCare Medical Appeal form, but it is not required.

The member or member's representative will file an appeal of an adverse benefit determination with TennCare Member Medical Appeals (TMMA):

TennCare Member Medical Appeals
P.O. Box 000593
Nashville, TN 37202-0593
Fax: **888-345-5575**
Phone: **800-878-3192**
TTY/TDD: **866-771-7043**
Español: **800-878-3192**

TMMA will forward any valid factual disputes to Amerigroup for reconsideration. An *On Request Report* will be faxed to Amerigroup by TMMA requesting reconsideration of the member's appeal.

Notification of appeal reconsideration
In addition to the information indicated in the notification of adverse benefit determination section of this procedure, the following will also be included in the notice of the appeal reconsideration:

- The results of the resolution process and the date the decision was completed. The member's right to request continuation of benefits during the appeal to the state's fair hearing process and that the member may be held liable for the cost of those continued benefits if the state fair hearing decision upholds the Amerigroup decision.

Member eligibility and eligibility-related grievances and appeals including termination of eligibility, effective dates of coverage, and the determination of premium and copay responsibilities will be directed to the Department of Human Services.

The medical director who reviews the clinical documentation for the appeal cannot be a subordinate of the reviewer who made the initial adverse benefit determination and must not have been involved in making the original denial.

The reconsideration of the adverse benefit determination previously made includes at least one practitioner in the same or similar specialty, including chiropractic, that typically manages the medical or dental condition, procedure, or treatment under discussion for review of the adverse benefit determination, unless otherwise indicated by the state.

The review will be conducted by an actively licensed, practicing medical doctor, doctor of osteopathy or doctor of dental surgery not involved in the initial determination.

Amerigroup is responsible for eliciting pertinent medical history information from the treating health care provider(s) for the purpose of making medical necessity coverage determinations. Amerigroup will take action (e.g., sending a provider representative to obtain the information and/or discuss the issue with the provider, imposing financial penalties against the provider for failure to request, etc.), to address the problem if a treating health care provider is uncooperative in supplying needed information. Amerigroup will make documentation of such action available to TennCare, upon request. Providers who do not provide requested medical information for purposes of making a medical necessity determination for a particular item or service will not be entitled to payment for the provision of such item or service.

Continuation or reinstatement of services
The following services or benefits are subject to continuation or reinstatement if all applicable conditions are met:

- Those covered services currently or most recently provided to a member
- Those services being provided to a member in an inpatient psychiatric facility or residential treatment facility where the discharge plan has not been accepted by the member or appropriate step-down services are not available
- Those services being provided to treat a member's chronic condition across a continuum of services when the next appropriate level of covered services is not available
- Those services prescribed by the member's provider on an open-ended basis or with no specific ending date where Amerigroup has not reissued precertification
- A different level of covered service offered by Amerigroup and accepted by the member for the same illness or medical condition for which the disputed service has previously been provided

For the services noted above, the member has the right to continue (or have reinstated) services pending final resolution of an appeal if the member appeals and requests:

- Continuation of services within 10 days of the receipt of notice of action to terminate, suspend or reduce other ongoing covered services. The member must provide written consent for the provider to request Continuation of Benefits.

For all other timely requests for continuation or reinstatement requests for covered services, the services will be continued or reinstated pending appeal only if they are prescribed by the member's treating clinician.

Services will not be continued but may be immediately reduced, terminated, or suspended if the services are determined medically contraindicated.

*Continuation or reinstatement of services does not apply to CoverKids Member Appeals.

Standard appeal
The total time for an Amerigroup reconsideration of the appeal will not be more than 14 calendar days from the date Amerigroup receives appeal from the TMMA. Amerigroup provides a written notice of the outcome of the reconsideration to TMMA, and the member is notified.

If Amerigroup completes the reconsideration and overturns its previous action and approves the service, corrective action will be provided within 72 hours. If Amerigroup completes the reconsideration and upholds its earlier denial, in whole or in part, the state then proceeds with its review of the reconsideration response, including review of the timeliness of the member's initial request for precertification of the service (if applicable) and review of the initial notice of adverse benefit determination to the member.

Expedited appeals
An expedited appeal process is available for adverse benefit determinations related to time-sensitive care. Care qualifies as time-sensitive if the acute presentation of this medical condition is of sufficient severity that the absence of a decision within three business days could seriously jeopardize the enrollee's life; physical health; mental health; or their ability to attain, regain or maintain full function.

For internal purposes, Amerigroup must determine if the appeal is considered expedited. If the appeal is considered expedited, Amerigroup has 72 hours to respond to TennCare with the reconsideration decision. However, if the appeal is not considered expedited, it will be downgraded to an Standard appeal timeframe.* If Continuation of Benefits has been approved, the appeal will be processed as a "COB Approved" appeal.

A physician or provider who has not previously reviewed the case will conduct the review. The physician or provider will be the same or a similar specialty as one that typically manages the medical condition, procedure, or treatment under review. He or she will have no direct financial interest or connection with the case. The physician or provider will review and render a final decision. The review may include an interview of the patient or patient's representative.

The Amerigroup time frame in which the reconsideration of an expedited appeal must be completed is based on the medical or dental immediacy of the condition, procedure, or treatment, but may not exceed three calendar days from the date the reconsideration request is received from TMMA. If Amerigroup upholds its original adverse benefit determination through its reconsideration process, the state then proceeds with its review of the reconsideration response, including review of the timeliness of the member's initial request for precertification of the service (if applicable) and review of the initial notice of adverse benefit determination to the member.

For internal purposes, Amerigroup has five calendar days to respond to the Division of TennCare for a "COB Approved" appeal reconsideration.

A physician or provider who has not previously reviewed the case will conduct the review. The physician or provider will be the same or a similar specialty as one that typically manages the medical condition, procedure, or treatment

under review. He or she will have no direct financial interest or connection with the case. The physician or provider will review and render a final decision. The review may include an interview of the patient or patient's representative.

The Amerigroup time frame in which the reconsideration of a "COB Approved" appeal must be completed is based on the medical or dental immediacy of the condition, procedure, or treatment, but may not exceed five calendar days from the date the reconsideration request is received from TMMA. However, Amerigroup may request an extension if additional time is required to obtain a member's medical/dental records.

Care is not time sensitive, and an appeal is not expedited if the member's treating physician certifies in writing that the matter is not time sensitive.

If Amerigroup upholds its original adverse benefit determination through its reconsideration process, the state then proceeds with its review of the reconsideration response, including review of the timeliness of the member's initial request for precertification of the service (if applicable) and review of the initial notice of adverse benefit determination to the member.

Request for correction of a defective notice
When a notice of adverse benefit determination that has been issued by Amerigroup is determined to be defective, the state sends an *On Request Report* to Amerigroup, identifying the notice defect(s) and requesting submission of a corrected notice that cures the deficiencies of the notice to the state within two business days for review/approval prior to issuance to the member. The state is bound by the original notice of adverse benefit determination or, if a corrected notice has been issued, by the corrected notice at hearing.

Medicaid fair hearing
If the state upholds the Amerigroup reconsideration determination, the member's appeal is automatically forwarded to TennCare and docketed for fair hearing before an Administrative Law Judge (ALJ).

Neither Amerigroup nor TennCare will prohibit or discourage any individual from testifying on behalf of a member.

If the ALJ rules in favor of the member, a directive is issued to Amerigroup for the requested service. Implementation of the corrective action and proof of such action must be submitted to the Directive Services Unit within 72 hours except upon demonstration of good cause.

TennCare may develop additional appeal process guidelines or rules, including requirements as to content and timing of notices to members, which will be followed by Amerigroup. However, Amerigroup will not be precluded from challenging any judicial requirements; and to the extent judicial requirements that are the basis of such additional guidelines or rules are stayed, reversed or otherwise rendered inapplicable, Amerigroup will not be required to comply with such guidelines or rules during any period of inapplicability.

Demonstration of good cause
Good cause is limited to circumstances that are beyond the control of Amerigroup and that have been shown, based on documented diligent efforts to implement the decision, to prevent its timely implementation. Good cause may also be requested if Amerigroup believes the directive requires the provision of a medical item or service that is medically contraindicated for the member. Such request must then include documentation that supports the Amerigroup finding of medical contra-indication for review by the TennCare Office of the Medical Director (OMD).

A good cause request for extension of the 72-hour timeline for implementation of corrective action must be submitted in writing to the DSU and must be received by the DSU on or before the compliance date along with documentation of diligent efforts to provide corrective action within five calendar days or documentation that supports a finding of medical contraindication. If the good cause request is approved by the OCCP (or, in the case of

contraindication, by the OMD), written notification including a revised compliance date, if applicable, will be provided.

Single state agency review and final agency action
Pursuant to Section 1902(a)(3) of the Social Security Act and federal regulations at 42 C.F.R. 431, subpart E., the single state agency must retain the authority to review or overturn the decisions of nonagency hearing officers when contrary to applicable law, regulations or agency policy interpretations.

An ALJ order is not, therefore, deemed final pending review and final agency action by the single state agency in order to determine whether such ruling is contrary to applicable law, regulations or agency policy interpretations, including decisions regarding the defined package of covered benefits, determinations of medical necessity, and decisions based on incorrect interpretation/application of the TennCare Rules. Review by the single state agency does not relieve Amerigroup of its responsibility to implement prompt corrective action within five calendar days of a decision in favor of the member. However, to the extent that the ruling is subsequently determined by the state to be contrary to applicable law, regulations or agency policy interpretations, the state will not be prohibited from taking timely final agency action and immediately implementing such order to reduce, suspend or terminate such service for which corrective action had been provided since the fifth day from issuance of the order by the ALJ.

TennCare Member Medical Appeals
P.O. Box 000593
Nashville, TN 37202-0593
Fax (toll free): **888-345-5575**

Member Appeals tracking and reporting
Upon receipt of an *On Request Report* (*ORR*) from the TennCare Member Medical Appeals, Amerigroup will track the appeal through its core processing and document management systems including tracking of all materials and records requested and received, communications with applicable parties, and all required correspondence. Appeals and data will be trended through our Quality Management department. Appeals trending data will be reported on an annual basis to the Quality Management Committee (QMC) meeting.

Records will include:
- Date filed.
- Date and outcome of all actions and findings.
- Date and decision of any appeal proceeding.
- Date and proceedings of any litigation.
- All letters and documentation submitted regarding the appeal.

The Amerigroup appeal system modules will categorize by cause and disposition and include length of time for resolution of each appeal.

Documentation for all appeals and actions taken are maintained for a period of six years from the date of the receipt of the *ORR*. The member has a right to a copy of the record within 30 calendar days of the request.

Amerigroup requires providers to display notices of members' rights to appeal adverse benefit determinations affecting services in public areas of each facility in accordance with TennCare rules and regulations. Amerigroup will ensure that providers have correct and adequate supply of public notices.

Permitted sanctions
Amerigroup may impose sanctions for a provider's failure to comply with contractual and/or credentialing requirements, or failure or refusal to respond to the request for information by Amerigroup including credentialing documentation, medical records and other records demonstrating the medical care provided to members. At the

discretion of Amerigroup or by specific directive of TennCare, Amerigroup may impose sanctions against the provider as appropriate generally in accordance with the following chart:

Examples of permitted sanctions

Program issues	Damage
Failure to comply with the TennCare Contractor Risk Agreement and federal rules/law regarding sterilizations/abortions/hysterectomies	$500 per occurrence or the actual amount of any federal penalty for the failure of Amerigroup to comply, whichever is greater
Failure to provide coverage for prenatal care without a delay in care	$500 per day per occurrence for each calendar day that care is not provided in accordance with the terms of this Agreement
Failure to provide a timely and complete response to a TennCare request for Amerigroup's internal Appeal file or for Appeal related documentation, such as notices issued to enrollee, medical records, and prior authorization requests and decisions.	$500 per calendar day Amerigroup is in default
Failure to provide a written discharge plan or provision of a defective discharge plan from a psychiatric inpatient facility or mental health residential treatment facility	$1,000 per occurrence per case
Failure to timely provide an approved service as required in this Agreement or required by or within reasonable promptness; or failure to issue appropriate notice of delay with documentation upon request of ongoing diligent efforts to provide such approved service	The cost of the services not provided plus $500 per day per occurrence for each day: 1. Approved care is not provided timely 2. Notice of delay is not provided and/or Amerigroup fails to provide upon request sufficient documentation of ongoing diligent efforts to provide such approved service
Failure to comply in any way with encounter data submission requirements (excluding the failure to address or resolve problems with individual encounter records in a timely manner as required by TennCare)	Up to $25,000 per occurrence depending on the circumstances
Failure to (1) provide an approved service timely, i.e., in accordance with timelines specified in this Contract, or when not specified therein, with reasonable promptness; or (2) issue appropriate notice of delay with documentation upon request of ongoing diligent efforts to provide such approved service	The cost of services not provided plus $500 per day, per occurrence, for each day: 1. that approved care is not provided timely; or 2. notice of delay is not provided and/or Amerigroup to provide upon request sufficient documentation of ongoing diligent efforts to provide such approved service

Program issues	Damage
Failure to review nursing and aide care notes and the results of face-to-face assessments, including care coordination or case management visits conducted by Amerigroup prior to the reduction of any covered home health or private duty nursing services prescribed by a treating physician for a chronic condition, or to provide such documentation which supports Amerigroup medical necessity determination to TENNCARE upon request.	The cost of home health or private duty nursing services not provided plus $500 per day, per occurrence, for each day that care was not provided (i.e., denied or reduced)
Failure to address or resolve problems with individual encounter records in a timely manner as required by TennCare	An amount equal to the paid amount of the individual encounter record(s) that was rejected or, in the case of capitated encounters, the fee-for-service equivalent thereof as determined by TennCare

Amerigroup retains the right to impose sanctions on a provider in an amount up to the amount assessed by any regulatory agency for any Amerigroup deficiency that is directly caused by that provider's actions or omissions. Amerigroup will retain a record of the sanctions imposed as required by TennCare.

14 Service authorizations

Hospital and elective admission management
Amerigroup requires precertification of all inpatient elective and/or planned admissions. The referring or specialty physician identifying the need to schedule a hospital admission must then submit the request for precertification. 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 can be done via the secure provider website **Availity.com** or faxing the information into the health plan. 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 individual's health care needs and medical history in conjunction with Tennessee's medical necessity criteria along with MCG Care Guidelines. Depending on the requested procedure(s) and/or CPT code(s) Carelon Medical Benefits Management Guidelines may be utilized. Provider should utilize Precertification Look-Up Tool (PLUTO) available via provider portal to determine appropriate process for submission of request, i.e. (Interactive Care Reviewer (ICR) Provider Portal).

Notification or Request Prior Authorization
The quickest, most efficient way to request prior authorization is through Availity Essentials at **Availity.com**. Through this secure multi-payer platform, you can access the digital authorization application, which offers a streamlined and efficient experience for providers requesting inpatient and outpatient behavioral health services for Amerigroup members. Providers can also use this applicationto inquire about previously submitted requests regardless of how they were submitted (phone, fax, or other online tool).

- **Initiate preauthorization requests online**, eliminating the need to fax. The digital authorization applicaiton allows detailed text, photo images and attachments to be submitted along with your request.
- **Review** requests previously submitted via phone, fax, or other online tool.
- **Instant accessibility** from almost anywhere, including after business hours.
- **Utilize the dashboard** to provide a complete view of all utilization management requests with real-time status updates.
- **Real-time results** for some common procedures.
- **Access the digital authorization application from the Patient Registration menu on Availity Essentials home page.** Select *Authorizations and Referrals.*.
- **Enhanced Analytics** that can provide immediate authorizations for certain higher levels of care
- **Increased Efficiency** so that use of fax is no longer needed

For an optimal experience with the digital authorization application, use a browser that supports 128-bit encryption. This includes Microsoft Edge, Chrome or Firefox.

You may also request authorizations for inpatient mental health services via the Availity Essentials secure multi-payer platform , 24/7, 365 days a year. Please be prepared to provide clinical information in support of the request. See Behavioral Health Services (section 9) for additional information. Fax forms are on our website at **providers.amerigroup.com/TN**. Our website will be updated as additional functionality, and lines of business are added throughout the year.

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 appropriate guidelines, 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.

Amerigroup will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness or condition.

Amerigroup may deny services that are not covered except as otherwise required by TennCare Kids or unless otherwise directed to provide them by TennCare and/or an Administrative Law Judge.

All medically necessary services will be covered for members under 21 years of age in accordance with TennCare Kids requirements.

If medical necessity criteria for the admission are not met on the initial review, the medical director may attempt to contact the requesting physician to discuss the case. The provider will be asked in this instance to provide further explanation and/or evidence in support of the requested service and the medical director will evaluate the new information considering the member's individual circumstances. If the provider fails to provide additional justification or the additional justification fails to cure the original deficiency, the medical director may issue a denial of coverage.

If the precertification documentation is incomplete or inadequate, the precertification nurse will not approve coverage of the request but will notify the referring provider to submit the additional necessary documentation. Again, the provider will be asked to provide further information as described above.

If the medical director denies coverage of the request, the appropriate notice of action (including the member's appeal rights) will be faxed to the requesting provider and mailed to the member within mandated time frames.

Newborn authorization requirements
Only non-normal newborn inpatient services require an authorization. When billing non-normal newborn level of care, the required approved authorization must be on file for us to consider the claim for non-normal newborn reimbursement.

For newborn inpatient claims billing services other than a normal newborn admission for which there is no authorization on file, reimbursement will equal the normal newborn rate (DRG 795) if the mother's delivery admission is authorized and on file.

Newborn claims for which neither the mother nor the newborn have an authorization on file will be denied for no authorization. Normal newborns do not require authorization. These claims will be processed under the mother's approved authorization.

This will appear on your *Explanation of Payment* for newborn claims billing a higher level of care without the required authorization on file. You must notify us of any newborn admissions that are not normal newborns within one business day of the admission. It is not necessary to notify us of normal-newborn admissions.

For non-normal newborn admissions, please fax your request with the supporting clinical information to **877-423-9975**.

Emergent admission notification requirements
Amerigroup prefers immediate notification by network hospitals of emergent admissions. Network hospitals must notify Amerigroup of emergent admissions within one business day. The Utilization Management nurse will review the requested admission along with the supporting medical documentation utilizing MCG Care Guidelines to determine the medical appropriateness.

If the documentation is incomplete or inadequate, the Utilization Management nurse will not approve coverage of the request but will notify the referring provider to submit the additional necessary documentation. Again, the provider will be asked to provide further information as described above. If the supporting clinical information is not provided within 24 hours of request, the request will be sent to the medical director for review and possible denial.

If the medical director denies coverage of the request, the appropriate notice of action (including the member's appeal rights) will be faxed to the requesting provider and mailed to the member within mandated time frames. We are available 24 hours a day, 7 days a week to accept emergent admission notification at **800-454-3730**.

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 at the time of the request for prior authorization:

- Member name and ID
- Name, telephone number and fax number of physician performing the selective service
- Name of the facility and telephone number where the service is to be performed
- Date of service, frequency of service and length of time if known
- 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)

Requests for prior authorization with all supporting documentation should be submitted at least 72 hours prior to the rendering of services. This will allow Amerigroup to verify benefits and process the precertification request. For services requiring precertification, Amerigroup makes case-by-case determinations that consider the individual's health care needs and medical history in conjunction with the TennCare required medical necessity rules and regulations and appropriate Amerigroup review criteria.

Amerigroup is available 24 hours a day, 7 days a week to accept precertification requests via phone, fax, or digitally, through Availity Essentials. 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.

Amerigroup may administratively deny any request for service rendered prior to receipt of the request.

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 provider in identifying alternatives for health care delivery as supported by the medical director.

When the clinical information received is in accordance with the Tennessee definition of medical necessity and in conjunction with the approved Amerigroup review criteria, an Amerigroup reference number will be issued within 14

days (or as expeditiously as the member's health condition warrants) to the provider. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

Amerigroup will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness or condition.

Amerigroup may deny services that are noncovered except as otherwise required by TennCare Kids or unless otherwise directed to provide them by TennCare.

All medically necessary services will be covered for members under 21 years of age in accordance with TennCare Kids requirements.

If the request is urgent in nature (expedited service authorization), the decision will be made within 72 hours upon receipt of all necessary documentation. As defined by 2020 NCQA Standards for Utilization Management – an Urgent Request is: A request for medical care or services where application of the time frame for making routine or non-life-threatening care determinations.

If the precertification documentation is incomplete or inadequate, the nurse will not approve coverage of the request but will instead notify the provider to submit the additional necessary documentation.

If medical necessity criteria for the service are not met on the initial review, the requesting provider may contact the health plan and request to discuss the case with the medical director conducting the review. The provider will be asked in this instance to provide further explanation and/or evidence in support of the requested service, and the medical director will evaluate the new information considering the member's individual circumstances. If the provider fails to provide additional justification or the additional justification fails to cure the original deficiency, the medical director may issue a denial of coverage.

If the medical director denies the request for coverage, the appropriate notice of action will be faxed to the requesting provider, the member's primary physician, the facility and mailed to the member within mandated time frames. For expedited requests, the answer is provided verbally and then followed by a letter within mandated time frames.

Hospice

Hospice authorizations (Q codes) are not required for all members (members enrolled in both Medicare and Medicaid) as of July 1, 2017.

Although authorization is not a requirement at this time, Amerigroup medical directors may reach out to discuss members who are receiving benefits beyond 3-6 months.

Authorization is required for Service Intensity Add-On (SIA) procedure codes G0299, G0300 and G0155. SIAs are post-authorization requests and can be requested up to two weeks after a member's death. When completing the *Precertification Request* form, please include all member and provider information, as well as the member's date of death, dates of service for SIA, number of visits/hours and procedure code(s). Fax the request to **866-495-5789**.

Outpatient concurrent review
If the provider deems additional services are indicated beyond the approved services, the provider must recontact Amerigroup prior to the expiration of the orginal authorization to obtain an extension. The provider should use the same process used to obtain the prior authorization for the services.

Outpatient and Inpatient Precertification/Notification Requirements

Precertification/notification coverage requirements		
Service	**Requirement**	**Comments**
Cardiac rehabilitation	Precertification	Precertification is required for coverage of all services.
Chemotherapy		• Procedures related to the administration of approved chemotherapy medications do not require approval when performed in outpatient settings by a participating facility, provider office, outpatient hospital or ambulatory surgery center. • For information on coverage of and precertification requirements for chemotherapy drugs, please refer to the Precertification Lookup Tool on our website. • Precertification is required for coverage of inpatient chemotherapy.
Chiropractic		Medicaid eligible, age 21 and older: No precertification is required. Chiropractic care will only be covered for spinal manipulation and must include spine ICD-10-CM codes. Maintenance therapy will not be covered. The chiropractor will be allowed to perform spine X-rays per area to include cervical, thoracic, lumbar, sacroiliac joint, and sacral region once per calendar year. DME is not covered when ordered by a chiropractor as part of the treatment plan of care. Medicaid/Standard eligible, under age 21: : No precertification is required. Covered as medically necessary in accordance with TennCare Kids requirements. **CoverKids:** : No precertification is required. Covered by the CoverKids program for children under age 19 as medically necessary. Maintenance visits not covered when no additional progress is apparent or expected to occur. Mothers (Age 19 and over) of Eligible Unborn Children: Not Covered.
Court-ordered services		Court-ordered behavioral health services will be provided in accordance with state laws. Amerigroup may apply medical necessity criteria after 24 hours of emergency services unless there is a court order prohibiting release. Mandatory Outpatient Treatment: Amerigroup will provide mandatory outpatient treatment for members found not guilty by reason of insanity following a 30- to 60-day inpatient evaluation or for other reasons. Treatment can be terminated only by the court.
Dermatology services		No precertification is required for network provider for evaluation and management (E&M), testing and most procedures. Services considered cosmetic in nature are not covered. Services related to previous cosmetic procedures are not covered. See Diagnostic Testing.

Precertification/notification coverage requirements		
Service	**Requirement**	**Comments**
Diagnostic testing		• No precertification is required for routine diagnostic testing. • No precertification is required for tests performed in conjunction with a precertified inpatient stay. • Precertification through Carelon Medical Benefits* Outpatient Imaging Utilization Manager is required for coverage of CTA, MRA, MRI, CT scans, nuclear cardiology, stress echocardiography (SE), Echo, resting transthoracic echocardiography (TTE) and PET scans. • To initiate a review request with Carelon Medical Benefits Management, please visit www.providerportal.com or call Carelon Medical Benefits Management at **844-767-8159** Monday-Friday from 8 a.m.-8 p.m. ET. Fax requests will no longer be accepted. Carelon Medical Benefits Management will locate a preferred imaging facility from the Amerigroup network of radiology service providers.
Durable medical equipment (DME)		All DME, including all referrals, should be coordinated through Amerigroup Utilization Management (UM). Please refer to the Precertification Lookup Tool on our website for information on coverage and precertification requirements.
Educational consultation	No precertification	No notification or precertification is required for diabetic/nutritional or weight management counseling.
Emergency room	Self-referral	No notification is required for emergency care given in the ER. If emergency care results in admission, notification to Amerigroup is required within 24 hours or the next business day. For observation precertification requirements, see Observation.
ENT services (otolaryngology)		No precertification required for network provider for E&M, testing and most procedures. Precertification required for tonsillectomy and/or adenoidectomy; 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 provider. Covered services include pelvic and breast examinations, lab work, drugs, biological, genetic counseling, devices, and supplies related to family planning (e.g., an intra-uterine device). Infertility services and treatments are not covered.
Gastroenterology services		No precertification required for network provider for E&M, testing and most procedures. Precertification is required for upper endoscopy, bariatric surgery, including insertion, removal and/or replacement of adjustable gastric restrictive devices and subcutaneous port components. See Diagnostic Testing.
Genetic testing		If precertification is required, most services will be provided through Carelon Medical Benefits Management (CMBM). Please utilize PLUTO (Precertification Look Up Tool) **provider.amerigroup.com/tennessee-provider/resources/precertification/precertification-lookup** to view if service is authorized by CMBM. The ordering provider is responsible for obtaining an authorization., You can access Carelon Medical Benefits Management at **providerportal.com**. You can also contact Carelon

Precertification/notification coverage requirements		
Service	**Requirement**	**Comments**
		Medical Benefits Management toll free at **844-767-8159** or follow the instructions per PLUTO.
Hearing aids		Precertification is required for hearing aids for members under 21 years of age. Hearing services, including the prescribing, fitting, changing of hearing aids, and cochlear implants for members older than 21 years of age are not a covered benefit.
Hearing screening	No precertification	No notification or precertification is required for coverage of diagnostic and screening tests, hearing aid evaluations and counseling. Audiological therapy or training not covered for members 21 years of age or older.
Home Health care	Precertification	• No precertification required for members under 21 years of age for Home Health Physical, Occupational, and Speech Therapy • No precertification on the first 12 visits per plan year for members over the age 21 if performed by In-Network providers. • Home Health Skilled Nursing(G0299/G0300), Physical Therapy/Physical Therapy Assistant(G0151/G0157), Occupational Therapy/Occupational Therapy Assistant(G0152/G0157), Speech Therapy (G0153) • After first 12 visits per plan year, Precertification is required for all members regardless of age for covered services. • Covered services include skilled nursing; home health aide; physical, occupational and speech therapy services; and physician-ordered supplies. • Rehabilitation Therapy, drugs and DME require separate precertification if required.
Hospice		• Hospice Q codes do not require authorization. • SIA Add-On Codes (G0299, G0300 and G0155.) require authorization.
Hospital admission	Precertification	• Elective and planned admissions require precertification for coverage. Minimum of 72 hour notification. • 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. See provider referral directory for a complete listing of participating vendors. • Respite Care; personal comfort and convenience items; and supplies not directly related to patient care are not covered. Examples are cell phone charger, movie rentals, and take-home supplies. • For non-normal newborn inpatient admissions, please refer to non-normal newborn admissions below.

Precertification/notification coverage requirements		
Service	**Requirement**	**Comments**
Laboratory services (outpatient)		• No precertification is required if lab work is performed in a participating physician's office or in a participating lab provider's patient service center. • Precertification is required for all laboratory services furnished by non-network providers, except for hospital laboratory services in the event of an emergency medical condition. • Hospitals may only perform STAT labs. • To ensure outpatient laboratory services are directed to the most appropriate setting, providers may perform laboratory testing in their offices but must otherwise direct outpatient diagnostic laboratory tests to an Amerigroup participating lab such as Quest Diagnostics or LabCorp. You can find a list of participating laboratories in our provider referral directory available on our website.
Medical supplies		All medical supplies, including all referrals, should be coordinated through Amerigroup Utilization Management (UM). **Please refer to the Precertification Lookup Tool on our website for information on coverage and precertification requirements** **provider.amerigroup.com/tennessee-provider/resources/precertification/precertification-lookup**
Neurology		No precertification required for network provider for E&M and most procedures. Precertification is required for neurosurgery, spinal fusion, and artificial intervertebral disc surgery. See diagnostic testing.
Newborn nursery inpatient admissions	No Precertification	Normal newborn inpatient admissions do not require authorization if approved delivery authorization for the mother is on file. For non-normal newborn inpatient admissions, refer to the non-normal newborn admissions below.
Non-normal newborn admissions	Precertification	Precertification is required for non-normal newborn inpatient admissions. Fax your precertification requests to **877-423-9975**.
Observation	No precertification	• No precertification or notification required for in-network observation. If observation results in inpatient admission, notification to Amerigroup is required within 24 hours or the next business day from date of observation conversion to inpatient admission

Precertification/notification coverage requirements		
Service	**Requirement**	**Comments**
Obstetrical care		• 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 of age. • No precertification is required for the ordering physician for OB diagnostic testing. • Notification of delivery is required within 24 hours with a completed newborn assessment. Required Newborn information includes: Date of Birth (DOB), Birth weight, Gender, Gestational age, Live birth, APGAR, and Type of delivery • OB case management programs are available. • See diagnostic testing.
Ophthalmology		• No precertification required for E&M and testing. • Precertification is required for repair of eyelid defects. Services considered cosmetic in nature are not covered. See diagnostic testing. • Ophthalmology procedures please refer to the Precertification Lookup Tool on our website for information on coverage and precertification requirements. •
Oral maxillofacial	Precertification	See plastic/cosmetic/reconstructive surgery.
Otolaryngology (ENT) services	See ENT services (otolaryngology)	
Out-of-area/out-of-plan care	Precertification	Precertification is required except for coverage of emergency care (including self-referral).
Outpatient/ ambulatory surgery		Precertification requirement is based on the service performed. **For information on coverage of and precertification requirements, please refer to the Precertification Lookup Tool on our website.**

Precertification/notification coverage requirements		
Service	**Requirement**	**Comments**
Pharmacy		Outpatient pharmacy benefits are covered by TennCare. Products considered non-self-administered and obtained in an office or clinic setting are to be billed to Amerigroup. Injectable drugs obtained directly from a pharmacy provider are to be billed directly to the TennCare program. The injectable drugs covered under the pharmacy benefit, located at **optumrx.com/oe_tenncare/prescriber** are available by having the member obtain the drug through his or her local pharmacy. The pharmacy must bill TennCare. Some of these drugs require precertification through TennCare to ensure clinical criteria are met. For full details, please refer to the TennCare program. Amerigroup reimburses providers for certain injectables administered in a provider's office as well as home infusion. Please refer to the Precertification Lookup Tool on our website at **provider.amerigroup.com/tn** under **Resources**.
Physical medicine and rehabilitation (including pain management)	Precertification	Precertification is required for coverage of majority of services and procedures related to pain management. **Please refer to the Precertification Lookup Tool on our website for information on coverage and precertification requirements provider.amerigroup.com/tennessee-provider/resources/precertification/precertification-lookup**
Plastic/cosmetic/ reconstructive surgery (including oral maxillofacial services)		• 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 (e.g., scar revision or keloid removal resulting from pierced ears). Reduction mammoplasty requires a post service medical necessity review upon claim submission. • No precertification is required for coverage of oral maxillofacial E&M services. • Precertification is required for the coverage of trauma to the teeth and oral maxillofacial medical and surgical conditions, including temporomandibular joint disorder.
Podiatry		No precertification for coverage of E&M, testing and most procedures when provided by a participating podiatrist.
Prosthetics and Orthotics		Precertification is required for coverage of certain prosthetics and orthotics. For code-specific precertification requirements for prosthetics and orthotics ordered by a network provider or facility, refer to our online *Precertification Lookup Tool* provider.amerigroup.com/tennessee-provider/resources/precertification/precertification-lookup

Precertification/notification coverage requirements		
Service	**Requirement**	**Comments**
Radiation therapy	Precertification	All radiation therapies and procedures are reviewed by Carelon Medical Benefits Management. To initiate a review request with Carelon Medical Benefits Management, please visit **providerportal.com** or call Carelon Medical Benefits Management at **844-767-8159** Monday-Friday from 8 a.m.-8 p.m. ET.
Radiology services	See diagnostic testing	
Rehabilitation therapy (short term): OT, PT, RT and ST	Precertification	• No precertification required however providers should verify by using the Precertification Lookup Tool on our website for information on coverage and precertification requirements. **provider.amerigroup.com/tennessee-provider/resources/precertification/precertification-lookup** • Therapy services that are required to improve a child's ability to learn or participate in a school setting should be evaluated for school-based therapy. Other therapy services for rehabilitative care will be covered as medically necessary.
Skilled nursing facility	Precertification	Precertification is required for coverage. Requests should be faxed to **866-920-6005**.
Sleep study	Precertification	Precertification is required. All sleep management studies are reviewed by Carelon Medical Benefits Management. To initiate a review request with Carelon Medical Benefits Management, please visit **providerportal.com** or call **844-767-8159** Monday-Friday from 8 a.m. to 8 p.m. ET.
Sterilization	No precertification	• Sterilization services are a covered benefit for members age 21 and older. • No precertification or notification is required for coverage of sterilization procedures including tubal ligation and vasectomy, performed as an out-patient procedure. • **A *Sterilization Consent* form is required for claims submission for the procedure, not the consultation.** • Reversal of sterilization is not a covered benefit.
TennCare Kids/EPSDT office visits	Self-referral	Use TennCare Kids schedule and **document** visits.
Transportation		• All nonemergency medical transportation, including facility discharges should be coordinated through Tennessee Carriers. • Out of state travel requires precertification through health plan based on case-by-case review.
Urgent care center		No notification or precertification is required for a participating facility.
Urology		• For Urology procedures please refer to the Precertification Lookup Tool on our website for information on coverage and precertification requirements.

Precertification/notification coverage requirements		
Service	**Requirement**	**Comments**
Weight management services		Members who need or are interested in weight management services can be referred to Member Services at **800-600-4441**. For in-network providers, no notification or precertification is required for diabetic/nutritional or weight management counseling. **Mid Cumberland Region — Lifestyle Balance Program via County Health Departments** Dickson: **615-797-5056** Humphreys: **931-296-2231** Williamson: **615-794-1542** Rutherford: **615-898-1891** Stewart: **931-232-5329** Montgomery: **931-648-5747** Davidson: • Matthew Walker Comprehensive Health Center: **615-327-9400** • United Neighborhood Health Services: **615-226-1695** Member should contact local health department or FQHC for an appointment. **Local Health Department — Registered Dietician or Nutritionist available by appointment only.** Bedford: **931-684-3426** Maury: **931-388-5757** **Upper Cumberland Region — Local Health Departments (Nutritionist available by appointment only)** All counties in the region.
Well-woman exam	Self-referral	Well-woman exams are covered one per calendar year when performed by a PCP or in-network GYN. Exam includes routine lab work, STD screening, Pap smear and mammogram (age 35 or older), every two years or more frequently on physician recommendation for ages 40-50 and annually for ages 50 and older.
Revenue (RV) codes		To the extent the following services are covered benefits, precertification (preauthorization) or notification is required for all services billed with the following revenue codes: • All inpatient and behavioral health accommodations • 0023 — Home health prospective payment system • 0240 through 0249 — All-inclusive ancillary psychiatric • 0250 — Pharmacy general • 0632 — Pharmacy multiple source • 3101 through 3109 — Adult day care and foster care

Precertification/notification coverage requirements for behavioral health		
Service	**Precertification required for in-network provider?**	**Precertification required for out-of-network provider?**
Psychiatric Inpatient Hospital Services	Yes	Yes
23-hour Observation Bed	No	Yes
24 Hour Psychiatric Residential Treatment	Yes	Yes
Outpatient Mental Health Services:		
MD Services (Psychiatry)	No	Yes
Outpatient Non-MD Services	No	Yes
Partial Hospitalization	Yes	Yes
Intensive Outpatient	Yes	Yes
Inpatient, Residential and Outpatient Substance Use Disorder Services:		
Inpatient Facility Services (including detoxification)	Yes	Yes
Residential Treatment Services	Yes	Yes
Partial Hospital	Yes	Yes
Intensive Outpatient	Yes	Yes
Outpatient Treatment Services	No	Yes
Ambulatory Detoxification	Yes	Yes
Intensive Community Based Treatment (includes Continuous Treatment Team (CTT), Comprehensive Child and Family Treatment (CCFT), Program of Assertive Community Treatment (PACT))	Yes	Yes
Psychiatric Rehabilitation Services (includes psychosocial rehabilitation, supported employment, peer recovery, family support services, illness management and recovery)	No	Yes
Psychiatric Rehabilitation Services Supported Housing Enhanced Supported Housing	Yes	Yes
Behavioral Health Crisis Services		
Mobile Crisis Services	No	Yes
Crisis Respite	No	Yes
Crisis Stabilization	No	Yes
Home Health Care	Yes	Yes
Psychological/Neuropsychological Testing	Yes	Yes
Injectable Drugs	No	Yes
Electroconvulsive Therapy	Yes	Yes
Emergency Room Services	No	No
Court-ordered Services	Yes	Yes
Transportation, Nonemergency For Medically Necessary Treatment	Yes	Yes

Note: For any inpatient or outpatient behavioral health services that are not covered by contract, precertification is needed.

Amerigroup precertification requirements by procedure code are searchable through our Precertification Look-up Tool online at: **provider.amerigroup.com/tn/Pages/PLUTO.aspx**.

Inpatient reviews

Inpatient admission reviews
All inpatient hospital admissions, including urgent and emergent admissions, should be requested within 24 hours or the next business day for authorization. Our Utilization Review clinician determines the member's medical status through communication with the hospital's Utilization Review department. Appropriateness of stay is documented, and the review is initiated utilizing MCG CARE Guideline criteria. Cases may be referred to our medical director who renders a decision regarding the coverage of hospitalization based on medical necessity criteria. Discharge planning begins on member's admission and may result in coordination with our Case Management (CM) and Long-Term Services and Supports (LTSS) programs.

If members have behavioral health (BH) questions, they can access the BH department at **800-600-4441** and follow the respective prompts. If there is a crisis, they are prompted on the front end to enter **9**.

Inpatient concurrent review
Each network hospital will have an assigned Amerigroup UM clinician. The UM clinician will conduct a review of the supporting clinical information using the appropriate MCG Care Guidelines to determine if medical necessity has been met for an in-patient stay. If unable to make a determination, the request will be sent to the medical director for review and final determination. Clinical information may be provided via EMR access, electronically (i.e., fax, secure email), or via telephone to the UM clinician. When the clinical information received meets medical necessity criteria, an authorization will be communicated to the hospital for the stay. The UM clinicians will also conduct a continued stay review as indicated using updated clinical information provided by the facility.

Discharge planning begins on admission. The Amerigroup UM clinician will help coordinate discharge planning needs with the hospital utilization review staff and attending physician. The UM clinician will assist in making the appropriate referrals (i.e., Case Management (PH or BH), LTSS/CHOICES, Condition Care, Home Health) 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 member has secured an appointment for a follow-up visit with a behavioral health provider to occur within seven calendar days of discharge.

Amerigroup will authorize covered length of stay one day at a time based on the clinical information that supports the continued stay for per diem hospitals. 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:

- Critical Care Unit
- Behavioral health inpatient or residential treatment
- C-section or vaginal deliveries

Exceptions may be made by our medical director.

If, based upon appropriate criteria and after attempts to speak to the attending physician, the medical director denies coverage for an inpatient request, the appropriate notice of action or letter will be faxed to the provider and mailed to the member. The facility is notified of the determination telephonically or electronically.

Discharge planning
Discharge planning begins on admission and is designed to assist the provider and member in the coordination of health care services post-discharge when acute care (hospitalization) is no longer necessary.

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

- Hospice facility.
- Skilled nursing or convalescent facility.
- Home health care program (e.g., home I.V. antibiotics).

When the provider identifies medically necessary and appropriate services for the member, Amerigroup will assist the provider and the discharge planner in obtaining a timely and effective transfer to the next appropriate level of care.

In the case of a behavioral health discharge, the following minimum requirements should be incorporated and documented in all discharge plans for inpatient and residential treatment:

1. Discharge planning beginning at admission.
2. Involvement of member, family (if appropriate), treatment team and the Amerigroup UM care manager/any active case managers, as appropriate, in the discharge planning process.
3. Seeking collateral information from established outpatient providers, if applicable, and referring back to established providers.
4. Ensuring adequate/appropriate housing on discharge, equivalent to living situation prior to admission.
5. Coordinating medical and behavioral health services as necessary.
6. Evaluating for additional treatment needs post-discharge. If patient is to be discharged to outpatient care, ensuring follow-up with Tennessee Health Link or Intensive Community Based Treatment Provider is scheduled to occur within seven calendar days of discharge if appropriate.
7. Notifying Amerigroup care management staff of a pending discharge in accordance with the Grier Consent Decree.
8. Upon discharge, contacting the Amerigroup UM care manager with the following information:
    - Confirmation of the date of discharge
    - Member's home address and phone number
    - Axis 1 through 5 at discharge
    - Current medications
    - Aftercare plans (include agency name and telephone number of Tennessee Health Link or Intensive Community Based Treatment provider if appropriate, other outpatient appointment date/time)

Discharge plan authorizations follow individualized medical necessity criteria and documentation guidelines based on service(s) requested (refer to Precertification Look-Up Tool on Amerigroup Provider Portal). Authorizations include transportation, home health, Durable Medical Equipment (DME), follow-up visits to practitioners or outpatient procedures.

Emergency services
Amerigroup provides 24 hours a day, 7 days a week Nurse Helpline service (**800-600-4441**) with clinical staff to provide triage advice, 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. Emergency medical services are available at any available emergency care facility 24 hours a day, 7 days a week (including services outside the usual service area).

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. 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.

An emergency medical condition is defined as 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:

- 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
- Serious impairment to bodily functions
- 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 services, 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 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 once notified. 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, notify us to request an authorization for the inpatient admission within 24 hours of admission or next business day. An Amerigroup review nurse will implement the review process. Medical necessity criteria will be applied based on the severity of illness and intensity of service.

If members have BH questions, they can access the BH department at **800-600-4441** and follow the respective prompts.

Urgent care

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

15 Quality management

Quality Management program

Overview
Amerigroup maintains a comprehensive Quality Management/Quality Improvement (QM/QI) program to objectively monitor and systematically evaluate the care and service provided to members. The scope and content are to comply and coordinate QM program activities with applicable state and federal regulations, the National Committee for Quality Assurance (NCQA), the Utilization Review Accreditation Commission (URAC) and/or the Accreditation Association for Ambulatory Health Care (AAAHC) Accreditation standards while reflecting the demographic and epidemiological needs of the population served. We inform members and practitioners annually about the QM/QI program, and they have opportunities to make recommendations for areas of improvement. The QM/QI program goals and outcomes are available upon request to providers and members, and studies are planned across the continuum of care and service with proactive evaluation and refinement of the program.

This initial program development is based on reviewing the needs of the specific population we serve. Systematic re-evaluation of those needs occur on an annual basis. This includes not only age/sex distribution and language and specialized needs, but also a review of utilization data (i.e., inpatient, emergent/urgent care and office visits by type, cost and volume). This information defines high-volume or problem-prone areas.

There is a comprehensive committee structure in place with oversight from Amerigroup. This structure includes traditional committees, such as a peer review committee and credentialing committee, community/member/provider advisory committees for CHOICES and ECF CHOICES services, and a Medical Advisory Committee (MAC) for practitioner engagement and feedback. In addition, there are informal opportunities for provider engagement and feedback, via town halls, individual meetings or Patient-Centered Medical Home and Tennessee Health Link Collaboration meetings.

Practitioners and providers must allow Amerigroup to use performance data in cooperation with our QI program and activities. Pursuant to Section 5.1 of the provider contract, performance data includes access to medical records including but not limited to HEDIS® reporting and other reports aimed at improving clinical outcomes. Amerigroup is included in the reference of applicability to state and federal agency access.

Providers will permit Amerigroup or its designated agent to review records directly related to services provided to covered persons, by making records available to Amerigroup onsite at a provider's facility upon reasonable notice from Amerigroup and during regular business hours, participation in Electronic Medical Record (EMR) transmission programs or providing Amerigroup associates direct access into the provider or provider groups EMR. Providers must obtain all necessary releases, consents and authorizations to permit Amerigroup access to Amerigroup members' medical records. Providers must also supply one copy of the records described above to Amerigroup at no charge upon request. This would include performance data in cooperation with the Amerigroup QI program and activities, and access to medical records for HEDIS reporting and other reports aimed at improving clinical outcomes. Subsequent requests or medical records will be at the provider's current charge.

Quality Management Committee
The purpose of the Quality Management Committee (QMC) is to maintain 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 and monitor and support implementation of the QM program.
- Establish processes and structure that ensure accreditation compliance.

- Review planning, implementation, measurement and outcomes of clinical and service QI studies.
- Coordinate communication of QM activities throughout the health plans.
- Review HEDIS and CAHPS® data and action plans for improvement.
- Review and approve the annual QM/QI program description, work plans for each service area and evaluation.
- Provide oversight and ensure compliance delegated services.
- Provide oversight and review of subordinate committees.
- Review and approve the annual UM program and reports
- Review and approve the annual Population Health program description.
- Work plans for each service area and evaluation.
- Ensure full integration of CHOICES and ECF CHOICES members in all aspects contained within the QI program, including reporting, analysis and interventions designed to improve overall health and well-being.
- Ensure practitioner involvement through direct input from Medical Advisory Committees or other mechanisms that allow practitioner involvement.
- Monitor practice patterns in order to identify appropriateness of care and for improvement/risk prevention activities.

Medical Advisory Committee (MAC)
The purpose of the MAC is to:

- Provide applicable advice and input to the corporate committee with oversight over the development and updating of Clinical Practice Guidelines (CPGs).
- Solicit advice regarding aspects of health plan policy and operations affecting network providers or members.
- Assess the levels and quality of care provided to members.
- Recommend, evaluate, and monitor minimum standards of care for members.
- Provide guidance and feedback regarding technology assessments.

A TennCare Medical Director is invited as a guest and receives notice of the meetings no fewer than 10 days prior to the meeting date.

The MAC's responsibilities are to:

- Review and provide input, based on characteristics of the local delivery system, including clinical protocols/guidelines to facilitate the delivery of quality care and appropriate resource utilization.
- Review clinical study results and develop action plans/recommendations regarding clinical QI studies.
- Review and provide input to clinically-oriented health plan policies and procedures.
- Support a review of demographic and epidemiologic information targeting high-volume, high-cost, high-risk and problem-prone conditions.
- Utilize an ongoing peer review system to assess levels of care and quality of care provided; consider and act in regard to physician sanctions.
- Monitor practice patterns in order to identify appropriateness of care and to improve risk prevention activities.

Peer review activities performed by the MAC are legally protected from discovery. The MAC is considered a peer review body as defined by the Healthcare Quality Improvement Act and Tennessee Peer Review Stature (Tennessee Code Annals §63-1-150. Applicability; Quality Improvement Committee; record confidentiality; discovery; liability).

Credentialing Committee
The purpose of the Credentialing Committee is to credential and recredential all participating practitioners according to health plan, state, federal and accreditation standards and to consider or act in regard to practitioner sanctions. The Credentialing Committee conducts review for all providers who apply for participation in the plan and reviews all

participating providers for recredentialing purposes, including the review of any quality or utilization data and reports.

Clinical Services Committee

The purpose of the Clinical Services Committee(CSC)is to bring multidisciplinary leaders together to address over-and-underutilization management that present significant challenges and/or risks to the organization. The CSC also identifies opportunities to improve services and clinical performance based on a review of demographic and epidemiologic information targeting high-volume, high-cost, high-risk and problem-prone conditions.

Detail Responsibilities:

- Provide oversight of and monitor all Clinical Operations functions ensuring effectiveness of clinical programs and compliance with regulatory requirements
- Monitor over and under utilization
- Annual review of Utilization Management (UM) and Care Management (CM) Program Descriptions and Evaluations
- Clinical Practice Guidelines
- Clinical Criteria for UM Decisions
- Review of UM and CM Policies and Procedures ensuring compliance with Federal, State and NCQA requirements and standards;

Quality of care

All physicians, nurse practitioners, physician assistants (PA), and other contracted facilities and ancillary providers are evaluated for compliance with pre-established standards as described in the Amerigroup credentialing program. We monitor and evaluate individual practitioner performance in the areas of health care quality and service, administration, and member satisfaction and provide appropriate feedback and remediation of individual findings when needed. Quality review of individuals may result in significant interventions depending on severity including termination from the network, reporting to state licensing agencies, the National Practitioner Data Bank (NPDB), and Healthcare Integrity and Protection Data Bank (HIPDB).

Review standards are based on medical community standards, external regulatory and accrediting agencies requirements, and contractual compliance. Reviews are accomplished by appropriate personnel who strive to develop relationships with practitioners and providers 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. Staff use member complaints, reported adverse occurrences (i.e., “never events”), potential quality of care or service issues, and other information to evaluate the quality of service and care provided to our members.

16 Claim submission and adjudication procedures

Secondary non-billing provider requirements
Effective June 1, 2017, all secondary/non-billing Medicaid providers (e.g., referring, rendering, ordering, etc.) must be registered with TennCare during the claims date of service. If not, the claim will reject or deny. This is for both participating and nonparticipating providers.

Medication Therapy Management Pilot (MTM)
For specific information on the requirements that need to be met to bill for MTM services, please see the *MTM Provider Operations Manual*, which can be found at **tn.gov/tenncare/providers/managed-care-contractors/pharmacy-benefits-manager/medication-therapy-management-pilot-program.html**.

Medication Therapy Management Program
Reimbursement for MTM services will cover a **per month case rate** that includes an initial face- to-face, one-on-one visit with the TennCare member. Follow-up monthly case rate visits may be done face-to-face or indirectly (i.e., telephonically) at the member's preference. Initial case rate is based on a minimum of at least 15 minutes per month.

As part of MTM pilot **reporting and tracking**, the pharmacist must use professional claim (CMS-1500) for billing MTM services and utilize the required CPT codes to submit for MCO reimbursement. It is important for participating pharmacists to submit the following CPT© code(s) to identify the MTM service in conjunction with the service modifier (case rate) to properly receive reimbursement payments.

Participating pharmacists provide MTM under a collaborative practice agreement (CPA) with a TennCare Patient Centered Medical Home (PCMH) or Tennessee Health Link (THL

Medication Therapy Management (MTM) Reimbursement Guidelines: The Case Rates for MTM Covered Services are described below:

Service Description	Modifier Code	Payment Limits	Units
Targeted Disease States (Juvenile Asthma or Diabetes)	U1	2 Months	1 unit for each case rate
Medium-High Risk	U2	3 Months	1 unit for each case rate
Critical, High Risk	U3	6 Months	1 unit for each case rate
Exceptions (Requires appropriate approval)	U4	Limit based on appropriate approval	1 unit for each case rate
Moderate Risk	U5	2 Months	1 unit for each case rate

The below CPT codes will be used to indicate the services the member received:

CPT Code	CPT Code Description
99605	Medication therapy management service(s) provided by pharmacist, individual, **face-to-face** with patient, with assessment and intervention if provided; **new** patient visit, initial 15 minutes
99606	Medication therapy management service(s) provided by pharmacist, individual, **face-to-face** with patient, with assessment and intervention if provided; **established** patient visit, initial 15 minutes
99607	Add-on code for each additional 15-minute increment
98966	**Telephone** assessment and management services provided by a qualified non-physician health care professional to an established patient. 5-10 minutes
98967	**Telephone** assessment and management services provided by a qualified non-physician health care professional to an established patient. 11-20 minutes
98968	**Telephone** assessment and management services provided by a qualified non-physician health care professional to an established patient. 21-30 minutes

Pharmacist will bill the appropriate CPT code (99605 for a new patient or 99606 for an established patient) in conjunction with the service modifier to receive appropriate case rate reimbursement. To track and report time, if a visit lasts more than 15 minutes, pharmacist will also submit 99607 with an additional unit for each 15-minute increment. Please note, CPT 99607 code is for informational purposes only and does not impact the claims payment. MTM services provided by Indirect (telephonic) must be submitted using 98966, 98967, or 98968.

Pharmacist must complete and upload an MTM exception (ME) form to the CCT for any service limit exceptions. Claims submitted beyond the risk-based maximum limit as described in this section may be subject to recoupment unless -an MTM exception (ME) form is received. The MCOs will review the ME form for completeness to determine reimbursement appropriateness based on the guidelines provided by TennCare. Upon billing, the U4 modifier is to be addressed on the claim as the second modifier. The pharmacist might need to submit MTM exception form to each MCO subject to MCO requirements

Non-Physician Medical Practitioners

Allied Professionals to include non-physician practitioners commonly referred to as midlevel practitioners are reimbursed in accordance with the applicable methodology for the contracted Fee Schedule. If the Fee Schedule is AMERIGROUP Professional Provider Market Master Fee Schedule, the applicable state methodology on which such fee schedule is based on shall be used to determine the appropriate level of reimbursement. AMERIGROUP follows the CMS non-physician practitioner claim reimbursement methodology.

Practitioner Emergency Department Reimbursement

The following guidelines apply when determining Emergency Department (ED) methodology for practitioner providers:

1. If the provider bills CPT codes 99281-99285 and the claim meets ED criteria, the Participating (PAR) provider is reimbursed in accordance to their Amerigroup contract. Nonparticipating (NonPar) providers are reimbursed the equivalent reimbursement as a Par provider in accordance with TennCare rule 1200-13-13-08(2) (no less than 80% of the lowest paid rate by Amerigroup to an equivalent Par provider for the same service).
2. Effective July 1, 2011, if the provider bills with CPT codes 99281-99285 and the claim does not meet defined ED criteria, PAR providers are reimbursed a maximum of $50 or their contracted reimbursement, whichever is less. NonPar providers are reimbursed a maximum of $50 or the equivalent PAR provider contracted amount, whichever is less in accordance with TennCare rule 1200-13-13-.08(2). The respective claim's Explanation of Payment (EOP) will provide an explanation code of "ERC" – DX billed does not meet ER criteria".

Facility Emergency Department Reimbursement

The following guidelines apply when determining ED reimbursement methodology for facility providers:

1. Emergency services do not require prior authorization or primary care physician referral and are provided for emergency services needed to screen and/or stabilize emergency physical/behavioral health conditions found to exist using the prudent layperson standard regardless of the final diagnosis or whether these services are provided by a contract or noncontract provider.
2. If the facility is contracted on levels for ED services and a non-emergent diagnosis code is in box 67 or 70A, claims will be paid at the lowest-level emergency room level contracted rate (99281) or billed charges, whichever is less.
3. If the facility is contracted with non-emergent ED rates and a non-emergent diagnosis code is in box 67 or 70A, claims will be paid at the non-emergent contracted rate or billed charges, whichever is less.
4. If the facility is contracted other than on levels of with a non-emergent ED rate and a non-emergent diagnosis is in box 67 or 70A, claims will be paid at the Emergency Medical Treatment and Labor Act (EMTALA) calculated rate (revenue code 0451/CPT 99281) per the contract. The revenue code 0451/CPT 99281 rates will be calculated and paid regardless of the service billed. No additional ancillary services will be paid.
5. If the facility bills only a screening charge (revenue 0451), the claim will be paid regardless of the primary diagnosis or presenting symptom in accordance with CRA A.2.7.1.3. The payment for a screening is all-inclusive, and no additional ancillary services will be paid.

***CLIA* requirements**

Background: Amerigroup Community Care implemented *Clinical Laboratory Improvement Amendments (CLIA)* requirements for claims with dates of service on or after September 15, 2019, for *CLIA* certification validation. Our system reads directly from the CMS Provider of Service (POS) *CLIA* file to validate *CLIA* information. CMS updates this file every three months. To ensure your claims process correctly and the POS files are current, we strongly advise that providers proactively submit an updated *CLIA* certificate three months prior to the *CLIA* certification expiration date.

Laboratory procedures are only covered and, therefore, payable if rendered by an appropriately licensed or certified laboratory having the appropriate level of *CLIA* accreditation for the particular test performed. Thus, any claim that does not contain the *CLIA* ID, has an invalid ID, has a lab accreditation level that does not support the billed service code or does not have complete servicing provider demographic information will be considered incomplete and rejected or denied. Please note: All out of network providers require an authorization.

Claim submission requirements

Professional service and independent laboratory providers are required to include a valid *CLIA* number on all claims submitted for laboratory services, including *CLIA*-waived tests. The *CLIA* certificate identification number must be submitted in one of the following manners:

Claim format and elements	*CLIA* number location options	Referring provider name and NPI number location options	Servicing laboratory physical location
CMS-1500 (formerly *HCFA-1500*), paper claim	Must be represented in field 23	Submit the referring provider name and NPI number in fields 17 and 17b, respectively.	Submit the servicing provider name, full physical address and NPI number in fields 32 and 32A, respectively, if the address is not equal to the billing provider address. The servicing or billing provider address must match **exactly to** the address associated with the *CLIA* ID entered in field 23.
HIPAA 5010 837 professional, electronic claim	Must be represented in the 2300 loop, REF02 element, with qualifier of X4 in REF01	Submit the referring provider name and NPI number in the 2310A loop, NM1 segment.	Physical address of servicing provider must be represented in the 2310C loop if not equal to the billing provider address. The servicing or billing provider address must match **exactly to** the address associated with the *CLIA* ID submitted in the 2300 loop, REF02.

- This is an example of valid *CLIA* number format: 19DXXXXXXX.
- The first three characters are the two-digit state code followed by the letter D.
- The remaining seven digits are the unique *CLIA* system number assigned to the provider.
- Do not add the letters **CLIA** to the 10-character *CLIA* number.

Providers who have obtained a *CLIA Waiver* or Provider Performed Microscopy Procedure accreditation must include the QW modifier for *CLIA* waived laboratory service when reported on a *CMS-1500* claim form in order for the procedure to be evaluated to determine eligibility for benefit coverage.

Claim rejection/denial reason codes:

- GLI — Valid *CLIA* number must be submitted if the *CLIA* number is missing or invalid.
  - *B85 - CLIA* is not valid for claim dates of service.
  - B84 - CMS CLIA address does not match. The CMS address for *CLIA* does not match **exactly to** the address in box 32 or 33 of the *CMS-1500* form.
- GLJ — *CLIA* number invalid for services:
  - This denial code is applied to the claim line if the provider is billing for services that are beyond the scope of this *CLIA* certification level.
  - This edit should only apply to providers who have *CLIA Certificate of Waiver* or a *Certificate for Provider-Performed Microscopy Procedures*.

- Z71 — QW modifier (all of the following must apply):
    - The provider has a *Certificate of Waiver CLIA* level. ○ The service billed requires a QW modifier per current CMS list of waived codes. ○ The provider did not bill the QW modifier as required per CMS.

Tennessee payment reform initiatives
Beginning in 2021, Tennessee implemented a newly designed health care reform initiative based on value and outcome-based reimbursement models. This system rewards high-quality care and outcomes and encourages clinical effectiveness.

According to CRA Section A.2.13.1.9, providers will adhere to the retrospective episode-based reimbursement and Primary Care Transformation strategies, inclusive of Patient Centered Medical Home and Tennessee Health Link, consistent with Tennessee's multi-payer payment reform initiative in a manner and on a timeline approved by TennCare. This includes:

- Using a retrospective administrative process to reward cost and quality outcomes for the initiative's payment reform strategies that is aligned with the models designed by TennCare.
- Implementing key design choices as directed by TennCare including the definition of each episode and the definition of quality measures for the initiative's payment reform strategies.
- Delivering performance reports for the initiative's payment reform strategies with same appearance and content as those designed by the State/Payer coalition.
- Implementing payment reform strategies at a pace dictated by the state; for episodes, this is approximately three to six new episodes per quarter with appropriate lead time to allow payer and provider contracting.
- Participating in a state-led process to design and launch new episodes including the seeking of clinical input from payer medical teams and clinical leaders throughout Tennessee.

Amerigroup is required by CRA Section A.2.13.1.10 to implement state budget reductions and payment reform initiatives including retrospective episode-based reimbursement as described by TennCare.

Electronic submission
Availity is our exclusive partner for managing all Electronic Data Interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient, and cost-effective way for providers to do business.

Use Availity for the following EDI transactions:

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

Availity's EDI submission Options

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

EDI Response Reports

- Claims submitted electronically will return response reports that may contain rejections. If using a Clearinghouse or Billing Vendor, please work with them to ensure you are receiving all reports. It's important to review rejections as they will not continue through the process and require correction and resubmission.

For questions on electronic response reports contact your Clearinghouse or Billing Vendor or Availity at 800-AVAILITY (800-282-4548).

Payer ID
Claim Payer ID: 26375

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

Electronic Remittance Advice (835)
The 835 eliminates the need for paper remittance reconciliation.

Use Availity to register and manage ERA account changes with these three easy steps:
1. Log in to Availity **apps.availity.com/availity/web/public.elegant.login**
2. Select **My Providers**
3. Select on **Enrollment Center** and select **Transaction Enrollment**

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

Electronic Funds Transfer (EFT)
Electronic claims payment through electronic funds transfer (EFT) is a secure and fastest way to receive payment reducing administrative processes. EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.

Use EnrollSafe (**enrollsafe.payeehub.org/**) to register and manage EFT account changes.

Visit **provider.amerigroup.com/tennessee-provider/claims/electronic-data-interchange** for EFT registration instructions.

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

Paper claims submission
Providers also have the option of submitting paper claims. Paper claims must be submitted on original red claim forms in black and white, laser printed or typed in a large, dark font. The time frames for submitting and Amerigroup receiving an original Institutional *UB-04/CMS-1450* or *Professional CMS-1500 (02-12) Claim* form must be within 120 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. A corrected claim or replacement claim may be submitted within 120 calendar days of payment notification (paid or denied). Corrections to a claim should only be submitted if the original claim information was wrong or incomplete. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date that the third-party documents resolution of the claim. For cases of retroactive eligibility, the time frames for filing a claim will begin on the date that Amerigroup receives notification from TennCare of the member's eligibility/enrollment.

Please make sure that corrected claims are marked appropriately and submitted separately for each member and episode of care. If a corrected claim is not appropriately marked the claim may be processed as a new claim and may deny for timely filing or as a duplicate claim. Please ensure that the words "Corrected" or "Corrected Claim" are printed on each page of the claim in **blue or black ink**. Make certain that claims with multiple pages are labeled accordingly (e.g., 1 of 3, 2 of 3, etc.). Please note that corrected claims cannot be accepted by batch, bulk or packaged submissions. That is, one cover letter or claim that is stamped "corrected" cannot represent the status of

the claims that follow; each corrected claim must be labeled individually and accompanied by the appropriate *Provider Payment Dispute and Correspondence* form. This will help ensure that your claim and correspondence are scanned, interpreted and processed efficiently.

For additional information or if you have any questions, please contact our EDI Hotline at **800-590-5745**.

CMS-1500 (02-12) and *UB-04 CMS-1450* must include the following:

- Patient's ID number
- Patient's name
- Patient's date of birth
- Diagnosis code/revenue codes
- Date of service
- Place of service
- Resubmission code (when applicable)
- Procedures, services or supplies rendered
- CPT-4 codes/HCPC codes/DRGs with appropriate modifiers if necessary
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- Amerigroup provider number
- NPI number of billing, attending and rendering provider when applicable
- State Medicaid ID number
- COB/other insurance information
- Authorization/precertification number or copy of authorization/precertification
- Name of referring physician when applicable
- NPI number of referring physician when applicable
- Any other state required data

You can access the *CMS-1500* form and completion instructions at:
cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1188854.html.

Amerigroup cannot accept claims with alterations to billing information. Amerigroup does not accept computer-generated or typewritten claims with information that is marked through, handwritten or whited out. Claims that have been altered will be returned to the provider with an explanation of the reason for the return.

Behavioral health practitioners must use the appropriate modifier associated with their licensure for CPT codes:

Service description	Billing code	Modifier
Psychiatrist/M.D.	CPT	–
Licensed psychologist/Ph.D.	CPT	HP
Licensed master's clinician	CPT	HO
Clinical nurse specialist	CPT	SA

Paper claims must be submitted to the following address:

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

Use Availity Essentials platform for claim submissions, claim status inquiries, member eligibility and benefits information:

Availity.com
800-AVAILITY (800-282-4548)
Support@availity.com

International classification of diseases, 10th revision (ICD-10) description

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

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

Although we often use the term ICD-10 alone, there are two parts to ICD-10:

- Clinical modification (CM): ICD-10-CM is used for diagnosis coding
- Procedure coding system (PCS): ICD-10-PCS is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States

ICD-10-CM replaces the code sets ICD-9-CM, volumes one and two for diagnosis coding, and ICD-10-PCS replaces ICD-9-CM, volume three for inpatient hospital procedure coding.

National drug code reporting requirements

Federal and state guidelines mandate the inclusion of National Drug Code (NDC) codes on all claims with provider-administered drugs, and Amerigroup will edit claims for these NDC codes. This requirement originated from the Federal Deficit Recovery Act of 2005.

Any claim received by Amerigroup with a Healthcare Common Procedure Coding System (HCPCS) code for a provider-administered drug (generally a J-code) that does not include the applicable NDC code, unit of measure and quantity in the appropriate format (as explained below) will be rejected and will need to be corrected and resubmitted as a new claim. Also, all paper claims submitted with provider-administered drugs must use the *CMS-1500 (02-12) Claim* form. You can access the new *CMS-1500 (02-12)* form at **cms.hhs.gov**.

Professional claims that are submitted via EDI (837P) should include applicable NDC codes in Loop 2410, LIN03 segment. In addition, providers must submit the NDC Quantity in Loop 2410, CTP04 and the unit for measurement code in Loop 2410, CTP05-01.

All paper claims with provider-administered drugs must include each drug's NDC code in the shaded area of Form Locator 24A for each applicable claim line. Form Locator 24A must have the NDC qualifier N4 followed immediately (no spaces) by the NDC code (11 digits, no dashes) in the shaded area. The codes must be 11 digits in a 5-4-2 format. That is, the first five digits identify the manufacturer of the drug and are assigned by the FDA. The remaining digits

are assigned by the manufacturer and identify the specific product and package size. Some packages will display less than 11 digits, but leading zeroes can be assumed and need to be used when billing. See below for further details. You must also include each drug's 2-digit NDC unit of measure and numeric quantity administered to the patient in the shaded area following the NDC code of Form Locator 24A for each applicable claim line. There are five valid units of measure qualifiers that can be used (F2-International Unit, GR-Gram, ML-Milliliter, UN-unit or ME-Milligram). If reporting a fraction of a unit, use the decimal point. Nine numbers may precede the decimal, and three numbers may follow the decimal.

NDC 5-4-2 formatting for 10 digit NDC codes:
XXXX-XXXX-XX = 0XXXX-XXXX-XX – Submitted as 0XXXXXXXXXX
XXXXX-XXX-XX = XXXXX-0XXX-XX – Submitted as XXXXX0XXXXX
XXXXX-XXXX-X = XXXXX-XXXX-0X – Submitted as XXXXXXXXX0X

Below is an example of reporting NDC information on a CMS-1500 paper form:

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. #
N45914801665 UN1													N	1B	12345678901
10	01	05	10	01	05	11		J0400		1	250 00	40	N	NPI	0123456789

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. #
N44950267230 UN1 50.00													N	1B	12345678901
10	01	05	10	01	05	11		J7603		1	50 00	2.5	N	NPI	0123456789

Should you have any questions on proper NDC formatting and submissions, please contact our EDI Helpdesk at **800-590-5745** or VA1Claims@amerigroup.com for assistance.

NDC reporting requirements for facilities (*837I/CMS-1450* form)

Federal and state guidelines mandate the inclusion of NDC codes on all claims with provider-administered drugs, and Amerigroup will edit claims for these NDC codes.

The Federal Deficit Recovery Act of 2005 contains requirements for all state Medicaid agencies to obtain certain claim information (including NDC, unit of measure, quantity and unit price) for all provider-administered drugs except inpatient services, radiopharmaceuticals (unless billed separate from the related procedure) and vaccines. Amerigroup will edit claims to ensure that all 837I electronic claims or *CMS-1450* paper claims include this required information. This drug information is required on all Medicaid-related claim forms, even if Medicaid is a secondary or tertiary payer.

Any institutional claim received by Amerigroup with a Healthcare Common Procedure Coding System (HCPCS) code for a provider-administered drug (generally a J-code) that does not include the applicable NDC code and other quantity and pricing information in the appropriate format (as explained below) will be denied and will require additional information for reconsideration.

Each J-code submitted must have a corresponding NDC on each claim line. If the drug administered is comprised of more than one ingredient (e.g., compound drugs, same drug different strengths, etc.), each NDC must be represented. For the same drug with different strengths, the J-code should be repeated as necessary to cover each unique NDC. For compound drugs, each NDC should be represented via repeating the appropriate NDC or utilizing the compound drug section of the claim, depending on what is appropriate for the claim form.

A valid NDC must be used on all J-code drugs. To be considered valid, an NDC must be present in the correct field, in the correct format, using the 5-4-2 *HIPAA* standard 11-digit code, and be found on TennCare's drug file.

Institutional claims that are submitted via EDI (837I) should include applicable NDC codes in Loop 2410, LIN03 segment. In addition, providers must submit the NDC Quantity in Loop 2410, CTP04 and the unit of measure code in Loop 2410, CTP05-01.

All paper claims with provider-administered drugs must include each drug's NDC code in Form Locator 43 for each applicable claim line. Form Locator 43 must have the NDC qualifier N4 followed immediately (no spaces) by the NDC code. The NDC codes must be 11 characters (5-4-2 format as required by *HIPAA* guidelines with zeros or asterisks acting as placeholders), so it will be necessary to look up the 5-4-2 format code if something different is printed on the drug packaging.

You must also include each drug's two-digit NDC unit of measure and numeric quantity administered to the patient in Form Locator 43 with a space between the NDC number and the NDC unit of measure for each applicable claim line. There are five valid units of measure qualifiers that can be used (F2-International Unit, GR-Gram, ME-Milligram, ML-Milliliter, UN-unit, or ME-Milligram). If reporting a fraction of a unit, use the decimal point. Nine numbers may precede the decimal and three numbers may follow the decimal.

Should you have any questions on proper NDC formatting and submissions, please contact our EDI Helpdesk at **800-590-5745** or VA1Claims@amerigroup.com for assistance.

Here are some examples for the *UB-04 CMS-1450* paper form:

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	
1	0259	N400025016608 UN3	J3490	041207	3	13 00	1
2	0450	EMERGENCY ROOM	99282	041207	1	360 00	2
3	0636	N465174*84021 ML1	J1270	041207	4	11 12	3
4	0636	N4125162791*3 ML12.5	J2916	041207	10	47 50	4
5							5

Medical Coding

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

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

Amerigroup uses an automated claims auditing system to ensure claims are adjudicated in accordance with industry billing and reimbursement standards. Claims auditing software ensures compliance with an ever-widening array of edits and rules as well as consistency of payment for providers by ensuring correct coding and billing practices are being followed. Using a sophisticated auditing logic, our code editing system determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes and processes those services according to the NCCI. NCCI was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. NCCI code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services.

In addition to code pair edits, the NCCI includes a set of edits known as Medically Unlikely Edits (MUEs). An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a single HCPCS/CPT code billed by a provider on a date of service for a single beneficiary.

Reimbursement by Code Definition

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

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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 (02-12) Claim* form unless other arrangements are approved by Amerigroup. Data will be submitted in a timely manner but no later than 90 days from the date of service.

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
TN Claims
Virginia Beach, VA 23466-1010

Through claims and encounter data submissions, HEDIS information is collected. This includes the following:

- Preventive services (e.g., childhood immunization, mammography and Pap smears)
- Prenatal care (e.g., LBW and 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 improvement staff, coordinated with the medical director and reported to the Quality Management Committee on a quarterly basis. The PCP is monitored for compliance with reporting of utilization. Lack of compliance will result in training and follow-up audits and could result in provider 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-10 Manuals*. Hospital facility claims should be submitted using the *UB-04 CMS-1450* and provider services using the *CMS-1500*.

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 noncompliant 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.

Claims with diagnosis-related group (DRG) outlier charges will require an itemized bill to substantiate the outlier payment. If an itemized bill is not submitted with the claim, Amerigroup will pay the contracted DRG amount only, deny the outlier charge(s) and request an itemized bill through an explanation code on the *Explanation of Payment* (*EOP*). The explanation code will be “GMU”.

To avoid a split claim, when a provider submits one claim that contains more than one form, the provider should **not** total each page. The provider should enter “CONT’D” in fields 28, 29 and 30. We also request the provider add page 1 of 2, 1 of 3, etc. if possible.

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

- Claims must be received at Amerigroup within 120 days from the date the service is rendered or for inpatient claims filed by a hospital within 120 days from the date of discharge.
- In the case of other insurance, Amerigroup must receive the claim within 120 days of other insurance *EOP* date.
- Claims for members whose eligibility has not been added to the state’s eligibility system must be received within 120 days from the date the eligibility is added, and Amerigroup is notified of the eligibility/enrollment.
- A corrected claim or replacement claim may be submitted within 120 calendar days of Amerigroup payment notification (paid or denied). Corrections to a claim should only be submitted if the original claim information was wrong or incomplete.
- Claims, including corrected claims, received after the applicable filing deadlines will be denied.

After filing a claim with Amerigroup, you may review your *EOP*. **If the claim does not appear on an *EOP* within 15 business days as adjudicated or you have no other written indication that the claim has been received, check the status of your claim at provider.amerigroup.com/tn or call Provider Services at 800-454-3730.** If the claim is not on file with Amerigroup, resubmit your claim so it is received within the applicable filing time limit for an original or corrected claim. If filing electronically, check the confirmation reports for acceptance of the claim that you receive from your EDI or practice management vendor.

Clean claims adjudication

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

- Is timely submitted by a provider.
- Is accurate.
- Is submitted on a *HIPAA*-compliant standard claim form including a *CMS-1500 (02-12)* or *UB-04 CMS-1450* or successor forms thereto or the electronic equivalent of such claim form.
- Is a complete claims submission following any and all *HIPAA* compliance standards (Levels 1-7).
- Includes NPI and taxonomy information for rendering, attending and billing providers.
- Includes, for all J-codes billed, NDC code and drug pricing information (NDC quantity, unit price and unit of measurement) are required. Exceptions are:
    - Vaccines for children which are paid as an administrative fee.
    - Inpatient administered drugs.
    - Radiopharmaceuticals unless the drug is billed separately from the procedure.
- Requires no further information, adjustment or alteration (including written information or substantiation) by a provider in order to be processed and paid by Amerigroup.

Ninety percent of clean claims are adjudicated within 30 days and 99.5 percent within 60 days of receipt of a clean claim.

Paper or Amerigroup website claims that are determined to be unclean will be returned to the billing provider along with a letter stating the reason for rejection for those claims submitted on paper. Electronic claims (EDI) that are determined to be unclean will be returned to an Amerigroup contracted clearinghouse and, in turn, will be reported out to either the billing provider or the vendor the billing provider used to submit the claim.

Amerigroup produces and mails an *EOP* on a twice-per-week basis, which delineates for the provider the status of each claim that has been adjudicated during the previous claim cycle.

Disclosure of ownership

All contracted providers are required to register with TennCare and provide their disclosure information. TennCare collects this information when a provider registers/re-verifies with them and sends a file to us on a weekly basis as the authorized source of disclosure information. During the initial credentialing process, we verify the provider's information is in the state file before submitting any application or contract to be completed. If the provider is not in the state DOO file, the credentialing department will contact the provider to ensure he or she registers.

If an existing provider has not registered with TennCare and is not listed on the state file, we will give 120 days from the date of service on the claim for the provider to register with TennCare and reprocess the claim. A provider is required to reattest/revalidate every three years with TennCare. Failure to register/revalidate with TennCare will result in termination from the Amerigroup network.

Claims status
Providers can check the status of claims at **provider.amerigroup.com/tn** or call Provider Services at **800-454-3730** to check claims status. Providers should also use the claims status information available for claims that were electronically submitted through a clearinghouse for information on accepted and rejected claims.

Amerigroup supports the ability to obtain real time claim status information using the 276/277 transaction through Smart Data Solutions. Providers interested in utilizing this functionality can contact Smart Data Solutions directly at **855-297-4436** to obtain additional information.

Reimbursement Policies
Reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup benefit plan. These policies can be accessed on the provider site. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines, including using industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes which indicate the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities; a non-contracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup may:
- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup strives to minimize these variations.

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

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

Outlier reimbursement audit and review process — requirements and policies
This section includes guidelines on reimbursement to Providers and Facilities for services on claims paid by DRG with an outlier paid at percent of billed charge or when the entire claim is paid at percent of billed charge.

In addition to any header in this section, please refer to all other service specific sections which may have more stringent guidelines. There may be multiple sections that apply to any given reimbursable service.

Audits/records requests
At any time, a request may be made for on-site, electronic or hard copy medical records, utilization review documentation and/or itemized bills related to Claims for the purposes of conducting audit or reviews.

Blood and blood products
Administration of Blood or Blood Products are not separately reimbursable on inpatient claims. Administration charges on outpatient claims are separately reimbursable when submitted without observation/treatment room charges.

Charges for blood storage and processing, thawing fees charges, irradiation, and other processing charges, are also not separately reimbursable.

Emergency room supplies and services charges
The Emergency Room level reimbursement includes all monitoring, equipment, supplies, and, time and staff charges. Reimbursement for the use of the Emergency Room includes the use of the room and personnel employed for the examination and treatment of patients. This reimbursement does not typically include the cost of physician services.

Facility personnel charges
Charges for Inpatient Services for Facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), professional therapy functions, including Physical, Occupational, and Speech call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Charges for Outpatient Services for facility personnel are also not separately reimbursable. The reimbursement is included in the payment for the procedure or Observation charge.

Implants
Implants are objects or materials which are implanted such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert placed into a surgically or naturally formed cavity of the human body to continuously assist, restore or replace the function of an organ system or structure of the human body throughout its useful life. Implants include, but are not limited to: stents, artificial joints, shunts, pins, plates, screws, anchors and radioactive seeds, in addition to non-soluble, or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the Member's body upon discharge from the inpatient stay or outpatient procedure.

Staples, sutures, clips, as well as temporary drains, tubes, similar temporary medical devices and supplies shall not be considered implants. Implants that are deemed contaminated and/or considered waste and/or were not implanted in the Member will not be reimbursed.

IV sedation and local anesthesia
Charges for IV sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, is not separately reimbursable and is included as part of the Operating Room (“OR”) time/procedure reimbursement. Medications used for IV sedation and local anesthesia are separately reimbursable.

Lab charges

The reimbursement of charges for specimen are considered facility personnel charges and the reimbursement is included in the room and board or procedure/Observation charges. Examples include venipuncture, urine/sputum specimen collection, draw fees, phlebotomy, heel sticks, and central line draws.

Processing fees, handling fees, and referral fees are considered included in the procedure/lab test performed and not separately reimbursable.

Labor care charges
Reimbursement will be made for appropriately billed room and board or labor charges. Payment will not be made on both charges when billed concurrently.

Nursing procedures
Fees associated with nursing procedures or services provided by Facility nursing staff or unlicensed Facility personnel (technicians) performed during an inpatient ("IP") admission or outpatient ("OP") visit will not be reimbursed separately. Examples include, but are not limited, to intravenous ("IV") injections or IV fluid administration/monitoring, intramuscular ("IM") injections, subcutaneous ("SQ") injections, IV or PICC line insertion at bedside, nasogastric tube ("NGT") insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time, etc.) and inpatient blood transfusion administration/monitoring (with the exception of OP blood administration or OP chemotherapy administration which are submitted without observation/treatment room charges.)

Operating room time and procedure charges
The operating room ("OR") charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes. The operating room charge will reflect the cost of:

- The use of the operating room
- The services of qualified professional and technical personnel

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

Pharmacy charges
Reimbursement will be made for the cost of drugs prescribed by the attending physician. Additional separate charges for the administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel will not be reimbursed separately. All other services are included in the drug reimbursement rate. Example of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees, IV diluents such as saline and sterile water, IV Piggyback (IVPB), Heparin and saline flushes to administer IV drugs, and facility staff checking the pharmacy ("Rx") cart.

Portable charges
Portable Charges are included in the reimbursement for the procedure, test, or x-ray, and are not separately reimbursable.

Pre-operative care or holding room charges
Charges for a pre-operative care or a holding room used prior to a procedure are included in the reimbursement for the procedure and are not separately reimbursed. In addition, nursing care provided in the pre-operative care areas will not be reimbursed separately.

Preparation (set-up) charges
Charges for set-up, equipment, or materials in preparation for procedures or tests are included in the reimbursement for that procedure or test.

Recovery room charges
Reimbursement for recovery room services (time or flat fee) includes the use of all and/or available services, equipment, monitoring, and nursing care that is necessary for the patient's welfare and safety during his/her confinement. This will include but is not limited to cardiac/vital signs monitoring, pulse oximeter, medication administration fees, nursing services, equipment, supplies, (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

Recovery room services related to iv sedation and/or local anesthesia
Separate reimbursement will not be made for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post procedure room or a phase II recovery (step-down) Examples of procedures include arteriograms and cardiac catheterization.

Supplies and services
Items used for the patient which are needed as a direct result of a procedure or test are considered part of the room and board or procedure charges and are not separately reimbursable.

Any supplies, items, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately reimbursable in the inpatient and outpatient environments.

Special procedure room charge
Special procedure room charges are included in the reimbursement for the procedure. If the procedure takes place outside of the OR suite, then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Example: ICU, GI lab, etc.

Stand-by charges
Standby equipment and consumable items which are on standby, are not reimbursable. Standby charges for facility personnel are included in the reimbursement for the procedure and not separately reimbursable.

Stat charges
Stat charges are included in the reimbursement for the procedure, test, and/or X-ray. These charges are not separately reimbursable.

Supplies and equipment
Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, Oxygen, and isolation carts and supplies are not separately reimbursable.

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

Time calculation

- **Operating Room ("OR")**: Time should be calculated on the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes.

- **Hospital/ Technical Anesthesia**: Reimbursement of technical anesthesia time will be based on the time the patient enters the operating room (OR) until the patient leaves the room, as documented on the OR nurse's notes. The time the anesthesiologist spends with the patient in pre-op and the recovery room will not be reimbursed as part of the hospital anesthesia time.
- **Recovery Room**: The reimbursement of Recovery Room charges will be based on the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit ("PACU") record.
- **Post Recovery Room:** Reimbursement will be based on the time the patient leaves the Recovery Room until discharge.

Video or digital equipment used in operating room
Charges for video or digital equipment used in a surgery are included in the reimbursement for the procedure and are not separately reimbursable. Charges for batteries, covers, film, anti-fogger solution, tapes etc., are not separately reimbursable.

Additional reimbursement guidelines for disallowed charges
The disallowed charges (charges not eligible for reimbursement) include, but are not limited to, the following, whether billed under the specified Revenue Code or any other Revenue Code. These Guidelines may be superseded by your specific agreement. Please refer to your contractual fee schedule for payment determination.

The tables below illustrate examples of non-reimbursable items/services codes.

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0990 – 0999	Personal Care Items Courtesy/Hospitality Room Patient Convenience Items (0990) Cafeteria, Guest Tray (0991) Private Linen Service (0992) Telephone, Telegraph (0993) TV, Radio (0994) Non-patient Room Rentals (0995) Beauty Shop, Barber (0998) Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment Used in Operating Room
0270, 0271, 0272	Supplies and Equipment Blood Pressure cuffs/Stethoscopes Thermometers, Temperature Probes, etc. Pacing Cables/Wires/Probes Pressure/Pump Transducers Transducer Kits/Packs SCD Sleeves/Compression Sleeves/Ted Hose Oximeter Sensors/Probes/Covers Electrodes, Electrode Cables/Wires Oral swabs/toothettes; Wipes (baby, cleansing, etc.) Bedpans/Urinals Bed Scales/Alarms Specialty Beds Foley/Straight Catheters, Urometers/Leg Bags/Tubing Specimen traps/containers/kits Tourniquets Syringes/Needles/Lancets/Butterflies Isolation carts/supplies Dressing Change Trays/Packs/Kits Dressings/Gauze/Sponges Kerlix/Tegaderm/OpSite/Telfa Skin cleansers/preps Cotton Balls; Band-Aids, Tape, Q-Tips Diapers/Chucks/Pads/Briefs Irrigation Solutions ID/Allergy bracelets Foley stat lock Gloves/Gowns/Drapes/Covers/Blankets Ice Packs/Heating Pads/Water Bottles Kits/Packs (Gowns, Towels and Drapes) Basins/basin sets Positioning Aides/Wedges/Pillows Suction Canisters/Tubing/Tips/Catheters/Liners Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.) Preps/prep trays

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	Masks (including CPAP and Nasal Cannulas/Prongs) Bonnets/Hats/Hoods Smoke Evacuator Tubing Restraints/Posey Belts OR Equipment (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.) IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, fluid warmers, heparin and saline flushes, etc.)
0220 – 0222, 0229, 0250	Pharmacy Administrative Fee (including mixing meds) Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility) Patient transport fees
0223	Utilization Review Service Charges
263	IV Infusion for therapy, prophylaxis (96365, 96366) IV Infusion additional for therapy IV Infusion concurrent for therapy (96368) IV Injection (96374, 96379)
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) Medication prep Nonspecific descriptions Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges IV Solutions 250 cc or less, except for pediatric claims Miscellaneous Descriptions Non-FDA Approved Medications
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	Specimen collection Draw fees Venipuncture Phlebotomy Heel stick Blood storage and processing blood administration (Rev codes 0380, 0390 – 0392; 0399) Thawing/Pooling Fees
0270, 0272, 0300 – 0309	Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, glucose, etc.)
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	Supplies and Equipment Oxygen Instrument Trays and/or Surgical Packs Drills/Saws (All power equipment used in O.R.) Drill Bits Blades IV pumps and PCA (Patient Controlled Analgesia) pumps Isolation supplies Daily Floor Supply Charges X-ray Aprons/Shields Blood Pressure Monitor Beds/Mattress Patient Lifts/Slings Restraints Transfer Belt Bair Hugger Machine/Blankets SCD Pumps Heal/Elbow Protector

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	Burrs Cardiac Monitor EKG Electrodes Vent Circuit Suction Supplies for Vent Patient Electrocautery Grounding Pad Bovie Tips/Electrodes Anesthesia Supplies Case Carts C-Arm/Fluoroscopic Charge Wound Vacuum Pump Bovie/Electro Cautery Unit Wall Suction Retractors Single Instruments Oximeter Monitor CPM Machines Lasers Da Vinci Machine/Robot
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia Nursing care Monitoring Intervention Pre- or Post-evaluation and education IV sedation and local anesthesia if provided by RN Intubation/Extubation CPR
410	Respiratory Functions: Oximetry reading by nurse or respiratory Respiratory assessment/vent management Medication Administration via Nebs, Metered dose (MDI), etc. Charges Postural Drainage Suctioning Procedure Respiratory care performed by RN
0940 – 0945	Education/Training

Provider reimbursement
In accordance with TennCare contractor risk agreement (CRA) section A.2.13.2.2, Amerigroup shall not reimburse providers based on automatic escalators or linkages to other methodologies that escalate, such as current Medicare rates or inflation indexes, unless otherwise allowed by TennCare.

Electronic Funds Transfer and Electronic Remittance Advice
Amerigroup offers Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) with online viewing capability. Providers can choose to receive Amerigroup payments electronically through direct-deposit to their bank accounts. If providers choose to receive Amerigroup payment via EFT, they must contact one of our EFT/ERA vendors for enrollment. 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.

As a provider, you can gain immediate benefits by signing up for PaySpan Health:

- **Improve efficiency for free.** Reduce processing errors. You pay nothing to use PaySpan Health.
- **Improve cash flow.** Get payments electronically, improving cashflow.
- **Reduce accounting expenses.** Import ERAs/835s directly into practice management or health information systems, eliminating the need for manual entry.
- **Payments to advices/vouchers.** Reconcile electronic payments with advices/vouchers quickly and easily.
- **Maintain control over bank accounts.** Keep total control over the destination of claim payment funds. PaySpan Health supports multiple practices and accounts.
- **Manage multiple payers.** Reuse enrollment information to connect with multiple payers. Assign different payers to different bank accounts as desired.
- **Increase access to information.** Get faster access to adjudicated claim information and get more remittance details.
- **Mailbox capability.** Establish a mailbox for automated delivery of 835s and/or PDFs

To register for ERA/EFT, please visit our website at **provider.amerigroup.com/tn**.

PCP reimbursement
Amerigroup reimburses PCPs according to their contractual arrangement.

Specialty care provider 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 by Amerigroup.

Hospice
Effective July 1, 2018, there are no longer distinct Level 1 and Level 2 nursing facility rates in the state of Tennessee. The new blended rate will be loaded to the nursing facility Level 1 Medicaid ID.

Revenue code 0658 and procedure codes Q5003 or Q5004 should be used. The use of T codes will cause the claim to deny.

Hospices must report the NPI of any nursing facility where the patient is receiving hospice services, regardless of the level of care provided when the site of service is not the billing hospice. As of July 1, 2018, the billing hospice provider must obtain the NPI for the facility where the patient is receiving care and report the facility's name, address, and NPI in box 80 of the *UB-04* claim form. If any of the three items are missing in box 80, the claim will deny. Box 80 contains four lines with a 19-character limit on line 1 and a 24-character limit on lines 2-4.

Patient liability information should be in box 39, 40 or 41 with value code 23 and the patient liability amount. If there is no patient liability amount, please enter $0. If patient liability is left blank, the claim will deny.

Providers should bill for date of death.

Routine care (revenue code 0651 with applicable HCPCS Q codes) will be reimbursed depending on the number of days the member is in hospice. The payment will be reduced beginning with day 61. These calculations are subject to the normal wage index.

SIA payment for hospice services will include revenue code 0551 with HCPCS code G0299 (RN) or revenue code 0561 with HCPCS code G0155. Reimbursement will have a max of four hours (in 15-minute intervals) or 16 units per day combined for both disciplines. These services will occur during the last seven days of life. Per CMS, the state period cannot span accounting years.

Claims that are received for a member who has been disenrolled from hospice and elects to re-enroll within 60 days will continue with the current date/payment calculations.

Claims that are received for a member who has been disenrolled from hospice and elects to re-enroll outside of 60 days will restart routine care eligibility and day one for pricing.

Palliative care and physician charges
Services should be billed on a *CMS-1500* (professional) claim form.

For palliative care, the claim should include the appropriate required data including CPT codes, practitioner in box 24j and the hospice billing facility in box 33.

There are no benefit or lifetime maximum restrictions for palliative care.

Procedure for processing overpayments
Refund notifications may be identified by two entities, Amerigroup Cost Containment Unit (CCU) or the provider. The CCU researches and notifies the provider of an overpayment requesting a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified by Amerigroup, CCU will notify the provider of the overpayment. The provider will have the option to submit a *Refund Notification Form* along with the refund check or have the overpayment offset from future claim payments. If a provider identifies the overpayment and returns the Amerigroup check, a completed *Refund Notification Form* specifying the reason for the return must be included. This form can be found on the provider website at **provider.amerigroup.com/tn**. The submission of the *Refund Notification Form* will allow the CCU to process and reconcile the overpayment in a timely manner. For questions

regarding the refund notification procedure, please call Provider Services at **800-454-3730** and select the appropriate prompt.

Changes addressing the topic of overpayments have taken place with the passage of the Patient Protection and Affordable Care Act (PPACA), commonly known as the Healthcare Reform Act.

What does this mean for you?
The provision directly links the retention of overpayments to false claim liability. The language of 42 U.S.C.A. § 1320a-7k makes explicit that overpayments must now be reported and returned to states or respective MCOs within 60 days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the False Claims Act, including treble damages. In order to avoid such liability, health care providers and other entities receiving reimbursement under Medicare or Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the PPACA.

The provision entitled "Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments," codified at 42 U.S.C.A. § 1320a-7k, clarifies the uncertainty left by the 2009 Fraud Enforcement and Recovery Act.

This provision of the HealthCare Reform Act applies to providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations and Medicare Prescription Drug Program sponsors. It does not apply to beneficiaries.

Claim Billing Requirements for 340B Drug Pricing Providers

The Division of TennCare has announced billing requirements for providers who are registered on the Medicaid Exclusion File and participate in the federal 340B Drug Pricing Program. The modifier requirement will be determined by the presence of an NDC. While we encourage you to begin using the appropriate modifiers effective May 1, 2021, we won't begin disallowing drugs administered in an office/outpatient setting until Dec. 1, 2021. Professional and facility claims with a date of service on or after Dec. 1 for drugs administered in an office/outpatient setting will need to include one of these modifiers:

- **JG** – Drug or biological acquired with the 340B drug pricing program discount for Medicare Part B drugs for TennCare dual-eligible members
- **TB** – Drug or biological acquired with the 340B drug pricing program discount for Medicare Part B drugs for TennCare dual-eligible members (reported for informational purposes)
- **UD** – Drug or biological acquired with the 340B drug pricing program discount
- **UC** – Drug or biological acquired without the 340B drug pricing program discount

Effective Dec. 1, 2021, if a drug service is disallowed because a modifier isn't included on each applicable claim line, the line level denial will show:

- Reason code 16 – Claim/Service lacks information or has submission/billing error(s).
- Remark code N822 – Missing procedure modifier(s).

Please note that claims paid on a case rate or bundled payment are excluded from the modifier requirement. There will be no changes to the current reimbursement for drugs administered on an office/outpatient basis through the 340B Drug Pricing Program. If a claim is submitted without a valid NDC number on the drug line item, the entire claim will reject on the front end and will be sent back for correction.

Check Your Medicaid Exclusion File Participation

The Medicaid Exclusion File is maintained by the Health Resources and Services Administration (HRSA), and you can view the file and check your participation here: **340bopais.hrsa.gov/MedicaidExclusionFiles**. Please contact the HRSA directly to update your participation status.

Claim payment disputes
Provider claim payment dispute process

If you disagree with the outcome of a claim, you may begin the Amerigroup provider payment dispute process. The simplest way to define a claim payment dispute is when the claim is finalized but you disagree with the outcome.

Please be aware, there are three common claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, these are briefly defined below. They are:

- **Claim inquiry:** a question about a claim, but not a request to change a claim payment
- **Claims correspondence:** when Amerigroup requests further information to finalize a claim. Typically, these requests include medical records, itemized bills or information about other insurance a member may have. A full list of correspondence-related materials are in the *Correspondence Section* of this Provider Manual.
- **Medical necessity appeals:** a pre-service appeal for a denied service. For these, a claim has not yet been submitted.

For more information on each of these, please refer to the appropriate section in this Provider Manual.

The Amerigroup provider payment dispute process consists of two internal steps and a third external step. You will **not** be penalized for filing a claim payment dispute, and no action is required by the member.

1. **Claim payment reconsideration:** This is the first step in the Amerigroup provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.
2. **Claim payment appeal:** This is the second step in the Amerigroup provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.
3. **Regulatory complaint:** The state of Tennessee supports an external review process if you have exhausted both steps in the Amerigroup payment dispute process but still disagree with the outcome. See the Independent Review section of this Provider Manual.

A claim payment dispute may be submitted for multiple reason(s) including:

- Contractual payment issues.
- Disagreements over reduced or zero-paid claims.
- Postservice authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Retroeligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues.*

* Timely filing issues: Amerigroup will consider reimbursement of a claim, which has been denied due to failure to meet timely filing if you can 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists. Please refer to Provider Manual for additional information regarding timely filing and good cause requests.

Claim payment reconsideration
The first step in the Amerigroup claim payment dispute process is called the reconsideration. The reconsideration is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally and through our provider website within 365 calendar days from the date on the *EOP* (see below for further details on how to submit). Reconsiderations filed more than 365 calendar days from the *EOP* will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect. If a reconsideration requires clinical expertise, it will be reviewed by appropriate clinical Amerigroup professionals.

Amerigroup will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

We will send you our decision in a determination letter, which will include:
1. A statement of the provider's reconsideration request.
2. A statement of what action Amerigroup intends to take or has taken.
3. The reason for the action.
4. Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references.
5. An explanation of the provider’s right to request a claim payment appeal within 63 calendar days of the date of the reconsideration determination letter.
6. An address to submit the claim payment appeal.
7. A statement that the completion of the Amerigroup claim payment appeal process is a necessary requirement before requesting a state fair hearing.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

Claim payment appeal
If you are dissatisfied with the outcome of a reconsideration determination, you may submit a claim payment appeal.

We accept claim payment appeals through our provider website or in writing within 63 calendar days of the date on the reconsideration determination letter.

Claim payment appeals received more than 63 calendar days after the explanation of payment or the claims reconsideration determination letter will be considered untimely and will be upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. Please note, we cannot process a claim payment appeal without a reconsideration on file.

If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical Amerigroup professionals.

Amerigroup will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30

additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

The claim payment appeal determination letter will include:

1. A statement of the provider's claim payment appeal request.
2. A statement of what action Amerigroup intends to take or has taken.
3. The reason for the action.
4. Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references.
5. A statement about how to submit a state fair hearing.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

How to submit a claim payment dispute

We have several options when filing a claim payment dispute. They are described below:

- Verbal (reconsideration only): Verbal submissions may be submitted by calling Provider Services at **800-454-3730**.
- Website (reconsideration and claim payment appeal): Amerigroup can receive reconsiderations and claim payment appeals via the secure Provider Availity Payment Appeal Tool at **Availity.com**. Supporting documentation can be uploaded to the Availity Portal. You will receive immediate acknowledgement of your submission.
- Written (reconsideration and claim payment appeal): Written reconsiderations and claim payment appeals should be mailed along with the *Claim Payment Appeal Form* or the *Reconsideration Form* to:

  Provider Payment Disputes
  P.O. Box 61599
  Virginia Beach, VA 23466-1599

Submit reconsiderations on the *Reconsideration Form* located at: **provider.amerigroup.com/tn**.
Submit written claim payment appeals on the *Claim Payment Appeal* form located at: **provider.amerigroup.com/tn**.

Required documentation for claims payment disputes

Amerigroup requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal:

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

If a claim has been denied for timely filing, the following are acceptable forms of documentation for payment reconsideration:

- *EOB* or *Explanation of Medicaid Benefits* from the primary health payer dated within 120 days of claim submission to Amerigroup
- Confirmation of denial from the health payer within 120 days of claim submission to Amerigroup
- Documentation regarding the provision of the member's health plan insurance information dated within 120 days of claim submission to Amerigroup
- Documentation proving Amerigroup contributed to the filing delay
- Electronic report that states Amerigroup accepted the claim
- Computer-generated activity report that shows the date an electronic claim was originally submitted to Amerigroup (an acceptable report must contain a patient name or identification number, the date of service, and an indication the original claim was submitted electronically and accepted by Amerigroup)
- Copy of accounts receivable or billing statement to member showing dates of bills if no other insurance

The following are not acceptable forms of documentation for timely filing payment reconsideration:

- Screenshots showing dates of a claim previously submitted to the health plan
- *CMS-1450* or *UB-04* with print date located in box 31 or box 86, respectively
- Electronic report stating the health plan has rejected the claim

Claim inquiry

A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but outcome of the claim inquiry may result in the initiation of the claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Our Provider Experience program helps you with claim inquiries. Just call **800-454-3730** and select the *Claims* prompt within our voice portal. We connect you with a dedicated resource team called the Provider Service unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

Claim correspondence

Claim correspondence is different from a payment dispute. Correspondence is when Amerigroup requires more information in order to finalize a claim. Typically, Amerigroup makes the request for this information through the *EOP*. The claim or part of the claim may be denied, but it is only because more information is required to process the claim. Once the information is received, Amerigroup will use it to finalize the claim.

The following table provides examples of the most common correspondence issues along with guidance on the most efficient ways to resolve them.

Type of Issue	What Do I Need to Do?
Rejected claim(s)	Use the **EDI Hotline** at **800-590-5745** when your claim was submitted electronically but was never paid or was rejected. We're available to assist you with setup questions and help resolve submission issues or electronic claims rejections.
EOP requests for supporting documentation (*Sterilization/ Hysterectomy/Abortion Consent Forms*, itemized bills and invoices)	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the supporting documentation to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
EOP requests for medical records	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Need to submit a corrected claim due to errors or changes on original submission	Submit a *Claim Correspondence Form* and your corrected claim to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received in a timely manner, a corrected claim must be received within 365 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Amerigroup to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI *EOB*.
Submission of coordination of benefits (COB)/third-party liability (TPL) information	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the COB/TPL information to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Emergency room payment review	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599

Medical necessity appeals

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

Independent review

If Amerigroup continues to deny the provider's claim(s) or if Amerigroup does not respond to the reconsideration request within the specified time frames, then the provider may file a written request with TDCI to submit the payment dispute to an independent reviewer.

The provider must include a copy of the written request for reconsideration with the request for an independent review. If the provider does not have a written contract with Amerigroup on the date the request is filed with TDCI, then the provider must also send TDCI payment satisfactory to TDCI to cover the fees incurred by the independent reviewer. This payment will be refunded to the provider if the provider is not ultimately required to pay the independent reviewer. Otherwise, the payment will be used to reimburse any entity that paid the independent reviewer. The provider will also furnish TDCI any other information needed by TDCI to process the provider's request.

The provider must file a request for independent review within 365 calendar days after:

- The date Amerigroup denies the claim.
- The date Amerigroup recoups the claim.
- The date Amerigroup fails to respond within the specified time frames.

Claims payment disputes involved in litigation, arbitration or not associated with a TennCare member are not eligible for independent review.

TDCI will use best efforts to refer an equal proportion of the total disputed payment claims to each independent reviewer. A provider may request, and TDCI may allow, the payment claims of a provider involving Amerigroup to be aggregated and submitted for simultaneous review by an independent reviewer when the specific reason for nonpayment of the claims aggregated involve a dispute regarding a common substantive question of fact or law. The mere fact that a claim is not paid does not create a common substantive question of fact or law, unless the provider has received no remittance advice or other appropriate written or electronic notice from Amerigroup, either partially or totally denying a claim, within 60 calendar days of the receipt of the claim by Amerigroup and such claims regard a common substantive question of fact or law. The reviewer will, within 14 calendar days of receipt of the disputed claim or claims, request in writing that both the provider and Amerigroup provide the reviewer any and all information and documentation regarding the disputed claim or claims. The reviewer will request the provider and Amerigroup to identify all information and documentation that has been submitted by the provider to Amerigroup regarding the disputed claim or claims, and advise that the reviewer will not consider any information or documentation not received within 30 calendar days of receipt of the reviewer's request unless Amerigroup or the provider requests additional time to complete the investigation of independent review requests when a provider elected to aggregate his or her claims. Thereupon, the reviewer may grant Amerigroup or the provider an additional 30 calendar days. The reviewer will then examine all materials submitted and render a decision on the dispute within 60 calendar days of the receipt of the disputed claim or claims, unless either the reviewer requests guidance on a medical issue from the TennCare appeals unit, or the reviewer requests and receives an extension of time from TDCI to resolve the dispute. In reaching a decision, the reviewer will not consider any information or documentation from the provider that the provider did not submit to Amerigroup during that organization's review of the provider's disputed claim or claims.

Should the reviewer need assistance on a medical issue connected with the disputed claim or claims, then the reviewer will refer this specific issue for review and response to the person in charge of the TennCare appeals unit within the Division of TennCare, unless the department in writing designates a different contact. Medical issues requiring referral may include whether a medical benefit is a covered service under the TennCare contract. The TennCare appeals unit may respond to the request, refer the request to an independent contractor, or refer the request to the Division of TennCare for review. A request to determine whether a service received was medically necessary must be responded to by a physician licensed by one or more states in the United States. The appeals unit will provide a concise response to the request within 120 calendar days after receipt. If the appeals unit seeks the guidance of the Division of TennCare on whether a benefit is a covered service, then the Division of TennCare must respond to that request in writing in sufficient time to allow the appeals unit to timely respond to the reviewer. The reviewer will make a final decision within 30 calendar days of receipt of the appeals unit's response.

The reviewer will send Amerigroup, the provider and the TDCI TennCare Oversight Division a copy of the decision. Once the reviewer makes a decision requiring Amerigroup to pay any claims or portion thereof, Amerigroup will send the payment in full to the provider within 20 calendar days of receipt of the reviewer's decision.

Within 60 calendar days of a reviewer's decision, either party to the dispute may file suit in any court having jurisdiction to review the reviewer's decision and to recover any funds awarded by the reviewer to the other party. Any claim concerning a reviewer's decision not brought within 60 calendar days of the reviewer's decision will be forever barred. Suits filed pursuant to this section will be conducted in accordance with the Tennessee Rules of Civil Procedure, and the review by the court will be *de novo* without regard to the reviewer's decision. The reviewer, or any person assisting the reviewer in reaching a decision, will be prohibited from testifying at the court proceeding considering the reviewer's decision. Unless the contract between the parties specifies otherwise, venue and jurisdiction will be in accordance with Tennessee law. If the dispute between the parties is not fully resolved prior to the entry of a final decision by the court initially hearing the dispute, then the prevailing party will be entitled to an award of reasonable attorney's fees and expenses from the nonprevailing party. Reasonable attorney's fees means the number of hours reasonably expended on the dispute multiplied by a reasonable hourly rate and will not exceed 10% of the total monetary amount in dispute or $500, whichever amount is greater.

In lieu of requesting independent review, a provider may pursue any appropriate legal or contractual remedy available to the provider to contest the partial or total denial of the claim.

Providers who are owned by state or local governmental entities will retain the statutory right of setoff if available. Judicial review of a reviewer's decision regarding a state or local governmental provider will be in the Chancery Court of Davidson County, and not in the Tennessee Claims Commission, unless the provider and Amerigroup have agreed to another appropriate venue and jurisdiction by contract. The Prompt Pay Act, compiled in title 12, chapter 4, part 7, does not impact any claim of sovereign immunity that a state or local governmental provider may possess, although such a provider will be responsible for paying any appropriate attorney's fees and expenses awarded.

All costs associated with implementing these procedures will be paid by Amerigroup. However, the provider will reimburse Amerigroup the independent reviewer's fee within 20 calendar days of receipt of the reviewer's decision, if the reviewer finds that Amerigroup properly denied the claim being reviewed. If a provider fails to properly reimburse Amerigroup, the TDCI TennCare Oversight Division may prohibit that provider from future participation in the independent review process. The current fee associated with an independent review request is $750 (it may be subject to change at the State's discretion).

Providers who must reimburse Amerigroup the independent reviewer fee should send their check to:

Amerigroup Community Care
ATTN: Finance Department
22 Century Blvd., Suite 220
Nashville, TN 37214

Amerigroup will compensate the independent reviewer pursuant to their written agreement within 30 calendar days of the receipt by Amerigroup of the independent reviewer's bill for services rendered. If Amerigroup fails to pay any such bill for the independent reviewer's services, then the independent reviewer may request payment directly from the state from any funds held by the state that are payable to Amerigroup.

Coordination of Benefits and Third-party Liability Resources
TennCare Program requirements will be followed when third party liability resources (including subrogation) coordination of benefits procedures are necessary. Amerigroup agrees to use covered medical and hospital services whenever available or other public or private sources of payment for services rendered to members in the

Amerigroup plan. Amerigroup and its providers agree 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.

Providers have an obligation to request third-party payer information for TennCare enrollees. Providers generally request third-party information from patients at the point of service and should bill the third party prior to billing Amerigroup.

When Amerigroup is aware of third-party resources prior to paying for a medical service, it will avoid payment by denying a provider's claim and redirecting the provider to bill the appropriate insurance carrier unless certain pay and pursue circumstances apply. If Amerigroup denies a claim for third party liability, the provider may verify other health insurance by visiting our provider website at **provider.amerigroup.com/tn** or by contacting our Provider Services department at **800-454-3730** (or **866-805-4589** for Medicare providers).

When processing claims previously paid by a third-party resource, Amerigroup first reviews the primary carrier's EOP, and then the claim is coordinated by using the primary allowed amount or the Amerigroup allowed amount, whichever is the lesser. Third-party liability claims submitted for secondary payment by Amerigroup without the primary carrier's EOP will be denied stating the member has other insurance.

Pay and pursue circumstances are:

- When the services are rendered to a child under the age of 21 who does not have Medicare, including preventive, EPSDT and pediatric care
- If the claim is for prenatal or postpartum care or if service is related to OB care
- If the billed designated behavioral health services (typically not covered by major medical health plans) contain one of the following procedure codes:
    - **H0043-H0044** (supported housing)
    - **H2014-H2018** (skills training, community support and psychosocial rehab)
    - **H2023-H2027** (employment support)
    - **H0038** (peer support)
    - **T1016, T2022, T2023, H0036, H0037, H0039, H0049, H2015, H2016** (behavioral health case management services)
    - **H0031** (mental health assessments)
    - **H0019** (behavioral health residential without room and board)
    - **S9484, S9485** (crisis intervention)
- If any service rendered to a child of an absent parent (i.e., primary coverage is through a noncustodial parent after a divorce)

For these types of services, Amerigroup will pay the claim and pursue reimbursement from the appropriate party.

In some situations, Amerigroup may not learn of the existence of a third-party payer until after it has made payment on the claim. In these situations, Amerigroup has several options for recovering claim payment. One option is the provider may refund payments he or she has received from Amerigroup. Once a provider has refunded a payment received from Amerigroup, the provider may not resubmit another claim to Amerigroup for the same service furnished to the same member on the same date.

To return an overpayment to Amerigroup, a provider must complete a Refund Notification Form specifying the reason for the return.

The *Refund Notification Form* can be found at **provider.amerigroup.com/tn**. Under *Resources*, select **Forms** > **Claims & Billing** > **Refund Notification Form**.

All refunds along with a completed *Refund Notification Form* should be mailed to:

Cost Containment
Amerigroup
P.O. Box 933657
Atlanta, GA 31193-3657

If the provider does not refund the payment, Amerigroup may recover its payment to the provider if the following conditions are met:

- The claim was for a service delivered to an adult aged 21 and older, unless the adult is a pregnant woman who is receiving prenatal care.
- Fewer than nine months have passed since the date of service when there is a commercial insurer involved and fewer than two years have passed since the date of service when Medicare is involved.

Amerigroup will distribute a refund request letter that includes the:

- Name of the provider
- List of claims or a reference to a remit advice date
- Reason for the overpayment
- Contact and policy information for the third-party resource
- Time frames for payment or appeal of the decision of Amerigroup
- Information about how to file an appeal
- Request that the provider bill the commercial insurance carrier or Medicare

If the provider agrees with the refund request letter, the requested amount should be returned to Amerigroup within 45 calendar days from the date of the letter. If the provider does not agree, an appeal can be filed within 45 calendar days from the date of the refund request letter. The provider will have an additional 30 days to provide supporting documentation for the appeal. Providers should include a copy of the denial from the primary insurance carrier, if available, in the appeal request.

Please note that regardless of the type of service rendered, if Amerigroup determines that a duplicate payment has been received for a service (i.e., the provider billed and received payment from both the third-party insurance carrier and Amerigroup), Amerigroup has the right to recover the duplicate payment.

Medicaid Reclamation and Refunds for TennCare Providers

TennCare providers have an obligation to identify any available third-party liability (TPL) insurance for a particular enrollee and to bill that TPL insurance before billing TennCare. When you are paid by TennCare or Amerigroup prior to securing payment from the TPL insurance, your payments are subject to reclamation. If you then bill the TPL insurance and are notified your claim is being denied as a duplicate payment, you have an opportunity to get refunds of these payments from us or TennCare. The new TPL Policy can be accessed at **tn.gov/content/dam/tn/tenncare/documents2/con09001.pdf**.

If a member's third-party insurance denies your claim because payment has already been sent to TennCare, you may complete and submit TennCare's Provider Refund Request Form. You can find this form on the TennCare website at **tn.gov/content/dam/tn/tenncare/documents/medicaidreclamation.pdf**. For more detailed information on this process, see the TennCare Policy Manual.

If a member's third-party insurance denies your claim because payment has already been sent to us, you should contact your Amerigroup Provider Relations representative for assistance. For more detailed information on this

process, see our Medicaid Reclamation Refund Request Form, which is available in the forms appendix of this manual and on our website at **provider.amerigroup.com/tn**.

Note: When you contact TennCare with a reclamation refund request, TennCare will only pay the Medicaid amount initially paid to you on behalf of the member by Amerigroup, not the third-party insurer's rate.

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

According to CRA language 2.6.7.5 and the TennCare policy N0: PRO-08-001 (Rev. 9), providers or collection agencies acting on the provider's behalf may not bill members for amounts other than applicable TennCare cost sharing responsibilities for covered services, including services that the state or Amerigroup has not paid for, except as permitted by TennCare rules and regulations and as described below.
Providers may seek payment from a member only in the following situations:

- If the services are not covered services and, prior to providing the services, the provider informed the member that the services were not covered. The provider must inform the member of the noncovered service and have the member acknowledge the information. If the member still requests the service, the provider will obtain such acknowledgment in writing prior to rendering the service. Regardless of any understanding worked out between the provider and the member about private payment, once the provider bills Amerigroup for the service that has been provided, the prior arrangement with the member becomes null and void without regard to any prior arrangement worked out with the member.
- If the member's TennCare eligibility is pending at the time services are provided and if the provider informs the person that he or she will not accept TennCare assignment whether or not eligibility is established retroactively. Regardless of any understanding worked out between the provider and the member about private payment, once the provider bills Amerigroup for the service the prior arrangement with the member becomes null and void without regard to any prior arrangement worked out with the member.
- If the member's TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable TennCare cost sharing amounts must be refunded when a claim is submitted to Amerigroup because the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established (the monies collected will be refunded as soon as a claim is submitted and will not be held conditionally upon payment of the claim).
- If the services are not covered because they are in excess of a member's hard benefit limit, and the provider complies with applicable TennCare rules and regulations.

Amerigroup will require, as a condition of payment, that the provider accept the amount paid by Amerigroup or appropriate denial made by Amerigroup (or, if applicable, payment by Amerigroup that is supplementary to the member's third-party payer) plus any applicable amount of TennCare cost-sharing responsibilities due from the member as payment in full for the service. Except in the circumstances described above, if Amerigroup is aware that a provider, or a collection agency acting on the provider's behalf, bills a member for amounts other than the

applicable amount of TennCare cost sharing responsibilities due from the member, Amerigroup will notify the provider and demand that the provider and/or collection agency cease such action against the member immediately. If a provider continues to bill a member after notification by Amerigroup, Amerigroup will refer the provider to the Tennessee Bureau of Investigation.

Amerigroup members must not be balance-billed for an 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 120-day filing deadline
- Failure to submit a corrected claim within 120 calendar days of payment notification (paid or denied)
- Failure to dispute a claim within the 365-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 dispute 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."

Signature: _____

Date: _____

If the provider bills Amerigroup for noncovered services, the member cannot be billed, regardless of any written agreement with the member.

Amerigroup Website and the Provider Inquiry Line

Amerigroup recognizes that in order to provide the best service to members, you need accurate, up-to-date information. Amerigroup offers two methods of accessing claim status, member eligibility and authorization status 24 hours a day, 365 days a year:

- You can check the status of a claim anytime by logging in to Availity Essentials at **Availity.com*** and selecting **Claims & Payments > Claim Status**
- Toll-free automated provider inquiry line: **800-454-3730**

Our website provides a host of online resources, featuring our online provider inquiry tool for real-time claim status, eligibility verification and authorization status. Detailed instructions for use of the online provider inquiry tool can be found on our website.

Toll-free automated provider inquiry line (800-454-3730): for real-time member status, claim status and authorization status. This option also offers the ability to be transferred to the appropriate department for other needs such as requesting new authorizations, ordering referral forms or directories, seeking advice in case or care management, or obtaining a member roster. Detailed instructions on the use of the Provider Inquiry line are set forth below.

Follow these easy steps to access **member status** information:

1. Dial **800-454-3730**. After saying your **NPI** number or your **provider ID** and **TIN**, listen for the prompt.
    - You can say **member status**, **eligibility,** or **enrollment status**.
2. Be prepared to say the member's **Amerigroup number**, **ZIP code** and **date of service**.
3. You can also search by **Medicaid ID**, **Medicare ID** or **SSN**.
    - Just say **I don't have it** when asked to say the member's **Amerigroup number**, then say the ID type you would like to use when prompted for it.
4. The system will verify the member's eligibility and PCP

Say **another member** to access another member's status
Say **main menu** to perform other transactions
Say **representative** to be transferred to a live agent
Or simply **hang up** if you are done

Follow these easy steps to review **claim status**:

1. Dial **800-454-3730** and listen for the prompt.
    - At the main menu, say **claims**.
    - You can get the status of a **single claim** or the **five most recent claims**.
    - You can speak to someone about a **payment appeal form** or an **EOP**.
2. Be prepared to say the **claim number** or **member number/date of service**
    - If you don't have any of these you can hear the **five most recent claims** by saying **recent claims**.

Say **repeat** to hear the information again
Say **another claim**
Say **main menu** to perform other transactions
Say **representative** to be transferred to a live agent
Or simply **hang up** if you are done

Follow these easy steps to review **authorization** status:

1. Dial **800-454-3730** and listen for the prompt
    - At the main menu, say **authorizations** or **referrals**
    - Say **authorization status** to hear up to ten outpatient statuses or one inpatient authorization status
    - Say **new authorization** and be transferred to the correct department based on authorization type
    - Be prepared to say the member's **Amerigroup number**, **ZIP code**, **date of birth** and **date of service**
    - Say the admission date or the first date for the start of service in MM/DD/CCYY format

Say **repeat** to hear the information again
Say **another authorization**
Say **main menu** to perform other transactions
Say **representative** to be transferred to a live agent
Or simply **hang up** if you are done.

17 MEDICAL RECORDS

Amerigroup requires medical records to be maintained in a manner that is current, detailed and organized, and that promotes effective and confidential patient care and quality review. Medical records are available in the event use and disclosure of the medical records is required by law for administrative, civil and/or criminal investigations and/or prosecutions.

Providers are required to maintain medical records that conform to professional medical practice standards and appropriate health management. A permanent medical record must be maintained at the primary care site for every member and be available to the PCP and other providers with whom the member has a treatment relationship.

Medical records shall be maintained or available at the site where covered services are rendered. Enrollees (for purposes of behavioral health records, enrollee includes an individual who is age sixteen (16) or over) and their legally appointed representatives shall be given access to the enrollees' medical records, and subject to reasonable charges, be given copies thereof upon request and to request that they be amended or corrected;

Providers are to have provisions for ensuring that, in the event a patient-provider relationship with a TennCare primary care provider ends and the enrollee requests that medical records be sent to a second TennCare provider who will be the enrollee's primary care provider, the first provider does not charge the enrollee or the second provider for providing the medical records.

Medical record keeping practices are to be consistent with NCQA recommended standards for medical record documentation as follows:

1. Each page in the record contains the patient's name or ID number.
2. Personal biographical data include the address, employer, home and work telephone numbers and marital status.
3. All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier or initials.
4. All entries are dated.
5. The record is legible to someone other than the writer.
6. Significant illnesses and medical conditions are indicated on the problem list.
7. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
8. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
9. For patients 12 years and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances (for patients seen three or more times, query substance use disorder history).
10. The history and physical examination identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.
11. Laboratory and other studies are ordered, as appropriate.
12. Working diagnoses are consistent with findings.
13. Treatment plans are consistent with diagnoses.
14. Encounter forms or notes have a notation, regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months or as needed.
15. Unresolved problems from previous office visits are addressed in subsequent visits
16. There is review for under - or overutilization of consultants.
17. If a consultation is requested, there a note from the consultant in the record.
18. Consultation, laboratory and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review. (Review and signature by professionals other than the ordering practitioner do not

meet this requirement.) If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.

19. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
20. An immunization record (for children) is up to date or an appropriate history has been made in the medical record (for adults).
21. There is evidence that preventive screening and services are offered in accordance with the organization's practice guidelines.

The QM department may assess any provider's medical record documentation against the plan's clinical practice guidelines, state requirements, and HEDIS guidelines for outcome measures as needed, based on quality improvement outcomes, initiatives, and when there is a possible quality of care issue or trend identified. Assessments are performed to ensure the safety of members and compliance to standard clinical practice guidelines. Additionally, the QM department will perform routine reviews on all Contracted Opioid Buprenorphine Enhanced and Supportive Medication-Assisted Recovery and Treatment (BESMART) Providers against the TennCare required standards relevant to the TennCare Opioid BESMART Program Description (CRA A 2.11.4.1.1.1.2) and primary care Providers on EPSDT exam compliance. QM representatives conduct these audits and utilize a standard tool to measure compliance. To ensure continuity in the assessment of provider compliance, QM representatives must complete and pass an annual Inter-rator Reliability (IRR) test.

Contracted Opioid BESMART Providers must achieve a passing score of 80% in both the Program Structure and Member Audit Categories. Any score below passing may require the provider to submit a corrective or quality improvement action plan for review and approval by the health plan. Primary Care Providers are expected to achieve a score of 85% or more to be considered in compliance with EPSDT standards.

Amerigroup medical record standards for the Opioid BESMART program (adopted based on state requirements) and EPSDT Program are as follows:

TN STATE OPIOID BESMART PROGRAM STANDARDS

PROGRAM STRUCTURE	
Section I: Policy & Procedure	
1	The Provider has a defined policy and procedure for conducting a Controlled Substance Monitoring Data (CSMD) review each time and prior to prescribing, dispensing or administering opiates and/or a controlled substance. The policy should also include guidance around documenting the process in each patient's clinical record.
2	Provider employs, contracts, or partners with a behavioral health counselor to provide psychosocial assessment, addiction counseling, individual, group counseling, self-help and recovery support, and therapy for co-occurring disorders. The counselor should be independently licensed, have a master's degree, and if not independently licensed but with a master's degree they should be supervised by a licensed mental health provider (ex. LMSW supervised by LCSW)
3	Provider employs, contracts, partners, or shows effort towards, engagement with a Certified Peer Recovery Specialist (has certification through TDMHSAS) in the community for consumer education, treatment engagement, and recovery planning.
4	Provider employs, contracts, or partners with a local care coordination resource.
5	A Diversion Control Plan is in place and routine and random pill/film counts are performed.
6	A written plan to address medical emergencies including naloxone on-site is in place.
7	A written plan is in place to address psychiatric emergencies including involuntary hospitalization.

8	A policy and procedure is in place to address timely communications with other providers who are treating the member and with member's informal support system.
9	The provider has a policy and procedure for conducting routine and random drug screenings.
10	The provider assesses member experience by collecting surveys with the following elements: Support received during treatment initiation; accessibility to 7 day behavioral and/or physical health availability; and ease and ability of pharmacy services for MAT and psychiatric medications. Surveys may be completed anonymously as long as it has been documented that a survey has been completed.
MEMBER BASED ASSESSMENT	
Section II: Initial Assessment	
11	A physician performed and documented initial screening for the diagnostic criteria of an opioid use disorder diagnosis as defined in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM Code) determining the MAT program was the most appropriate level of care/treatment.
12	A physician conducted a substance use patient evaluation using standardized assessment and evaluation tools within 30 days of treatment initiation.
13	A physician conducted a psychiatric patient evaluation using standardized assessment and evaluation tools within 30 days of treatment initiation.
14	A physician conducted a full medical examination/review of systems within 30 days of treatment initiation.
15	The provider has discussed with the member about a referral to a Primary Care, Behavioral Health and/or Substance Use Disorder Specialist.
16	There is evidence that the member was trained on the provider's policy concerning involuntary termination of treatment.
17	A Narcotic or Controlled Substance Agreement (explaining risk/benefit to achieve informed consent) is present in the clinical record.
Section III: Appointment Frequency	
18	A patient in the induction or stabilization phases of treatment has had: 1. Weekly office visits scheduled;
19	2. Received counseling sessions at least twice a month;
20	3. Had one (1) observed drug screen at least weekly
21	A patient in the maintenance phase of treatment in first year has had: 1. Office visit at least every two (2) to four (4) weeks;
22	2. Received counseling sessions at least monthly;
23	3. Had an observed random drug screen at least eight (8) times annually
24	A patient in the maintenance phase of treatment for one (1) year or longer has had: 1. Have a scheduled office visit at least every two (2) months;
25	2. Follow-up counseling sessions discussed and/or considered for member; (monthly counseling sessions recommended)
26	3. Be subject to a random observed drug screen at least four (4) times annually
Section IV: Service Delivery	
27	There is evidence in the clinical record of member receiving training and education on the following topics (Note: training that occurred more than 2 years before audit was completed does NOT meet this criteria): (a) Treatment options, including detoxification, benefits/risks associated with each option;
28	(b) Risk of neonatal abstinence syndrome for all female patients of child bearing age (ages 15-44);
29	(c) Prevention and treatment of chronic viral illnesses, such as HIV and hepatitis C;

30	(d) Therapeutic benefits and adverse effects of treatment medication;
31	(e) Risks for overdose, and
32	(f) Overdose prevention and reversal agents.
33	There is evidence that the Controlled Substance Monitoring Database (CSMD) was queried each time and prior to a prescription being ordered (e.g., e-scribed/called in/written).
34	A psychosocial assessment was completed by a BH counselor.
35	For member's BH counseling services, there is a treatment plan that is individualized with problem statements specific to the member and goals/objectives are measurable, attainable, and age-appropriate for the member.
36	An individualized treatment plan was completed within 30-days of treatment initiation.
37	Member's individualized treatment plan was reviewed every six months.
38	The medication prescribed for the member reflects the preferred medication of buprenorphine/naloxone combination (as covered by the TennCare formulary) for induction as well as stabilization unless contraindicated (e.g. pregnancy) and then the buprenorphine monotherapy has been prescribed if contraindicated.
Section V: Coordination of Care	
39	A patient in the induction or stabilization phases of treatment received care coordination services weekly
40	A patient in the maintenance phase of treatment for less than or greater than one (1) year, received care coordination services at least monthly
41	Evidence that care coordination with BH counselor or provider took place within 30 days of treatment initiation and at least every 3 months following (if applicable). This can be with an internal or external provider.
42	Evidence that care coordination with Primary Care Provider (PCP) took place within 30 days of treatment initiation and at least annually (if applicable). *This item should only be skipped if there is documented refusal or documented that member was asked and reported no provider to include.*
43	Evidence that information was exchanged with PCP and/or OB/GYN for pregnant patients (e.g., sent records, requested records, phone call, updates, etc.). *This item should only be skipped if there is documented refusal or documented that member was asked and reported no provider to include.*

EPSDT EXAM STANDARDS

STD #	Standard
1	Comprehensive Health & Developmental History Present- includes Physical History, Mental Health Development History, and Dietary Practices.
2	Immunizations History is Present
3	Comprehensive Unclothed Physical completed.
4	Age Appropriate Developmental and Behavioral Screening Completed During Encounter
5	Laboratory tests or Risk Assessment for necessity of Laboratory Test, according to age, is present.
6	Vision and Hearing Screening as appropriate for age is present.
7	Anticipatory Guidance (Health Education) provided for age.
8	Documentation of any concerns or questions from the member or member's parent or guardian
9	Documentation in the chart to indicate any EPSDT services have been refused or declined during the encounter, such as immunizations, labs, or unclothed exam.

10	Evidence is present in the medical record for a referral to another medical, dental, or behavioral health provider was identified during encounter and provider documented referral assistance provided.
11	Documentation is present the provider has assessed member for a dental home or completed a dentition risk assessment.
12	Appropriate coding for EPSDT visit was used, including any codes for vaccinations, assessments, screenings, and laboratory tests if administered during the encounter.

18 CONFIDENTIALITY

Confidentiality of Information
Amerigroup complies with all state and federal law regarding the privacy and security of protected health information and the confidentiality of individually identifying information of a member or that of his/her family member. In the event of a conflict among these requirements, Amerigroup will comply with the most restrictive requirement.

All material and information, regardless of form, medium or method of communication, provided to Amerigroup by the state or acquired by Amerigroup pursuant to the TennCare Contractor Risk Agreement (Agreement) will be regarded as confidential information in accordance with the provisions of state and federal law and ethical standards and will not be disclosed. All necessary steps will be taken by Amerigroup to safeguard the confidentiality of such material or information in conformance with state and federal law and ethical standards.

Utilization management, case management, population health, 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 and the HITECH Act (A.R.R.A. Secs. 13001 et seq.). 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 within said entities who need access to such information in order to conduct utilization management and related processes.

Amerigroup ensures that all material and information, in particular information relating to members or potential members, which is provided to or obtained by or through the performance of Amerigroup under this Agreement, whether verbal, written, tape, electronic or otherwise, will be treated as confidential information to the extent confidential treatment is provided under state and federal laws. Amerigroup will not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and preservation of its rights in compliance with federal and state law.

All information as to personal facts and circumstances concerning members or potential members obtained by Amerigroup will be treated as privileged communications, held confidential, and not be divulged without the written consent of TennCare or the member/potential member, provided that nothing stated herein will prohibit the disclosure when allowed by federal or state law of information in a limited data set summary, statistical or other form which does not individually identify an individual member/patient or members of his/her family. The use or disclosure of information concerning members/potential members will be limited to purposes directly connected with the administration of this Agreement and will be in compliance with federal and state law.

Nothing in this agreement shall permit Amerigroup or the provider to share, use or disclose protected health information (PHI) in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States without express written authorization from the state.

Providers must adhere to Section 5, Responsibilities of the PCP concerning confidentiality of information.

HIPAA and the HITECH Act Compliance
The Health Insurance Portability and Accountability Act of 1996 (HIPAA), encompasses legislation intended to improve the portability and continuity of health benefits, ensure greater accountability in the area of health care fraud, ensure the privacy and security of individual protected health information, and simplify the administration of health insurance. The HITECH Act, as part of the American Recovery and Reinvestment Act of 2009, was enacted on February 17, 2009 to provide incentives to health care industry participants for the adoption of electronic health

records, to set forth a federal data breach law, and to heighten and enhance the privacy and security regulations provided under HIPAA.

In accordance with HIPAA regulations and HITECH, Amerigroup will:

- Comply with requirements of the Health Insurance Portability and Accountability Act of 1996, including the transactions and code set, privacy, security and identifier regulations, by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data partner situations required under the regulations.
- Transmit/receive to/from its providers, subcontractors, clearinghouses and TennCare all transactions and code sets required by the HIPAA regulations in the appropriate standard formats as specified under the law and as directed by TennCare so long as TennCare direction does not conflict with the law.
- Agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security and all subsequent HIPAA standards, that it will be in breach of this Agreement and will then take all reasonable steps to cure the breach or end the violation as applicable. Since inability to meet the transactions and code sets requirements, as well as the privacy and security requirements, can bring basic business practices between TennCare and Amerigroup and between Amerigroup and its providers and/or subcontractors to a halt, if for any reason Amerigroup cannot meet the requirements of this Section, TennCare may terminate this Agreement.
- Ensure that PHI data exchanged between Amerigroup and TennCare is used only for the purposes of treatment, payment or health care operations. Amerigroup shall ensure that requests by and responses to health oversight agencies are in keeping with federal regulations. All PHI data not transmitted for these purposes or for purposes allowed under the federal HIPAA regulations will be de-identified to protect the individual member's PHI under the privacy and security rules.
- Ensure that disclosures of PHI from Amerigroup to TennCare will be restricted as specified in the HIPAA regulations and will be permitted for the purposes of: treatment, payment or health care operation; health oversight; obtaining premium bids for providing health coverage; or modifying, amending or terminating the group health plan. Disclosures to TennCare from Amerigroup will be as permitted and/or required under the law.
- Report to TennCare immediately upon becoming aware of any use or disclosure of PHI in violation of this Agreement by Amerigroup, its officers, directors, employees, subcontractors or agents or by a third party to which Amerigroup disclosed PHI.
- Execute business associate agreements where required by law and specify in its agreements with any agent or subcontractor that will have access to PHI that such agent or subcontractor agrees to be bound by the same restrictions, terms and conditions that apply to Amerigroup.
- Make available to TennCare members the right to amend their PHI data in accordance with the federal HIPAA regulations. Amerigroup will also send information to members educating them of their rights and necessary steps in this regard.
- Make a member's PHI data accessible to TennCare immediately upon request by TennCare.
- Make available to TennCare within 10 calendar days of notice by TennCare to Amerigroup such information as in the possession of Amerigroup and is required for TennCare to make the accounting of disclosures required by 45 CFR 164.528. At a minimum, Amerigroup will provide TennCare with the following information:
    - The date of disclosure
    - The name of the entity or person who received the HIPAA protected information, and if known, the address of such entity or person
    - A brief description of the PHI disclosed
    - A brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure

- In the event that the request for an accounting of disclosures is submitted directly to Amerigroup, Amerigroup will within two business days forward such request to TennCare. It will be TennCare's responsibility to prepare and deliver any such accounting requested. Additionally, Amerigroup will institute appropriate record-keeping processes and procedures and policies to enable Amerigroup to comply with the requirements of this Section.
- Make its internal policies and procedures, records and other documentation related to the use and disclosure of PHI available to TennCare and to the U.S. Secretary of Health and Human Services for the purposes of determining compliance with the HIPAA regulations upon request.
- Create and adopt policies and procedures to periodically audit adherence to all HIPAA regulations, and for which Amerigroup acknowledges and promises to perform the following obligations and actions:
    - Use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the PHI Amerigroup creates, receives, maintains or transmits on behalf of TennCare.
    - Agree to ensure that any agent including a subcontractor to whom it provides PHI that was created, received, maintained or transmitted on behalf of TennCare agrees to use reasonable and appropriate safeguards to protect the PHI.
    - Agree to report to TennCare's privacy officer immediately upon becoming aware of any unauthorized use or disclosure of member PHI not otherwise permitted or required by HIPAA. Such immediate report will include any security incident of which Amerigroup becomes aware that represents unauthorized access to unencrypted computerized data and that materially compromises the security, confidentiality or integrity of member PHI maintained by Amerigroup. Amerigroup will also notify TennCare's privacy officer within two business days of any unauthorized acquisition of member PHI by an employee or otherwise authorized user of the Amerigroup system.
- If feasible, return or destroy all PHI, in whatever form or medium (including any electronic medium) and all copies of an any data or compilations derived from and allowing identification of any individual who is a subject of that PHI upon termination, cancellation, expiration or other conclusion of the Agreement. Amerigroup will complete such return or destruction as promptly as possible, but not later than 30 days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement. Amerigroup will identify any PHI that cannot feasibly be returned or destroyed. Within such 30 days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement, Amerigroup will:
    - Certify on oath in writing that such return or destruction has been completed
    - Identify any PHI which cannot feasibly be returned or destroyed
    - Certify that it will only use or disclose such PHI for those purposes that make its return or destruction infeasible
- Implement all appropriate administrative, technical and physical safeguards to prevent the use or disclosure of PHI in addition to the terms and conditions of this Agreement and including confidentiality requirements in 45 CFR Parts 160 and 164.
- Set up appropriate mechanisms to limit use or disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure.
- Create and implement policies and procedures to address present and future HIPAA/HITECH regulation requirements as needed to include: use and disclosure of data; de-identification of data; access according to the minimum necessary standard; accounting of disclosures; patients' rights to amend, access, request restrictions and confidential communications; and right to file a complaint and breach notification.
- Provide an appropriate level of training to its staff and members regarding HIPAA-related policies, procedures, member rights and penalties prior to the HIPAA implementation deadlines and at appropriate intervals thereafter.
- Track training of Amerigroup staff and maintain signed acknowledgements by staff of the Amerigroup HIPAA policies.

- Be allowed to use and receive information from TennCare where necessary for the management and administration of this Agreement consistent with the administration of the Medicaid Plan, or TennCare, and to carry out business operations.
- Be permitted to use and disclose PHI for the legal responsibilities of Amerigroup.
- Adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by Amerigroup employees and other persons, including subcontractors, performing work for Amerigroup to have only minimum necessary access to individually identifiable patient data within Amerigroup.
- For members who are deceased, continue to protect related personally identifiable information for 50 years following the date of death.
- Be responsible for informing its members of their privacy rights in the manner specified under the regulations.
- Make available PHI in accordance with 45 CFR 164.524.
- Make available PHI for amendment and incorporate any amendments to protected health information in accordance with 45 CFR 164.526.
- Obtain a third party certification of its HIPAA standard transaction compliance 90 calendar days before the start date of operations, if applicable, and upon request by TennCare.

Amerigroup will track all security incidents as defined by HIPAA. Amerigroup will periodically report in summary fashion such security incidents.

In the event of a breach, Amerigroup will indemnify and hold TennCare harmless for expenses and/or damages related to the breach. Such obligations will include mailing notifications to affected members.

In accordance with HIPAA regulations, TennCare will adhere to the following guidelines:

- Make its individually identifiable health information available to enrollees for amendment and access as specified and restricted under the federal HIPAA regulations
- Establish policies and procedures for minimum necessary access to individually identifiable health information with its staff regarding MCO administration and oversight
- Adopt a mechanism for resolving any issues of noncompliance as required by law
- Establish similar HIPAA data partner agreements with its subcontractors and other business associates

19 FRAUD, WASTE AND ABUSE

The Tennessee Bureau of Investigation Medicaid Fraud Control Division (TBI MFCD) is the state agency responsible for the investigation of provider fraud, waste and abuse in the TennCare program. Amerigroup will report suspected provider fraud, waste and abuse to TBI MFCD.

The Office of Inspector General (OIG) has the primary responsibility to investigate TennCare administration and member fraud, waste and abuse. Amerigroup will report suspected member fraud to the OIG. TennCare's Office of Program Integrity (OPI) is the State Medicaid Agency unit responsible for the prevention, detection, and investigation of alleged provider fraud, waste, and abuse of the TennCare program

Amerigroup and its network providers are required to cooperate with all state and federal agencies, including TBI MFCD and OIG, in investigating or prosecuting fraud, waste and abuse. Cooperation includes providing, upon request, information, access to records and access to interview providers and/or their employees or consultants, including those with expertise in the administration of the TennCare program and/or in medical or pharmaceutical questions or in any matter related to an investigation. Providers must make available to the TBI MFCD and OIG any and all administrative, financial, and medical records related to the delivery of items or services paid for with TennCare funds. In addition, the TBI MFCD and OIG must be allowed access to the place of business and to all TennCare records maintained by providers during normal business hours. Under certain special circumstances, TBI MFCD and OIG may request after-hours admissions. Said records are to be provided at no cost to the requesting agency.

Amerigroup maintains a written fraud, waste and abuse compliance plan designed to prevent and detect abuse, waste and fraud in the administration and delivery of services to TennCare members. Amerigroup will report all suspected and confirmed fraud, waste and abuse to the appropriate agency including:

- Suspected fraud, waste and abuse in the administration of the TennCare program will be reported to TBI MFCD, OPI and/or OIG
- Confirmed or suspected provider fraud, waste and abuse will be immediately reported to TBI MFCD or OPI
- Confirmed or suspected member fraud, waste and abuse will be immediately reported to OIG

Amerigroup will use the Fraud Reporting Forms or such other form as may be deemed satisfactory by the agency to which the report is to be made.

Member or provider fraud reporting forms can be accessed at **tn.gov/finance/fa-oig/fa-oig-report-fraud.html**. You may also email **TBI.MedicaidFraudTips@tn.gov** or ProgramIntegrity.TennCare@tn.gov to report fraud, waste or abuse**.**

Amerigroup will promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud, waste and abuse. Unless preapproval is obtained from the agency to whom the incident was reported, or from another agency (designated by the agency that received the report) after reporting confirmed or suspected fraud, waste or abuse, Amerigroup will **not** take any of the following actions as they specifically relate to TennCare claims:

- Contact the subject of the investigation about any matters related to the investigation
- Enter into or attempt to negotiate any settlement or agreement regarding the incident
- Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident

Amerigroup will promptly provide the results of its preliminary investigation to the agency to which the incident was reported, or to another agency designated by the agency that received the report.

More information on identifying fraud and abuse is located at **tn.gov/finance/fa-oig/fa-oig-fraud-info.html**. Information on ways to report fraud and abuse is located at **tn.gov/finance/fa-oig/fa-oig-report-fraud.html**.

TennCare defines **fraud** as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law (see 42 CFR 455.2).

TennCare defines **abuse** as provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (see 42 CFR 455.2).

Waste is the overutilization, underutilization, or other misuse of resources that result in unnecessary costs to the Medicaid program, such as providing services that are not medically necessary.

Health care fraud costs taxpayers increasingly more money every year. State and federal laws are designed to crack down on these crimes and impose stricter 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 prevent member and provider fraud by identifying the different types and by staging the first line of defense.

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

- **Member fraud**
    - Benefit sharing
    - Collusion
    - Drug trafficking
    - Forgery
    - Illicit drug seeking
    - Impersonation fraud
    - Misinformation/misrepresentation
    - Subrogation/third-party liability fraud
    - Transportation fraud
- **Provider fraud and abuse**
    - Billing for services not rendered
    - Billing for services that were not medically necessary
    - Unbundling
    - Upcoding

To help prevent fraud, providers can educate members about these types of fraud and the penalties levied. Also, spending time with patients/members and reviewing their records for prescription administration will help minimize drug fraud, waste 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 providing services to a patient who is not a member even if that patient presents an Amerigroup member identification card. Providers should take measures to ensure the cardholder is the person named on the card.

Every Amerigroup member identification card lists the following:

- Effective date of Amerigroup membership
- Date of birth of member
- Subscriber number (Amerigroup identification number)
- Carrier and group number (RXGRP number) for injectables
- Amerigroup logo
- Health plan name — Amerigroup Community Care
- PCP
- PCP telephone number
- PCP address
- If applicable, copays for office visits, emergency room visits and pharmacy
- Behavioral health benefit
- Vision service plan telephone number
- Amerigroup Member Services and 24-hour Nurse HelpLine telephone numbers

Presentation of an Amerigroup member identification card does not guarantee eligibility. Therefore, you should verify a member's status by inquiring online or via telephone. Online support is available for provider inquiries at **provider.amerigroup.com/tn** and telephonic verification may be obtained on the automated Provider Inquiry Line at **800-454-3730**.

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

Understanding the various opportunities for fraud and working with members to protect their Amerigroup ID card can help prevent fraud. If you suspect fraud, you should report such suspected fraud to any of the following:

- Amerigroup Special Investigations Unit Hotline at **866-847-8247** for provider or member fraud

Or report directly to the appropriate state agency:

- Office of Inspector General (OIG) at **800-433-3982** for member fraud
- Tennessee Bureau of Investigation (TBI) at **800-433-5454** for provider fraud
- State of Tennessee Office of Inspector General website at **tn.gov/finance/fa-oig.html**
- **The TBI Medicaid Fraud Control Division at** TBI.MFCU@tn.gov or the TennCare Office of Program Integrity at ProgramIntegrity.TennCare@tn.gov

No individual who reports violations or suspected fraud, waste or abuse is subject to retaliation by Amerigroup.

False Claims Act

Amerigroup requires its providers and affiliates to abide by federal and state laws and regulations governing the administration and operations of managed care entities within the health care program. This includes provider compliance with Section of 6032 of the Deficit Reduction Act of 2005 through provider's education of its employees, contractors and agents on the Federal False Claims Act. Section 6032 of the **Deficit Reduction Act of 2005** (DRA), effective January 1, 2007, requires all entities that receive $5 million or more in annual payments to establish written policies that provide detailed information about the Federal **False** Claims Act, the administrative remedies for **false** claims and statements, applicable state laws that provide civil or criminal penalties for making **false** claims and statements, the "whistleblower" protections afforded under such laws and the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs.

The DRA establishes liability for the following activities:

- Knowingly presenting or causing to be presented to an officer or employee of the United States and/or applicable state government a false or fraudulent claim for payment or approval

- Knowingly making, using or causing to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the government
- Conspiring to submit a false claim or to defraud the government by getting a false or fraudulent claim allowed or paid
- Possessing, having custody of or controlling property or money used or to be used by the government and intending to defraud the government or to willfully conceal the property, delivers or causes to be delivered less property than the amount for which the person receives a certificate or receipt
- After being authorized to make or deliver a document certifying receipt of property used or to be used by the government and with the intent to defraud the government, makes or delivers the receipt without completely knowing that the information on the receipt is true
- Knowingly buying or receiving as a pledge, obligation or debt public property from an officer or employee of the government or any person who lawfully may not sell or pledge the property
- Knowingly making, using or causing to be made or used a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the government
- Knowingly makes, uses or causes to be made or used any false or fraudulent conduct, representation or practice in order to procure anything of value directly or indirectly from the government

The federal government may impose penalties of not less than $10,781 and not more than $21,563 plus three times the amount of damages sustained by the government if there is a finding of a violation of the False Claims Act. The government may reduce the damages if there is a finding that the person committing the violation reports it within 30 days of discovering the violation and if the person cooperates fully with the federal government's investigation and if there are no criminal prosecutions, civil or administrative actions commenced at the time of the report and the person reporting does not have any knowledge of any such investigations. The federal government via the OIG may also use administrative remedies for the submission of false statements and/or claims that include administrative penalties of not more than $5,000 per false claim as well as determine whether suspension or debarment from the health care program is warranted.

Any employee who is discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against in the terms and conditions of employment by an employer due to lawful acts done by the employee on behalf of him or herself or others in furtherance of an action under this section, including investigation for, initiation of, testimony for or assistance in an action filed or to be filed under this section, is entitled to all relief necessary to make the employee whole. Such relief will include reinstatement with the same seniority status such employee would have had but for the discrimination, two times the amount of back pay, interest on the back pay and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate court for the relief provided in the subsection.

In addition, Amerigroup also requires its providers and affiliates to abide by state laws and regulations governing the administration and operations of managed care entities within the health care program. This includes compliance with the Tennessee Medicaid False Claims Act (T.C.A. § 71-5-181 et seq.) which establishes liability for the following activities:

- Presenting or causing to be presented to the state a claim for payment under the Medicaid program knowing that such claim is false or fraudulent
- Presenting or causing to be presented to the state a claim for payment under the Medicaid program knowing that the person receiving a Medicaid benefit or payment is not authorized or is not eligible for a benefit under the Medicaid program
- Making, using or causing to be made or used, a record or statement to obtain a false or fraudulent claim under the Medicaid program paid for or approved by the state while knowing that such a record or statement is false

- Conspiring to defraud the state by getting a claim allowed or paid under the Medicaid program while knowing that such claim is false or fraudulent
- Making, using or causing to be made or used a record or statement to conceal, avoid or decrease an obligation to pay or to transmit money or property to the state, relative to the Medicaid program, knowing that such record or statement is false
- Knowingly applying for and receiving a benefit or payment on behalf or another person, except pursuant to the lawful assignment of benefits under the Medicaid program, and converting that benefit or payment to his or her own personal use
- Knowingly making a false statement or misrepresentation of material fact concerning the conditions or operation of a health care facility in order that the facility may qualify for certification or recertification required by the Medicaid program
- Knowingly making a claim under the Medicaid program for a service or product that was not provided

Tennessee False Claims Acts (Tennessee Code Annotated 71-5-181 through 71-5-185) specify that:

A person or entity who presents (or causes to be presented) a claim for payment under the Medicaid program, knowing such claim is false or fraudulent, or who makes, uses or causes to be made or used, a record or statement to get a false or fraudulent claim under the Medicaid program paid for or approved by the state knowing such record or statement is false, is in violation of the Tennessee and federal False Claims Acts, and is subject to federal and state civil penalties. The state civil penalty is not less than $5,000 and not more than $25,000, plus three times the amount of damages that the state sustains because of the act of that person or entity.

Pre-admission evaluation (PAE) is submitted to TennCare for purposes of establishing eligibility for reimbursement of long term services and supports (LTSS), including nursing facility (NF) services and home and community based services (HCBS) received as an alternative to NF services. When approved, a PAE may also result in approval of Medicaid institutional eligibility and in a capitation payment to the MCO, as well as payment of claims for physical and behavioral health, pharmacy and LTSS. It is therefore critical that the information submitted on a PAE is complete and accurate, and does not result in payments being inappropriately authorized to an MCO or to the NF or other health care providers.

One situation in which NFs could submit information to TennCare in violation of the False Claims Acts is submission of an NF PAE when a person has elected to receive hospice services in the NF. Hospice services are **not** LTSS. When a person has elected to receive hospice services in an NF, the NF is providing hospice room and board and not NF services. However, if a PAE is submitted for NF services with a Medicaid-only payer date (MOPD) that Medicaid-reimbursed NF services will begin and the person meets NF level of care, a CHOICES capitation payment will be generated in error to the MCO, resulting in an overpayment and a violation of the False Claims Act. Further, the physician who certified the PAE may also be in violation of the False Claims Act, because he has certified medical necessity for NF services (which is required for approval of the PAE), when in fact, hospice services are being received.

NFs are therefore advised to NOT submit a PAE when a person has elected to receive hospice services in the NF. Another situation pertains specifically to the MOPD captured on the PAE application. This is the date that the facility certifies that Medicaid reimbursement for NF services will begin because the person has in fact been admitted to the facility and all other sources of reimbursement (including Medicare and private pay) have been exhausted. This date must be **known** (and not estimated) because it too may result in establishment of eligibility for LTSS and in many cases, eligibility for Medicaid, and in payment of a capitation payment as well as payments for Medicaid (including but not limited to LTSS) services received. To the extent that a facility submits an MOPD that is incorrect, overpayments may be made to the MCO as a result of the NF's actions, resulting in a violation of the False Claims Act.

NFs are therefore advised to ensure that staff submitting PAEs on behalf of the facility enter a MOPD *only* when such date is known and confirmed. The MOPD does **not** have to be submitted at the same time as the PAE. If you don't know the MOPD when the PAE is submitted, **leave it blank**. The PAE will still be processed. You can come back and complete the MOPD once it is known; however, do not forget to come back and enter this date when it *is* known. If an MOPD is not entered, the person will not be enrolled into CHOICES, and you will not be reimbursed for NF services.

If anyone acting on behalf of your facility has submitted any of these types of information that has resulted in an overpayment being paid — to you or to an MCO or other health care provider — you have **60 days to return any overpayments you have received and complete these notifications so that appropriate adjustments can be made and potential violations can be avoided** (See §6402 of the Affordable Care Act).

In addition, an NF's failure to provide proper notification of a change in a resident's status may result in violations of these acts. This includes situations in which a resident discharges from the facility, or remains in the facility but elects to receive hospice benefits. In these cases, if the NF does not timely notify the MCO using the form and process established by TennCare (visit the TennCare LTSS website to view memo and form 9/13/10), TennCare will continue to pay a capitation payment to the MCO for LTSS when the person is no longer receiving such services, resulting in an overpayment. In many cases, this also results in the person's eligibility in the institutional category being extended in error, payments for physical and behavioral health and pharmacy services for which the person no longer qualifies.

NFs are therefore advised to immediately submit a CHOICES Discharge/Transfer/Hospice Form to the MCO anytime a TennCare CHOICES member is discharged from your facility or is no longer receiving NF services (including when a member elects to receive hospice). This includes:

- Transfers to another nursing facility
- Discharges to the hospital (even when return to the facility is expected)
- Discharges home, with or without HCBS
- Election of hospice services
- Upon a resident's death

The Discharge/Transfer/Hospice Form is to be completed by the discharging facility and sent to the member's MCO.

Please note that while a facility is contractually obligated to submit the form for transfers to another facility and such notification is very important in terms of coordinating care for the resident, failure to notify the MCO of a transfer would not result in a potential violation of the False Claims Acts. However, failure to submit the form for discharges and hospice elections will.

When a person admits to an NF specifically for purposes of receiving hospice (rather than NF services), the person may nonetheless qualify in an institutional eligibility category once they have been "continuously confined" in the facility for a period of at least 30 days. Because a PAE is not required and should not be submitted for hospice services, TennCare can't use the PAE to prospectively establish "continuous confinement". However, upon conclusion of a 30-day institutional stay, TennCare may apply institutional income standards in determining eligibility for Medicaid services, including hospice. TennCare will not authorize Medicaid payment for LTSS; nor will a person receiving hospice in the NF be enrolled into CHOICES, since hospice services are not LTSS. A copy of the Division's hospice benefit policy is available online on the TennCare website.

For persons receiving hospice in an NF, TennCare will determine patient liability. Facilities are obligated pursuant to federal law to collect patient liability for hospice patients receiving hospice in an NF, and to use such payments to offset the cost of room and board billed to the hospice agency.

A PAE should be submitted ONLY for persons seeking Medicaid reimbursement of NF (not hospice) services. If a patient admits to the facility for NF services, facilities continue to be advised to submit a PAE as soon as you determine that Medicaid reimbursement will be needed, but no later than 10 days after the requested effective date of reimbursement. As you know, the earliest date of Medicaid reimbursement for NF services is the date that **ALL** of the following criteria are met:

- Completion of the PASRR process
- Effective date of level of care eligibility by TennCare (i.e., effective date of the PAE), which cannot be more than 10 days prior to date of submission of the approvable PAE
- Effective date of Medicaid eligibility (in most cases, the date of financial eligibility application)
- Date of NF admission

If a person appropriately enrolled into CHOICES for receipt of NF services subsequently elects to receive hospice services, the facility should not withdraw the MOPD, nor should the facility attempt to withdraw the original PAE. The PAE and MOPD are required in order for the facility to be reimbursed for NF services received prior to hospice election. Rather, the facility must submit to the MCO a CHOICES Discharge/Transfer/Hospice Form so that overpayments will not be made to the MCO since the person is no longer receiving NF services. The person who has elected hospice will be disenrolled from CHOICES, but not from Medicaid, so long as he continues to receive hospice services in the NF. The capitation payment will be adjusted accordingly.

Members who withdraw their election of hospice services may request to enroll in the CHOICES program. We would expect that such occurrences are rare, since hospice is by definition "end of life" care. An approved PAE will be required to facilitate this enrollment.

Conflict of Interest, Disclosures of Ownership and Control, and Criminal Activity

Amerigroup includes language in all subcontracts and provider agreements and any and all agreements that result from an agreement between Amerigroup and TennCare to ensure that it is maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization. No part of the total agreement amount shall be paid directly, indirectly or through a parent organization, subsidiary or an affiliate organization to any state or federal officer or employee of the state of Tennessee or any immediate family member (a spouse or minor children living in the household) of a state or federal officer or employee of the state of Tennessee as wages, compensation or gifts in exchange for acting as officer, agent, employee, subcontractor or consultant to Amerigroup in connection with any work contemplated or performed under this Agreement unless disclosed to the Commissioner, Tennessee Department of Finance and Administration.

Quarterly, by January 30, April 30, July 30 and October 30 each year, or at other times or intervals as designated by the Deputy Commissioner of the Division of TennCare, disclosure shall be made by Amerigroup to the Deputy Commissioner of the Division of TennCare, Department of Finance and Administration in writing, including a list of any state or federal officers or employees of the state of Tennessee, as well as any immediate family member of a state or federal officer or employee of the state of Tennessee who receives wages or compensation from Amerigroup, and a statement of the reason or purpose for the wages and compensation. The disclosures shall be made by Amerigroup and reviewed by TennCare in accordance with Standard Operating Procedures and the disclosures will be distributed to, among other persons, entities and organizations, the Commissioner, Tennessee Department of Finance and Administration, the Tennessee Ethics Commission, the TennCare Oversight Committee and the Fiscal Review Committee. Provider shall report any disclosures under this section directly to the Deputy Commissioner of the Division of TennCare, Department of Finance and Administration in writing and in accordance with the quarterly intervals required under this section. The provider shall report any disclosures under this section directly to the Deputy Commissioner of the Division of TennCare, Department of Finance and Administration in writing and in accordance with the quarterly intervals required under this section.

Amerigroup may be subject to sanctions, including liquidated damages, if it is determined that its agents or employees offered or gave gratuities of any kind to any state or federal officials or employees of the state of Tennessee or any immediate family member of a state or federal officer or employee of the state of Tennessee if the offering or giving of said gratuity is in contravention or violation of state or federal law.

In addition, Amerigroup is required by federal law to secure a current disclosure of ownership and a disclosure of criminal activity from each of its providers and contractors before executing any agreement with said provider or contractor. Such information shall be obtained from all individual physicians and provider entities that will be seeing patients, even if they are under a group agreement and shall be obtained at re-contracting and also at the following times: 1), at any time there is change to any such information on the disclosure form 2) at least once every three years 3) at any time upon request. Such information shall also be obtained from all of the staff at facilities who are considered managing employees or agents. This requirement also applies to nonparticipating providers when Amerigroup starts paying claims to them. TennCare will perform quarterly audits of randomly selected providers to determine that disclosures have been received. Failure to secure such disclosures may result in the assessment of penalties per occurrence/per day for every day of noncompliance. See Disclosure For Provider Entities, Disclosure For A Provider Person and Practitioner Attestation Forms in Appendix A.

Required Screenings for Excluded/Sanctioned/Debarred Employees/Contractors
The OIG of the United States Department of Health and Human Services (HHS-OIG) can exclude individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) and all federal and state health care programs (as defined in section 1128B(f) of the Social Security Act [the Act]) based on the authority contained in various sections of the Act, including sections 1128, 1128A and 1156.

When the HHS-OIG has excluded a provider, federal and state health care programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered or prescribed by excluded individuals or entities (section 1903(i)(2) of the Act and 42 CFR section 1001.1901(b)). This payment ban applies to any items or services reimbursable under a federal or state health care program, like Medicaid, which are furnished by an excluded individual or entity and extends to:

- All methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules or a prospective payment system.
- Payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients when those payments are reported on a cost report or are otherwise payable by the Medicaid program.
- Payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner or supplier that is not excluded (see 42 CFR section 1001.1901(b)). Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare members.

The listing below sets forth some examples of types of items or services that are reimbursed by Medicaid which, when provided by excluded parties, are not reimbursable:

- Services performed by excluded nurses, technicians or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays or review of treatment plans if such services are reimbursed directly or

indirectly (such as through a pay per service or a bundled payment) by a Medicaid program, even if the individuals do not furnish direct care to Medicaid recipients

- Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed directly or indirectly by a Medicaid program
- Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and reimbursed directly or indirectly by a Medicaid program
- Items or services provided to a Medicaid recipient by an excluded individual who works for an entity that has a contractual agreement with and is paid by a Medicaid program
- Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of recipients and reimbursed directly or indirectly by a Medicaid program

To further protect against payments for items and services furnished or ordered by excluded parties, Amerigroup requires all current providers and providers applying to participate in the Medicaid program to take the following steps to determine whether your employees and contractors are excluded individuals or entities:

1. Institute a policy requiring all employees and contractors immediately to disclose to you if and when they are or become excluded by the HHS-OIG or any other federal government agency.
2. Screen all employees, owners, managing agents and contractors against the System for Award Management (SAM) database (formerly GSA Excluded Parties List System) and HHS-OIG's List of Excluded Entities/Individuals database (a) prior to hiring or contracting, and (b) on a monthly basis to capture exclusions and reinstatements that have occurred since the last search.
3. Remove excluded employees and contractors immediately from responsibility for or involvement with business operations related to the federal and state health care programs and remove such employees and contractors from any position for which the employee's or contractor's compensation or the items or services furnished, ordered or prescribed by the employee or contractor are paid in whole or part, directly or indirectly, by federal or state health care programs or otherwise with federal or state funds at least until such time as the employee or contractor is reinstated into participation in the federal health care programs.
4. Report to Amerigroup any exclusion information discovered immediately via fax to the attention of the Amerigroup Tennessee Plan Compliance Officer at **866-796-4532**.

Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by TennCare and Amerigroup dependent upon which entity identifies the payment of unallowable funds to exclude individuals. Additionally, all current providers are required to conduct background checks in accordance with state law and TennCare policy. At a minimum, background checks shall include a check of the Tennessee Abuse Registry, the Tennessee Felony Offender Registry, the National and Tennessee Sexual Offender Registry, the Social Security Master Death File, the Excluded Parties List System (EPLS) and the HHS-OIG List of Excluded Individuals/Entities (LEIE). All background checks required in this section must be completed prior to the start date of employment.

Subcontracting

A provider may not subcontract any TennCare-covered service without written authorization from Amerigroup. Failure by the provider to obtain written approval from Amerigroup for a subcontract that is for the purposes of providing TennCare-covered services may lead to the contract being declared null and void at the option of TennCare. Claims submitted by the subcontractor or by the provider for services furnished by the subcontractor are considered to be improper payments and may be considered false claims. Any such improper payments may be subject to action under federal and state false claims statutes or be subject to be recouped by Amerigroup and/or TennCare as overpayment.

Return of Overpayments
In accordance with the Affordable Care Act and TennCare policy and procedures, providers must report in writing overpayments to Amerigroup and TennCare Office of Program Integrity (OPI), and when it is applicable, return overpayments to Amerigroup within 60 days from the date the overpayment is identified. Any reported and/or returned overpayments must include a detailed reason why the funds are being returned. Overpayments not returned within 60 days from the date the overpayment was identified by the provider may be a violation of state or federal law.

Reporting of Abuse of Adults and Children
All current providers must report suspected abuse, neglect and exploitation of members who are adults to Amerigroup and Adult Protective Services in accordance with T.C.A. 71-6-101 et seq. The reports should provide the following information if known:

- The name and address of the adult or of any other person responsible for the adult's care
- The age of the adult
- The nature and extent of the abuse, neglect or exploitation, including any evidence of previous abuse, neglect or exploitation
- The identity of the perpetrator if known
- The identity of the complainant if possible
- Any other information that the person believes might be helpful in establishing the cause of abuse, neglect or exploitation

All current providers must report suspected brutality, abuse or neglect of members who are children to Amerigroup and Child Protective Services in accordance with T.C.A. 37-1-401 *et seq*. To the extent known by the reporter, the report should include:

- The name, address, telephone number and age of the child
- The name, address and telephone number of the person responsible for the care of the child
- The facts requiring the report

No Payment Outside of the U.S.
All covered services to be performed by providers shall be performed in the United States of America and the provider shall not provide any payments for covered items or services to any financial institution, entity or person located outside the United States.

Billing Agents and Alternative Payees
Providers are not permitted to assign TennCare funds/payment to billing agents or alternative payee without executing a billing agent or alternative payee assignment agreement. Such billing agents and alternative payees are subject to initial and monthly federal exclusion (LEIE) and debarment (SAM) screening if the alternative payee assignment is ongoing. Further, TennCare direct and indirect payments to out-of-country individuals and/or entities are prohibited.

Payment Error Rate Measurement and Provider Obligations
Payment Error Rate Measurement (PERM) is a program implemented by CMS to measure improper payments in the Medicaid Program and CHIP. CMS audits TennCare payments for these programs every three years. If you are one of the providers randomly selected to supply medical and payment records, you must comply with the CMS request within 60 days. For more information about PERM, check the TennCare website at www.tn.gov/tenncare/providers.html

Provider-Preventable Conditions
Provider shall comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment by, at a minimum, nonpayment of provider preventable conditions, as well as appropriate reporting of these conditions to Amerigroup and TennCare.

Onsite Inspections and Audit of Records
TennCare, CMS, OIG, the Comptroller General or their representatives may conduct onsite inspections of premises, physical facilities and equipment of all health facilities and service delivery sites and audit any records or documents to be utilized by Amerigroup in fulfilling the obligations under the contract. Inspections may be made at any time during the contract period and without prior notice. The right to audit exists for 10 years from the final date of the contract period or the from the date of completion of any audit, whichever is later.

20 PROVIDER COMPLAINT PROCEDURES

Amerigroup has a formal process for the handling of complaints pertaining to administrative issues and nonpayment related matters. For payment disputes, see Section 16, Claims Payment Disputes. Providers may access this process by filing a written dispute.

Providers are not penalized for filing complaints. Any supporting documentation should accompany the complaint.

A provider can file a complaint in writing to:

Amerigroup Community Care
Attention: Operations Department – Provider Complaint
22 Century Boulevard, Suite 220
Nashville, TN 37214

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

21 TennCare CoverKids

Introduction
Amerigroup Community Care administers the CoverKids program on behalf of the State of Tennessee. Effective January 1, 2021, CoverKids is supported by Amerigroup Community Care CoverKids Network. The CoverKids program provides both maternity and medical benefits for children under age 19 years and pregnant women 19 years and over. Pregnant women stay eligible for CoverKids benefits through a 60-day postpartum period. This period begins the last day of the pregnancy and ends on the last day of the month in which the 60-day period ends.

Unlike TennCare Kids, CoverKids does have an out-of-pocket maximum which is calculated by the member's Managed Care Organization (MCO).

Benefits And Copays (Cost Sharing) :

	Benefit Level		
	1	**2**	**3**
Office/Outpatient Services			
Primary Care Visit • Office visit with family practice, general practice, internal medicine, OB/GYN, pediatrics, and walk in clinics • Includes nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider	$15 Copay	$5 Copay	No Copay
Specialist Visit and Outpatient Surgery • Office visit with any specialty provider • Outpatient surgery including invasive diagnostic services (e.g., colonoscopy) - **Single copay per date of service**	$20 Copay	$5 Copay	No Copay
Behavioral Health (Mental Health, Alcohol and Drug Abuse)) Services • Office visit • Outpatient Mental health and substance use disorder - **Single copay per date of service**	$15 Copay	$5 Copay	No Copay
Chiropractors • Only covered for children under age 19	$15 Copay	$5 Copay	No Copay
Rehabilitation and Therapy Services • Including Speech, Physical and Occupational • Limited to 52 visits per therapy type per Calendar Year	$15 Copay	$5 Copay	No Copay

	Benefit Level		
	1	**2**	**3**
Pharmacy - Benefits managed by OptumRx			
30 and 90-Day Supply/Specialty Pharmacy Drugs • The CoverKids formulary differs from TennCare's. The CoverKids formulary is available online at: optumrx.com/coverkids. • The CoverKids Pharmacy Benefit Appeal process differs from the CoverKids Medical Benefit Appeal process. For assistance in filing an appeal, the OptumRx Member Services Call Center is available 24/7 at: **844-568-2179**.	$5 generic $20 preferred brand $40 non-preferred brand	$1 generic $3 preferred brand $5 non-preferred brand	No Copay
Non-Emergency Care			
Emergency Room Visit deemed as NOT a True Medical Emergency • Facility (Medical & Behavioral Health (Mental Health, Alcohol and Drug Abuse), including Urgent Care • MUST be an In-Network Provider. If Out of Network provider, CoverKids will NOT pay.	$50 Copay	$10 Copay	No Copay
Inpatient Stays			
Inpatient Facility (Medical and Behavioral Health [Mental Health, Alcohol and Drug Abuse]) • Copay waived if readmitted within 48 hours of initial visit for same episode of illness or injury • Rehabilitation services • Mental Health, Alcohol and Drug Abuse Treatment	$100 Copay per admission	$5 Copay per admission	No Copay
Vision Services- These Services are only eligible for children under age 19. When both frames and lenses are ordered at the same time, one copay is charged			
Prescription Eyeglass Lenses • Including bifocal or trifocal • Limited to one per Plan Year	$15 Copay $85 Max Benefit	$5 Copay $85 Max Benefit	No Copay
Prescription Contact Lenses instead of Eyeglass Lenses • Limited to one per Plan Year	$15 Copay $150 Max Benefit	$5 Copay $150 Max Benefit	No Copay
Frames • Limited to every 2 Plan Years	$15 Copay $100 Max Benefit	$5 Copay $100 Max Benefit	No Copay

CoverKids Benefits (Effective January 1, 2021)

SERVICE		BENEFIT LIMIT
Ambulance Services,Air and Ground		As medically necessary.
Chiropractic care		**Children Under Age 19:** Maintenance visits not covered when no additional progress is apparent or expected to occur. **Mothers (Age 19 and over) of Eligible UnbornChildren:** Not Covered
Clinic Services and other Ambulatory Health Care Services		As medically necessary
Dental Services		**Dental Services shall be provided by the Dental Benefits Manager (DBM).** Facility, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall be covered services provided by the CONTRACTOR when the dental service is covered by the DBM.
Disposable MedicalSupplies		As medically necessary. Specified medical supplies shall be covered/non-coveredin accordance with TennCare Division rules and regulations.
Durable Medical Equipment (DME)		Must be medically necessary. Durable medical equipmentand and other medically related or remedial devices: Limited to the most basic equipment that will provide the needed care. Hearing aids are limited to one per ear per calendar year up to age 5, and limited to one per ear every two years thereafter. Specified DME services shall be covered/non-covered in accordance with TennCare Division rules andregulations.
Home HealthServices		Prior approval required. Limited to 125 visits per enrollee per calendar year.
Hospice Care		As medically necessary. Shall be provided by a Medicare certified hospice.
Inpatient HospitalServices		As medically necessary, including rehabilitation hospital lfacility.
Inpatient MentalHealth and Substance Use Disorder Services		As medically necessary.
Lab and X-rayServices		As medically necessary.
Outpatient MentalHealth and Substance Use Disorder Services		As medically necessary.

Outpatient Hospital Services		As medically necessary.

SERVICE		BENEFIT LIMIT
Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.		Limited to 52 visits per calendar year per type of therapy.
PhysicianInpatient Services		As medically necessary.
Physician Outpatient Services/CommunityHealth Clinic Services/Other ClinicServices		As medically necessary.
Prenatal care and pre-pregnancy family services and supplies		As medically necessary.
Preventive CareServices		As described in Section A.2.7.5.
Skilled NursingFacility services		Limited to 100 days per calendar year following an approved hospitalization.
Surgical Services		As medically necessary.
Vision Services		**Children Under Age 19:** 1. Annual vision exam including refractive exam andglaucoma screening. 2. Prescription eyeglass lenses. Limited to one pair percalendar year. $85 maximum benefit per pair. 3. Eyeglass frames. Coverage for replacement frames limited to once every two calendar years. $100 maximumbenefit per pair. 4. Prescription contact lenses in lieu of eyeglasses. Limited to one pair per calendar year. $150 maximumbenefit per pair. **Mothers (Age 19 and over) of Eligible Unborn Children:** Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), shall be covered as medically necessary. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered.One pair of cataract glasses or lenses is covered for adults following cataract surgery.

Out-of-Network Providers do not have a contract with the plan. This means the Provider will be able to charge the Member more than the amount set by the plan in their contracts. With Out-of-Network Providers, the Member will be responsible for the full amount that is charged.

Obtaining services not listed in the Member Handbook or not in accordance with Our Medical Management Policies and Procedures may result in the denial of payment. Obtaining prior authorization is not a guarantee of coverage. Our Medical Policies can help the Provider determine if a proposed service will be covered.

Referrals are not required for specialty care including well woman care.

Eligible Providers of Service

All services must be rendered by a Practitioner listed in the Directory of Network Providers. The services provided by a Practitioner must be within his or her specialty or degree. All services must be rendered by the Practitioner, or the delegate actually billing for the Practitioner, and be within the scope of his or her licensure.

An individual or facility, other than a Practitioner, duly licensed to provide Covered Services and listed in the Directory of Network Providers.

No benefits will be paid for services received from Out-of-Network Providers under this Plan. There are two exceptions to this:

1. There are benefits for Out-of-Network, hospital-based Practitioners in a Network facility.
2. In a true Emergency, there are benefits for Out-of-Network Providers (Facility and Practitioners).

Exclusions from Coverage for CoverKids participants

(1) The services and items set out in the TennCare Medicaid Exclusions Rule 1200-13-13-.10(1) and (3)(b) are excluded from coverage by the CoverKids program. View TennCare's benefit exclusions in the Exclusions section of the TennCare Rules on **publications.tnsosfiles.com/rules/1200/1200-13/1200-13-13.20220517.pdf**. Find 1200-13-13-10.

(2) In addition to the services and items excluded by (1), view other services, products and supplies also excluded from coverage by the CoverKids program. View TennCare's benefit exclusions for CoverKids in the Exclusions section of the TennCare Rules on **publications.tnsosfiles.com/rules/1200/1200-13/1200-13-21.20210411.pdf**. Find 1200-13-21-.06

CoverKids participants are not eligible for enrollment in the Vaccines for Children (VFC) program. The providers may bill for vaccines and the administration fee's and will be reimbursed as per their contractual fee schedule.

EPSDT (Early and Periodic Screening, Diagnostic and Treatment) does not apply to CoverKids. We do not require prior authorization for periodic and interperiodic screens PCP's conduct.

APPENDIX A — FORMS

Certification and Claim Submission Forms

1. **WIC Form —** A sample form that providers may use to make referrals to WIC, a provider agency
2. **Precertification Request —** Providers can use this form to submit a request for a precertification or for a notification of services
3. **CMS 1500 Claim Form —** A sample claim form
4. **CMS 1450 Claim Form —** A sample claim 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 not 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: _____

Amerigroup

Medicaid

Precertification Request Form

Today's date:
Provider return fax:

Prior authorization phone: 800-454-3730
Prior authorization fax: 800-964-3627

Member information		
First name:	Last name:	Amerigroup Community Care member ID:
Address:		City, State and ZIP code:
DOB:	Contact phone:	
Additional member information:		

Referring provider	**Participating**	**Nonparticipating**	
Full name:			
NPI:		Provider ID:	Tax ID number (TIN):
Office contact name:		Office phone:	Office fax:
Address:		City, State and ZIP code:	
Specialty:			

Servicing provider	**Participating**	**Nonparticipating**	
Full name:			
NPI:		Provider ID:	TIN:
Office contact name:		Office phone:	Office fax:
Address:		City, State and ZIP code:	
Specialty:			

Servicing facility	**Participating**	**Nonparticipating**	
Name:			
NPI:		Provider ID:	TIN:
Facility contact name:		Facility phone:	Facility fax:
Address:		City, State and ZIP code:	

Requested service (for type of service, check all that apply)	**Date/date range of service:**
ICD-10 code(s):	
CPT® code(s) (include requested units):	

Type of service: ☐ Outpatient ☐ Planned inpatient ☐ Emergent inpatient ☐ Skilled nursing facility ☐ Long-term services and supports/long-term care ☐ Home health

☐ Durable medical equipment ☐ Diagnostic study ☐ Hospice ☐ Office visit ☐ Personal care services ☐ Other:

Place of service: ☐ Hospital ☐Ambulatory surgery center ☐ Office ☐ Home ☐ Independent lab ☐ Nursing facility ☐ Other:

Additional information:

Please submit all appropriate clinical information, provider contact information and any other required documents with this form to support your request. If this is a request for extension or modification of an existing authorization from Amerigroup, please provide the authorization number with your submission.

To prevent any delay in processing your request, please fill out this form in its entirety.

Emergent: Use for **all** nonelective **inpatient** admissions only when provider indicates that the admission was urgent, emergent, or expedited (for admission on same day).

Urgent: Use for **outpatient** services only when provider indicates that the service is urgent, emergent, or expedited.

https://provider.amerigroup.com/TN

CMS-1500 (02-12) Claim Form

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) 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. RESERVED FOR NUCC USE	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. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) YES NO	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.
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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. 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. Rsvd for NUCC Use		
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. b.		33. BILLING PROVIDER INFO & PH # ( ) a. b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTI0NS 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 TENNCARE 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 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 CFA 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 TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE 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, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the Information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor;3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision;4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including bin not limited to the Federal anti-kickback statute and Physician Sell-Referral law (commonly known as Stark law);5} the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE;6} for each service rendered incident to my professional service, the identity (legal name and NPI, license number, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1} they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an Integral, although Incidental part of a covered physician 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 TENNCARE 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: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to line and Imprisonment under applicable Federal laws.

NOTICE TO PAT1ENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMAT10N (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for intonation needed in the administration of the Medicare, TRICARE, 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. E.g., 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 TRICARE 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 TRICARE/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 TRICI\RE.

DISCLOSURES: Voluntary; however, failure to provide intonation 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 intonation. 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 lor withholding this intonation.

You should be aware that P.L. 10Q-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify Information by way of computer matches.

MEDICAID 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, 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.

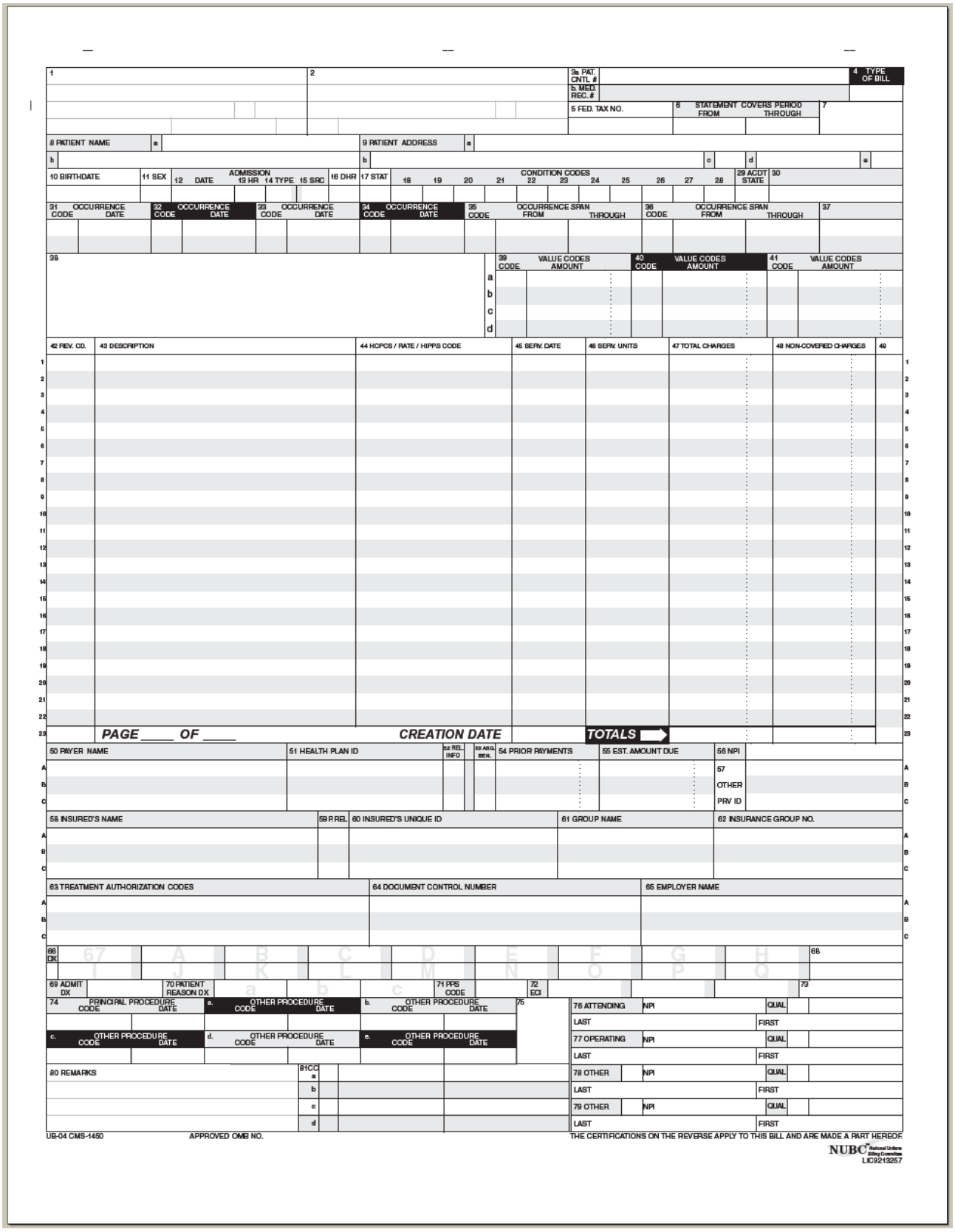
SIGNATURE OF PHYSICIAN (OR SUPPIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

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 Federaland 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 0938-1197. 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, 7500 Security Boulevard, Attn: PAA Reports Clearance Officer, Mail Stop C4-26-05, 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 **cms.hhs.gov**.



UNIFORM BILL: **NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.**

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or 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 particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.

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 Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.

5. Signature of patient or his/her representative on certifications, authorization to release information, and payment request, as required be Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1088, 32 CFR 199) and, any other applicable contract regulations, is on file.

6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing 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 their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

   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.

9. For CHAMPUS purposes:

   This is to certify that:

   (a) the information submitted as part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

   (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance 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 coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS 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 but excluding contract surgeons or other personnel employed by the Uniformed Services through 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 the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

   (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, 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. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

Refund Notification Form

Amerigroup
An Anthem Company

https://providers.amerigroup.com

Overpayment Refund Notification Form

In order for the overpayment refund to be processed in a timely manner, please submit a completed form with all refund checks and supporting documentation. If the refund check you are submitting is an Amerigroup Community Care check, please include a completed form specifying the reason for the return of the check.

Provider information	
Provider name/contact:	
Contact number:	Provider ID:
NPI number:	Provider tax ID:
Subscriber ID:	DCN number (Displayed on CCU letter):
Member information	
Member name:	
Member account number:	Date of service:
Total billed charges:	Claim number:
Overpayment information	
Total check amount:	Date overpayment identified:
Date range/time frame the issue(s) occurred:	Specific CPT/HCPCS/DRG code(s) involved with the reimbursement:
Have you performed due diligence to ensure this voluntary refund is isolated only to the identified claim(s)? ☐ Yes ☐ No	
Did you self-identify the overpayment? ☐ Yes ☐ No	
If no, then briefly explain who identified the overpayment and issues or billing codes that were identified.	

TNPEC-2223-18 March 2018

Additional claim(s)			
Claim number	**Member name**	**Member account #**	**Date of service**

Reason for refund or check return:

- ☐ Amerigroup letter
- ☐ Contract rate change
- ☐ Duplicate payment
- ☐ Incorrect member
- ☐ Incorrect provider
- ☐ Negative balance
- ☐ Other health insurance/third-party liability
- ☐ Payment error
- ☐ Billed in error/adjusted charge
- ☐ Other: _____

All refund checks should be mailed with a copy of this form to:
Amerigroup Community Care
P.O. Box 933657
Atlanta, GA 31193-3657

Once the Amerigroup Cost Containment Unit has reviewed the overpayment, you will receive a letter explaining the details of the reconciliation. Thank you for completing this *Overpayment Refund Notification Form*.

Medical Record Forms

Medical Record Forms: These are sample medical record forms that the provider may choose to use.
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

Problem Number	Date	Active Problem/Diagnosis	Date Resolved

Addressograph

MEMBER NAME: _____

DOB _____ EFF DATE _____

ID #_____ SSN #_____

Problem List 2

NAME: _____
DOB: _____
TELEPHONE: _____
MEMBER ID NUMBER:_____

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

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

Counsel for HIV Antibody Blood Test: This is a sample counsel form that the provider may choose to use.

Consent for HIV Antibody Blood Test: This is a sample consent form that the provider may choose to use.

Results of the HIV Antibody Blood Test: This is a sample results form that the provider may choose to use.

Counsel for HIV Antibody Blood Test

use patient imprint

Name: _____

In accordance with Chapter 174, P.L. 1995:

I acknowledge that _____ has counseled
(Name of physician or other provider)
and provided me with:

A. Information concerning how HIV is transmitted
B. The benefits of voluntary testing
C. The benefits of knowing if I have HIV or not
D. The treatments which are available to me and my unborn child should I test positive
E. The fact that I have a right to refuse the test and I will not be denied treatment

I have consented to be tested for infection with HIV. ☐

I have decided not to be tested for infection with HIV. ☐

This record will be retained as a permanent part of the patient's medical record.

_____ _____
Signature of Patient Date

_____
Signature of Witness

Consent for the HIV Antibody Blood Test

I have been told that my blood will be tested for antibodies to the virus named HIV (Human Immunodeficiency Virus). This is the virus that causes AIDS (Acquired Immunodeficiency Syndrome), but it is not a test for AIDS. I understand that the test is done on blood.

I have been advised that the test is not 100 percent accurate. The test may show that a person has antibodies to the virus when 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 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

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 test for
(Name or title of person who is to receive results)
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 for 12 months indefinitely or until _____, 20____, whichever is shorter unless I withdraw my permission.

I have the right to withdraw my permission at any time. I cannot take back information that has been used to take action on my case or that has been given to you before I take back my permission. To withdraw my permission, I can write the Department of Human Services in my county, or write my doctors, hospitals or other health care providers or insurance company or health plan.

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

G. If this authorization is signed by my personal representative, a description of such representative's authority to act for me in the capacity of health care decisions must be provided. Legal authority as personal representative, i.e., conservatorship, etc., must be attached or documentation must be on file in plan or provider's records.

Note: this form must be in at least 8-point type.

Blood Lead Risk Forms

Verbal Blood Lead Risk Assessment: This is a sample assessment form that the provider may choose to use.

Blood Lead Testing for High-risk Children: This is a sample assessment form that the provider may choose to use.

Elevated Blood Lead Testing Result Form: This is a sample results form the provider may choose to use.

Verbal Blood Lead Risk Assessment

Member Name: _____
Date: _____
ID Number: _____
Person Interviewed/Relationship: _____

	Yes	No
Does your child live in or regularly visit a house built before 1960? Does the house have chipping or peeling paint?		
Was your child's day care center/preschool/babysitter's home built before 1960? Does the house have chipping or peeling paint?		
Does your child live in or regularly visit a house built before 1960 with recent, ongoing or planned renovation or remodeling?		
Have any of your children or their playmates had lead poisoning?		
Does your child frequently come in contact with an adult who works with lead? Examples include construction, welding or pottery.		
Do you give your child home or folk remedies that may contain lead?		

Blood Lead Testing for High-Risk Children

Member Name: _____
Date: _____
ID Number: _____
Person Interviewed/Relationship: _____

Has your child's blood been tested for lead?	Yes	No
When your child was last tested?	Date:	
What was the result?	Result:	
Has the child seen the pediatrician since his or her last blood test?	Yes	No
When?	Date:	
Was the child tested for lead poisoning?	Yes	No
When?	Date:	

- If the PCP has not seen the child, encourage and help arrange a visit.
- If it has been over one year since the child's last visit, encourage and help arrange a visit.
- If the child has been/is being treated for lead poisoning, apply risk assessment and encourage continuation of follow-up. Assist member through any barriers identified.

Elevated Blood Lead Testing Result Form

Member Name:_____ Date: _____

ID Number: _____ Date of Birth: _____

Provider Name: _____ Provider ID Number: _____

Has a risk assessment been performed? ❑Yes ❑No

Environmental risks (please specify):

When was the member tested for lead poisoning? Date:_____

When the member was last tested for lead poisoning? Date:_____

Result:_____

Laboratory that performed testing: _____

Planned follow-up treatment:

_____ _____
Provider Signature Date

Please fax the completed form to **Attn: Pediatric CM** at **866-495-5788** within five days of notification of an elevated lead blood level.

Abortion, Hysterectomy and Sterilization Forms

Every time you submit a claim for the procedures for abortion, hysterectomy and sterilization services and related procedures, (i.e., ancillary procedures such as anesthesia services), you must include one of the following applicable forms for reimbursement and/or such form must be on file for the service. The form must be filled out correctly and in its entirety:

- Certification of Medical Necessity for Abortion
- Sterilization Consent Form
- Hysterectomy Acknowledgment Form

Printable forms and instructions to complete the forms are on the Division of TennCare website at https://www.tn.gov/tenncare/providers/tenncare-provider-news-notices-forms/miscellaneous-provider-forms.html. Failure to fully complete these forms in accordance with the applicable instructions will result in the denial of your claim.

Note: Amerigroup and TennCare will only accept the Sterilization Consent form with the 2018 expiration date. Claims with consent forms that show any other expiration date will be denied.

Practitioner Evaluation and Audit Tools

Practitioner Evaluation and Audit Tools: These tools may be used by Amerigroup when auditing provider medical records for credentialing or investigation of quality management issues.

Practitioner Office Site Evaluation

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
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	2				
alternative plan of action? Access throughout the office including bathroom(s)?					
2 Is accessible parking clearly marked? (Sign/painted symbol on pavement) Only applies to off-street parking;	2				
N/A is parking is street-side only.					
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	2				
spills on floors / furnishings)					
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?	2				
(If not appropriate, check N/A)					

* 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

_____ _____
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

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

Advance Directive

I, _____, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

If at any time I should have a terminal condition and my attending physician has determined there is no reasonable medical expectation of recovery and which, as a medical probability, will result in my death, regardless of the use or discontinuance of medical treatment implemented for the purpose of sustaining life, or the life process, I direct that medical care be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medications or the performance of any medical procedure deemed necessary to provide me with comfortable care or to alleviate pain.

ARTIFICIALLY PROVIDED NOURISHMENT AND FLUIDS:
By checking the appropriate line below, I specifically:
_____ Authorize the withholding or withdrawal of artificially provided food, water or other nourishment or fluids.

_____ DO NOT authorize the withholding or withdrawal of artificially provided food, water or other nourishment or fluids.

ORGAN DONOR CERTIFICATION:
Notwithstanding my previous declaration relative to the withholding or withdrawal of life-prolonging procedures, if as indicated below I have expressed my desire to donate my organs and/or tissues for transplantation, or any of them as specifically designated herein, I do direct my attending physician, if I have been determined dead according to Tennessee Code Annotated, § 68-3-501(b), to maintain me on artificial support systems only for the period of time required to maintain the viability of and to remove such organs and/or tissues.
By checking the appropriate line below, I specifically:
_____ Desire to donate my organs and/or tissues for transplantation
_____ Desire to donate my _____
(Insert specific organs and/or tissues for transplantation)

_____ **DO NOT** desire to donate my organs or tissues for transplantation

In the absence of my ability to give directions regarding my medical care, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical care and accept the consequences of such refusal.

The definitions of terms used herein shall be as set forth in the Tennessee Right to Natural Death Act, Tennessee Code Annotated, § 32-11-103.

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

In acknowledgment whereof, I do hereinafter affix my signature on this the _____ day of _____, 20____.

_____
Declarant

We, the subscribing witnesses hereto, are personally acquainted with and subscribe our names hereto at the request of the declarant, an adult, whom we believe to be of sound mind, fully aware of the action taken herein and its possible consequence.

We, the undersigned witnesses, further declare that we are not related to the declarant by blood or marriage; that we are not entitled to any portion of the estate of the declarant upon the declarant's decease under any will or codicil thereto presently existing or by operation of law then existing; that we are not the attending physician, an employee of the attending physician or a health facility in which the declarant is a patient; and that we are not persons who, at the present time, have a claim against any portion of the estate of the declarant upon the declarant's death.

_____
Witness

_____
Witness

STATE OF TENNESSEE
COUNTY OF _____

Subscribed, sworn to and acknowledged before me by _____, the declarant, and subscribed and sworn to before me by _____ and _____, witnesses, this _____ day of _____, 20____.

_____
Notary Public

My Commission Expires: _____

Advanced Care Plan

TennCare's Advance Directive forms are available at **tn.gov/health/health-program-areas/health-professional-boards/hcf-board/hcf-board/advance-directives.html**.

Appointment of Health Care Agent

I, _____, give my agent named below permission to make health care decisions for me if I cannot make decisions for myself, including any health care decision that I could have made for myself if able. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place.

Agent:

_____
Name

_____
Address

_____
City State ZIP Code

_(___)_____
Area Code Home Phone Number

_(___)_____
Area Code Work Phone Number

_(___)_____
Area Code Mobile Phone Number

Alternate:

_____
Name

_____
Address

_____
City State ZIP Code

_(___)_____
Area Code Home Phone Number

_(___)_____
Area Code Work Phone Number

_(___)_____
Area Code Mobile Phone Number

_____ _____
Patient's name (please print or type) Date Signature of patient (must be at least 18 or emancipated minor)

To be legally valid, **either** block A **or** block B must be properly completed and signed.

Block A Witnesses (two witnesses required)

1. I am a competent adult who is not named above. I witnessed the patient's signature on this form.

_____
Signature of witness number 1

2. I am a competent adult who is not named above. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of witness number 2

Block B Notarization

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is shown above as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ _____
Signature of Notary Public

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 3, 2005

Behavioral Health Forms

Behavioral Health Forms: On the following pages, you will find sample behavioral health forms that you may choose to use.

Discharge Report Form
Request for Substance Use Disorder PHP/IOP Services Form (PF-TN-0007-11)
Request for Comprehensive and Family Treatment – CCFT (PF-TN-0009-12)
Request for Continuous Treatment Team Services Form – Adults Only (PF-TN-0010-12)
Request for Continuous Treatment Team Services Form – Child/Adolescent Only (PF-TN-0011-12)
Request for Supported Housing Services Form (PF-TN-0012-12)
Request for Residential Treatment Services Form (PF-TN-0013-12)

Amerigroup
An Anthem Company

866-920-6006 (Fax) **800-454-3730** (Phone)
This form should be completed and submitted to Amerigroup Community Care within 48 hours of all inpatient, IOP, RTC, sub acute, SH/SR and PHP discharges and within 7 days of all CTT, CCFT and PACT discharges.

Discharge Report Form

Type of service: ☐ CTT ☐ CCFT ☐ IP ☐ IOP ☐ PACT ☐ PHP ☐ SH/SR ☐ Subacute ☐ RTC ☐ Other:_____

Type of discharge: ☐ Successful/goals met ☐ Unsuccessful/treatment baseline ☐ Treatment refusal ☐ AMA ☐ Eligibility change/termination ☐ Administrative discharge (i.e., rule violation)

DEMOGRAPHICS		
Admission date:	**Discharge date:**	**Units/days used:**
Patient's name:	**SS#:**	**DOB:**
Discharge address:		
City:	**State:**	**ZIP:**
Guardian/conservator:		

AFTERCARE APPOINTMENTS				
Provider:	**Service type:**		**Appointment date:**	
	Contact #:		**Appointment time:**	
Provider:	**Service type:**		**Appointment date:**	
	Contact #:		**Appointment time:**	
Provider:	**Service type:**		**Appointment date:**	
	Contact #:		**Appointment time:**	
Provider:	**Service type:**		**Appointment date:**	
	Contact #:		**Appointment time:**	

DISCHARGE DIAGNOSIS			
AXIS I:			
AXIS II:			
AXIS III:			
AXIS IV:			
AXIS V:			

DISCHARGE MEDICATIONS (include dosage and frequency)		

DISCHARGE MENTAL HEALTH STATUS			
Alert:	☐ Yes ☐ No	**Thought content and process:**	☐ Coherent ☐ Illogical ☐ Irrational
Orientation to:		**Memory:**	
Person	☐ Yes ☐ No	**Remote**	☐ Intact ☐ Impaired
Place	☐ Yes ☐ No	**Recent**	☐ Intact ☐ Impaired
Time	☐ Yes ☐ No	**Immediate**	☐ Intact ☐ Impaired
Appearance:	☐ Appropriate ☐ Disheveled	**Attention concentration:**	☐ Distracted ☐ Attentive
Mood:	☐ Euthymic ☐ Depressed ☐ Elevated ☐ Irritable	**Affect:**	☐ Broad ☐ Flat ☐ Restricted ☐ Labile
Judgment:	☐ Poor ☐ Fair ☐ Good		
Insight:	☐ Poor ☐ Fair ☐ Good		
Impulse control:	☐ Poor ☐ Fair ☐ Good		

MEDICAL CONDITIONS/CONCERNS		
PCP:		

Provider signature:_____ **Date**____/____/____

Provider/discharging agency:_____

Request for Comprehensive Child and Family Treatment (CCFT) Form

Review Type: Precertification ☐ Concurrent ☐

(Please note: Failure to complete this form in its entirety with all information necessary to make medical necessity determination may result in delay or denial of services. Additional information attached is considered supplemental.)

Fax:	**888-881-6309**	**Phone:**	**800-454-3730** or **615-316-2400**	**Address:**	Behavioral Health Unit, 22 Century Blvd., Suite 310 Nashville, TN 37214

REQUESTING PROVIDER INFORMATION

Treating provider *name/title:		Phone #:		Fax #:	
Facility/program (referral source):				Phone #:	
Medicaid ID:		Tax ID:		Provider ID:	
If currently enrolled in a lower level of care, list service type and current length of stay:					
Currently in hospital? ☐ Yes ☐ No		If yes, list facility name/service type:			

MEMBER INFORMATION

Member's name:		DOB:			
Amerigroup #:		SSN:			
Member's address:		City/State:		ZIP Code:	
Member's phone #:		Alternate phone #:			
Legal guardian/ conservator name:					

AUTHORIZATION REQUEST INFORMATION

Start date requested (dd/mm/yy):	
Last authorized date (Concurrent review ONLY):	
Number of units/days requested:	
Number of CCFT visits within the past 90 days:	

DSM-IV TR DIAGNOSIS

Axis I		Axis II		Axis III	
Axis IV		Axis V		Highest in past year:	

(Continued on next page.)

TREATMENT HISTORY

Substance Use Disorder Treatment (List all prior treatment episodes — most recent first):

Date of Admission	Date of Discharge	Facility Name	Level of Care Episodes (ER, crisis services, INPT, PHP, IOP, home-based treatment, other pertinent clinical treatment)	Was treatment effective?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Mental Health Treatment (List all prior treatment episodes—most recent first):

Date of Admission	Date of Discharge	Facility Name	Level of Care Episodes (ER, crisis services, INPT, PHP, IOP, home-based treatment, other pertinent clinical treatment)	Was treatment effective?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Reason for Referral (List specific precipitant including factors contributing to need for service — precertification ONLY.):

Current Clinical Information (Include mental status exam and severity of each symptom/problem.):

Support System (Family involvement in treatment):

(Continued on next page.)

Measurable Goals for CCFT (Include findings from EPSDT if appropriate.):

SUBSTANCE USE DISORDER HISTORY

Drug	Date of Onset/Age	Method/Route	Amount	Frequency	Date of Last Use

If substance use disorder is current, specify how this will be/is being addressed in current treatment?

Medical history:

MEDICATIONS

Name	Dosage	Frequency	Compliant
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

OUTPATIENT TREATMENT INFORMATION

Psychiatrist:		Number of visits:		Frequency:	
Therapist (PhD, LPC, LCSW):		Number of visits:		Frequency:	
PCP (name and contact #):					
Name of other mental health providers:					

(Continued on next page.)

TREATMENT PLAN COORDINATION		
I have requested permission from the member to release information to the PCP. ☐ Yes ☐ No If no, rationale why this is inappropriate:		
Was the treatment plan discussed with the member? ☐ Yes ☐ No		
Does the member understand and agree to treatment plan goals? ☐ Yes ☐ No		
If no, explain:		
Discharge Plan (Include specific services.):		
Projected Discharge Date:		
SUBMISSION DOCUMENTS (optional)		
Document	Document Included?	
Psychiatric evaluation (within 60 days):	☐ Yes ☐ No	
Psychosocial evaluation (60 days):	☐ Yes ☐ No	
All treating provider notes (for the last 30 days):	☐ Yes ☐ No (Concurrent reviews only)	
Other (list):	☐ Yes ☐ No	
Certification for CCFT		(Must check one box for each item.)
A. Both of the following criteria must be met: **1. Does the member have primary DSM IV TR diagnosis per the priority enrollee[1] definition?**		☐ Yes ☐ No
2. Does the member meet the criteria for a priority enrollee?		☐ Yes ☐ No
B. Two of the following criteria must be met: **1. Is there imminent risk of out-of-home placement as a result of the mental illness, current DCS involvement and/or hospitalization in an acute psychiatric setting?**		☐ Yes ☐ No
2. Is there a major time-limited weakening of the child's/adolescent's support system and ability to function independently or within the current support system?		☐ Yes ☐ No
3. Is there documentation within the preceding six months of inability to meet identified service goals while in traditional case management?		☐ Yes ☐ No
4. Is the child/adolescent being discharged or has the child/adolescent been discharged from a more restrictive level of care, or has the child/adolescent exhibited behavior that has escalated in the home, school or elsewhere in the community to suggest that this more restrictive level of care is imminent and the use of this level of services is appropriate to stabilize the current placement?		☐ Yes ☐ No
5. **Has the family/guardian agreed to participate in this service?**		☐ Yes ☐ No

(Continued on next page.)

[1] Priority Enrollee: An enrollee who has been identified as a priority enrollee by the Division of TennCare by using specified diagnoses. Priority identification occurs when the Division receives claims information from its contracted Managed Care Contractors (MCCs). A claim must be received that includes a diagnosis designated as priority in order for the member to remain a priority member. A member only becomes nonpriority if the Division does not receive a claim with a diagnosis from the priority list during the following 13 months. If a member is deemed priority and a claim is received during the following 13 months with a nonpriority diagnosis, the member will not automatically be reclassified as nonpriority. Designation as a priority enrollee is applicable to all age groups with a priority diagnosis. Priority diagnoses are available via the provider web site at https://providers.realsolutions.com/pages/home.aspx or upon request.

Treating Practitioner Certification:

As the *treating practitioner, I certify that this member meets criteria for CCFT level of care.

(*Treating provider/practitioner is defined as a member of the treatment team who has direct knowledge of the member's clinical needs and progress AND who can sufficiently participate in peer-to-peer reviews when additional clinical information is needed to determine medical necessity.)

_____ _____

Treating Practitioner's Signature Date

_____ _____

Print Treating Practitioner's Name Date

Authorization indicates that Amerigroup determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon member eligibility and benefit limitations at the time services are rendered.

FOR AMERIGROUP USE ONLY:

Authorization #_____

Amerigroup
An Anthem Company

Request for Continuous Treatment Team Services Form
Adults ONLY

Review Type: Precertification ☐ Concurrent ☐

(Please note: Failure to complete this form in its entirety with all information necessary to make medical necessity determination may result in delay or denial of services. Additional information attached is considered supplemental.)

Fax:	**866-920-6006**	**Phone:**	**800-454-3730** or **615-316-2400**	**Address:**	Behavioral Health Unit, 22 Century Blvd., Suite 310 Nashville, TN 37214

REQUESTING PROVIDER INFORMATION

Treating provider *Name/title:		Phone #:		Fax #:	
Facility/program (referral source):				Phone #:	
Medicaid ID:		Tax ID:		Provider ID:	
If currently enrolled in lower level of care, list service type and current length of stay:					
Currently in hospital? ☐ Yes ☐ No	If yes, list facility name/service type:				

MEMBER INFORMATION

Member's name:		DOB:			
Amerigroup #:		SSN:			
Member's address:		City/State:		ZIP Code:	
Member's phone #:		Alternate phone #:			
Legal guardian/ conservator name:					

AUTHORIZATION REQUEST INFORMATION

Start date requested (dd/mm/yy):	
Last authorized date (Concurrent review ONLY):	
Number of units/days requested:	
Number of CTT visits during the past 90 days:	

DSM-IV TR DIAGNOSIS

Axis I		Axis II		Axis III	
Axis IV		Axis V		Highest in past year:	

(Continued on next page.)

TREATMENT HISTORY

Substance Use Disorder Treatment (List all prior treatment episodes — most recent first.):

Date of Admission	Date of Discharge	Facility Name	Level of Care Episodes (ER, crisis services, INPT, PHP, IOP, home-based treatment, other pertinent clinical treatment)	Was treatment effective?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Mental Health Treatment (List all prior treatment episodes — most recent first.):

Date of Admission	Date of Discharge	Facility Name	Level of Care Episodes (ER, crisis services, INPT, PHP, IOP, home-based treatment, other pertinent clinical treatment)	Was treatment effective?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Reason for Referral (List specific precipitant, including factors contributing to need for service — precertification ONLY.):

Progress Since Last Review (Concurrent review ONLY.):

Current Clinical Information (Include mental status exam and severity of each symptom/problem.):

Support System (Family involvement in treatment):

(Continued on next page.)

Measurable Goals for CTT (Include findings from EPSDT if appropriate under 21.):

SUBSTANCE USE DISORDER HISTORY:

Drug	Date of Onset/Age	Method/Route	Amount	Frequency	Date of Last Use

If substance use disorder is current, specify how this will be/is being addressed in current treatment?

Medical history:

MEDICATIONS

Name	Dosage	Frequency	Compliant
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

OUTPATIENT TREATMENT INFORMATION

Psychiatrist:		Number of visits:		Frequency:	
Therapist (PhD, LPC, LCSW):		Number of visits:		Frequency:	
PCP (name and contact number):					
Name of other mental health providers:					

(Continued on next page.)

TREATMENT PLAN COORDINATION	
I have requested permission from the member to release information to the PCP. ☐ Yes ☐ No If no, rationale why this is inappropriate: _____ **Was the treatment plan discussed with the member?** ☐ Yes ☐ No **Does the member understand and agree to treatment plan goals?** ☐ Yes ☐ No	
If no, explain:	
Discharge plan (include specific services):	
Projected discharge date:	

SUBMISSION DOCUMENTS (optional)	
Document	Document Included?
Psychiatric evaluation (within 60 days):	☐ Yes ☐ No
Psychosocial evaluation (within 60 days):	☐ Yes ☐ No
All treating provider notes (for the last 30 days):	☐ Yes ☐ No (Concurrent review only.)
Other (list):	☐ Yes ☐ No

Certification for CTT	(Must check one box for each item.)
C. Both of the following criteria must be met:	
3. Does the member have Primary DSM-IV TR diagnosis?	☐ Yes ☐ No
4. Does the member meet the criteria for priority enrollee[2]?	☐ Yes ☐ No
D. One of the following criteria must be met:	
6. Is the member at risk of hospitalization in an acute psychiatric setting, or did the member have a history of being hospitalized in an acute psychiatric setting within the past six months?	☐ Yes ☐ No
7. Was there a major time-limited weakening of the member's support system or major change in other social factors and decrease in ability to function independently or within the current support system?	☐ Yes ☐ No
8. Was there documentation within the preceding six months of inability to meet identified service goals while in traditional case management?	☐ Yes ☐ No

(Continued on next page.)

[2] Priority Enrollee: An enrollee who has been identified as a priority enrollee by the Division of TennCare by using specified diagnoses. Priority identification occurs when the Division receives claims information from its contracted Managed Care Contractors (MCCs). A claim must be received that includes a diagnosis designated as priority in order for the member to remain a priority member. A member only becomes nonpriority if the Division does not receive a claim with a diagnosis from the priority list during the following 13 months. If a member is deemed priority and a claim is received during the following 13 months with a nonpriority diagnosis, the member will not automatically be reclassified as nonpriority. Designation as a priority enrollee is applicable to all age groups with a priority diagnosis. Priority diagnoses are available via the provider web site at https://providers.realsolutions.com/pages/home.aspx or upon request.

Treating Practitioner Certification:

As the *treating practitioner, I certify that the above criteria (Items A1 and A2; AND either B1, B2 or B3) have been met and that this member is appropriate for CTT services.

(*Treating provider/practitioner is defined as a member of the treatment team who has direct knowledge of the member's clinical needs and progress AND who can sufficiently participate in peer-to-peer reviews when additional clinical information is needed to determine medical necessity.)

_____ _____

Treating Practitioner's Signature Date

_____ _____

Print Treating Practitioner's Name Date

Authorization indicates that Amerigroup determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon member eligibility and benefit limitations at the time services are rendered.

FOR AMERIGROUP USE ONLY:

Authorization #_____

Amerigroup
An Anthem Company

Request for Continuous Treatment Team Services Form
Child/Adolescent ONLY

Review Type: Precertification ☐ Concurrent ☐

(Please note: Failure to complete this form in its entirety with all information necessary to make medical necessity determination may result in delay or denial of services. Additional information attached is considered supplemental.)

Fax:	**888-881-6309**	**Phone:**	Medicaid: **800-454-3730** Medicare: **866-805-4589** or **615-316-2400**	**Address:**	Behavioral Health Unit, 22 Century Blvd., Suite 310 Nashville, TN 37214

REQUESTING PROVIDER INFORMATION

Treating provider *Name/Title:		Phone #:		Fax #:	
Facility/program (referral source):				Phone #:	
Medicaid ID:		Tax ID:		Provider ID:	
If currently enrolled in lower level of care, list service type and current length of stay:					
Currently in hospital? ☐ Yes ☐ No		If yes, list facility name/service type:			

MEMBER INFORMATION

Member's name:		DOB:			
Amerigroup #:		SSN:			
Member's address:		City/State:		ZIP Code:	
Member's phone #:		Alternate phone #:			
Legal guardian/conservator name:					

AUTHORIZATION REQUEST INFORMATION

Start date requested (dd/mm/yy):	
Last authorized date (Concurrent review ONLY):	
Number of units/days requested:	
Number of CTT visits in the past 90 days:	

DSM-IV TR DIAGNOSIS

Axis I		Axis II		Axis III	
Axis IV		Axis V		Highest in past year:	

(Continued on next page.)

TREATMENT HISTORY

Substance Use Disorder Treatment (List all prior treatment episodes — most recent first.):

Date of Admission	Date of Discharge	Facility Name	Level of Care Episodes (ER, crisis services, INPT, PHP, IOP, home-based treatment, other pertinent clinical treatment)	Was treatment effective?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Mental Health Treatment (List all prior treatment episodes — most recent first.):

Date of Admission	Date of Discharge	Facility Name	Level of Care Episodes (ER, crisis services, INPT, PHP, IOP, home-based treatment, other pertinent clinical treatment)	Was treatment effective?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Reason for Referral (List specific precipitant including factors contributing to need for service — precertification ONLY.):

Current Clinical Information (Include mental status exam and severity of each symptom/problem.):

Support System (Family involvement in treatment):

Measurable Goals for CTT (Include findings from EPSDT if appropriate.):

(Continued on next page.)

SUBSTANCE USE DISORDER HISTORY

Drug	Date of Onset/Age	Method/Route	Amount	Frequency	Date of Last Use

If substance use disorder is current, specify how this will be/is being addressed in current treatment.

Medical history:

MEDICATIONS

Name	Dosage	Frequency	Compliant
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

OUTPATIENT TREATMENT INFORMATION

Psychiatrist:		Number of visits:		Frequency:	
Therapist (PhD, LPC, LCSW):		Number of visits:		Frequency:	

PCP (name and contact number):	
Name of other mental health providers:	

TREATMENT PLAN COORDINATION

I have requested permission from the member to release information to the PCP. ☐ Yes ☐ No
If no, rationale why this is inappropriate:

The treatment plan was discussed with the member. ☐ Yes ☐ No

The member understands and agrees to the treatment plan goals. ☐ Yes ☐ No

If no, explain:

(Continued on next page.)

Discharge plan (include specific services):	
Projected discharge date:	

SUBMISSION DOCUMENTS (optional)

Document	Document Included?
Psychiatric evaluation (within 60 days):	☐ Yes ☐ No
Psychosocial evaluation (within 60 days):	☐ Yes ☐ No
All treating provider notes (for the last 30 days):	☐ Yes ☐ No (Concurrent reviews only)
Other (list):	☐ Yes ☐ No

Certification for CTT	Must check one box for each item.
E. Both of the following criteria must be met: **1. Does the member have primary DSM-IV TR diagnosis?**	☐ Yes ☐ No
2. Does the member meet the criteria of the Priority Enrollee[3] definition?	☐ Yes ☐ No
F. **One of the following criteria must be met:** **9. Is the member at risk of hospitalization in an acute psychiatric setting, or has the member had a history of being hospitalized in an acute psychiatric setting within the past six months?**	☐ Yes ☐ No
10. Has there been a major time-limited weakening of the child's/adolescent's support system and ability to function independently or within the current support system?	☐ Yes ☐ No
11. Has there been documentation within the preceding six months of the inability to meet identified service goals while in traditional case management?	☐ Yes ☐ No

(Continued on next page.)

[3] Priority Enrollee: An enrollee who has been identified as a priority enrollee by the Division of TennCare by using specified diagnoses. Priority identification occurs when the Division receives claims information from its contracted Managed Care Contractors (MCCs). A claim must be received that includes a diagnosis designated as priority in order for the member to remain a priority member. A member only becomes nonpriority if the Division does not receive a claim with a diagnosis from the priority list during the following 13 months. If a member is deemed priority and a claim is received during the following 13 months with a nonpriority diagnosis, the member will not automatically be reclassified as nonpriority. Designation as a priority enrollee is applicable to all age groups with a priority diagnosis. Priority diagnoses are available via the provider web site at https://providers.realsolutions.com/pages/home.aspx or upon request.

Treating Practitioner Certification:

As the *treating practitioner, I certify that this member meets CTT level of care.

(*Treating provider/practitioner is defined as a member of the treatment team who has direct knowledge of the member's clinical needs and progress AND who can sufficiently participate in peer-to-peer reviews when additional clinical information is needed to determine medical necessity.)

_____ _____

Treating Practitioner's Signature Date

_____ _____

Print Treating Practitioner's Name Date

Authorization indicates that Amerigroup determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon member eligibility and benefit limitations at the time services are rendered.

FOR AMERIGROUP USE ONLY:

Authorization #_____

Amerigroup
An Anthem Company

Request for Supported Housing Services Form

Review Type: Precertification ☐ Concurrent ☐

(Please note: Failure to complete this form in its entirety with all information necessary to make medical necessity determination may result in delay or denial of services. Additional information attached is considered supplemental.)

Fax:	**888-881-6287**	**Phone:**	**800-454-3730** or **615-316-2400**	**Address:**	Behavioral Health Unit, 22 Century Blvd., Suite 310 Nashville, TN 37214

REQUESTING PROVIDER INFORMATION

Treating provider *Name/title:		Phone #:		Fax #:	
Facility/program (referral source):				Phone #:	
Medicaid ID:		Tax ID:		Provider ID:	
If currently enrolled in lower level of care, list service type and current length of stay:					
Currently in hospital? ☐ Yes ☐ No	If yes, list facility name/service type:				

MEMBER INFORMATION

Member's name:		DOB:			
Amerigroup #:		SSN:			
Member's address:		City/state:		ZIP code:	
Member's phone #:		Alternate phone #:			
Legal guardian/ conservator name:					

AUTHORIZATION REQUEST INFORMATION

Start date requested (dd/mm/yy):	
Last authorized date (concurrent review ONLY):	
Number of units/days requested:	

DSM-IV TR DIAGNOSIS

Axis I		Axis II		Axis III	
Axis IV		Axis V		Highest in past year:	

(Continued on next page.)

TREATMENT HISTORY

Substance Use Disorder Treatment (List all prior treatment episodes—most recent first.):

Date of Admission	Date of Discharge	Facility Name	Level of Care Episodes (ER, crisis services, INPT, PHP, IOP, home-based treatment, other pertinent clinical treatment)	Was treatment effective?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Mental Health Treatment (List all prior treatment episodes—most recent first.):

Date of Admission	Date of Discharge	Facility Name	Level of Care Episodes (ER, crisis services, INPT, PHP, IOP, home-based treatment, other pertinent clinical treatment)	Was treatment effective?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Reason for Referral (List specific precipitant including factors contributing to need for service—precertification ONLY.):

(Continued on next page.)

Progress Since Last Review (Concurrent Review ONLY):		
Continued Service Criteria	Was treatment effective?	If yes, provide summary of member specific status:
Member is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals.	☐ Yes ☐ No	
Member is not yet making progress but has the capacity to resolve his or her problems. He or she is actively working toward the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the member to continue to work toward his or her treatment goals.	☐ Yes ☐ No	
New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the member's new problems can be addressed effectively.	☐ Yes ☐ No	
Current Clinical Information (Include mental status exam and severity of each symptom/problem.):		
Current Risk Factors:		
Support System (Family involvement in treatment):		

(Continued on next page.)

Activities of Daily Living	Consistent, significant impairment? (You must check one box for each area.)
Health care:	☐ Yes ☐ No
Personal hygiene:	☐ Yes ☐ No
Finances:	☐ Yes ☐ No
Healthy diet/food preparation:	☐ Yes ☐ No
Maintaining a home:	☐ Yes ☐ No
Community service needs (legal, transportation, housing, etc.):	☐ Yes ☐ No
Mobility limitations:	☐ Yes ☐ No
Physical limitations:	☐ Yes ☐ No
Other (List): _____	☐ Yes ☐ No
Other (List): _____	☐ Yes ☐ No

SUBSTANCE USE DISORDER HISTORY

Drug	Date of onset/age	Method/route	Amount	Frequency	Date of last use

If substance use disorder is current, specify how this will be/is being addressed in current treatment?

Measurable goals for supported housing:

Medical history:

MEDICATIONS

Name	Dosage	Frequency	Compliant
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

(Continued on next page.)

OUTPATIENT TREATMENT INFORMATION					
Psychiatrist:		Number of visits:		Frequency:	
Therapist (PhD, LPC, LCSW):		Number of visits:		Frequency:	
PCP (name and contact #):					
Name of other mental health providers:					

TREATMENT PLAN COORDINATION

I have requested permission from the member to release information to the PCP. ☐ Yes ☐ No
If no, rationale why this is inappropriate: _____

The treatment plan was discussed with the member. ☐ Yes ☐ No

The member understands and agrees to treatment plan goals. ☐ Yes ☐ No

If no, explain:

Discharge plan (include specific services):

Projected discharge date:	

SUBMISSION DOCUMENTS (optional)

Document	Document Included?
Psychiatric evaluation (within 60 days):	☐ Yes ☐ No
Psychosocial evaluation (within 60 days):	☐ Yes ☐ No
All treating provider notes (for the last 30 days):	☐ Yes ☐ No (Concurrent reviews only)
Other (list):	☐ Yes ☐ No

(Continued on next page.)

Certification for Supported Housing	(Must check one box for each item.)
G. All of the following criteria must be met:	
5. Does the member have primary DSM IV TR diagnosis?	☐ Yes ☐ No
6. Does the member meet criteria for being a priority enrollee[4]?	☐ Yes ☐ No
7. Does the member have referral from a treating behavioral health clinician?	☐ Yes ☐ No
8. Is the member either actively involved in outpatient treatment or reasonably expected to participate in such treatment?	☐ Yes ☐ No
9. Does the service plan, as per TennCare, meet approved Amerigroup Supported Housing Guidelines?	☐ Yes ☐ No
H. One of the following criteria must be met:	
12. Is the member at risk of hospitalization in an acute psychiatric setting, or has the member had a history of being hospitalized in an acute psychiatric setting within the past six months?	☐ Yes ☐ No
13. Has the member had a major time-limited weakening of his or her support system, or has the member had a major change in other social factors and a decrease in the ability to function independently or within the current support system resulting in the member having difficulty in sustaining housing or maintaining a safe living environment?	☐ Yes ☐ No
14. Has the member had consistent and significant difficulty independently managing activities of daily living?	☐ Yes ☐ No

Treating Practitioner Certification:

As the *treating practitioner, I certify that the above criteria (Items A1, A2, A3, A4 and A5; AND either B1, B2 or B3) have been met and that it is appropriate for this member to have supported housing services.

(*Treating provider/practitioner is defined as a member of the treatment team who has direct knowledge of the member's clinical needs and progress AND who can sufficiently participate in peer-to-peer reviews when additional clinical information is needed to determine medical necessity.)

_____ _____

Treating Practitioner's Signature Date

_____ _____

Print Treating Practitioner's Name Date

Authorization indicates that Amerigroup determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon member eligibility and benefit limitations at the time services are rendered.

FOR AMERIGROUP USE ONLY:

Authorization #_____

[4] Priority Enrollee: An enrollee who has been identified as a priority enrollee by the Division of TennCare by using specified diagnoses. Priority identification occurs when the Division receives claims information from its contracted Managed Care Contractors (MCCs). A claim must be received that includes a diagnosis designated as priority in order for the member to remain a priority member. A member only becomes nonpriority if the Division does not receive a claim with a diagnosis from the priority list during the following 13 months. If a member is deemed priority and a claim is received during the following 13 months with a nonpriority diagnosis, the member will not automatically be reclassified as nonpriority. Designation as a priority enrollee is applicable to all age groups with a priority diagnosis. Priority diagnoses are available via the provider website at https://providers.realsolutions.com/pages/home.aspx or upon request.

Amerigroup
An Anthem Company

Request for Residential Treatment Center Services Form

Review type: Precertification ☐ Concurrent ☐

Please note: Failure to complete this form in its entirety, including all information required to make medical necessity determination, may result in delay or denial of services. Additional information attached is considered supplemental.

Fax	**888-881-6309**	**Phone**	Medicaid: **800-454-3730** Medicare: **866-805-4589** **or 615-316-2400**	**Address**	Behavioral Health Unit 22 Century Blvd., Suite 310 Nashville, TN 37214

Requesting Provider Information					
Treating provider name/title		Phone		Fax	
Facility/program (referral source)				Phone	
Medicaid ID		Tax ID		Provider ID	
If currently enrolled in lower-level care, list service type and current length of stay.					
Currently in hospital: ☐ Yes ☐ No	If yes, list facility name or service type:				

Member Information					
Member name				Date of birth	
Amerigroup ID				Social Security number	
Member address		City, state		ZIP code	
Member phone		Alternate phone			
Legal guardian/ conservator name					

Recommended Facility Information (Precertification Only)					
Facility name		Phone		Fax	
Medicaid ID		Tax ID		Provider ID	
Contact name		Phone		Fax	

Authorization Request Information	
Start date requested (dd/mm/yy)	
Last authorized date (concurrent review only)	
Number of units/days requested	

DSM-IV Treatment Diagnosis					
Axis I		Axis II		Axis III	
Axis IV		Axis V		Highest in past year	

Treatment History

Substance use disorder treatment (list all prior treatment episodes, most recent first):

Date of admission	Date of discharge	Facility name	Level of care episode(s) (e.g., emergency room, crisis services, inpatient, partial hospitalization, intensive outpatient, home-based or other pertinent clinical treatment)	Was treatment effective?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Mental health treatment (list all prior treatment episodes, most recent first):

Date of admission	Date of discharge	Facility name	Level of care episode(s) (e.g., emergency room, crisis services, inpatient, partial hospitalization, intensive outpatient, home-based or other pertinent clinical treatment)	Was treatment effective?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Reason for referral (list specific precipitant, including factors contributing to imminent risk):

Current clinical information (include mental status exam and severity of each symptom and/or problem):

Support system (indicate family involvement in treatment):

Complex treatment issues:

Substance use disorder History					
Drug	Date of onset/age	Method/route	Amount	Frequency	Date of last use

If substance use disorder is current, specify how this will be or is being addressed in current treatment:

Measurable goals for residential treatment (indicate the appropriate review period and outline goals for that period):

Precertification ☐ 30 days ☐ 60 days ☐ 90 days ☐

Goals:

Medical history:

Medications			
Name	Dosage	Frequency	Compliant?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Outpatient Treatment Information					
Psychiatrist		Number of visits		Frequency	
Therapist (PhD, LPC, LCSW)		Number of visits		Frequency	
Primary Care Provider (PCP) (name and contact phone)					
Name(s) of other mental health provider(s)					

Treatment Plan Coordination	
I have requested permission from the member to release information to the PCP. If no, provide rationale:	☐ Yes ☐ No
The treatment plan was discussed with the member.	☐ Yes ☐ No
The family understands and agrees to at least weekly contact with the member or facility during the member's stay. If no, explain:	☐ Yes ☐ No
Discharge plan (include specific services):	
Projected discharge date:	

Discharge planner name/title (concurrent review only)		Phone		Fax	

Required Submission Documents	
Please verify that you have included each document.	
Document	**Document included?**
Psychiatric evaluation (within 60 days)	☐ Yes ☐ No
Psychosocial evaluation (within 60 days)	☐ Yes ☐ No
Psychological evaluation (within two years)	☐ Yes ☐ No
Psychosexual evaluation (within two years, if applicable)	☐ Yes ☐ No
All treating provider notes (for the last 30 days)	☐ Yes ☐ No
Recommendation letter for residential treatment care placement from treating provider	☐ Yes ☐ No
Other (list):	☐ Yes ☐ No

Treating Provider* Certification

As the treating provider, I certify this member is appropriate for residential treatment because he or she is deemed at imminent risk of harm to self or others and cannot be safely maintained in a lower level of care.

_____ _____

Treating provider's signature Date

_____

Printed name

* Treating provider is defined as a member of the treatment team who has direct knowledge of the member's clinical needs and progress and who can sufficiently participate in peer-to-peer reviews when additional clinical information is needed to determine medical necessity.

Note: Authorization indicates Amerigroup determined medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon member eligibility and benefit limitations at the time services are rendered.

For Amerigroup use only.

Authorization number: _____

Member Name: Member DOB: _____

PF-TN-0013-12

Authorization to Release Information

Instructions: This form Allows the Release of Information about a Recipient of Services under Title 33, Tennessee Code Annotated, and the Privacy Notice required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. I understand that this Authorization is Voluntary, and that if the Person or Organization Authorized to Receive the Information is Not a Health Plan or Health Care Provider, the Released Information May No Longer Be Protected by Federal Privacy Regulations (HIPAA).

I,_____/_____, authorize
(Print name of service recipient) (Print date of birth)
_____ /_____
(Print name of agency/program making disclosure) and (Mailing address of agency/program making disclosure)

To disclose to_____ /_____
(Print name of person(s) or organization to which disclosure is to be made, and their mailing address)

The following information: _____
(Describe the specific information to be used or disclosed)
_____
_____

The purpose of the authorized disclosure is to: _____
(Specific purpose/use of the disclosure)
_____
I understand that I Am Not Required to Sign this Authorization, and that my treatment, payment, enrollment, or eligibility for benefits, is Not Conditioned on my Execution of this Authorization. I may Revoke this Consent in Writing at Any Time, Except to the extent that Action has been Taken in Reliance on it, and that, in any event, this Consent Expires Automatically as follows:
_____
_____
(Specify the date, event, or condition of expiration)

X_____ _____
(Signature of service recipient who is 16 years of age or older) (Date)

(All blanks must be filled in before signing)

*Signature of individual acting on behalf of the service recipient if the individual is: (1) the parent, legal guardian, or legal custodian of a service recipient who is under 18 years of age; (2) the conservator or guardian for the service recipient; (3) the guardian-ad-litem of the service recipient but only for the purposes of the litigation in which the guardian-ad-litem serves; (4) the attorney-in-fact under a power of attorney who has the right to make disclosures under the power for the service recipient; (5) the executor, administrator, or personal representative on behalf of a deceased recipient; and (6) the treatment review committee, acting within the authority and scope of §33-6-107, Tennessee Code Annotated. *The signature of any individual other than a parent of a child is insufficient to permit release of information unless the individual intending to act on behalf of the individual produces proof of her or his authority to act on behalf of the service recipient.*

X_____ _____
*(Signature of individual acting on behalf of the service recipient) (Date)

(All blanks must be filled in before signing)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

**If a service recipient gives oral consent or signs with an X, the form must be signed by two (2) witnesses:

X_____ /_____ X_____/_____
**(Witness) (Date) **(Witness) (Date)

MHDD-5025 Revised 03-06

SECTION A—Behavioral Health Notification of Initial Outpatient Treatment

Fax Number: 1-800-505-1193 Telephone Number: 1-800-454-3730
Address: Behavioral Health Unit, P.O. Box 62509, Virginia Beach, VA 23466-2509

INSTRUCTIONS

1. Complete Section A for the initial 10 sessions.
2. Complete Section B for additional requested sessions.
3. Fax or mail the form to the above number or address. You will receive a confirmation number by fax.

MEMBER INFORMATION

PATIENT'S NAME:	**DOB:**	**AMERIGROUP #:**
PATIENT'S ADDRESS:	**STATE:**	**ZIP:**

PROVIDER INFORMATION

PROVIDER NAME:	**PHONE#:**	**FAX#:**
TAX ID #:		
NAME OF PCP:	**NAME OF OTHER MENTAL HEALTH PROVIDER:**	

SERVICES BEING PROVIDED

PROCEDURE CODE:	**NUMBER OF VISITS:**	**FREQUENCY:**
PROCEDURE CODE:	**NUMBER OF VISITS:**	**FREQUENCY:**

SECTION B—Behavioral Health Additional Request for Outpatient Treatment

DSM-IV TR DIAGNOSIS

AXIS I:	**AXIS II:**	**AXIS III:**
DATE FIRST SEEN:	**ANTICIPATED # OF SESSIONS TO COMPLETION OF TREATMENT:**	

TREATMENT REPORT

CURRENT CLINICAL INFORMATION:

COMPLEX TREATMENT ISSUES:

GOALS FOR CONTINUED TREATMENT:

MEDICATIONS (OPTIONAL FOR NON-PHYSICIANS)

Name	Dosage	Frequency

REQUESTED SERVICES

PROCEDURE CODE:	**NUMBER OF VISITS:**	**FREQUENCY:**
PROCEDURE CODE:	**NUMBER OF VISITS:**	**FREQUENCY:**

TREATMENT PLAN COORDINATION

I have requested permission from the member to release information to the PCP. ❑ Yes ❑ No

If no, rationale why this is inappropriate:

Treatment plan was discussed with patient. ❑ Yes ❑ No

PROVIDER'S SIGNATURE:	**DATE:**
PRINT PROVIDER'S NAME:	**DATE:**

Authorization indicates that AMERIGROUP determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is in part contingent upon member eligibility and benefit limitations at the time services are rendered.

For AMERIGROUP Use Only Authorization # _____

Declaration for Mental Health Treatment Form

A Document to Help People Make Choices about Their Mental Health Treatment

The Tennessee Department of Mental Health and Developmental Disabilities developed this form based on Tennessee Code Annotated Title 33, Chapter 6, Part 10.

Introduction

The Tennessee mental health and developmental disability law gives the right to individuals 16 years of age and over to be involved in decisions about their mental health treatment. The law also recognizes that, at times, some individuals are unable to make treatment decisions. A Declaration for Mental Health Treatment allows persons receiving services to plan ahead; it may also assist service providers in giving appropriate treatment.

The Declaration for Mental Health Treatment form describes what a service recipient wants to occur when he/she receives mental health treatment. It describes mental health services that a service recipient might consider, the conditions under which the Declaration may be acted upon, and directions on how a service recipient can revoke a Declaration.

For example, completion of a Declaration for Mental Health Treatment form allows you to state:

- Conditions or symptoms that might cause the Declaration to be acted upon
- Medications you are willing to take and medications you are not willing to take
- Specific instructions for or against electroconvulsive or other convulsive treatment
- Mental health facilities and mental health providers which you prefer
- Treatments or actions which you will allow or those which you refuse to permit
- Any other matter pertaining to your mental health treatment which you wish to make known

Instructions

1. Please read the form carefully. See https://www.tn.gov/content/dam/tn/mentalhealth/documents/Declaration_for_Mental_Health_Treatment-Form.pdf.

2. Where there are places on the form that ask you to choose between two or more items, you must choose at least one. For example, the following statement from the form requires you to choose one of the options.

"If I am unable to make mental health treatment decisions, my wishes regarding psychoactive and other medications are as follows:

You must check one.

❑ I do not have a preference regarding medications.

❑ I do not consent to the administration of the following medications."

3. Be as specific as possible when identifying your preferences.

4. Be sure to initial and date at the bottom of each page.

5. You must sign the form in front of two adult witnesses who know you.

6. You must discuss the contents of this form with the witnesses required to sign it.

7. It is highly recommended that you discuss the contents of this form with the significant persons in your life and your mental health service providers.

Declaration for Mental Health Treatment
*for*_____
Print Full Name

This Declaration states my wishes for the provision of mental health treatment when I am unable to make informed decisions about my mental health treatment. It is authorized by Tennessee Code Annotated Title 33, Chapter 6, Part 10.

I understand that I may become unable to make informed decisions about my mental health treatment due to symptoms of a diagnosed mental disorder. These symptoms may include:
_____
_____
_____

I recognize that I am able to state my treatment preferences in the following areas: psychoactive and other medications, electroconvulsive and other convulsive therapies, and psychiatric hospitalization for a maximum of fifteen (15) days. This Declaration may include consent to, or refusal to, permit mental health treatment and other instructions and information for mental health service providers.

Psychoactive and Other Medications

If I am unable to make mental health treatment decisions, my wishes regarding psychoactive and other medications are as follows:

You must check one.

❑ I do not have a preference regarding medications.
❑ I do not consent to the administration of the following medications.

Medication	Reason for Not Consenting

The following medications have worked for me.

Medication	

Conditions or Limitations: _____
_____
_____

*Admission to and Remaining in a Hospital for Mental Health Treatment**

If I am unable to make informed mental health treatment decisions, my wishes regarding admission to, or remaining in, a hospital are as follows:

You must check one.

- ❑ I do not have a preference regarding admission to a hospital for mental health treatment.
- ❑ I consent to being admitted to a hospital for mental health treatment.
- ❑ I do not consent to voluntary admission to a hospital.

If I am admitted to a hospital for mental health treatment:

You must check one.

- ❑ I consent to remain voluntarily in the hospital for mental health treatment.
- ❑ I do not consent to remain voluntarily in the hospital for mental health treatment.

Conditions or Limitations: _____
_____
_____
_____
_____

**Authorization under a Declaration is limited to 15 days for psychiatric hospitalization.*

Admission to and Continuation of Mental Health Services from Other Facilities

If I am unable to make informed mental health treatment decisions, my wishes about receiving mental health services, or continuation of services, are as follows:

You must check one.

- ❑ I do not have a preference about receiving mental health services from a facility, which is not a hospital.
- ❑ I consent to receiving services from a facility, which is not a hospital.
- ❑ I do not consent to receiving mental health services from a facility, which is not a hospital.

Conditions or Limitations: _____
_____
_____
_____

Treatment Provider or Facility

If I am unable to make informed mental health treatment decisions, my wishes regarding treatment providers or treatment facilities are as follows:

Check each that applies.

- ❑ I do not have a preference of providers or treatment facilities.
- ❑ I do not consent to receiving treatment by the listed providers or treatment facilities.
- ❑ I do prefer the following:

Providers

Do not consent	*Prefer*

Treatment Facility

Do not consent	*Prefer*

Conditions or Limitations: _____
_____
_____

Electroconvulsive and Other Convulsive Therapies

If I am unable to make informed mental health treatment decisions, my wishes regarding electroconvulsive and other convulsive therapies are as follows:

You must check one.

- ❑ I do not have a preference regarding electroconvulsive or other convulsive therapies.
- ❑ I do not consent to the administration of electroconvulsive or other convulsive therapies.
- ❑ I consent to electroconvulsive or other convulsive therapies, under the following conditions:

Conditions or Limitations: _____
_____
_____

Other Preferences

If I am unable to make informed mental health treatment decisions, my wishes regarding other information or preferences are listed below: _____
_____
_____
_____
_____
_____

If I am unable to make informed mental health treatment decisions, please inform one of the following:
Name _____ Area Code and Phone Number _____
_____ _____
_____ _____

My Affirmation

I am sixteen (16) years of age or older. I am capable of making informed mental health treatment decisions. I make this Declaration for Mental Health Treatment to be followed, if I become unable to make informed mental health treatment decisions. The determination that I am unable to make an informed decision about my mental health treatment must be made by (1) a court in a conservatorship or guardianship proceeding, or (2) two physicians, or (3) a physician with expertise in psychiatry and a doctoral level psychologist with health service provider designation.

I know that I may cancel this Declaration at any time, orally or in writing, when I am able to make informed treatment decisions.

This Declaration will expire two years from the day it is signed by me and the two witnesses or a shorter period specified by this date: _____.

I affirm that the preferences expressed in this document were made after due consideration and without coercion. I affirm that I have discussed this document with the witnesses.

Print Name _____
Signature _____ Date _____
Address _____
_____
Area Code and Phone Number _____
Date of Birth _____

Affirmation of First Witness

I affirm that _____ is personally known to me; that he/she signed this Declaration for Mental Health Treatment in my presence; that he/she talked to me about the document and its contents and the reasons for preparing and wanting the document to be effective. He/she appears to be able to make informed mental health treatment decisions and is not under duress, fraud or undue influence. The Declaration was not signed on the premises of a mental health service provider.

I affirm that I am an adult and that I am not:

The service recipient's mental health service provider; or
An employee of the service recipient's mental health service provider; or
The operator of a mental health facility; or
An employee of a mental health facility.

YOU MUST CHECK ONE

Yes ❑ No ❑ I am a relative by blood, marriage, or adoption.*

YOU MUST CHECK ONE

Yes ❑ No ❑ I am likely to be entitled to a portion of this person's estate in the event of his/her death.**

Signature _____ Date _____
Address _____
Area Code and Phone Number _____
**Only one of the two witnesses can be a relative by blood, marriage, or adoption.*
***Only one of the two witnesses can be a person likely to benefit from the death of the person completing the Declaration.*

Affirmation of Second Witness

I affirm that _____ is personally known to me; that he/she signed this Declaration for Mental Health Treatment in my presence; that he/she talked to me about the document and its contents and the reasons for preparing and wanting the document to be effective. He/she appears to be able to make informed mental health treatment decisions and is not under duress, fraud or undue influence. The Declaration was not signed on the premises of a mental health service provider.

I affirm that I am an adult and that I am not:

The service recipient's mental health service provider; or
An employee of the service recipient's mental health service provider; or
The operator of a mental health facility; or
An employee of a mental health facility.

YOU MUST CHECK ONE

Yes ❑ No ❑ I am a relative by blood, marriage, or adoption.*

YOU MUST CHECK ONE

Yes ❑ No ❑ I am likely to be entitled to a portion of this person's estate in the event of his/her death.**

Signature _____ Date _____

Address _____

Area Code and Phone Number _____

**Only one of the two witnesses can be a relative by blood, marriage, or adoption.*

***Only one of the two witnesses can be a person likely to benefit from the death of the person completing the Declaration.*

Declaration for Mental Health Treatment

Tennessee Department of Mental Health. Authorization No. 339408, 10,000 copies, November 2001. This document was promulgated at a cost of $0.15 per copy.

Additional copies of this form may be obtained from the Tennessee Department of Mental Health website at **tn.gov/mental**.

For additional information contact the Tennessee Department of Mental Health Office of Consumer Affairs **800-560-5767**. Document number MHDD-5067.

The Tennessee Department of Mental Health is committed to the principles of equal opportunity, equal access, and affirmative action. Contact the Department's EEO/AA Coordinator at **(615) 532-6580**, the Title VI Coordinator at **(615) 532-6700** or the ADA Coordinator at **(615) 532-6700** for further information. Persons with hearing impairments call **(615) 532-6612.**

Request for Authorization — Psychological Testing
Amerigroup — Behavioral Health Services
Telephone: **800-454-3730** Fax: **800-505-1193**

REQUEST FOR AUTHORIZATION – PSYCHOLOGICAL TESTING

General Information

Member Name:	Date Of Birth: Age:	Member Amerigroup ID:

Name Of Psychologist: Address:	Amerigroup Provider Number:	Phone:	Fax:

Formal psychological testing is not clinically indicated for routine screening or assessment of behavioral health disorders. Nor is psychological testing indicated for the administration of brief behavior rating scales and inventories. Such scales and inventories are an expected part of a routine and complete diagnostic process. Other than in exceptional cases, a diagnostic interview and relevant rating scales should be completed by the psychologist prior to submission of requests for psychological testing authorization. Requests for educational testing or learning disabilities assessment for educational purposes should be referred to the public school system.

Clinical Assessment

Indicate which of the following assessments have been completed:

☐ Psychiatric and medical history	☐ Clinical interview with patient	☐ Structured developmental and psychosocial history	☐ Direct observation of parent-child interactions
☐ Family history pertinent to testing request	☐ Interview with family member(s)	☐ Consultation with school/other important persons	☐ Medical evaluation
☐ Consultation with patient's physician	☐ Brief inventories and/or rating scales		

Clinical Information

Presenting problems, symptoms indicating need for testing:			
☐ Inattention	☐ Irritability	☐ Disorganization	☐ Anxiety
☐ Mood liability	☐ Lethargy	☐ Low motivation	☐ Poor attention span
☐ Distractibility	☐ Impulsivity	☐ Depression	☐ Acting out behavior
☐ Attention seeking	☐ Hallucinations	☐ Low frustration tolerance	☐ Delusions
☐ Other Symptoms _____			
Duration of symptoms: ☐ 0 – 3 Months ☐ 3 – 6 Months ☐ 6 – 12 Months ☐ Over 12 Months			

Please list any other pertinent history or clinical information relevant to the request for psychological testing authorization:

_____
_____
_____
_____

Date(s) of Diagnostic Interview(s): _____. Please identify any behavior rating scales or self-report measures (e.g., depression or anxiety scale, parent or teacher questionnaires, MAST, etc.) that were administered as

part of the diagnostic interview and cite the results (percentiles, T-scores or standard scores):

_____
_____

Current possible DSM-IV TR diagnosis under evaluation:
Axis I: _____ Axis IV: _____
Axis II: _____ Axis V: _____
Axis III: _____(current/highest in 12 months)

Has this patient had previous psychological testing? ☐ Yes ☐ No. If yes, date of testing _____. What were the results and reasons for retesting?

_____
_____
_____

What are the specific questions to be answered by psychological testing that cannot be determined through other means, such as a comprehensive clinical assessment, history taking, family assessment, referral for psychiatric assessment, review of pertinent records, a medication review, chemical dependency assessment, referral for psycho-educational testing and/or use of observational rating scales?

_____
_____
_____

Specifically, how will the proposed testing impact treatment decisions?

_____
_____

Possible tests requested:

☐ Rorschach Test	☐ Sentence Completion	☐ Anxiety Scale
☐ Conner's continuous performance test	☐ Bender Gestalt	☐ MMPI
☐ Personality inventory for children	☐ Wechsler Scales	☐ Depression Scale
☐ Personality Assessment Inventory	☐ WRAT-4	☐ Millon Inventories
Other :		

Total time requested in hours: _____

_____ _____
Provider Signature/Credentials Date submitted

Amerigroup USE ONLY

Date received: _____	Auth from: _____		Auth to: _____
Reference #: _____	96101 _____ hrs	96118 _____ hrs	Other: _____
	96102 _____ hrs	96119 _____ hrs	
	96103 _____ hrs	96120 _____ hrs	
	96116 _____ hrs		

Authorization for routine outpatient care (90801, 90806, 90846, 90847) is not required for network providers treating eligible Amerigroup members.

NOTE: We are unable to process illegible or incomplete requests.

Request For Authorization — Neuropsychological Testing

Amerigroup Community Care — Behavioral Health Services
Telephone: **800-454-3730** Fax: **800-505-1193**

REQUEST FOR AUTHORIZATION – NEUROPSYCHOLOGICAL TESTING

General Information

Member Name:	Date of Birth Age:	Member's Amerigroup ID:

Name of Psychologist: Address:	Amerigroup Provider #: Provider NPI#:	Phone:	Fax:
Referral Source:	Specialty:	Address:	Phone:

Neuropsychological testing may be medically necessary for assessment of neurocognitive functioning following traumatic brain injury, stroke or neurosurgery. It also may be useful for monitoring the progression of cognitive impairment secondary to neurological disorders, to assist in the development of rehabilitation strategies for persons with neurological disorders, and to aid in differential diagnosis between psychogenic and neurogenic syndromes. Formal psychological or neuropsychological testing beyond structured interviews and direct, structured behavioral observation is rarely considered medically necessary for the diagnosis of attention-deficit/hyperactivity disorder or pervasive development disorders. Neither is it considered to be medically necessary for diagnosing learning disorders in the absence of verified brain injury.

Clinical Information

Check any that apply:			
☐ Traumatic brain injury, date:	☐ Encephalitis, date:	☐ Epilepsy and cognitive impairment suspected or documented, date:	☐ Multiple sclerosis and suspected/demonstrated cognitive impairment
☐ Anoxic/hypoxic brain injury, date:	☐ CVA, date:	☐ Psychosis	☐ Major affective disorder
☐ History of intracranial surgery, date:	☐ Brain tumor in remission with slow progression	☐ Neurosurgery planned for epilepsy control, date:	☐ Head injury with loss of consciousness, date:
☐ Confirmed neurotoxin exposure, date:	☐ Dementia suspected		
Duration of symptoms: ☐ 0 – 3 Months ☐ 3 – 6 Months ☐ 6 – 12 Months ☐ Over 12 Months			

Other pertinent history or clinical information relevant to request for neuropsychological testing authorization:

_____

_____

_____

Current possible DSM-IV TR diagnosis under evaluation:

Axis I: _____ Axis IV: _____

Axis II: _____ Axis V: _____

Axis III: _____ (current/highest in 12 months)

Has this patient had previous psychological/neuropsychological testing? ☐ Yes ☐ No
If yes, date of testing ____ /____/_____. What were the results and reasons for retesting?

_____

_____

Is patient taking medications? Yes ☐ No ☐. If Yes, please list:

_____

_____

Have drug effects been ruled out as a cause of cognitive impairment? Yes ☐ No ☐

Substance use disorder history to date:

_____

_____

Clinical Assessment

Indicate which of the following assessments have been completed:

☐ Clinical interview with patient, date:	☐ Psychiatric evaluation, date:	☐ Structured developmental and psychosocial history, date:	☐ EEG, date:
☐ Neurological exam, date:	☐ Interview with family member(s), date:	☐ Consultation with school or other important persons, date:	☐ Medical evaluation, date:
☐ Consultation with PCP, date:	☐ Brief inventories and/or rating scales	☐ Neuro-imaging (CT, MRI, PET, etc.), date:	

What are the specific questions to be answered by neuropsychological testing that cannot be determined from the above services? How will the test results impact this patient's treatment?

_____

_____

_____

Possible tests requested:

☐ Wechsler intelligence scale	☐ Luria-Nebraska
☐ MMPI	☐ Bender Gestalt
☐ WRAT-4	☐ Wechsler Memory Scale
☐ Halstead-Reitan Neuropsychological Battery	☐ Reitan-Indiana Neuropsychological Test Battery
Other (List):	

Total time requested in hours: _____

_____ _____

Provider Signature/Credentials **Date submitted**

Amerigroup USE ONLY

Date received: _____	Auth from: _____		Auth to: _____
Reference #:	96101 _____ hrs	96116 _____ hrs	Other: _____
	96102 _____ hrs	96118 _____ hrs	
_____	96103 _____ hrs	96119 _____ hrs	
		96120 _____ hrs	

Authorization for routine outpatient care (90801, 90806, 90846, 90847) is not required for network providers treating eligible Amerigroup members.

NOTE: We are unable to process illegible or incomplete requests

Outpatient Treatment Report Form C

Outpatient Treatment Report Form C for BH: The behavioral health provider may use this form instead of calling Amerigroup to precertify outpatient behavioral health services.

Outpatient Treatment Report FORM C

AMERIGROUP Community Care

TELEPHONE: 1-800-454-3730 FAX: 1-866-920-6006

FILL OUT COMPLETELY TO AVOID DELAYS

IDENTIFYING DATA

PATIENT'S NAME:	MEDICAID #:	DOB:
PATIENT'S ADDRESS:	STATE:	ZIP CODE:

PROVIDER INFORMATION

PROVIDER NAME:	TAX ID NUMBER:
PHONE #:	FAX #:
PCP NAME:	NAME OF OTHER BEHAVIORAL HEALTH PROVIDER(S):

DSM-IV TR DIAGNOSIS

AXIS I:	AXIS II:	AXIS III:
AXIS IV:	AXIS V CURRENT:	HIGHEST IN PAST YEAR:

CURRENT CLINICAL INFORMATION

Symptoms/Problems	Mild	Moderate	Severe	Acute	Chronic			Mild	Moderate	Severe	Acute	Chronic
Anxiety disorders							**Psychotic disorders**					
■ Obsessions/compulsions							■ Delusions/paranoia					
■ Generalized anxiety							■ Self-care issues					
■ Panic attacks							■ Hallucinations					
■ Phobias							■ Disorganized thought process					
■ Somatic complaints							■ Loose associations					
■ PTSD symptoms							**Substance abuse**					
Depression							■ Loss of control of dosage					
■ Impaired concentration							■ Amnesic episodes					
■ Impaired memory							■ Legal problems					
■ Psychomotor retardation							■ Alcohol abuse					
■ Sexual issues							■ Opiate abuse					
■ Appetite disturbance							■ Prescription medication abuse					
■ Irritability							■ Polysubstance abuse					
■ Agitation							**Personality Disorder**					
■ Sleep disturbance							■ Oddness/eccentricities					
■ Hopelessness/helplessness							■ Oppositional					
Mania							■ Disregard for law					
■ Insomnia							■ Recurring self-injuries					
■ Grandiosity							■ Sense of entitlement					
■ Pressured speech							■ Passive aggressive					
■ Racing thoughts/flight of ideas							■ Dependency					
■ Poor judgment/impulsiveness							■ Enduring traits of:					

PATIENT NAME:

MEDICATIONS *(optional for non-physicians)*

CURRENT MEDICATIONS *(indicate changes since last report)*	**DOSAGE**	**FREQUENCY**

CURRENT RISK FACTORS:

SUICIDE: ❑ None ❑ Ideation ❑ Intent without means ❑ Intent with means ❑ Contracted not to harm self
HOMICIDE: ❑ None ❑ Ideation ❑ Intent without means ❑ Intent with means ❑ Contracted not to harm others
PHYSICAL OR SEXUAL ABUSE OR CHILD/ELDER NEGLECT: ❑ Yes ❑ No

- If "YES" patient is: ❑ Victim ❑ Perpetrator ❑ Both ❑ Neither, but abuse exists in family
- Abuse or neglect involves a child or elder: ❑ Yes ❑ No
- Abuse has been legally reported: ❑ Yes ❑ No

SYMPTOMS THAT ARE THE FOCUS OF CURRENT TREATMENT:

PROGRESS SINCE LAST REVIEW:

FUNCTIONAL IMPAIRMENTS OR SUPPORTS:

Family/interpersonal relationships:

JOB/SCHOOL:

HOUSING:

CO-OCCURRING MEDICAL/PHYSICAL ILLNESSES:

FAMILY HISTORY OF MENTAL ILLNESS:

PATIENT NAME:

PATIENT'S TREATMENT HISTORY INCLUDING ALL LEVELS OF CARE:

Level of care	Number of distinct episodes/sessions of	Date of last episode/session		Level of care	Number of distinct episodes/ sessions of	Date of last episode/ session
Outpatient Psych				PHP		
Outpatient – substance abuse				Inpatient – psych RTC		
IOP				Inpatient – substance abuse		

TREATMENT GOALS:

1.
2.
3.

OBJECTIVE OUTCOME CRITERIA BY WHICH GOAL ACHIEVEMENT IS MEASURED:

1.
2.
3.

DISCHARGE PLAN AND ESTIMATED DISCHARGE DATE:

EXPECTED OUTCOME AND PROGNOSIS:

- ❑ Return to normal functioning
- ❑ Expect improvement, anticipate less than normal functioning
- ❑ Relieve acute symptoms, return to baseline functioning
- ❑ Maintain current status, prevent deterioration

RISK HISTORY:

Explain any significant history of suicidal, homicidal, impulse control or any behavior that may impact patient's level of functioning:

REQUESTED AUTHORIZATION:

Procedure Code:	Number of Units:	Frequency:	Units Approved:
Procedure Code:	Number of Units:	Frequency:	Units Approved:
Procedure Code:	Number of Units:	Frequency:	Units Approved:
Procedure Code:	Number of Units:	Frequency:	Units Approved:

❑ Approved – Auth #:

PROVIDER'S SIGNATURE: **DATE:**

Disclaimer: Authorization indicates that AMERIGROUP determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the eligibility and benefit limitations at the time services are rendered.

TennCare Medical Appeal Form

The TennCare Medical Appeal Form is located at:
tn.gov/tenncare/members-applicants/how-to-file-a-medical-appeal.html.

Having problems getting health care or medicine in TennCare?

Use this page **only** to file a
TennCare Medical Appeal.

Need help filing a medical appeal?
☐Call **1-800-878-3192** for free.

Fill out **both** pages. These are **facts we must have to work your appeal.** If you don't tell us all the facts we need, we may not be able to decide your appeal. You may **not** get a fair hearing. Need help understanding what facts we need? Call us for free at **1-800-878-3192.** If you call, we can also take your **appeal by phone.**

---

1. Who is the person that wants to appeal?

Full name _____ _____ Date of birth ____/____/____

Social Security Number _____ - _____ - _____ Or number on their TennCare card _____

Current mailing address _____

City _____ State _____ Zip Code _____

The name of the person we should call if we have questions about this appeal: _____

A daytime phone number for that person (____) _____-_____

2. Who filled out this form?

If **not** the person that wants to appeal, tell us your name. _____

Are you a: _____ Parent, relative, or friend _____ Advocate or attorney _____ Doctor or health care provider

3. What is the appeal for? (Place an **X** beside the right answer below.)

___Want to **change health plans.** (Fill out **Part A** on page 2.)

___ **Need care or medicine.** (Fill out **Part B** on page 2.)

___ Have **bills or paid for care or medicine** you think TennCare should pay. (Fill out **Part C** on page 2.)

4. Do you think you have an emergency?

Usually, your appeal is decided within **90 days** after you file it. But, **if you have an emergency,** you may be able to get an **expedited** appeal. An expedited appeal must be decided in **3 business days.** An emergency means that if you don't get a decision on your appeal within 3 business days, it could **SERIOUSLY JEOPARDIZE…**

- your life;
- your physical health;
- your mental health; or
- your ability to attain, regain, or maintain full function.

Do you STILL think you have an emergency? If so, you can ask TennCare for an expedited appeal. Your health plan will decide if your appeal should be expedited because you have an emergency. If so, then your appeal will be decided in three business days from the date TennCare receives your appeal. However, if your health plan decides that your appeal should not be expedited, then you will get a hearing within 90 days.

Additionally, if your **PROVIDER** thinks you need an expedited appeal, your provider can visit **http://tn.gov/tenncare/topic/miscellaneous-provider-forms** to fill out a certificate. Your provider should return the certificate to **1-866-211-7228.** Your health plan will review the provider's certificate and make a decision about your appeal. If your health plan decides that your appeal should be expedited after reviewing your provider's certificate then your appeal will be decided in three business days from then. However, if your health plan decides your appeal should not be expedited after reviewing your provider's certificate then you will get a hearing within 90 days from the date you filed your appeal.

Rev: 01Jan17 **Keep reading.** There is **1 more page** for you to fill out.

5. Tell us why you want to appeal this problem. Include any mistake you think TennCare made. And, send copies of any papers that you think may help us understand your problem.

_____

_____

_____

To see which Part(s) you should fill out below, look at number **3** on page 1.

Part A. Want to change health plans. Name of health plan you want _____

Part B. Need care or medicine. What kind - be specific _____

What's the problem? ___Can't get the care or medicine at all.
___Can't get as much of the care or medicine as I need.
___The care or medicine is being cut or stopped.
___Waiting too long to get the care or medicine.

Did your doctor prescribe the care or medicine? ___Yes ___No If yes, doctor's name _____

Have you asked your health plan for this care or medicine? ___Yes ___No If yes, when? _____

What did they say? _____

Did you get a letter about this problem? ___Yes ___No If yes, the date of the letter _____

Who was the letter from? _____

Are you getting this care or medicine from TennCare now? ___ Yes ___ No

Do you want to see if you can keep getting it during your appeal? ___ Yes ___ No

Does your doctor say you still need it? ___ Yes ___ No If yes, doctor's name _____

If you keep getting care or medicine during your appeal and you lose, you may have to pay TennCare back.

Part C. Bills for care or medicine you think TennCare should pay for

The date you got the care or medicine _____ Name of doctor, drug store, or other place that gave you the care or medicine _____ Their phone number (__) _____-_____

Their address _____

Did you **pay for the care or medicine and want to be paid back?** ___ Yes ___ No

If yes, you must send a copy of a **receipt** that proves you paid for the care or medicine.

If you didn't pay, **are you getting a bill?** ___ Yes ___ No If yes, and you think TennCare should pay, you must send a copy of a **bill.** Tell us the date you first got a bill (if you know). _____

How to file your medical appeal

Make a copy of the completed pages to keep.

Then, **mail** these pages and other facts to:

TennCare Solutions
P.O. Box 593
Nashville, TN 37202-0593

Or, **fax** it (toll-free) to 1-888-345-5575. **Keep a copy** of the page that shows your fax went through.

To appeal by **phone**, call 1-800-878-3192 for free.
Have speech or hearing problems? Call our TTY/TDD line for free at 1-866-771-7043.

We do not allow unfair treatment in TennCare.

No one is treated in a different way because of race, color, birthplace, language, sex, age, religion, or disability.
If you think you've been treated unfairly, call the Tennessee Health Connection for free at **1-855-259-0701.**

Rev:01Jan17

Expedited TennCare Appeal Form

The Expedited TennCare Appeal Form is located at: **tn.gov/tenncare/providers/tenncare-provider-news-notices-forms/miscellaneous-provider-forms.html** .

Treating Provider's Certificate: *Expedited* TennCare Appeal

An expedited appeal is an administrative appeal for a medical service that must be either approved or denied within three (3) business days, as opposed to up to ninety (90) days, because of the patient's health. An appeal will only be expedited if waiting up to ninety (90) days for a decision, "could seriously jeopardize the enrollee's life, physical health, or mental health or their ability to attain, regain, or maintain full function."

To request an expedited appeal for your patient:

1. Read the statement below. If you agree, indicate your certification and sign and date in the spaces provided.

☐ I certify that I am the treating clinician of the patient named below, and that ***the acute presentation of this medical condition is of sufficient severity that the absence of a decision within three business days could seriously jeopardize the enrollee's life, physical health, or mental health or their ability to attain, regain, or maintain full function.***

Provider's Signature:_____ Date:_____

2. Identify the desired service:_____

3. Identify the patient.

_____

(Name) (SS#) **or** (date of birth)

4. At your discretion, please attach a narrative and/or medical records that support this request.

Fax this completed form and any accompanying documentation to the **Bureau of TennCare** at **866-211-7228**. (NOTICE: If your patient has already requested this expedited appeal from TennCare, please submit this certificate and documentation as soon as possible.)

TC0181 (Rev. 28Dec.2016) RDA 2045

Provider Appeals Form

Appeal Form

Thank you for contacting Amerigroup. All nonexpedited appeals must be submitted in writing to the Amerigroup Centralized Appeals Team. This form will help ensure that your appeal is processed as efficiently and effectively as possible. Please fill out the form completely.

Note: Per Federal Privacy Regulations (HIPAA), Amerigroup can only accept an appeal from a provider appealing on behalf of a member if the member has issued a written statement naming that provider as his/her designated representative.

Member Information

Last Name: _____ First Name: _____
Member Number: _____
Address:_____
City:_____ State: _____ ZIP_____

Provider Information

Last Name: _____ First Name: _____
Facility _____
TIN: _____ Provider Number: _____
Address: _____
City:_____ State: _____ ZIP: _____

Claim Data (If Applicable)

Claim Number: _____ Authorization Number: _____
Date Service Started:_____ Date Service Ended:_____

Please provide an explanation of the appeal reason. Attach a separate sheet if additional space is needed:

_____
_____
_____
_____
_____

Please place a check mark next to the items being submitted with the appeal.

___Copy of original claim
___Copy of the Amerigroup EOP
___EOP or EOB from another carrier
___Evidence of eligibility verification
___Medical records
___Approved referral and authorization forms from Amerigroup indicating the authorization number
___Contract rate sheets indicating evidence of payment rates
___Evidence of previous appeal submission or timely filing
___Letter from member designating provider as his/her designated representative

Appeals forms and supporting documentation should be addressed to:

Amerigroup Centralized Appeal Team
P.O. Box 61599
Virginia Beach, VA 23466-1599

Independent Review Forms

There are three different forms available to request an independent review:

1. The *Request to Commissioner for Independent Review of Disputed TennCare Claim* form can be electronically completed on the state's website at **tn.gov/commerce/tenncare-oversight/mco-dispute-resolution/independent-review-process.html**.
2. The *Request to Commissioner of Commerce & Insurance for Independent Review of Disputed TennCare Claim* form on the following page is a traditional form that can be printed and completed by the provider.
3. The *Request to Commissioner for Independent Review of Disputed TennCare Episode of Care Cycle Provider Gain/Risk Share Total* form, which is specific to requests related to disputes regarding the annual provider Episode of Care report, can be electronically completed on the state's website at **tn.gov/commerce/tenncare-oversight/mco-dispute-resolution/independent-review-process.html**.

REQUEST to COMMISSIONER of COMMERCE & INSURANCE for INDEPENDENT REVIEW of DISPUTED TENNCARE CLAIM

TO: Compliance Officer, TennCare Division, Tenn. Dept. of Commerce & Insurance
500 James Robertson Parkway, 11th Floor, Nashville, TN 37243-1169
Telephone: (615) 741-2677 or Fax: (615) 401-6834

FROM: Provider Contact Person: _____
Mailing Address: _____
City, State, Zip Code: _____
Telephone: (_____) _____
Fax Number: (_____) _____
E-mail Address: _____

Fill out this form completely or it may be returned as ineligible. Read the attached Instruction Sheet for completing this form.
(Submit a separate request form for each claim unless claims will be aggregated. See # 14 below.)

1. Provider Name: _____ NPI#: _____
2. TennCare MCO that denied claim: _____
3. Date(s) of Service(s): _____
4. Enrollee Name & ID #: _____
5. Claim(s) Amount: _____
6. Initial claim(s) submission date: _____
7. **Attach submitted claim(s).**
8. Date MCO partially or totally denied payment of claim (s): _____
9. **Attach MCO written denial(s). [Claim(s) must be submitted to Independent Review within 365 days of the MCO's 1st denial.]**
10. Date Provider requested reconsideration in writing: _____. **(Reconsideration request is required, regardless of whether a denial was received.)**
11. **Attach copy of dated written reconsideration request.**
12. **Attach MCO's response to your reconsideration request if you received one.**
13. **Briefly** describe disputed claim. Description may include, but not limited to: reason given for denial and your position explaining why the MCO should pay the claim. _____
    _____
    _____
14. Do you want your claims aggregated? ___ Yes ___ No. Only claims involving a common question of fact or law may be aggregated. The fact that a claim is not paid does not create a common question of fact or law. If you wish to aggregate your claims, explain the common question of fact or law: _____
    _____
    _____

Only claims which meet ALL of the requirements set forth in T.C.A. § 56-32-126(b)(2)(A) thru (D) are eligible for Independent Review. Claims payment disputes involved in litigation, arbitration or not associated with a TennCare member are not eligible.

ACKNOWLEDGEMENT OF FEE OBLIGATION

By my signature below, I hereby request independent review of the above claim, pursuant to T.C.A. §§ 56-32-126(b) or 71-5-2314. I also confirm that the above mentioned disputed claim will not be raised as an issue in litigation or arbitration until the reviewer issues his decision. Any provider who brings a lawsuit or initiates arbitration involving a claims payment dispute raised in an independent review request before the independent reviewer renders a decision, must ultimately pay the independent reviewer's fee. Any provider who initiates independent review for a non-TennCare claim is ultimately responsible for paying the reviewer's fee. I also understand that there is a mandatory fee of $750.00 per claim and if I have a contract with the MCO, the MCO is initially responsible for paying the fee. I further understand that if the reviewer determines the MCO correctly denied payment of this disputed claim(s), then I must reimburse the MCO for the reviewer's fee as established by the Selection Panel for TennCare Reviewers.

15. Are you a contracted provider with the MCO? ___ Yes ___ No
16. **Attach evidence of contract.** (A copy of the signature page from the provider contract is sufficient.)
17. **If you do not have a contract with the MCO, you must submit the reviewer's fee with your request.** (Per claim, attach check for $750 made payable to the Department of Commerce and Insurance).
18. Amount of check sent to TN Dept. of Commerce and Insurance for the reviewer's fee: $_____

_____ _____
Signature (Name & Title) Date

_____
(Type or Print Name & Title)

Revised July 2015

Disclosure for Provider Entities

This information is required during the provider registration on the TennCare Web portal at **tn.gov/tenncare/providers/provider-registration.html**.

Practitioner Attestation Form
Practitioner Attestation:

I certify and attest that the following is true and correct. I understand that factual misrepresentation may result in my nonselection, or if discovered after selection, my termination, as an Amerigroup Community Care practitioner for the TENNCARE MANAGED CARE Program.

TennCare Rule 1200-13-1-05 (1.a.3.) requires that I disclose whether (i) I am under a federal Drug Enforcement Agency (DEA) restriction of my prescribing and/or dispensing certification for scheduled drugs, or (ii) I have been convicted of a criminal offense in any program under the Medicare, Medicaid, or the Federal Title XX services program since the inception of those programs. Pursuant to Chapter 42 CFR Part 455, Subpart B State plans require disclosure of information regarding a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid, and the Title XX Programs.

Amerigroup Community Care is required to disclose to TENNCARE, the Comptroller General and CMS full and complete information regarding persons convicted of criminal activity related to Medicare, Medicaid, or Federal Title XX programs in accordance with federal and State requirements, including Public Chapter 379 of the Acts of 1999.

I, _____, hereby certify and attest that I have not been convicted of fraud, or any other criminal offense in connection with obtaining or attempting to obtain, or performing a public (federal, State, or Local) transaction or grant under a public transaction, a violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property, nor have I had a civil judgment rendered against me for commission of any of the above offenses. I am not under a federal Drug Enforcement Agency (DEA) restriction of my prescribing and/or dispensing certification for scheduled drugs, and I have not been convicted of a criminal offense in any program under Medicare, Medicaid, or the Federal Title XX services program since the inception of those programs.

By: _____
Please Type or write name

_____
Signature

_____
Date

_____
Title-Position

_____
Practice-Facility-Affiliation

_____
Tax Identification Number

Amerigroup
An Anthem Company

Provider Payment Dispute and Correspondence - Submission Form

This form should be completed by Tennessee Providers for Payment Disputes and Claim Correspondence only.

Member First/Last Name____ 1 ____ Member DOB ____ 2 ____

AMERIGROUP, Medicaid or Medicare (circle one) Member # ____ 3 ____

Provider First/Last Name____ 4 ____ Provider # ____ 5 ____

Provider Contact First/Last Name____ 6 ____ Contact Phone (____) ____ 7 ____

8 ☐ Participating

☐ Non-Participating: If filing for a Medicare member and the member has potential financial liability, you must include a completed CMS Waiver of Liability form.

Provider Street Address____ 9a ____

City____ 9b ____ State____ 9c Zip____ 9d Phone (____) ____ 9e ____

Claim #____ 10 ____ Billed Amount $____ 11 ____ Amount Received $ ____ 12 ____

Start Date of Service ____ 13 ____ End Date of Service ____ 14 ____ Auth #____ 15 ____

In accordance with Tennessee regulation T.C.A 56-32-126 , providers have an external independent review process available if you continue to disagree with a payment decision after receiving a decision from a health plan's internal dispute process. For specific instructions and requirements for this process, please review the Tennessee regulation. A form for filing is located at http://www.tn.gov/tncoversight/PCIR.shtml. Please be aware there is a fee associated with each claim requested for review that must be paid by the provider if the external reviewer upholds our determination. Please note this process is not applicable to Medicare member's liability denials.

PAYMENT DISPUTE

A payment dispute is defined as a dispute between the provider and AMERIGROUP in reference to a claim determination where the member cannot be held financially liable. All disputes with member liability must follow the applicable appeals process. Please refer to the explanation of payment to ensure you are following the correct process.

16 Clearly and completely indicate the payment dispute reason(s). You may attach an additional sheet if necessary. **Please include appropriate medical records.**

____

____

____

17 **CLAIM CORRESPONDENCE:** Check (√) appropriate box below.

Claim correspondence is defined as a request for additional/needed information in order for a claim to be considered clean, to be processed correctly or for a payment determination to be made.

☐ **Itemized Bill/Medical Records** (In response to an AMERIGROUP claim denial or request)

☐ **Corrected Claim** ☐ **Other Insurance/Third-Party Liability Information** ☐ **Other Correspondence**

18 Clearly and completely indicate the reason(s) for your correspondence. You may attach an additional sheet if necessary.

____

____

Mail this form and supporting documentation to:

19 **AMERIGROUP Community Care**
Payment Disputes
PO Box 61599
Virginia Beach, VA 23466-1599

How to complete the Provider Payment Dispute Form

Use the Provider Payment Dispute Form to request payment reconsideration for any claim(s) that have been previously denied or underpaid by Amerigroup Community Care.

1) Insert **Member Name** for claim(s) in dispute
2) Insert **Member Date of Birth** for claim(s) in dispute
3) Insert **Amerigroup Medicaid or Medicare Member number** for claim(s) in dispute. Circle type of ID applicable for member
4) Insert **Provider First and Last Name** disputing the claim(s)
5) Insert **Provider Number** for provider disputing the claim(s)
6) Insert **Contact First and Last Name** who is familiar with the disputed claim(s) and should receive correspondence regarding the dispute being submitted
7) Insert **Contact Phone Number** to be reached between the hours of 8:00 a.m. – 5:00 p.m. Monday – Friday
8) Check applicable box indicating whether Provider disputing claim(s) is **Par** (In Network) or **Non-Par** (Out of Network)
9) (a-e) Insert **Provider Street Address, City, State, ZIP Code and Phone Number**
10) Insert the **Claim(s) Number** of claim(s) in dispute — Attach a separate sheet if additional claim(s) with the same issue are being disputed
11) Insert **Billed Amount** for claim(s) in dispute
12) Insert **Amount Received** (Paid Amount) for claim(s) in dispute
13) Insert the **Start Date of Service** (Earliest date shown from the claim(s) in dispute)
14) Insert the **End Date of Service** (Latest date shown from the claim(s) in dispute)
15) Insert the **Authorization Number** the disputed claim(s) falls under if applicable
16) Check applicable box indicating if this is a **First Level or Second Level** payment dispute.
    (1) First Level – Claim(s) have never been submitted for dispute.
    (2) Second Level – Claim(s) sent for First Level Dispute was denied and the provider received a First Level Dispute determination letter; Second Level Dispute is being submitted for reconsideration.
17) Indicate a **brief description of the reason(s) claim(s) is being disputed**. Attach an additional page if necessary. Also, include appropriate medical records
18) Check applicable box indicating what **type of correspondence** is being submitted
19) Indicate **reason(s) for the correspondence** clearly and completely. Attach an additional page if necessary
20) **Mail Provider Dispute Form** and all supporting documentation to address given

Adverse Occurrence Reporting Form

TennCare Behavioral Health Adverse Occurrence Report

Provider Name:	**Consumer Name:** (Last, First)
Name of Reporting Person:	**Address:**
Name/Title of Person Submitting Report:	**SSN:**
Contact Number:	**DOB:**
Date Reported:	**Date of Incident:**
	MCO: ☐ **UHCCP** ☐ **Amerigroup** ☐ **BlueCare** ☐ **TennCare Select**

Persons Involved (Check all that apply) ☐ **Clients** ☐ **Staff** ☐ **Persons Not Associated with Facility** ☐ **Other** _____	**Location of Incident** ☐ **Residential**_____ ☐ **Inpatient** _____ ☐ **Crisis Stabilization Unit (CSU)**_____

Type of Behavioral Health Adverse Occurrence (Check One) ☐ **Suicide Death** ☐ **Non-Suicide Death** ☐ **Death-Cause Unknown** ☐ **Homicide** ☐ **Homicide Attempt w/significant medical intervention*** ☐ **Suicide Attempt w/significant medical intervention***	☐ **Allegation of Abuse/Neglect-Including Peer to Peer (Physical, Sexual, Verbal)** ☐ **Accidental Injury w/significant medical intervention*** ☐ **Use of Restraints/Seclusion (Physical, Chemical, Mechanical) requiring significant medical intervention*** ☐ **Treatment Complications (medications errors and adverse medication reaction) requiring significant medical intervention*** ***Significant Medical Intervention: Requiring an ER visit or inpatient hospital stay**

Summary of Adverse Occurrence: (Be specific, precise and as detailed as possible)

Summary of Action Taken by Facility/Provider:	☐ **Notified Parents or Next of Kin**
☐ **Notified 911**	☐ **Staff Debriefing/Training**

☐ **Taken to Physician**	☐ **Reported to DHS _____(Date)**
☐ **Taken to Hospital**	☐ **Reported to DCS _____(Date)**
☐ **Notified Fire Department**	☐ **Other**
☐ **Notified Police**	**(Specify) _____**
☐ **Notified Mental Health Case Manager**	**_____**

MCO USE ONLY

Summary of MCO follow up actions to address reported adverse occurrence: (Please be specific, precise and detailed as possible)
UHCCP has received notification of this AO and will follow up with provider as appropriate. UHCCP will work with provider surrounding any issues identified.

FAX TO: 877-423-9976

Medicaid Reclamation Claim Refund Form

AMERIGROUP MEDICAID RECLAMATION REFUND REQUEST FORM

This form should be used by a provider to obtain payment for services rendered when:

- Amerigroup obtained payment from the Third Party Liability (TPL),
- Amerigroup subsequently recouped payments from the provider, and
- The above actions resulted in the denial of payment to the provider from the TPL, leaving the provider without payment.

General Information:

Provider Name/Contact _____

Contact Number _____

Provider ID _____Provider Tax ID _____

Subscriber ID _____

Member Name _____

Member Account Number _____

Primary Insurance information: (Provide as much information as possible to expedite processing.)

Primary Insurance Name _____ Member ID# _____

Amount Paid to Amerigroup $_____ Check # _____ Check Date ___/___/____

Total Check Amount $_____ Date Check Cleared _____/_____/_____
(Attach copy of check if able to obtain from the TPL Carrier)

Refund Information:

Amerigroup Claim Number _____

Total Billed Charges $_____ Date of Service_____/_____/_____

Dollar Amount Due Provider to be refunded by Amerigroup $_____

Brief Description of Situation: _____
_____
_____

I hereby certify that the information provided above is correct and that Provider is due amount indicated.

Signature _____ Date _____/_____/_____

Mail to: [Amerigroup Community Care
P.O. Box 933657
Atlanta, GA 31193-3657]

This form is not to be used to obtain additional payments from Amerigroup to satisfy the provider's contracted rate with the other carrier. Any payments made to Amerigroup by the other carrier greater than Amerigroup's original payment to the provider will be repaid to the other carrier, not the provider.

Member Discrimination Complaint Form (English)

TN Division of TennCare

TENNCARE DISCRIMINATION COMPLAINT

Federal and State laws do not allow the TennCare Program to treat you differently because of your race, color, birthplace, disability, age, sex, religion, or any other group protected by law. Do you think you have been treated differently for these reasons? Use these pages to report a complaint to TennCare.

The information marked with a star (*) must be answered. If you need more room to tell us what happened, use other sheets of paper and mail them with your complaint.

1.* Write your name and address.
Name: _____

Address: _____

_____ Zip: _____

Telephone: (_____) _____ Date of Birth: _____

Email Address: _____

Name of MCO/Health Plan:

_____

2.* Are you reporting this complaint for someone else? Yes: _____ No: _____
If Yes, who do you think was treated differently because of their race, color, birthplace, disability/handicap, age, sex, religion, or any other group protected by law?
Name: _____

Address: _____

_____ Zip: _____

Telephone Home: (_____) _____ Date of Birth: _____

How are you connected to this person (wife, brother, friend)?

_____

Name of this person's MCO/Health Plan:

_____

3.* Which part of the TennCare Program do you think treated you in a different way:
Medical Services_____ Dental Services____ Pharmacy Services_____ Behavioral Health ____
Long-Term Services & Supports_____ Eligibility Services_____ Appeals_____

4.* How do you think you were you treated in a different way? Was it your:
Race___ Birthplace____ Color____ Sex____ Age____ Disability_____ Religion____
Other_____

5. What is the best time to talk to you about this complaint?
_____

1

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6.* When did this happen to you? Do you know the date?
Date it started: _____ Date of the last time it happened:

_____

7. Complaints must be reported by 6 months from the date you think you were treated in a different way. You may have more than 6 months to report your complaint if there is a good reason (like a death in your family or an illness) why you waited.

_____
_____
_____
_____
_____
_____

8.* What happened? How and why do you think it happened? Who did it? Do you think anyone else was treated in a different way? You can write on more paper and send it in with these pages if you need more room.

_____
_____
_____
—

9. Did anyone see you being treated differently? If so, please tell us their:
Name Address Telephone

_____
_____
_____

10. Do you have more information you want to tell us about?

_____
_____
_____

11.* We cannot take a complaint that is not signed. Please write your name and the date on the line below. Are you the Authorized Representative of the person who thinks they were treated differently? Please sign your name below. As the Authorized Representative, you must have proof that you can act for this person. If the patient is less than 18 years old, a parent or guardian should sign for the minor. Declaration: *I agree that the information in this complaint is true and correct and give my OK for TennCare to investigate my complaint.*

_____
(Sign your name here if you are the person this complaint is for) (Date)

_____
(Sign here if you are the Authorized Representative) (Date)

Are you reporting this complaint for someone else but you are not the person's Authorized Representative? Please sign your name below. The person you are reporting this complaint for must sign above or must tell his/her health plan or TennCare that it is okay for them to sign for him/her. Declaration: *I agree that the information in this complaint is true and correct and give my OK for TennCare to contact me about this complaint.*

_____
(Sign here if you reporting this for someone else) (Date)

Are you a helper from TennCare or the MCO/Health Plan assisting the member in good faith with the completion of the complaint? If so, please sign below:

_____

(Sign here if you are a helper from TennCare or the MCO/Health Plan) (Date)

It is okay to report a complaint to your MCO/Health Plan or TennCare. Information in this complaint is treated privately. Names or other information about people used in this complaint are shared only when needed. Please mail a signed Agreement to Release Information page with your complaint. If you are filing this complaint on behalf of someone else, have that person sign the Agreement to Release Information page and mail it with this complaint. Keep a copy of everything you send. Please mail or email the completed, signed Complaint and the signed Agreement to Release Information pages to us at:

TennCare, Office of Civil Rights Compliance
310 Great Circle Road; Floor 3W • Nashville, TN 37243
615-507-6474 or for free at 855-857-1673 (TRS 711)
HCFA.fairtreatment@tn.gov

You can also call us if you need help with this information.

TN Division of TennCare

TennCare Agreement to Release Information

To investigate your complaint, TennCare may need to tell other persons or organizations important to this complaint your name or other information about you.

To speed up the investigation of your complaint, read, sign, and mail one copy of this Agreement to Release Information with your complaint. Please keep one copy for yourself.

- I understand that during the investigation of my complaint TennCare may need to share my name, date of birth, claims information, health information, or other information about me to other persons or organizations. And TennCare may need to gather this information about you from persons or organizations. For example, if I report that my doctor treated me in a different way because of my color, TennCare may need to talk to my doctor and gather my medical records.

- You do not have to agree to release your name or other information. It is not always needed to investigate your complaint. If you do not sign the release, we will still try to investigate your complaint. If you don't agree to let us use your name or other details, it may limit or stop the investigation of your complaint. We may have to close your case. Before we close your case because you did not sign the release, we may contact you to find out if you want to sign a release so the investigation can continue.

If you are filing this complaint for someone else, we need that person to sign the Agreement to Release Information. Are you signing this as an Authorized Representative? Then you must also give us a copy of the documents appointing you as the Authorized Representative.

By signing this Agreement to Release Information, I agree that I have read and understand my rights written above. I agree to TennCare sharing my name or other information about me to other persons or organizations important to this complaint during the investigation and outcome.

This Agreement to Release Information is in place until the final outcome of your complaint. You may cancel your agreement at any time by calling or writing to TennCare without canceling your complaint. If you cancel your agreement, information already shared cannot be made unknown.

Signature: _____ Date: _____

Name (Please print): _____

Address:

_____

Telephone: _____

Need help? Want to report a complaint? Please contact or mail a completed, signed Complaint and a signed Agreement to Release Information form:

TennCare OCRC
310 Great Circle Road, 3W
Nashville, TN 37243

Phone: 1-615-507-6474 or for free at 1-855-857-1673 (TRS 711)
Email: HCFA.fairtreatment@tn.gov

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Do you need free help with this letter?
If you speak a language other than English, help in your language is available for free. This page tells you how to get help in a language other than English. It also tells you about other help that's available.
Spanish: **Español** ATENCION: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-259-0701 (TTY: 1-800-848-0298).
Kurdish: **کوردیی** ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە 1- 855-259-0701 (1-800-848-0298) TTY بکە.
Arabic: **العربية** ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-259-0701 (رقم هاتف الصم والبكم:1-800-848-0298).
Chinese: **繁體中文** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-259-0701 （TTY 1-800-848-0298）。
Vietnamese: **Tiếng Việt** CHU Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-259-0701 (TTY: 1-800-848-0298).
Korean: **한국어** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-259-0701 (TTY: 1-800-848-0298)번으로 전화해 주십시오.
French: **Français** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-259-0701 (ATS : 1-800-848-0298).
Amharic: □□□□ ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-259-0701 (መስማት ለተሳናቸው: 1-800-848-0298).
Gujarati: □□□□□□□□ □□□□□: □□ □□□ □□□□□□□ □□□□□ □□, □□ □□:□□□□□ □□□□ □□□□ □□□□□ □□□□□ □□□□ □□□□□□ □□. □□□ □□□ 1-855-259-0701 (TTY: 1-800-848-0298).
Laotian: **ພາສາລາວ** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍ່ວ່ການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-855-259-0701 (TTY: 1-800-848-0298).
German: **Deutsch** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-259-0701 (TTY: 1-800-848-0298).
Tagalog: **Tagalog**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-259-0701 (TTY: 1-800-848-0298).
Hindi: □□□□□ ध्यान दें: यदि आप □□□□□ बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-259-0701 (TTY: 1-800-848-0298) पर कॉल करें।
Serbo-Croatian: **Srpsko-hrvatski** OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-259-0701 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1- 800-848-0298).
Russian: **Русский** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-259-0701 (телетайп: 1-800-848-0298).
Nepali: □□□□□□ ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् 1-855-259-0701 (टिटिवाइ: 1-800-848-0298)।
Persian: **توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم میباشد.با 1-855-259-0701 (TTY: 1-800-848-0298) تماس بگیرید.

- **Do you need help talking with us or reading what we send you?**
- **Do you have a disability and need help getting care or taking part in one of our programs or services?**
- **Or do you have more questions about your health care?**

Call us for free at 1-855-259-0701. We can connect you with the free help or service you need.
(For TTY call: 1-800-848-0298)

Member Discrimination Complaint Form (Spanish)

TN Division of TennCare

TENNCARE QUEJA DE DISCRIMINACIÓN

Las leyes federales y estatales no permiten que el Programa TennCare lo trate de manera diferente debido a su **raza, color de la piel, lugar de nacimiento, discapacidad, edad, sexo, religión o cualquier otro grupo protegido por la ley**. ¿Piensa que ha sido tratado de manera diferente por estas razones? Use estas hojas para presentar una queja a TennCare.

Es obligatorio proporcionar la información marcada con un asterisco (*). Si necesita más espacio para decirnos lo que pasó, use otras hojas de papel y envíelas con su queja.

1.* Escriba su nombre y dirección.

Nombre:

_____

Dirección:

_____

_____ Código postal _____

Teléfono: Hogar: (_____)_____ Trabajo o Celular: (_____)_____

Dirección de correo electrónico: _____

Nombre del MCO/plan de seguro médico:

_____

2.*¿Está usted presentando esta queja en nombre de otra persona?

Sí: _____ No: _____

Si respondió Sí, ¿quién piensa usted que fue tratado de manera diferente debido a su **raza, color de la piel, lugar de nacimiento, discapacidad, edad, sexo, religión o cualquier otro grupo protegido por la ley?**

Nombre: _____

Dirección:

_____

_____ Código postal _____

Teléfono: Hogar: (_____)_____ Trabajo o Celular: (_____)_____

¿Qué relación tiene usted con esta persona (cónyuge, hermano, amigo)?

_____

Nombre del MCO/plan de seguro médico de esa persona:

_____

3.* ¿Cuál parte del Programa TennCare cree que lo trató de una manera diferente?

Servicios médicos____ Servicios dentales_____ Servicios de farmacia____ Salud conductual_____

Servicios y apoyos de largo plazo_____ Servicios de elegibilidad_____ Apelaciones_____

4.* ¿Por qué cree que lo trataron de una manera diferente? Fue a causa de su

Raza____ Lugar de nacimiento_____ Color de la piel_____Sexo_____ Edad_____

Discapacidad_____ Religión_____ Otra cosa_____

5. ¿Cuál es la mejor hora para llamarlo acerca de esta queja?

_____

6.* ¿Cuándo sucedió esto? ¿Sabe la fecha?

Fecha en que comenzó: _____ Última fecha en que sucedió: _____

7. Las quejas deben reportarse no más de 6 meses de la fecha en que piensa que fue tratado de una manera diferente. Si tiene una causa justificada (como enfermedad o fallecimiento en la familia), puede reportar su queja más de 6 meses después.

_____

_____

8.* ¿Qué sucedió? ¿Cómo y por qué piensa que pasó? ¿Quién lo hizo? ¿Piensa que alguna otra persona también fue tratada de una manera diferente? Si necesita más lugar, puede escribir en otra(s) hoja(s) y enviarlas con estas hojas.

_____

_____

_____

9. ¿Alguien vio cómo lo trataban de una manera diferente? Si es así, por favor, proporcione la siguiente información sobre esa persona:

Nombre	**Dirección**	**Teléfono**

10. ¿Tiene usted más información que nos desee dar?

_____

_____

_____

11.*No podemos aceptar ninguna queja que no esté firmada. Por favor, escriba su nombre y la fecha en la línea de abajo. ¿Es usted el Representante Autorizado de la persona que piensa que fue tratada de manera diferente? Firme abajo. Como el Representante Autorizado, usted debe tener un comprobante de que puede actuar en nombre de esta persona. Si el paciente es menor de 18 años de edad, uno de los padres o tutor debe firmar en su nombre. **Declaración:** *Declaro que la información presentada en esta queja es verídica y correcta y doy mi autorización para que TennCare investigue mi queja.*

_____

(Firme aquí si usted es la persona de quien trata esta queja) (Fecha)

_____

(Firme aquí si usted es el Representante Autorizado) (Fecha)

¿Está usted reportando esta queja en nombre de otra persona pero usted **no** es el Representante Autorizado de la persona? Firme abajo. **La persona para quien usted está reportando esta queja debe firmar arriba o debe decirle a su plan de seguro médico o a TennCare que está bien que él/ella firme en su lugar. Declaración:** *Afirmo que la información contenida en esta queja es verdadera y correcta y doy mi permiso para que TennCare se comunique conmigo acerca de esta queja.*

_____

(Firme aquí si está reportando en nombre de otra persona) (Fecha)

¿Es usted ayudante de TennCare o del MCO/plan de seguro médico y está ayudando al miembro de buena fe a presentar la queja? Si es así, por favor firme abajo:

_____

(Firme aquí si usted es ayudante de TennCare o del MCO/plan de seguro médico) (Fecha)

Está bien que reporte una queja a su MCO/plan de seguro médico o a TennCare. La información contenida en esta queja se trata de manera privada. Los nombres y otros datos sobre las personas que aparecen en esta queja sólo se divulgan cuando es necesario. Por favor, envíe una hoja de Autorización para Divulgar Información con su queja. Si está presentando esta queja en nombre de otra persona, pídale a la persona que firme la hoja de Autorización para Divulgar Información y envíela por correo con esta queja. Conserve una copia de todo lo que envíe. Envíe las hojas firmadas de la Queja **y la** Autorización para Divulgar Información a:

TennCare OCRC
310 Great Circle Road, 3rd Floor
Nashville, TN 37243
Teléfono: 1-615-507-6474 o gratis en el 1-855-857-1673
Para TRS gratis, marque el 711
Correo electrónico: HCFA.fairtreatment@tn.gov

También puede llamarnos si necesita ayuda con esta información.

TN Division of TennCare

Acuerdo de divulgación de información de TennCare

Para investigar su reclamo, es posible que TennCare deba informar a otras personas u organizaciones importantes su nombre u otra información sobre usted.

Para acelerar la investigación de su reclamo, lea, firme y envíe por correo postal una copia de este Acuerdo de divulgación de información junto con él. Guarde una copia para usted.

- Comprendo que durante la investigación de mi reclamo, es posible que TennCare deba compartir mi nombre, fecha de nacimiento, información sobre reclamaciones, información médica u otra información sobre mí con otras personas u organizaciones. Igualmente, es posible que TennCare deba recopilar esta información sobre usted a través de personas u organizaciones. Por ejemplo, si denuncio que mi médico me trató de una manera diferente debido a mi color, es posible que TennCare deba hablar con mi médico y recopilar mis registros médicos.

- Usted no estará obligado a aceptar la divulgación de su nombre u otra información. No siempre será necesario investigar su reclamo. Si no firma la autorización de divulgación, igualmente intentaremos investigar su reclamo. Si no acepta permitirnos usar su nombre u otros datos, la investigación de su reclamo se podrá ver limitada o suspendida. Es posible que tengamos que cerrar su caso. Antes de cerrar su caso por el hecho de que usted no firmó la autorización de divulgación, podremos comunicarnos con usted para averiguar si desea firmar una autorización de divulgación para que la investigación pueda continuar.

Si usted presenta este reclamo en nombre de otra persona, necesitaremos que esa persona firme el Acuerdo de divulgación de información. ¿Está firmando este documento como representante autorizado? Entonces, también deberá proporcionarnos una copia de los documentos que lo designan a usted como el representante autorizado.

Al firmar este Acuerdo de divulgación de información, acepto que he leído y comprendo los derechos que se mencionaron anteriormente. Acepto que TennCare comparta mi nombre u otra información sobre mí con otras personas u organizaciones que sea importante para este reclamo durante la investigación y el resultado del mismo.

Este Acuerdo de divulgación de información tendrá vigencia hasta el resultado final de su reclamo. Usted podrá cancelar su acuerdo en cualquier momento llamando o escribiendo a TennCare sin cancelar su reclamo. Si cancela el acuerdo, no se podrá eliminar por completo la información que ya se haya compartido.

Firma: _____ Fecha:

Nombre (en letra de imprenta):

_____

Dirección:

_____

Teléfono:

_____

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¿Desea realizar un reclamo? Envíe por correo postal un reclamo completado y **firmado** y un formulario del **Acuerdo de divulgación de información firmado** a la siguiente dirección:

OCRC de TennCare
310 Great Circle Road, 3W
Nashville, TN 37243

Teléfono: 1-615-507-6474 o en forma gratuita al 1-855-857-1673 (TRS 711)
Correo electrónico: HCFA.fairtreatment@tn.gov

¿Necesita ayuda gratuita con esta carta?
Si usted habla un idioma diferente al inglés, existe ayuda gratuita disponible en su idioma. Esta página le indica cómo obtener ayuda en otro idioma. Le indica también sobre otras ayudas disponibles.
Spanish: **Español** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-259-0701 (TTY: 1-800-848-0298).
Kurdish: **کوردی** ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە TTY (1-800-848-0298) 1- 855-259-0701 بکە.
Arabic: **العربية** ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-259-0701 (رقم هاتف الصم والبكم:1-800-848-0298).
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Vietnamese: **Tiếng Việt** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-259-0701 (TTY: 1-800-848-0298).
Korean: **한국어** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-259-0701 (TTY: 1-800-848-0298)번으로 전화해 주십시오.
French: **Français** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-259-0701 (ATS : 1-800-848-0298).
Amharic: □□□□ □□□□□: □□□□□□ □□□ □□□□ □□□ □□□□□ □□□□ □□□□□□ □□□ □□□□□□ □□□□□□□□ □□ □□□□□ □□□ □□□□ **1-855-259-0701 (□□□□ □□□□□□: 1-800-848-0298).**
Gujarati: **ગુજરાતી** **સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો** 1-855-259-0701 (TTY: 1-800-848-0298).
Laotian: **ພາສາລາວ**

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍ່ເສັຽຄ່າ ພາສາ, ໃດຍບໍ່ເສັຽຄ່າ, ຄວາມຊ່ວຍເຫລືອ ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-259-0701 (TTY: 1-800-848-0298).
German: **Deutsch** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-259-0701 (TTY: 1-800-848-0298).
Tagalog: **Tagalog** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-259-0701 (TTY: 1-800-848-0298).
Hindi: **हिंदी** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-259-0701 (TTY: 1-800-848-0298) पर कॉल करें।
Serbo-Croatian: **Srpsko-hrvatski** OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-259-0701 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1- 800-848-0298).
Russian: **Русский** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-259-0701 (телетайп: 1-800-848-0298).
Nepali: **नेपाली** ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् 1-855-259-0701 (टिटिवाइ: 1-800-848-0298)।
Persian: **توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم میباشد.با 1-855-259-0701 (TTY: 1-800-848-0298) تماس بگیرید.

- ¿Necesita ayuda para hablar con nosotros o para leer lo que le enviamos?
- ¿Tiene alguna discapacidad y necesita ayuda para su cuidado o para tomar parte en uno de nuestros programas o servicios?
- ¿O tiene más preguntas sobre su atención médica?

Llámenos gratis al 1-855-259-0701. Podemos conectarlo con la ayuda o servicio gratuito que necesite.
(Para el sistemaTTY (Para los sordos) llame al: 1-800-848-0298)

Member Discrimination Complaint Form (Arabic)

Division of TennCare

TENNCARE DISCRIMINATION COMPLAINT

لا تسمح القوانين الاتحادية وقوانين الولايات لبرنامج TennCare أن يقوم بالتمييز ضدك بسبب **عرقك أو لونك أو مكان ميلادك، أو عجزك، أو عمرك، أو جنسك، أو دينك، أو أي فئة أخرى يحميها القانون**. هل تعتقد أنك قد تعرضت للتمييز لهذه الأسباب؟ استخدم تلك الصفحات للإبلاغ عن أي شكوى إلى برنامج TennCare.

يتعين عليك الإجابة على المعلومات التي تحمل علامة نجمة (*). وإن احتجت إلى المزيد من المساحة لتخبرنا بما حدث، فاستخدم أوراق أخرى وارسلها مع شكوتك.

1. * اكتب اسمك وعنوانك.

الاسم:_____

العنوان:_____

_____الرمز البريدي _____

الهاتف: المنزل (_____)_____ العمل أو المحمول (_____)_____

البريد الإلكتروني: _____

اسم منظمة الرعاية المدارة /خطة الصحة:

_____

2. * هل تبلغ عن هذه الشكوى من أجل شخص آخر؟ نعم: _____ لا:_____

إن كانت الإجابة نعم، فمن هو الشخص تعرض للتمييز بسبب **العرق، أو اللون، أو مكان الميلاد، أو العجز/الإعاقة، أو العمر، أو الجنس، أو الدين، أي فئة أخرى يحميها القانون؟**

الاسم:_____

العنوان: _____

_____الرمز البريدي _____

الهاتف: المنزل (_____)_____ العمل أم المحمول (_____)_____

ما هي صلتك بذلك الشخص (زوجة، أخ، صديق)؟

اسم منظمة الرعاية المدارة /خطة الصحة الخاصة بذلك الشخص:

TN Division of TennCare

TENNCARE DISCRIMINATION COMPLAINT

لا تسمح القوانين الاتحادية وقوانين الولايات لبرنامج TennCare أن يقوم بالتمييز ضدك بسبب **عرقك أو لونك أو مكان ميلادك، أو عجزك، أو عمرك، أو جنسك، أو دينك، أو أي قئة أخرى يحميها القانون.** هل تعتقد أنك قد تعرضت للتمييز لهذه الأسباب؟ استخدم تلك الصفحات للإبلاغ عن أي شكوى إلى برنامج TennCare.

يتعين عليك الإجابة على المعلومات التي تحمل علامة نجمة (*). وإن احتجت إلى المزيد من المساحة لتعبرنا بما حدث، فاستخدم أوراق أخرى وارسلها مع شكوتك.

1. * اكتب اسمك وعنوانك.

الاسم:_____

العنوان:_____

_____الرمز البريدي _____

الهاتف: المنزل (_____)_____ العمل أو المحمول (_____)_____

البريد الإلكتروني: _____

اسم منظمة الرعاية المدارة \خطة الصحة:

_____

2. * هل تبلغ عن هذه الشكوى من أجل شخص آخر؟ نعم: _____ لا:_____

إن كانت الإجابة نعم، فمن هو الشخص تعرض للتمييز بسبب **العرق، أو اللون، أو مكان الميلاد، أو العجز\الإعاقة، أو العمر، أو الجنس، أو الدين، أي قئة أخرى يحميها القانون؟**

الاسم:_____

العنوان: _____

_____الرمز البريدي _____

الهاتف: المنزل (_____)_____ العمل أم المحمول (_____)_____

ما هي صلتك بذلك الشخص (زوجة، أخ، صديق)؟

_____

اسم منظمة الرعاية المدارة \خطة الصحة الخاصة بذلك الشخص:

_____

3. * أي جزء من برنامج TennCare تعتقد أنه قام بالتمييز ضدك:

الخدمات الطبية _____ خدمات طب الأسنان _____ الخدمات الصيدلية _____ الصحة السلوكية _____

الدعم والخدمات طويلة المدى _____ خدمات الأهلية _____ الالتماسات _____

4. *كيف تعرضت للتمييز؟ هل كان بسبب

عرقك___ مكان ميلادك ___ لونك ___ عمرك ___

عجزك ___ دينك ___ سبب آخر _____

5. ما هو أنسب وقت للتحدث إليك بشأن هذه الشكوى؟

_____

6. * متى حدث ذلك لك؟ هل تعلم التاريخ؟

تاريخ بداية الحدث: _____ تاريخ آخر مرة حدث ذلك: _____

7. يتعين عليك الإبلاغ عن الشكوى قبل 6 أشهر من تاريخ اليوم الذي تعرضت فيه للتمييز.

يجوز لك الحصول على أكثر من 6 أشهر للإبلاغ عن الشكوى إذا كانت هناك أسباب قوية لانتظارك كل هذه الفترة (مثل حالة وفاة في عائلتك أو مرض ما).

_____

_____

_____

8. * **ما الذي حدث؟** كيف ولماذا تعتقد أن ذلك حدث؟ من قام بذلك؟ هل تعتقد أن أي هناك شخص آخر تعرض للتمييز؟ يمكنك الكتابة على المزيد من الورق وإرساله مع هذه الصفحات إذا احتجت لمزيد من المساحة.

_____

_____

_____

9. **هل هناك شاهد على ذلك التمييز؟** إن كان الأمر كذلك، يرجى إخبارنا بـ:

الاسم	العنوان	الهاتف
_____		
_____		

_____

3. * أي جزء من برنامج TennCare تعتقد أنه قام بالتمييز ضدك:

الخدمات الطبية _____ خدمات طب الأسنان _____ الخدمات الصيدلية _____ الصحة السلوكية _____

الدعم والخدمات طويلة المدى _____ خدمات الأهلية _____ الالتماسات _____

4. *كيف تعرضت للتمييز؟ هل كان بسبب

عرقك___ مكان ميلادك ___ لونك ___ عمرك ___

عجزك ___ دينك ___ سبب آخر _____

5. ما هو أنسب وقت للتحدث إليك بشأن هذه الشكوى؟

_____

6. * متى حدث ذلك لك؟ هل تعلم التاريخ؟

تاريخ بداية الحدث: _____ تاريخ آخر مرة حدث ذلك: _____

7. يتعين عليك الإبلاغ عن الشكوى قبل 6 أشهر من تاريخ اليوم الذي تعرضت فيه للتمييز.

يجوز لك الحصول على أكثر من 6 أشهر للإبلاغ عن الشكوى إذا كانت هناك أسباب قوية لانتظارك كل هذه الفترة (مثل حالة وفاة في عائلتك أو مرض ما).

_____

_____

_____

8. * ما الذي حدث؟ كيف ولماذا تعتقد أن ذلك حدث؟ من قام بذلك؟ هل تعتقد أن أي هناك شخص آخر تعرض للتمييز؟ يمكنك الكتابة على المزيد من الورق وإرساله مع هذه الصفحات إذا احتجت لمزيد من المساحة.

_____

_____

_____

9. هل هناك شاهد على ذلك التمييز؟ إن كان الأمر كذلك، يرجى إخبارنا بـ:

الاسم	**العنوان**	**الهاتف**

_____

_____

10. هل لديك مزيد من المعلومات تريد أن تطلعنا عليها؟

_____

_____

11.* لا يمكننا استلام شكوى غير موقعة. يرجى كتابة اسمك والتاريخ على السطر أدناه. هل تعد ممثلاً مخولاً للشخص الذي تظن أنه تعرض للتمييز؟ يرجى توقيع اسمك أدناه. وبصفتك الممثل المخول، فلابد أن يكون لديك دليل على أنه يمكنك التصرف نيابة عن ذلك الشخص. إذا كان المريض أصغر من 18 عام، فيتعين على الوالد و الوصي التوقيع للقاصر. ***بيان:*** *أوافق على أن المعلومات المتضمنة في تلك الشكوى حقيقة وصحيحة وأعطي برنامج* ***TennCare*** *موافقتي للتحقيق في شكوتي؟*

_____

(وقع اسمك هنا إن كنت أنت الشخص الذي تتعلق به هذه الشكوى) (التاريخ)

_____ (وقع هنا إن كنت الممثل المخول) (التاريخ)

هل تبلغ عن هذه الشكوى لشخص آخر ولكنك **لست** الممثل المخول للشخص؟ يرجى توقيع اسمك بالأسفل. **يتعين على الشخص الذي تبلغ عن هذه الشكوى له التوقيع أعلاه أو إخبار خطة الصحة الخاصة بهأيها أوبرنامج TennCare بأنه لا يوجد مانع من قيامك بالتوقيع له/لها. بيان:** أوافق على أن المعلومات المتضمنة في تلك الشكوى حقيقة وصحيحة وأعطي برنامج **TennCare** موافقتي للاتصال بي بشأن تلك الشكوى.

_____

(وقع هنا إن كنت تبلغ عن هذه الشكوى من أجل شخص آخر) (التاريخ)

هل أنت مساعد من برنامج TennCare أو خطة الصحة/ منظمة الرعاية المدارة التي تساعد العضو بنية طيبة لملء تلك الشكوى؟ إن كان الأمر كذلك، يرجى التوقيع بالأسفل:

_____ (وقع هنا إن كنت مساعد من TennCare أو من خطة الصحة/ منظمة الرعاية المدارة) (التاريخ)

لا يوجد مانع من الإبلاغ عن أي شكوى لخطة الصحة/ منظمة الرعاية المدارة الخاصة بك أو برنامج TennCare. ويتم التعامل مع المعلومات المتضمنة في تلك الشكوى بسرية. ولا يتم مشاركة الأسماء وأي معلومات أخرى بشأن الأشخاص المستخدمين في تلك الشكوى إلا عند الحاجة. يرجى إرسال اتفاق الكشف عن المعلومات موقعًا مع شكوتك. وفي حال تقديمك لتلك الشكوى نيابة عن شخص آخر، فيتعين على هذا الشخص توقيع اتفاق الكشف عن المعلومات وارساله مع تلك الشكوى. احتفظ بنسخة من كل شيء ترسله. يرجى ارسال بريد أو بريد إلكتروني بالشكوى الموقعة والكاملة وصفحات اتفاق الكشف عن المعلومات الموقع لنا على:

TennCare, Office of Civil Rights Compliance
310 Great Circle Road; Floor 3W • Nashville, TN 37243
615-507-6474 or for free at 855-857-1673 (TRS 711)
HCFA.fairtreatment@tn.gov

كما يمكنك الاتصال بنا إن احتجت للمساعدة بخصوص تلك المعلومات.

10. هل لديك مزيد من المعلومات تريد أن تطلعنا عليها؟

_____

_____

11.* لا يمكننا استلام شكوى غير موقعة. يرجى كتابة اسمك والتاريخ على السطر أدناه. هل تعد ممثلاً مخولاً للشخص الذى تظن أنه تعرض للتمييز؟ يرجى توقيع اسمك أدناه. وبصفتك الممثل المخول، فانبذ أن يكون لديك دليل على أنه يمكنك التصرف نيابة عن ذلك الشخص. إذا كان المريض أصغر من 18 عام، فيتعين على الوالد و الوصي التوقيع للقاصر. ***بيان:*** *أوافق على أن المعلومات المتضمنة في تلك الشكوى حقيقية وصحيحة وأعطي برنامج* ***TennCare*** *موافقتي للتحقيق في شكوتي؟*

_____

(وقع اسمك هنا إن كنت أنت الشخص الذي تتعلق به هذه الشكوى) (التاريخ)

_____ (وقع هنا إن كنت الممثل المخول) (التاريخ)

هل تبلغ عن هذه الشكوى لشخص آخر ولكنك **لست** الممثل المخول للشخص؟ يرجى توقيع اسمك بالأسفل. **يتعين على الشخص الذي تبلغ عن هذه الشكوى له التوقيع أعلاه أو إخبار خطة الصحة الخاصة به/بها أوبرنامج TennCare بأنه لا يوجد مانع من قيامك بالتوقيع له/لها. بيان:** أوافق على أن المعلومات المتضمنة في تلك الشكوى حقيقية وصحيحة وأعطي برنامج **TennCare** موافقتي للاتصال بي بشأن تلك الشكوى.

_____

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كما يمكنك الاتصال بنا إن احتجت للمساعدة بخصوص تلك المعلومات.

TN Division of TennCare

اتفاقية برنامج TennCare للإفصاح عن المعلومات

قد يحتاج برنامج TennCare من أجل التحقيق في شكواك إلى إطلاع أشخاص آخرين أو مؤسسات أخرى ذات أهمية بالنسبة لهذه الشكوى على اسمك أو معلومات أخرى عنك.

لتعجيل التحقيق في شكواك، احرص على قراءة نسخة من اتفاقية الإفصاح عن المعلومات هذه وتوقيعها وإرسالها بالبريد مع شكواك. ويُرجى الاحتفاظ بنسخة لنفسك.

- أفهم أنه أثناء التحقيق في شكواي، يجوز لبرنامج TennCare مشاركة اسمي أو تاريخ ميلادي أو معلومات المطالبات أو المعلومات الصحية أو غيرها من المعلومات المتعلقة بي مع أشخاص آخرين أو مؤسسات أخرى. وقد يحتاج برنامج TennCare إلى جمع هذه المعلومات عنك من بعض الأشخاص أو المؤسسات. فعلى سبيل المثال، إذا اشتكيت من أن طبيبي قد عاملني بطريقة مختلفة بسبب لوني، فقد يحتاج برنامج TennCare إلى التحدث إلى طبيبي والحصول على سجلاتي الطبية.

- لست مُلزمًا بالموافقة على الإفصاح عن اسمك أو أي معلومات أخرى. فقد لا تكون هذه المعلومات ضرورية في جميع الأوقات من أجل التحقيق في شكواك. وإذا لم توقع على اتفاقية الإفصاح، فسنستمر في محاولة التحقيق في شكواك. لكن يُرجى العلم أنه إذا لم توافق على السماح لنا باستخدام اسمك أو تفاصيل أخرى، فقد يؤدي ذلك إلى تقييد أو إيقاف التحقيق في شكواك. وقد نضطر إلى إغلاق حالتك. قبل إغلاق حالتك بسبب عدم توقيعك على اتفاقية الإفصاح، قد نتصل بك لمعرفة ما إذا كنت تريد توقيع اتفاقية إفصاح حتى يتسنى مواصلة التحقيق.

إذا كنت تقدم هذه الشكوى نيابة عن شخص آخر، فإننا بحاجة إلى توقيع هذا الشخص على اتفاقية الإفصاح عن المعلومات. هل توقع على هذه الاتفاقية بصفتك ممثلًا مفوضًا؟ في هذه الحالة، يجب عليك أيضًا أن تقدم لنا نسخة من وثائق تعيينك كممثل مفوض.

بالتوقيع على اتفاقية الإفصاح عن المعلومات هذه، أوافق على أنني قد قرأت وفهمت حقوقي المكتوبة أعلاه. كما أوافق على السماح لبرنامج TennCare بمشاركة اسمي أو معلومات أخرى عني مع أشخاص آخرين أو مؤسسات أخرى مهمة بالنسبة لهذه الشكوى أثناء التحقيق وحتى الوصول إلى النتيجة.

تسري اتفاقية الإفصاح عن المعلومات هذه حتى الوصول إلى النتيجة النهائية لشكواك. ويمكنك إلغاء الاتفاقية في أي وقت عن طريق الاتصال ببرنامج TennCare أو مراسلته كتابيًا ولن يؤدي ذلك إلى إلغاء شكواك. في حالة إلغاء الاتفاقية، لا يمكن منع المعرفة بالمعلومات التي تمت مشاركتها بالفعل.

التوقيع: _____ التاريخ: _____

الاسم (يُرجى الكتابة بحروف واضحة): _____

العنوان: _____

الهاتف: _____

Division of TennCare

اتفاقية برنامج TennCare للإفصاح عن المعلومات

قد يحتاج برنامج TennCare من أجل التحقيق في شكواك إلى إطلاع أشخاص آخرين أو مؤسسات أخرى ذات أهمية بالنسبة لهذه الشكوى على اسمك أو معلومات أخرى عنك.

لتعجيل التحقيق في شكواك، احرص على قراءة نسخة من اتفاقية الإفصاح عن المعلومات هذه وتوقيعها وإرسالها بالبريد مع شكواك. ويُرجى الاحتفاظ بنسخة لنفسك.

- أفهم أنه أثناء التحقيق في شكواى، يجوز لبرنامج TennCare مشاركة اسمي أو تاريخ ميلادى أو معلومات المطالبات أو المعلومات الصحية أو غيرها من المعلومات المتعلقة بي مع أشخاص آخرين أو مؤسسات أخرى. وقد يحتاج برنامج TennCare إلى جمع هذه المعلومات عنك من بعض الأشخاص أو المؤسسات. فعلى سبيل المثال، إذا اشتكيت من أن طبيبي قد عاملني بطريقة مختلفة بسبب لوني، فقد يحتاج برنامج TennCare إلى التحدث إلى طبيبي والحصول على سجلاتي الطبية.

- لست مُلزمًا بالموافقة على الإفصاح عن اسمك أو أى معلومات أخرى. فقد لا تكون هذه المعلومات ضرورية في جميع الأوقات من أجل التحقيق في شكواك. وإذا لم توقع على اتفاقية الإفصاح، فسنستمر في محاولة التحقيق في شكواك. لكن يُرجى العلم أنه إذا لم توافق على السماح لنا باستخدام اسمك أو تفاصيل أخرى، فقد يؤدى ذلك إلى تقييد أو إيقاف التحقيق في شكواك. وقد نضطر إلى إغلاق حالتك. قبل إغلاق حالتك بسبب عدم توقيعك على اتفاقية الإفصاح، قد نتصل بك لمعرفة ما إذا كنت تريد توقيع اتفاقية إفصاح حتى يتسنى مواصلة التحقيق.

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بالتوقيع على اتفاقية الإفصاح عن المعلومات هذه، أوافق على أنني قد قرأت وفهمت حقوقي المكتوبة أعلاه. كما أوافق على السماح لبرنامج TennCare بمشاركة اسمي أو معلومات أخرى عني مع أشخاص آخرين أو مؤسسات أخرى مهمة بالنسبة لهذه الشكوى أثناء التحقيق وحتى الوصول إلى النتيجة.

تسرى اتفاقية الإفصاح عن المعلومات هذه حتى الوصول إلى النتيجة النهائية لشكواك. ويمكنك إلغاء الاتفاقية في أى وقت عن طريق الاتصال ببرنامج TennCare أو مراسلته كتابيًا ولن يؤدى ذلك إلى إلغاء شكواك. في حالة إلغاء الاتفاقية، لا يمكن منع المعرفة بالمعلومات التي تمت مشاركتها بالفعل.

التوقيع: _____ التاريخ: _____

الاسم (يُرجى الكتابة بحروف واضحة): _____

العنوان: _____

الهاتف: _____

هل تريد تقديم شكوى؟ يُرجى إرسال نموذج شكوى شخصي وموقع واتفاقية إفصاح عن المعلومات موقعة بالبريد إلى:

TennCare OCRC
الاتصالات 711)
310 Great Circle Road, 3W
Nashville, TN 37243

هاتف: 1-615-507-6474 أو مجانًا عبر 1-855-857-1673 (خدمة ترحيل

بريد إلكتروني: HCFA.fairtreatment@tn.gov

Do you need free help with this letter? If you speak a language other than English, help in your language is available for free. This page tells you how to get help in a language other than English. It also tells you about other help that's available.
Spanish: **Español** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-259-0701 (TTY: 1-800-848-0298).
Kurdish: **کوردی** ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە بکە TTY (1-800-848-0298) 1- 855-259-0701.
Arabic: **العربية** ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-259-0701 (رقم هاتف الصم والبكم:1-800-848-0298).
Chinese: **簡體中文** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-259-0701 （TTY 1-800-848-0298）。
Vietnamese: **Tiếng Việt** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-259-0701 (TTY: 1-800-848-0298).
Korean: **한국어** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-259-0701 (TTY: 1-800-848-0298)번으로 전화해 주십시오.
French: **Français** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-259-0701 (ATS : 1-800-848-0298).
Amharic: **አማርኛ** ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-259-0701 (መስማት ለተሳናቸው: 1-800-848-0298).
Gujarati: **ગુજરાતી** સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-259-0701 (TTY: 1-800-848-0298).

هل تريد تقديم شكوى؟ يُرجى إرسال نموذج شكوى مُسترقى وموقع واتفاقية إفصاح عن المعلومات موقعة بالبريد إلى:

TennCare OCRC
(711 الاتصالات)
310 Great Circle Road, 3W
Nashville, TN 37243

هاتف: 1-615-507-6474 أو مجانًا عبر 1-855-857-1673 (خدمة ترحيل)
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Arabic: **العربية**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-259-0701 (رقم هاتف الصم والبكم:1-800-848-0298).

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Amharic: **አማርኛ**

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Gujarati: □□□□□□□

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TC 0136 (REV. 2-2021)

RDA – 11078

Laotian:	**ພາສາລາວ**
ໂປຣດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-259-0701 (TTY: 1-800-848-0298).	
German:	**Deutsch**
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-259-0701 (TTY: 1-800-848-0298).	
Tagalog:	**Tagalog**
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-259-0701 (TTY: 1-800-848-0298).	
Hindi:	**हिंदी**
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-259-0701 (TTY: 1-800-848-0298) पर कॉल करें।	
Serbo-Croatian:	**Srpsko-hrvatski**
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-259-0701 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1- 800-848-0298).	
Russian:	**Русский**
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-259-0701 (телетайп: 1-800-848-0298).	
Nepali:	**नेपाली**
ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-259-0701 (टिटिवाइ: 1-800-848-0298) ।	
Persian:	
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم میباشد.با 1-855-259-0701 (TTY: 1-800-848-0298) تماس بگیرید.	

- هل تحتاج إلى مساعدة في التحدث إلينا أو قراءة ما نرسله إليك؟
- هل تعاني من إعاقة وتحتاج إلى المساعدة في الحصول على الرعاية أو المشاركة في أحد برامجنا أو خدماتنا؟
- أو هل لديك أسئلة أخرى بشأن رعايتك الصحية؟

اتصل بنا مجانًا على 1-855-259-0701. يمكننا توصيلك بالمساعدة المجانية أو الخدمة التي تحتاجها.
(للاتصال عبر الهاتف النصي (TTY): 1-800-848-0298

Laotian: **ພາສາລາວ** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍ່ເສັຽຄ່າ ການຊ່ວຍເຫລືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-259-0701 (TTY: 1-800-848-0298).
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- **هل تحتاج إلى مساعدة في التحدث إلينا أو قراءة ما نرسله إليك؟**
- **هل تعاني من إعاقة وتحتاج إلى المساعدة في الحصول على الرعاية أو المشاركة في أحد برامجنا أو خدماتنا؟**
- **أو هل لديك أسئلة أخرى بشأن رعايتك الصحية؟**

اتصل بنا مجانًا على 1-855-259-0701. يمكننا توصيلك بالمساعدة المجانية أو الخدمة التي تحتاجها.
(للاتصال عبر الهاتف النصي (TTY): 1-800-848-0298

APPENDIX B — CLINICAL PRACTICE GUIDELINES

Based on the health care needs of the member population and opportunities for improvement identified through the QM program, clinical practice and preventive health guidelines are adopted by the health plan. These guidelines are reviewed, revised and approved at least every two years using nationally recognized evidenced-based literature and developed through a collaborative review process. This review process involves both board-certified and credentialing network practitioners from appropriate specialties and internal medical directors. The guidelines are available online at **provider.amerigroup.com/tn**.

We continuously look for ways to assist you in improving the care provided to your Amerigroup patients. As the CPGs tend to be updated more frequently than the provider manual, having them available online ensures you will always be able to access the most current information. A full copy of the manual can also be downloaded from the provider website.

APPENDIX C — TENNCARE REGULATORY REQUIREMENTS

Amerigroup will not reimburse providers based on automatic escalators or linkages to other methodologies that escalate, such as current Medicare rates or inflation indexes, unless otherwise allowed by TennCare as specified in Section A.2.13.2.2 of the CRA.

Additional provider requirements are set forth in this Appendix. Contracting providers agree to comply with the language requirements set forth in the Medicaid Addendum in addition to the provisions of their Amerigroup Participating Provider Agreement. Required language can be updated by inclusion in the provider manual as referenced in Article II Section 2.2 of the Amerigroup Participating Provider Agreement. If any requirement in this Appendix conflicts with a provision of the Amerigroup Participating Provider Agreement, the terms of the Amerigroup Participating Provider Agreement shall govern, unless the provider manual terms are mandated by a program.

Participating Provider Agreement, Enterprise Global Base

Name According to W-9 Form with d/b/a: _____

AMERIGROUP
PROVIDER AGREEMENT

This Provider Agreement (hereinafter "Agreement") is made and entered into by and between Amerigroup Tennessee, Inc. d/b/a Amerigroup Community Care, Amerigroup, Texas, Inc. (collectively referred in this Agreement as "Amerigroup") and the undersigned Provider (hereinafter "Provider"), effective as of the date next to Amerigroup's signature (the "Effective Date"). In accordance with this Agreement, Amerigroup Tennessee, Inc. manages the Medicaid Program under TennCare and Amerigroup Texas, Inc. manages the Medicare Advantage Program. In consideration of the mutual promises and covenants herein contained, the sufficiency of which is acknowledged by the parties, the parties agree as follows:

This Provider Agreement (hereinafter "Agreement") is made and entered into by and between Amerigroup Tennessee, Inc. d/b/a Amerigroup Community Care, Amerigroup, Texas, Inc. (collectively referred in this Agreement as "Amerigroup") and _____, ("Provider") on behalf of itself and the Participating Providers set forth on the Participating Providers Exhibit and shall be effective as of the date next to Amerigroup's signature (the "Effective Date"). Unless otherwise specifically delineated, all references herein to "Provider" may also mean and refer **to "Participating Provider" as defined below.** In accordance with this Agreement, Amerigroup Tennessee, Inc. manages the Medicaid Program under TennCare and Amerigroup Texas, Inc. manages the Medicare Advantage Program. In consideration of the mutual promises and covenants herein contained, the sufficiency of which is acknowledged by the parties, the parties agree as follows:

ARTICLE I
DEFINITIONS

"Affiliate" means any person, firm, corporation (including, without limitation, service corporation and professional corporation), partnership (including, without limitation, general partnership, limited partnership and limited liability partnership), limited liability company, joint venture, business trust, association or other entity or organization that (i) now or in the future directly or indirectly controls, is controlled by, or is under common control with the Amerigroup and/or (ii) that is identified as an Affiliate on a designated web site as referenced in the provider manual(s). Unless otherwise set forth in the Agreement, an Affiliate may access the rates, terms and conditions of this Agreement.

"Agency" means a federal, state or local agency, administration, board or other governing body with jurisdiction over the governance or administration of a Health Benefit Plan.

"Amerigroup Compensation Schedule" ("ACS") means the document(s) attached hereto and incorporated herein by reference, and which sets forth the Amerigroup Rate(s) and compensation related terms for the Network(s) in which Provider participates. The ACS may include additional Provider obligations and specific Amerigroup compensation related terms and requirements.

"Amerigroup Rate" means the lesser of one hundred percent (100%) of Eligible Charges for Covered Services, or the total reimbursement amount that Provider and Amerigroup have agreed upon as set forth in the Amerigroup Compensation Schedule ("ACS"). The Amerigroup Rate includes applicable Cost Shares, and shall represent payment in full to Provider for Covered Services.

"Audit" means a post-payment review of the Claim(s) and supporting clinical information reviewed by Amerigroup to ensure payment accuracy. The review ensures Claim(s) comply with all pertinent aspects of submission and payment including, but not limited to, contractual terms, Regulatory Requirements, Coded Service Identifiers (as defined in the ACS) guidelines and instructions, Amerigroup medical policies and clinical utilization management guidelines, reimbursement policies, and generally accepted medical practices. Audit does not include medical record review for quality and risk adjustment initiatives, or activities conducted by Amerigroup's Special Investigation Unit ("SIU").

"Claim" means either the uniform bill claim form or electronic claim form in the format prescribed by Amerigroup submitted by a provider for payment by a Amerigroup for Health Services rendered to a Member.

"CMS" means the Centers for Medicare & Medicaid Services, an administrative agency within the United States Department of Health & Human Services ("HHS").

"Cost Share" means, with respect to Covered Services, an amount which a Member is required to pay under the terms of the applicable Health Benefit Plan. Such payment may be referred to as an allowance, coinsurance, copayment, deductible, penalty or other Member payment responsibility, and may be a fixed amount or a percentage of applicable payment for Covered Services rendered to the Member.

"Covered Services" means Medically Necessary Health Services, as determined by Amerigroup and described in the applicable Health Benefit Plan, for which a Member is eligible for coverage.

"Government Contract" means the contract between Amerigroup and an applicable party, such as an Agency, which governs the delivery of Health Services by Amerigroup to Member(s) pursuant to a Government Program.

"Government Program" means any federal or state funded program under the Social Security Act, and any other federal, state, county or other municipally funded program or product in which Amerigroup maintains a contract to furnish services. For purposes of this Agreement, Government Program does not include the Federal Employees Health Benefits Program ("FEHBP"), or any state or local government employer program.

"Health Benefit Plan" means the document(s) that set forth Covered Services, rules, exclusions, terms and conditions of coverage. Such document(s) may include but are not limited to a Member handbook, a health certificate of coverage, or evidence of coverage.

"Health Service" means those services, supplies or items that a health care provider is licensed, equipped and staffed to provide and which he/she/it customarily provides to or arranges for individuals.

"Medically Necessary" or "Medical Necessity" means the definition as set forth in the applicable Participation Attachment(s).

"Member" means any individual who is eligible, as determined by TennCare, as applicable, and Amerigroup, to receive Covered Services under a Health Benefit Plan. For all purposes related to this Agreement, including all schedules, attachments, exhibits, provider manual(s), notices and communications related to this Agreement, the term "Member" may be used interchangeably with the terms Insured, Covered Person, Covered Individual, Enrollee, Subscriber, Dependent Spouse/Domestic Partner, Child, Beneficiary or Contract Holder, and the meaning of each is synonymous with any such other.

"Network" means a group of providers that support, through a direct or indirect contractual relationship, one or more product(s) and/or program(s) in which Members are enrolled.

"Participating Provider" means a An institution, facility, agency, physician, health care practitioner, or other entity that is licensed or otherwise authorized to provide any of the Covered Services in the state in which they are furnished and that is party to an agreement to provide Covered Services to Members that has met all applicable required Amerigroup credentialing requirements and accreditation requirements for the services the Participating Provider provides, and that is designated by Amerigroup to participate in one or more Network(s). Unless otherwise specifically delineated, all references herein to "Provider" may also mean and refer to "Participating Provider". Participating Provider does not include consumer-directed workers (refer to Consumer-Directed Worker); nor does provider include the FEA (refer to Fiscal Employer Agent).

"Participation Attachment(s)" means the document(s) attached hereto and incorporated herein by reference, and which identifies the additional duties and/or obligations related to Network(s), Government Program(s), Health Benefit Plan(s), and/or Amerigroup programs such as quality and/or incentive programs.

"Regulatory Requirements" means any requirements, as amended from time to time, imposed by applicable federal, state or local laws, rules, regulations, guidelines, instructions, Government Contract, or otherwise imposed by an Agency or government regulator in connection with the procurement, development or operation of a Health Benefit Plan, or the performance required by either party under this Agreement. The omission from this Agreement of an express reference to a Regulatory Requirement applicable to either party in connection with their duties and responsibilities shall in no way limit such party's obligation to comply with such Regulatory Requirement.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Member Identification. Amerigroup shall ensure that Amerigroup provides a means of identifying Member either by issuing a paper, plastic, electronic, or other identification document to Member or by a telephonic, paper or electronic communication to Provider. This identification need not include all information necessary to determine Member's eligibility at the time a Health Service is rendered, but shall include information

necessary to contact Amerigroup to determine Member's participation in the applicable Health Benefit Plan. Provider acknowledges and agrees that possession of such identification document or ability to access eligibility information telephonically or electronically, in and of itself, does not qualify the holder thereof as a Member, nor does the lack thereof mean that the person is not a Member.

2.2 Provider Non-discrimination. Provider shall provide Health Services to Members in a manner similar to and within the same time availability in which Provider provides Health Services to any other individual. Provider will not differentiate, or discriminate against any Member as a result of his/her enrollment in a Health Benefit Plan, or because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for Health Services, status as a litigant, status as a Medicare or Medicaid beneficiary, sexual orientation, gender identity, or any other basis prohibited by law. Provider shall not be required to provide any type, or kind of Health Service to Members that he/she/it does not customarily provide to others. Additional requirements may be set forth in the applicable Participation Attachment(s).

2.3 Publication and Use of Provider Information. Provider agrees that Amerigroup, its Affiliates or designees may use, publish, disclose, and display, for commercially reasonable general business purposes, either directly or through a third party, information related to Provider, including but not limited to demographic information, information regarding credentialing, affiliations, performance data, and information related to Provider for transparency initiatives except for information protected by federal and state confidentiality laws.

2.4 Use of Symbols and Marks. Neither party to this Agreement shall publish, copy, reproduce, or use in any way the other party's symbols, service mark(s) or trademark(s) without the prior written consent of such other party. Notwithstanding the foregoing, the parties agree that they may identify Provider as a participant in the Network(s) in which he/she/it participates.

2.5 Submission and Adjudication of Claims. Provider shall submit, and Amerigroup shall adjudicate, Claims in accordance with the applicable Participation Attachment(s), the ACS, the provider manual(s) and Regulatory Requirements. If Provider submits Claims prior to receiving notice of Amerigroup's approval pursuant to section 2.13, then such Claims must be submitted in accordance with prior authorization requirements, and shall be processed as out of network. Amerigroup shall not make retroactive adjustments with respect to such Claims.

2.6 Payment in Full and Hold Harmless.

2.6.1 Provider agrees to accept as payment in full, in all circumstances, the applicable Amerigroup Rate whether such payment is in the form of a Cost Share, a payment by Amerigroup, or a payment by another source, such as through coordination of benefits or subrogation. Provider shall bill, collect, and accept compensation for Cost Shares. Provider agrees to make reasonable efforts to verify Cost Shares prior to billing for such Cost Shares. In no event shall Amerigroup be obligated to pay Provider or any person acting on behalf of Provider for services that are not Covered Services, or any amounts in excess of the Amerigroup Rate less Cost Shares or payment by another source, as set forth above. Consistent with the foregoing, Provider agrees to accept the Amerigroup Rate as payment in full if the Member has not yet satisfied his/her deductible.

2.6.2 Except as expressly permitted under Regulatory Requirements, Provider agrees that in no event, including but not limited to, nonpayment by Amerigroup, insolvency of Amerigroup, breach of this Agreement, or Claim payment denials or adjustment requests or recoupments based on miscoding or other billing errors of any type, whether or not fraudulent or abusive, shall Provider, or any person acting on behalf of Provider, bill, charge, collect a deposit from, seek compensation from, or have any other recourse against a Member, or a person legally acting on the Member's behalf, for Covered Services provided pursuant to this Agreement. Notwithstanding the foregoing, Provider may collect reimbursement from the Member for the following:

2.6.2.1 Cost Shares, if applicable;

2.6.2.2 Health Services that are not Covered Services. However, Provider may seek payment for a Health Service that is not Medically Necessary or is experimental/investigational only if Provider obtains a written waiver that meets the following criteria:

a) The waiver notifies the Member that the Health Service is likely to be deemed not Medically Necessary, or experimental/investigational;

b) The waiver notifies the Member of the Health Service being provided and the date(s) of service;

c) The waiver notifies the Member of the approximate cost of the Health Service;

d) The waiver is signed by the Member, or a person legally acting on the Member's behalf, prior to receipt of the Health Service.

2.7 Recoupment/Offset/Adjustment for Overpayments. Amerigroup shall be entitled to offset and recoup an amount equal to any overpayments or improper payments made by Amerigroup to Provider against any payments due and payable by Amerigroup to Provider with respect to any Health Benefit Plan under this Agreement. Provider shall voluntarily refund all duplicate or erroneous Claim payments regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Amerigroup that any recoupment, improper payment, or overpayment is due from Provider, Provider must refund the amount to Amerigroup within thirty (30) days of when Amerigroup notifies Provider. If such reimbursement is not received by Amerigroup within the thirty (30) days following the date of such notice, Amerigroup shall be entitled to offset such overpayment against any Claims payments due and payable by Amerigroup to Provider under any Health Benefit Plan in accordance with Regulatory Requirements. In such event, Provider agrees that all future Claim payments applied to satisfy Provider's repayment obligation shall be deemed to have been paid in full for all purposes, including section 2.6.1. Should Provider disagree with any determination by Amerigroup that Provider has received an overpayment, Provider shall have the right to appeal such determination under Amerigroup's procedures set forth in the provider manual, and such appeal shall not suspend Amerigroup's right to recoup the overpayment amount during the appeal process unless suspension of the right to recoup is otherwise required by Regulatory Requirements. Amerigroup reserves the right to employ a third party collection agency in the event of non-payment.

2.8 Use of Subcontractors. Provider and Amerigroup may fulfill some of their duties under this Agreement through subcontractors. For purposes of this provision, subcontractors shall include, but are not limited to, vendors and non-Participating Providers that provide supplies, equipment, staffing, and other services to Members at the request of, under the supervision of, and/or at the place of business of Provider. Provider shall provide Amerigroup with thirty (30) days prior notice and obtain written approval from Amerigroup of any Health Services subcontractors with which Provider may contract to perform Provider's duties and obligations under this Agreement. Failure by the provider to obtain Amerigroup's written approval may lead to the contract being declared null and void by Amerigroup. Claims submitted by the subcontractor or by the provider for services furnished by the unapproved subcontractor are considered to be improper payments and may be considered false claims. Any such improper payments may be subject to action under Federal and State false claims statutes or be subject to be recouped by Amerigroup and/or TennCare as overpayment. Provider shall remain responsible to Amerigroup for the compliance of his/her/its subcontractors with the terms and conditions of this Agreement as applicable, including, but not limited to, the Payment in Full and Hold Harmless provisions herein.

2.9 Compliance with Provider Manual(s) and Policies, Programs and Procedures. Provider agrees to cooperate and comply with, Amerigroup's provider manual(s), and all other policies, programs and procedures (collectively "Policies") established and implemented by Amerigroup applicable to the Network(s) in which Provider participates. Amerigroup or its designees may modify the provider manual(s) and its Policies providing at least thirty (30) days notice to Provider in advance of the effective date of modifications thereto.

2.10 Referral Incentives/Kickbacks. Provider represents and warrants that Provider does not give, provide, condone or receive any incentives or kickbacks, monetary or otherwise, in exchange for the referral of a Member, and if a Claim for payment is attributable to an instance in which Provider provided or received an incentive or kickback in exchange for the referral, such Claim shall not be payable and, if paid in error, shall be refunded to Amerigroup.

2.11 Networks and Provider Panels. Provider shall be eligible to participate only in those Networks designated on the Provider Networks Attachment of this Agreement. Provider shall not be recognized as a Participating Provider in such Networks until the later of: 1) the Effective Date of this Agreement or; 2) as determined by Amerigroup in its sole discretion, the date Provider has met Amerigroup's applicable credentialing

requirements and accreditation requirements. Provider acknowledges that Amerigroup may develop, discontinue, or modify new or existing Networks, products and/or programs. In addition to those Networks designated on the Provider Networks Attachment, Amerigroup may also identify Provider as a Participating Provider in additional Networks, products and/or programs designated in writing from time to time by Amerigroup. The terms and conditions of Provider's participation as a Participating Provider in such additional Networks, products and/or programs shall be on the terms and conditions as set forth in this Agreement unless otherwise agreed to in writing by Provider and Amerigroup.

In addition to and separate from Networks that support some or all of Amerigroup's products and/or programs (e.g., HMOand PPO), Provider further acknowledges that certain Health Services, including by way of example only, laboratory or behavioral health services, may be provided exclusively by designated Participating Providers (a "Health Services Designated Network"), as determined by Amerigroup. Provider agrees to refer Members to such designated Participating Providers in a Health Services Designated Network for the provision of certain Health Services, even if Provider performs such services. Notwithstanding any other provision in this Agreement, if Provider provides a Health Service to a Member for which Provider is not a designated Participating Provider in a Health Services Designated Network, then Provider agrees that he/she/it shall not be reimbursed for such services by Amerigroup or the Member, unless Provider was authorized to provide such Health Service by Amerigroup.

2.12 Change in Provider Information. Provider shall immediately send written notice, in accordance with the Notice section of this Agreement, to Amerigroup of:

2.12.1 Any legal, governmental, or other action or investigation involving Provider which could affect Provider's credentialing status with Amerigroup, or materially impair the ability of Provider to carry out his/her/its duties and obligations under this Agreement, except for temporary emergency diversion situations; or

2.12.2 Any change in Provider accreditation, affiliation, hospital privileges (if applicable), insurance, licensure, certification or eligibility status, or other relevant information regarding Provider's practice or status in the medical community.

2.13 Provider Credentialing and Accreditation. Provider warrants that he/she/it meets all Amerigroup credentialing requirements, and accreditation requirements for the Networks in which Provider participates. A description of the applicable credentialing requirements and accreditation requirements, are set forth in the provider manual(s) and/or in the ACS. Provider acknowledges that until such time as Provider has been determined to have fully met Amerigroup's credentialing requirements and accreditation requirements, as applicable, Provider shall not be entitled to the benefits of participation under this Agreement, including without limitation the Amerigroup Rates set forth in the ACS attached hereto.

2.14 Provider Staffing and Staff Privileges. Provider agrees to maintain professional staffing levels to meet community access standards and for applicable facilities, agrees to facilitate and to expeditiously grant admitting privileges to Participating Providers who meet Provider's credentialing standards.

2.15 Adjustment Requests. If Provider believes a Claim has been improperly adjudicated for a Covered Service for which Provider timely submitted a Claim to Amerigroup, Provider may submit a request for an adjustment to Amerigroup in accordance with the the applicable Participation Attachment and/or provider manual(s) as incorporated into this Agreement.

2.16 Provision and Supervision of Services. In no way shall Amerigroup be construed to be a provider of Health Services or responsible for, exercise control, or have direction over the provision of such Health Services. Provider shall be solely responsible to the Member for treatment, medical care, and advice with respect to the provision of Health Services. Provider agrees that all Health Services provided to Members under this Agreement shall be provided by Provider or by a qualified person under Provider's direction. Provider warrants that any nurses or other health professionals employed by or providing services for Provider shall be duly licensed or certified under applicable law. In addition, nothing herein shall be construed as authorizing or permitting Provider to abandon any Member.

2.17 Coordination of Benefits/Subrogation. Subject to Regulatory Requirements, Provider agrees to cooperate with Amerigroup regarding subrogation and coordination of benefits, as set forth in Policies and the provider manual(s), and to notify Amerigroup **promptly after receipt of information regarding any Member who may** have a Claim involving subrogation or coordination of benefits.

2.18 Cost Effective Care. Provider shall provide Covered Services in the most cost effective, clinically appropriate setting and manner. In addition, in accordance with the provider manual(s) and Policies, Provider shall utilize Participating Providers, and when Medically Necessary or appropriate, refer and transfer Members to Participating Providers for all Covered Services, including but not limited to specialty, laboratory, ancillary and supplemental services.

2.19 Facility-Based Providers. Provider agrees to require its contracted facility-based providers or those with exclusive privileges with Provider to obtain and maintain Participating Provider status with Amerigroup. Until such time as facility-based providers enter into agreements with Amerigroup, Provider agrees to fully cooperate with Amerigroup to prevent Members from being billed amounts in excess of the applicable Amerigroup non-participating reimbursement for such Covered Services. Facility-based providers may include, but are not limited to, anesthesiologists, radiologists, pathologists, neonatologists, hospitalists and emergency room physicians.

ARTICLE III
CONFIDENTIALITY/RECORDS

3.1 Proprietary and Confidential Information. Except as otherwise provided herein, all information and material provided by either party in contemplation of or in connection with this Agreement remains proprietary and confidential to the disclosing party. This Agreement, including but not limited to the Amerigroup Rates, is Amerigroup's proprietary and confidential information. Neither party shall disclose any information proprietary or confidential to the other, or use such information or material except: (1) as otherwise set forth in this Agreement; (2) as may be required to perform obligations hereunder; (3) as required to deliver Health Services or administer a Health Benefit Plan; (4) to Amerigroup or its designees; (5) upon the express written consent of the parties; or (6) as required by Regulatory Requirements. Notwithstanding the foregoing, either party may disclose such information to its legal advisors, lenders and business advisors, provided that such legal advisors, lenders and business advisors agree to maintain confidentiality of such information. Provider and Amerigroup shall each have a system in place that meets all applicable Regulatory Requirements to protect all records and all other documents relating to this Agreement which are deemed confidential by law. Any disclosure or transfer of proprietary or confidential information by Provider or Amerigroup will be in accordance with applicable Regulatory Requirements. Provider shall immediately notify Amerigroup if Provider is required to disclose any proprietary or confidential information at the request of an Agency or pursuant to any federal or state freedom of information act request.

3.2 Confidentiality of Member Information. Both parties agree to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), and as both may be amended, as well as any other applicable Regulatory Requirements regarding confidentiality, use, disclosure, security and access of the Member's personally identifiable information ("PII") and protected health information ("PHI"), (collectively "Member Information"). Provider shall review all Member Information received from Amerigroup to ensure no misrouted Member Information is included. Misrouted Member Information includes but is not limited to, information about a Member that Provider is not currently treating. Provider shall immediately destroy any misrouted Member Information or safeguard the Member Information for as long as it is retained. In no event shall Provider be permitted to misuse or re-disclose misrouted Member Information. If Provider cannot destroy or safeguard misrouted Member Information, Provider must contact Amerigroup to report receipt of misrouted Member Information.

3.3 Network Provider/Patient Discussions. Notwithstanding any other provision in this Agreement and regardless of any benefit or coverage exclusions or limitations associated with a Health Benefit Plan, Provider shall not be prohibited from discussing fully with a Member any issues related to the Member's health including recommended treatments, treatment alternatives, treatment risks and the consequences of any benefit coverage or payment decisions made by Amerigroup or any other party. In addition, nothing in this Agreement shall be construed to, create any financial incentive for Provider to withhold Covered Services, or prohibit Provider from disclosing to the Member the general methodology by which Provider is compensated under this Agreement, such as for example, whether Provider is paid on a fee for service, capitation or Percentage Rate basis. Amerigroup shall not refuse to allow or to continue the participation of any otherwise eligible provider, or refuse to compensate Provider in connection with services rendered, solely because Provider has in good faith communicated with one or more of his/her/its current, former or prospective patients regarding the provisions, terms or requirements of a Health Benefit Plan as they relate to the health needs of such

patient. Nothing in this section shall be construed to permit Provider to disclose Amerigroup Rates or specific terms of the compensation arrangement under this Agreement.

3.4 Amerigroup Access to and Requests for Provider Records. Provider and its designees shall comply with all applicable state and federal record keeping and retention requirements, and, as set forth in the provider manual(s) and/or Participation Attachment(s), shall permit Amerigroup or its designees to have, with appropriate working space and without charge, on-site access to and the right to perform an Audit, examine, copy, excerpt and transcribe any books, documents, papers, and records related to Member's medical and billing information within the possession of Provider and inspect Provider's operations, which involve transactions relating to Members and as may be reasonably required by Amerigroup in carrying out its responsibilities and programs including, but not limited to, assessing quality of care, complying with quality initiatives/measures, Medical Necessity, concurrent review, appropriateness of care, accuracy of Claims coding and payment, risk adjustment assessment as described in the provider manual(s), including but not limited to completion of the Encounter Facilitation Form (also called the "SOAP" note), compliance with this Agreement, and for research. In lieu of on-site access, at Amerigroup's request, Provider or its designees shall submit records to Amerigroup, or its designees via photocopy or electronic transmittal, within thirty (30) days, at no charge to Amerigroup from either Provider or its designee. Provider shall make such records available to the state and federal authorities involved in assessing quality of care or investigating Member grievances or complaints in compliance with Regulatory Requirements. Provider acknowledges that failure to submit records to Amerigroup in accordance with this provision and/or the provider manual(s), and/or Participation Attachment(s) may result in a denial of a Claim under review, whether on pre-payment or post-payment review, or a payment retraction on a paid Claim, and Provider is prohibited from balance billing the Member in any of the foregoing circumstances.

3.5 Transfer of Medical Records. Following a request, Provider shall transfer a Member's medical records in a timely manner, or within such other time period required under applicable Regulatory Requirements, to other health care providers treating a Member at no cost to Amerigroup, Amerigroup, the Member, or other treating health care providers.

3.6 Clinical Data Sharing. Amerigroup and Provider desire to collaborate by sharing data, including Member Information, to enhance certain health care operations activities, primarily to help improve quality and efficiency of health care. Each party's access to better clinical and administrative data is critical to the mutual goal of Amerigroup and Provider improving health care quality as it relates to their respective Members and patients. Therefore and upon request, Provider agrees to provide data to Amerigroup for treatment purposes, for payment purposes, for health care operations purposes consistent with those enumerated in the first two paragraphs of the health care operations definition in HIPAA (45 CFR 164.501), or for purposes of health care fraud and abuse detection or compliance. Provider shall provide data as set forth in Policies or the provider manual(s), as applicable.

ARTICLE IV
INSURANCE

4.1 Amerigroup Insurance. Amerigroup shall self-insure or maintain insurance as required under applicable Regulatory Requirements to insure Amerigroup and its employees, acting within the scope of their duties.

4.2 Provider Insurance. Provider shall self-insure or maintain all necessary liability and malpractice insurance in types and amounts reasonably determined by Provider, or as required under applicable Regulatory Requirements.

ARTICLE V
RELATIONSHIP OF THE PARTIES

5.1 Relationship of the Parties. For purposes of this Agreement, Amerigroup and Provider are and will act at all times as independent contractors. Nothing in this Agreement shall be construed, or be deemed to create, a relationship of employer or employee or principal and agent, partnership, joint venture, or any relationship other than that of independent entities contracting with each other for the purposes of effectuating this Agreement.

5.2 Provider Representations and Warranties. Provider represents and warrants that it has the corporate power and authority to execute and deliver this Agreement on its own behalf, and on behalf of any other individuals

or entities that are owned, or employed or subcontracted with or by Provider to provide services under this Agreement. Provider further certifies that individuals or entities that are owned, employed or subcontracted with Provider agree to comply with the terms and conditions of this Agreement.

ARTICLE VI
INDEMNIFICATION AND LIMITATION OF LIABILITY

6.1 Indemnification. Amerigroup and Provider shall each indemnify, defend and hold harmless the other party, and his/her/its directors, officers, employees, agents, Affiliates and subsidiaries ("Representatives"), from and against any and all losses, claims, damages, liabilities, costs and expenses (including without limitation, reasonable attorneys' fees and costs) arising from third party claims resulting from the indemnifying party's or his/her/its Representative's failure to perform the indemnifying party's obligations under this Agreement, and/or the indemnifying party's or his/her/its Representative's violation of any law, statute, ordinance, order, standard of care, rule or regulation. The obligation to provide indemnification under this Agreement shall be contingent upon the party seeking indemnification providing the indemnifying party with prompt written notice of any claim for which indemnification is sought, allowing the indemnifying party to control the defense and settlement of such claim, provided however that the indemnifying party agrees not to enter into any settlement or compromise of any claim or action in a manner that admits fault or imposes any restrictions or obligations on an indemnified party without that indemnified party's prior written consent which will not be unreasonably withheld, and cooperating fully with the indemnifying party in connection with such defense and settlement.

6.2 Limitation of Liability. Regardless of whether there is a total and fundamental breach of this Agreement or whether any remedy provided in this Agreement fails of its essential purpose, in no event shall either of the parties hereto be liable for any amounts representing loss of revenues, loss of profits, loss of business, the multiple portion of any multiplied damage award, or incidental, indirect, consequential, special or punitive damages, whether arising in contract, tort (including negligence), or otherwise regardless of whether the parties have been advised of the possibility of such damages, arising in any way out of or relating to this Agreement. Further, in no event shall Amerigroup or its Affiliates be liable to Provider for any extracontractual damages relating to any claim or cause of action assigned to Provider by any person or entity.

ARTICLE VII
DISPUTE RESOLUTION AND ARBITRATION

7.1 Dispute Resolution. All disputes between Amerigroup and Provider arising out of or related in any manner to this Agreement shall be resolved using the dispute resolution and arbitration procedures as set forth below. Provider shall exhaust any other applicable provider appeal/provider dispute resolution procedures under this Agreement and any applicable exhaustion requirements imposed by Regulatory Requirements as a condition precedent to Provider's right to pursue the dispute resolution and arbitration procedures as set forth below.

7.1.1 In order to invoke the dispute resolution procedures in this Agreement, a party first shall send to the other party a written demand letter that contains a detailed description of the dispute and all relevant underlying facts, a detailed description of the amount(s) in dispute and how they have been calculated and any other information that the Amerigroup provider manual(s) may require Provider to submit with respect to such dispute. If the total amount in dispute as set forth in the demand letter is less than two hundred thousand dollars ($200,000), exclusive of interest, costs, and attorneys' fees, then within twenty (20) days following the date on which the receiving party receives the demand letter, representatives of each party's choosing shall meet to discuss the dispute in person or telephonically in an effort to resolve the dispute. If the total amount in dispute as set forth in the demand letter is two hundred thousand dollars ($200,000) or more, exclusive of interest, costs, and attorneys' fees, then within ninety (90) days following the date of the demand letter, the parties shall engage in non-binding mediation in an effort to resolve the dispute unless both parties agree in writing to waive the mediation requirement. The parties shall mutually agree upon a mediator, and failing to do so, Judicial Arbitration and Mediation Services ("JAMS") shall be authorized to appoint a mediator.

7.2 Arbitration. Any dispute within the scope of subsection 7.1.1 that remains unresolved at the conclusion of the applicable process outlined in subsection 7.1.1 shall be resolved by binding arbitration in the manner as set forth below. Except to the extent as set forth below, the arbitration shall be conducted pursuant to the JAMS Comprehensive Arbitration Rules and Procedures, provided, however, that the parties may agree in writing to further modify the JAMS Comprehensive Arbitration Rules and Procedures. The parties agree to be bound by the findings of the arbitrator(s) with respect to such dispute, subject to the right of the parties to appeal such findings as set forth herein. No arbitration demand shall be filed until after the parties have completed

the dispute resolution efforts described in section 7.1 above. If the dispute resolution efforts described in section 7.1 cannot be completed within the deadlines specified for such efforts despite the parties' good faith efforts to meet such deadlines, such deadlines may be extended as necessary upon mutual agreement of the parties. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. The parties agree that the arbitration shall be conducted on a confidential basis pursuant to Rule 26 of the JAMS Comprehensive Arbitration Rules and Procedures. Subject to any disclosures that may be required or requested under Regulatory Requirements, the parties further agree that they shall maintain the confidential nature of the arbitration, including without limitation, the existence of the arbitration, information exchanged during the arbitration, and the award of the arbitrator(s). Nothing in this provision, however, shall preclude either party from disclosing any such details regarding the arbitration to its accountants, auditors, brokers, insurers, reinsurers or retrocessionaires.

7.2.1 Location of Arbitration. The arbitration hearing shall be held in the county and state where Amerigroup is located. Notwithstanding the foregoing, both parties can agree in writing to hold the arbitration hearing in some other location.

7.2.2 Selection and Replacement of Arbitrator(s). If the total amount in dispute is less than four million dollars ($4,000,000), exclusive of interest, costs, and attorneys' fees, the dispute shall be decided by a single arbitrator selected, and replaced when required, in the manner described in the JAMS Comprehensive Arbitration Rules and Procedures. If the total amount in dispute is four million dollars ($4,000,000) or more, exclusive of interest, costs, and attorneys' fees, the dispute shall be decided by an arbitration panel consisting of three (3) arbitrators, unless the parties agree in writing that the dispute shall be decided by a single arbitrator.

7.2.3 Appeal. If the total amount of the arbitration award is five million dollars ($5,000,000) or more, inclusive of interest, costs, and attorneys' fees, or if the arbitrator(s) issues an injunction against a party, the parties shall have the right to appeal the decision of the arbitrator(s) pursuant to the JAMS Optional Arbitration Appeal Procedure. A decision that has been appealed shall not be enforceable while the appeal is pending. In reviewing a decision of the arbitrator(s), the appeal panel shall apply the same standard of review that a United States Court of Appeals would apply in reviewing a similar decision issued by a United States District Court in the jurisdiction in which the arbitration hearing was held.

7.2.4 Waiver of Certain Claims. The parties, on behalf of themselves and those that they may now or hereafter represent, each agree to and do hereby waive any right to join or consolidate claims in arbitration by or against other individuals or entities or to pursue, on a class basis, any dispute; provided however, if there is a dispute regarding the applicability or enforcement of the waiver provision in this subsection 7.2.4, that dispute shall be decided by a court of competent jurisdiction. If a court of competent jurisdiction determines that such waiver is unenforceable for any reason with respect to a particular dispute, then the parties agree that section 7.2 shall not apply to such dispute and that such dispute shall be decided instead in a court of competent jurisdiction.

7.2.5 Limitations on Injunctive Relief. The parties, on behalf of themselves and those that they may now or hereafter represent, each agree that any injunctive relief sought against the other party shall be limited to the conduct relevant to the parties to the arbitration and shall not be sought for the benefit of individuals or entities who are not parties to the arbitration. The arbitrator(s) are not authorized to issue injunctive relief for the benefit of an individual or entity who is not a party to the arbitration. The arbitrator shall be limited to issuing injunctive relief related to the specific issues in the arbitration.

7.3 Attorney's Fees and Costs. The shared fees and costs of the non-binding mediation and arbitration (e.g. fee of the mediator, fee of the independent arbitrator) will be shared equally between the parties. Each party shall be responsible for the payment of its own specific fees and costs (e.g. the party's own attorney's fees, the fees of the party selected arbitrator, etc.) and any costs associated with conducting the non-binding mediation or arbitration that the party chooses to incur (e.g. expert witness fees, depositions, etc.). Notwithstanding this provision, the arbitrator may issue an order in accordance with Federal Rule of Civil Procedure Rule 11.

ARTICLE VIII
TERM AND TERMINATION

8.1 Term of Agreement. This Agreement shall commence at 12:01 AM on the Effective Date for a term of one (1) year, and shall continue automatically in effect thereafter for consecutive one (1) year terms unless otherwise terminated as provided herein.

8.2 Termination Without Cause. Either party may terminate this Agreement without cause at any time by giving at least one hundred eighty (180) days prior written notice of termination to the other party. Notwithstanding the foregoing, should a Participation Attachment(s) contain a longer without cause termination period, the Agreement shall continue in effect only for such applicable Participation Attachment(s) until the termination without cause notice period in the applicable Participation Attachment(s) ends.

8.3 Breach of Agreement. Except for circumstances giving rise to the Immediate Termination section, if either party fails to comply with or perform when due any material term or condition of this Agreement, the other party shall notify the breaching party of its breach in writing stating the specific nature of the material breach, and the breaching party shall have thirty (30) days to cure the breach. If the breach is not cured to the reasonable satisfaction of the non-breaching party within said thirty (30) day period, the non-breaching party may terminate this Agreement by providing written notice of such termination to the other party. The effective date of such termination shall be no sooner than sixty (60) days after such notice of termination.

8.4 Immediate Termination.

8.4.1 This Agreement or any Participation Attachment(s) may be terminated immediately by Amerigroup if:

8.4.1.1 Provider commits any act or conduct for which his/her/its license(s), permit(s), or any governmental or board authorization(s) or approval(s) necessary for business operations or to provide Health Services are lost or voluntarily surrendered in whole or in part; or

8.4.1.2 Provider commits fraud or makes any material misstatements or omissions on any documents related to this Agreement which Provider submits to Amerigroup or to a third party; or

8.4.1.3 Provider files a petition in bankruptcy for liquidation or reorganization by or against Provider, if Provider becomes insolvent, or makes an assignment for the benefit of its creditors without Amerigroup's written consent, or if a receiver is appointed for Provider or its property; or

8.4.1.4 Provider's insurance coverage as required by this Agreement lapses for any reason; or

8.4.1.5 Provider fails to maintain compliance with Amerigroup's applicable credentialing requirements, accreditation requirements; or

8.4.1.6 Amerigroup reasonably believes based on Provider's conduct or inaction, or allegations of such conduct or inaction, that the well-being of patients may be jeopardized; or

8.4.1.7 Provider has been abusive to a Member, an Amerigroup employee or representative; or

8.4.1.8 Provider and/or his/her/its employees, contractors, subcontractors, or agents are ineligible, excluded, suspended, terminated or debarred from participating in a Medicaid, Medicare, and/or SCHIP Program pursuant to Sections 1128 or 1156 of the Social Security Act and 42 CFR 455.101, and in the case of an employee, contractor, subcontractor or agent, Provider fails to remove such individual from responsibility for, or involvement with, the Provider's business operations related to this Agreement, or if Provider has voluntarily withdrawn his/her/its participation in any Government Program as the result of a settlement agreement; or

8.4.1.9 Provider is convicted or has been finally adjudicated to have committed a felony or misdemeanor, other than a non-DUI related traffic violation.

8.4.2 This Agreement may be terminated immediately by Provider if:

8.4.2.1 Amerigroup commits any act or conduct for which its license(s), permit(s), or any governmental or board authorization(s) or approval(s) necessary for business operations are lost or voluntarily surrendered in whole or in part; or

8.4.2.2 Amerigroup commits fraud or makes any material misstatements or omissions on any documents related to this Agreement which it submits to Provider or to a third party; or

8.4.2.3 Amerigroup files for bankruptcy, or if a receiver is appointed;or

8.4.2.4 Amerigroup's insurance coverage as required by this Agreement lapses for any reason.

8.5 Partial Termination of Participating Providers. Amerigroup shall be entitled to terminate this Agreement as it applies to one or a number of Participating Providers under the terms of this Article VIII, without terminating the Agreement in its entirety, and in such case, the Agreement shall continue in full force and effect in connection with Provider and/or any and all Participating Providers as to which the Agreement has not been terminated. Notwithstanding the foregoing, Amerigroup reserves the right to terminate Participating Provider(s) from any or all Network(s) under the terms of this Article VIII while continuing the Agreement for the remaining Participating Provider(s).

8.6 Transactions Prior to Termination. Except as otherwise set forth in this Agreement, termination shall have no effect on the rights and obligations of the parties arising out of any transaction under this Agreement occurring prior to the date of such termination.

8.7 Continuation of Care Upon Termination. If this Agreement or any Participation Attachment terminates for any reasons other than one of the grounds set forth in the "Immediate Termination" section, then Provider shall, at Amerigroup's discretion, continue to provide Covered Services to all designated Members under this Agreement or any terminating Participation Attachment, as applicable, in accordance with Regulatory Requirements. During such continuation period, Provider agrees to: (i) accept reimbursement from Amerigroup for all Covered Services furnished hereunder in accordance with this Agreement and at the rates set forth in the ACS attached hereto; and (ii) adhere to Amerigroup's Policies, including but not limited to, Policies regarding quality assurance requirements, referrals, pre-authorization and treatment planning.

8.8 Survival. The provisions of this Agreement set forth below shall survive termination or expiration of this Agreement or any Participation Attachment(s):

8.8.1 Publication and Use of Provider Information;

8.8.2 Payment in Full and Hold Harmless;

8.8.3 Recoupment/Offset/Adjustment for Overpayments;

8.8.4 Confidentiality/Records;

8.8.5 Indemnification and Limitation of Liability;

8.8.6 Dispute Resolution and Arbitration;

8.8.7 Continuation of Care Upon Termination; and

8.8.8 Any other provisions required in order to comply with Regulatory Requirements.

ARTICLE IX
GENERAL PROVISIONS

9.1 Amendment. Except as otherwise provided for in this Agreement, Amerigroup retains the right to amend this Agreement, any attachments or addenda by making a good faith effort to provide notice to Provider at least

thirty (30) days in advance of the effective date of the amendment. Except to the extent that Amerigroup determines an amendment is necessary to effectuate Regulatory Requirements, if Provider objects to the amendment prior to its effective date, then Provider has the right to terminate this Agreement, and such termination shall take effect on the later of the amendment effective date identified by Amerigroup or one hundred eighty (180) days from the date Provider has provided notice of his/her/its intention to terminate the Agreement pursuant to this section. Failure of Provider to provide such notice to Amerigroup within the time frames described herein will constitute acceptance of the amendment by Provider.

9.2 Assignment. This Agreement may not be assigned by Provider without the prior written consent of Amerigroup. Any assignment by Provider without such prior consent shall be voidable at the sole discretion of Amerigroup. Amerigroup may assign this Agreement in whole or in part. In the event of a partial assignment of this Agreement by Amerigroup, the obligations of the Provider shall be performed for Amerigroup with respect to the part retained and shall be performed for Amerigroup's assignee with respect to the part assigned, and such assignee is solely responsible to perform all obligations of Amerigroup with respect to the part assigned. The rights and obligations of the parties hereunder shall inure to the benefit of, and shall be binding upon, any permitted successors and assigns of the parties hereto.

9.3 Scope/Change in Status.

9.3.1 Amerigroup and Provider agree that this Agreement applies to Health Services rendered by Provider at the Provider's location(s) on file with Amerigroup. Amerigroup may, in its discretion, limit this Agreement to Provider's locations, operations, business or corporate form, status or structure in existence on the Effective Date of this Agreement and prior to the occurrence of any of the events set forth in subsections 9.3.1.1 – 9.3.1.5. Unless otherwise required by Regulatory Requirements, Provider shall provide at least ninety (90) days prior written notice of any such event.

9.3.1.1 Provider (a) sells, transfers or conveys his/her/its business or any substantial portion of his/her/its business assets to another entity through any manner including but not limited to a stock, real estate or asset transaction or other type of transfer; (b) is otherwise acquired or controlled by any other entity through any manner, including but not limited to purchase, merger, consolidation, alliance, joint venture, partnership, association, or expansion; or

9.3.1.2 Provider transfers control of his/her/its management or operations to any third party, including Provider entering into a management contract with a physician practice management company or with another entity which does not manage Provider as of the Effective Date of this Agreement, or there is a subsequent change in control of Provider's current management company; or

9.3.1.3 Provider acquires or controls any other medical practice, facility, service, beds or entity; or

9.3.1.4 Provider changes his/her/its locations, business or operations, corporate form or status, tax identification number, or similar demographic information; or

9.3.1.5 Provider creates or otherwise operates a licensed health maintenance organization or commercial health plan (whether such creation or operation is direct or through a Provider affiliate).

9.3.2 Notwithstanding the termination provisions of Article VIII, and without limiting any of Amerigroup's rights as set forth elsewhere in this Agreement, Amerigroup shall have the right to terminate this Agreement by giving at least sixty (60) days written notice to Provider if Amerigroup determines, that as a result of any of the transactions listed in subsection 9.3.1, Provider cannot satisfactorily perform the obligations hereunder, or cannot comply with one or more of the terms and conditions of this Agreement, including but not limited to the confidentiality provisions herein; or Amerigroup elects in its reasonable business discretion not to do business with Provider, the successor entity or new management company, as a result of one or more of the events as set forth in subsection 9.3.1.

9.3.3 Provider shall provide Amerigroup with thirty (30) days prior written notice of:

9.3.3.1 Addition or removal of individual provider(s) who are employed or subcontracted with Provider, if applicable. Any new individual providers must meet Amerigroup's credentialing requirements prior to being designated as a Participating Provider; or

9.3.3.2 A change in mailing address.

9.3.4 If Provider is acquired by, acquires or merges with another entity, and such entity already has an agreement with Amerigroup, Amerigroup will determine in its sole discretion which Agreement will prevail.

9.4 Definitions. Unless otherwise specifically noted, the definitions as set forth in Article I of this Agreement will have the same meaning when used in any attachment, the provider manual(s) and Policies.

9.5 Entire Agreement. This Agreement, exhibits, attachments, appendices, and amendments hereto, and the provider manual(s), together with any items incorporated herein by reference, constitute the entire understanding between the parties and supersedes all prior oral or written agreements between them with respect to the matters provided for herein. This Agreement incorporates by reference all Regulatory Requirements, TennCare rules and regulations, consent decrees or court orders, as applicable to the services under this Agreement and revisions of such laws, regulations, consent decrees or court orders, as applicable to the services under this Agreement shall automatically be incorporated into this Agreement, as they become effective. In addition, if there is an inconsistency between the terms of this Agreement and the terms provided in any exhibits, attachments, appendices, or amendments to this Agreement, then the terms provided in the applicable Participation Attachment shall govern.

9.6 Force Majeure. Neither party shall be deemed to be in violation of this Agreement if such party is prevented from performing any of his/her/its obligations hereunder due to natural or man-made disasters, including fire, flood, earthquake, terrorism, or any similar unforeseeable act beyond its reasonable control, acts of any public enemy, statutory or other laws, regulations, rules, orders, or actions of the federal, state, or local government or any agency thereof.

9.7 Compliance with Regulatory Requirements. Amerigroup and Provider agree to comply with all applicable Regulatory Requirements, as amended from time to time, relating to their obligations under this Agreement, and maintain in effect all permits, licenses and governmental and board authorizations and approvals as necessary for business operations. Provider warrants that as of the Effective Date, he/she/it is and shall remain licensed and certified for the term of this Agreement in accordance with all Regulatory Requirements (including those applicable to utilization review and Claims payment) relating to the provision of Health Services to Members. Provider shall supply evidence of such licensure, compliance and certifications to Amerigroup upon request. If there is a conflict between this section and any other provision in this Agreement, then this section shall control.

9.7.1 In addition to the foregoing, Provider warrants and represents that at the time of entering into this Agreement, neither he/she/it nor any of his/her/its employees, contractors, subcontractors, principals or agents are ineligible, excluded, suspended terminated or debarred from participating in a Medicaid, Medicare, and/or SCHIP Program ("Ineligible Person") pursuant to Sections 1128 or 1156 of the Social Security Act and 42 CFR 455.101. Provider shall remain continuously responsible for ensuring that his/her/its employees, contractors, subcontractors, principals or agents are not Ineligible Persons. If Provider or any employees, subcontractors, principals or agents thereof becomes an Ineligible Person after entering into this Agreement or otherwise fails to disclose his/her/its Ineligible Person status, Provider shall have an obligation to (1) immediately notify Amerigroup of such Ineligible Person status and (2) within ten (10) days of such notice, remove such individual from responsibility for, or involvement with, Provider's business operations related to this Agreement.

9.8 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the state where Amerigroup has its primary place of business, unless such state laws are otherwise preempted by federal law. However, coverage issues specific to a Health Benefit Plan are governed by the state laws where the Health Benefit Plan is issued, unless such state laws are otherwise preempted by federal law.

9.9 Intent of the Parties. It is the intent of the parties that this Agreement is to be effective only in regards to their rights and obligations with respect to each other; it is expressly not the intent of the parties to create any independent rights in any third party or to make any third party a third party beneficiary of this Agreement,

except to the extent specified in the Payment in Full and Hold Harmless section of this Agreement, or in a Participation Attachment(s).

9.10 Non-Exclusive Participation. None of the provisions of this Agreement shall prevent Provider or Amerigroup from participating in or contracting with any provider, preferred provider organization, health maintenance organization/health insuring corporation, or any other health delivery or insurance program. Provider acknowledges that Amerigroup does not warrant or guarantee that Provider will be utilized by any particular number of Members.

9.11 Notice. Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be delivered by hand, facsimile, electronic mail, or mail. Notice shall be deemed to be effective: (a) when delivered by hand, (b) upon transmittal when transmitted by facsimile transmission or by electronic mail, (c) upon receipt by registered or certified mail, postage prepaid, (d) on the next business day if transmitted by national overnight courier, or (e) if sent by regular mail, five (5) days from the date set forth on the correspondence. Unless specified otherwise in writing by a party, Amerigroup shall send Provider notice to an address that Amerigroup has on file for Provider, and Provider shall send Amerigroup notice to Amerigroup's address as set forth in the provider manual(s). Notwithstanding the foregoing, and unless otherwise required by Regulatory Requirements, Amerigroup may post updates to its provider manual(s) and Policies on its web site.

9.12 Severability. In case any one or more of the provisions of this Agreement shall be invalid, illegal, or unenforceable in any respect, the remaining provisions shall be construed liberally in order to effectuate the purposes hereof, and the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby. If one or more provisions of the Agreement are invalid, illegal or unenforceable and an amendment to the Agreement is necessary to maintain its integrity, the parties shall make commercially reasonable efforts to negotiate an amendment to this Agreement and any attachments or addenda to this Agreement which could reasonably be construed not to contravene such statute, regulation, or interpretation. In addition, if such invalid, unenforceable or materially affected provision(s) may be severed from this Agreement and/or attachments or addenda to this Agreement without materially affecting the parties' intent when this Agreement was executed, then such provision(s) shall be severed rather than terminating the Agreement or any attachments or addenda to this Agreement.

9.13 Waiver. Neither the waiver by either of the parties of a breach of any of the provisions of this Agreement, nor the failure of either of the parties, on one or more occasion, to enforce any of the provisions of this Agreement, shall thereafter be construed as a waiver of any subsequent breach of any of the provisions of this Agreement.

9.14 Construction. This Agreement shall be construed without regard to any presumption or other rule requiring construction against the party causing this Agreement to be drafted.

9.15 Counterparts and Electronic Signatures.

9.15.1 This Agreement and any amendment hereto may be executed in two (2) or more counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute one and the same agreement.

9.15.2 Either party may execute this Agreement or any amendments by valid electronic signature, and such signature shall have the same legal effect of a signed original.

Each party warrants that it has full power and authority to enter into this Agreement and the person signing this Agreement on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Agreement.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION WHICH MAY BE ENFORCED BY THE PARTIES

Provider shall be designated as a Participating Provider in the Networks set forth on the Provider Network Attachment on the later of: (1) the Effective Date of this Agreement or; (2) as determined by Amerigroup in its sole discretion, the date Provider has met applicable credentialing requirements and accreditation requirements.

PROVIDER LEGAL NAME ACCORDING TO W-9 FORM WITH D/B/A: _____

By: _____ _____
Signature, Authorized Representative of Provider(s) Date

Printed: _____ _____
Name Title

Address _____ _____
Street City State Zip

(Note: if any of the following is not applicable, please leave blank)

Phone Number: _____

Amerigroup Tennessee, Inc. d/b/a Amerigroup Community Care

AMERIGROUP INTERNAL USE ONLY

By: _____ _____
Signature, Authorized Representative of Amerigroup Date

Printed: _____ _____
Name Title

Medicaid Participation Attachment

TENNCARE/MEDICAID/COVERKIDS
(AMERIGROUP COMMUNITY CARE)
PARTICIPATION ATTACHMENT TO THE
AMERIGROUP PROVIDER AGREEMENT

This is a TennCare/Medicaid/CoverKids Participation Attachment ("Attachment") to the Amerigroup Provider Agreement ("Agreement"), entered into by and between Amerigroup and Provider and is incorporated into the Agreement.

ARTICLE I
DEFINITIONS

The following definitions shall apply to this Attachment. Terms not otherwise defined in this Attachment shall carry the meaning set forth in the Agreement.

All references to "Amerigroup" under this Medicaid Participation Attachment shall mean and refer to Amerigroup Tennessee, Inc.

"Amerigroup Compensation Schedule" ("ACS") means the document(s) attached hereto and incorporated herein by reference, and which sets forth the Amerigroup Rate(s) and compensation related terms for the Network(s) in which Provider participates. The ACS may include additional Provider obligations and specific Amerigroup compensation related terms and requirements.

"Audit" means a review or audit of any and all obligations, requirements, records and information set forth in this Participation Attachment by the entities named herein.

"Clean Claim" means, unless otherwise required by applicable state Regulatory Requirements, an accurate and timely filed Claim submitted pursuant to this Attachment, that has no defect or impropriety, for which all information necessary to process such Claim and make a benefit determination is included. This includes but is not limited to, the claim being submitted in a nationally accepted format in compliance with standard coding guidelines, and which does not require adjustment, or alteration by Provider of the services in order to be processed and paid.

"Cloning of Medical Notes" means documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloned documentation does not meet Medical Necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the Medical Necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of Medical Necessity and recoupment of all overpayments made.

"CoverKids" includes children under age 19 and Mothers of unborn eligible who do not qualify for TennCare but meet the condition of the State Child Health Plan under Title XXI of the Social Security Act State Children's Health Insurance Program.

"Eligible" means, for purposes of this Attachment, any person certified by TennCare as eligible to receive services and benefits under the TennCare program or the CoverKids program.

"Ethical and Religious Directives (ERDs)" means a document that offers moral guidance on various aspects of health care delivery and is based on a religious organization's theological and moral teachings.

"Medicaid Covered Services" means, for purposes of this Attachment, only those Covered Services provided under Amerigroup's Medicaid Program(s), i.e., the package of health care services, including physical health, behavioral health, and long-term care services, that define the covered services available to TennCare members.

"Medicaid Member" means, for purposes of this Attachment, a Member who is enrolled in Amerigroup's Medicaid Program(s) under TennCare. For all purposes related to this Attachment, including all schedules, exhibits, provider manual(s), notices and communications related to this Attachment, the term "Medicaid Member" may be used interchangeably with the terms TennCare Standard Enrollee, TennCare Medicaid Enrollee, and the meaning of each is synonymous with any such other unless otherwise stated in this Attachment.

"Medicaid Program(s)" means, for purposes of this Attachment, a medical assistance program provided under a Health Benefit Plan approved under Title XVI, Title XIX and/or Title XXI of the Social Security Act or any other federal or state funded program or product as designated by Amerigroup.

"Medically Necessary/Medical Necessity" means:

A. Those services that are recommended by a physician or other licensed healthcare provider practicing within the scope of the physician's license who is treating the Medicaid Member. A Medically Necessary Medicaid Covered Service must satisfy each of the following criteria:

(i) It must be required in order to diagnose or treat a Medicaid Member's medical condition. The convenience of a Medicaid Member, a Medicaid Member's family, or a provider shall not be a factor or justification in determining that a medical item or service is Medically Necessary;

(ii) It must be safe and effective. To qualify as safe and effective, the type and level of medical item or service must be consistent with the symptoms or diagnosis and treatment of the particular medical condition, and the reasonably anticipated medical benefits of the item or service must outweigh the reasonably anticipated medical risks based on the Medicaid Member's condition and scientifically supported evidence;

(iii) It must be the least costly alternative course of diagnosis or treatment that is adequate for the medical condition of the Medicaid Member. When applied to medical items or services delivered in an inpatient setting, it further means that the medical item or service cannot be safely provided for the same or lesser cost to the person in an outpatient setting. Where there are less costly alternative courses of diagnosis or treatment, including less costly alternative settings that are adequate for the medical condition of the Medicaid Member, more costly alternative courses of diagnosis or treatment are not Medically Necessary. An alternative course of diagnosis or treatment may include observation, lifestyle or behavioral changes or, where appropriate, no treatment at all; and

(iv) It must not be experimental or investigational. A medical item or service is experimental or investigational if there is inadequate empirically-based objective clinical scientific evidence of its safety and effectiveness for the particular use in question. This standard is not satisfied by a provider's subjective clinical judgment on the safety and effectiveness of a medical item or service or by a reasonable medical or clinical hypothesis based on an extrapolation from use in another setting or from use in diagnosing or treating another condition such as:

(a) Use of a drug or biological product that has not been approved under a new drug application for marketing by the United States Food and Drug Administration (FDA) and is deemed experimental; or

(b) Use of a drug or biological product that has been approved for marketing by the FDA but is proposed to be used for other than the FDA-approved purpose. It will not be deemed Medically Necessary unless the use can be shown to be widespread, to be generally accepted by the professional medical community as an effective and proven treatment in the setting and for the condition for which it is used, and to satisfy the requirements of subdivisions (A)(i) – (A)(iii).

B. It is the responsibility of the Medicaid Program ultimately to determine what medical items and services are Medically Necessary for the Medicaid Program. The fact that a provider has prescribed, recommended or approved a medical item or service does not, in itself, make such item or service Medically Necessary. Medical Necessity and Medically Necessary as used in the Agreement shall have the meaning contained in Tenn. Code Ann. 71-5-144, TennCare Rule 1200-13-16, and other TennCare rules, as applicable. In the case of enrollees under 21 years of age, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.

"State Agency," if used, means a federal, state or local agency, administration, board or other governing body with jurisdiction over the governance or administration of a Medicaid Program.

"Subcontract" means a contract to perform or assist, even if incidentally or in an auxiliary capacity, in the performance of all or part of the Provider's duties or obligations under the Agreement and/or this Attachment. An agreement entered

into by the Provider with any other organization or person who agrees to perform any administrative function or service for the Provider specifically related to securing or fulfilling the Provider's obligations to Amerigroup under the terms of this Attachment when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this Attachment. This shall also include any and all agreements between any and all subcontractors for the purposes related to securing or fulfilling the Provider's obligations to Amerigroup under the terms of this Attachment.

"Subcontractor" means an individual, agency, or organization that pursuant to a Subcontract performs or assists, even if incidentally or in an auxiliary capacity, in the performance of all or part of the Provider's duties or obligations under the Agreement and/or this Attachment. Any organization or person who provides any function or service for the Provider specifically related to securing or fulfilling the Provider's obligations to Amerigroup under the terms of this Attachment. Subcontractor does not include Provider unless the Provider is responsible for services other than those that could be covered in a Provider Agreement.

"TennCare" or "TennCare Program" means the program administered by the single state agency, as designated by the state and CMS, pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs. For purposes of the contract requirements herein, references to TennCare or the TennCare Program shall include CoverKids unless otherwise specified.

"TennCare Kids" means the Early Periodic Screening, Diagnostic and Treatment ("EPSDT") program operated by TennCare. The EPSDT service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Participation-Medicaid Network. As a participant in Amerigroup's Medicaid Network, Provider will render Medicaid Covered Services to Medicaid Members in accordance with the terms and conditions of the Agreement and this Attachment. Such Medicaid Covered Services provided shall be within the scope of Provider's licensure, expertise, and usual and customary range of services pursuant to the terms and conditions of the Agreement and this Attachment, and Provider shall be responsible to Amerigroup for his/her/its performance hereunder. Except as set forth in this Attachment or the Amerigroup Compensation Schedule ("ACS"), all terms and conditions of the Agreement will apply to Provider's participation in Amerigroup's Medicaid Network. The terms and conditions set forth in this Attachment are limited to the provision of and payment for Health Services provided to Medicaid Members.

2.2 Provider's Duties and Obligations to Medicaid Members. All of Provider's duties and obligations to Members set forth in the Agreement shall also apply to Medicaid Members unless otherwise specifically set forth in this Attachment. Provider shall not discriminate in the acceptance of Medicaid Members for treatment, and shall provide to Medicaid Members the same access to services, including but not limited to, hours of operation, as Provider gives to all other patients. Provider shall furnish Amerigroup with at least ninety (90) days prior written notice if Provider plans to close its practice to new patients or ceases to continue in Provider's current practice.

2.2.1 To the extent mandated by Regulatory Requirements, Provider shall ensure that Medicaid Members have access to twenty-four (24) hour-per-day, seven (7) day-per-week urgent and Emergency Services, as defined in the ACS.

2.2.2 Unless otherwise required under Regulatory Requirements, a PCP, as defined in the ACS, shall provide Covered Services or make arrangements for the provision of Covered Services to Medicaid Members on a twenty-four (24) hour-per-day, seven (7) day-per-week basis to assure availability, adequacy, and continuity of care to Medicaid Members. If Provider is unable to provide Covered Services, Provider shall arrange for another Participating Provider to cover Provider's patients in accordance with Amerigroup's Policies. Provider and any PCPs employed by or under contract with Provider may arrange for Covered Services to Medicaid Members to be performed by a Specialist Physician only in accordance with Amerigroup's Policies.

2.2.3 If Provider is furnishing Specialist Physician services under this Attachment, Provider and the Specialist Physician(s) employed by or under contract with Provider, shall accept as patients all

Medicaid Members and may arrange for Covered Services to Medicaid Members to be performed by Specialist Physician only in accordance with Amerigroup's Policies.

2.2.4 Provider may not refuse to provide Medically Necessary or covered preventive services to a child under the age of twenty-one (21) or a Medicaid Member under this Attachment for non-medical reasons. However, Provider shall not be required to accept or continue treatment of a patient with whom Provider feels he/she cannot establish and/or maintain a professional relationship.

2.3 Provider Responsibility. Amerigroup shall not be liable for, nor will it exercise control or direction over, the manner or method by which Provider provides Health Services to Medicaid Members. Provider shall be solely responsible for all medical advice and services provided by Provider to Medicaid Members. Provider acknowledges and agrees that Amerigroup may deny payment for services rendered to a Medicaid Member which it determines are not Medically Necessary, are not Medicaid Covered Services under the applicable Medicaid Program(s), or are not otherwise provided or billed in accordance with the Agreement and/or this Attachment. A denial of payment or any action taken by Amerigroup pursuant to a utilization review, referral, discharge planning program or claims adjudication shall not be construed as a waiver of Provider's obligation to provide appropriate Health Services to a Medicaid Member under applicable Regulatory Requirements and any code of professional responsibility. However, this provision does not require Provider to provide Health Services if Provider objects to such service on moral or religious grounds.

2.4 Reporting Fraud and Abuse. Provider shall cooperate with Amerigroup's anti-fraud compliance program. If Provider identifies any actual or suspected fraud, abuse or misconduct in connection with the services rendered hereunder in violation of Regulatory Requirements, Provider shall immediately report such activity directly to the compliance officer of Amerigroup or through the compliance hotline in accordance with the provider manual(s) or to the TennCare Office of Program Integrity. In addition, Provider is not limited in any respect in reporting other actual or suspected fraud, abuse, or misconduct to Amerigroup.

2.5 Amerigroup Marketing/Information Requirements. Provider agrees to abide by Amerigroup's marketing/information requirements. Provider shall forward to Amerigroup for prior approval all flyers, brochures, letters and pamphlets Provider intends to distribute to TennCare Members concerning its payor affiliations, or changes in affiliation or relating directly to the TennCare population. Provider will not distribute any marketing or recipient informing materials without the consent of Amerigroup or TennCare. Provider shall not use TennCare name or trademark for any materials intended for dissemination to Medicaid Members unless said material has been submitted to TennCare by Amerigroup for review and approval. This prohibition shall not include references to whether or not Provider participates in TennCare.

2.6 Schedule of Benefits and Determination of Medicaid Covered Services. Amerigroup shall make available upon Provider's request schedules of Medicaid Covered Services for applicable Medicaid Program(s), and will notify Provider in a timely manner of any material amendments or modifications to such schedules. Amerigroup will not issue any payments to Provider until Provider has obtained a Tennessee Medicaid provider number and has complied with the disclosure requirements, as applicable, in accordance with 42 CFR 455.100 through 106 and TennCare policies and procedures.

2.7 Medicaid Member Verification. Provider shall establish a Medicaid Member's eligibility for Medicaid Covered Services prior to rendering services, except in the case of an Emergency Condition, as defined in the ACS, where such verification may not be possible. In the case of an Emergency Condition, Provider shall establish a Medicaid Member's eligibility as soon as reasonably practical. Amerigroup provides for member eligibility verification 24/7/365 on its website. Nothing contained in this Attachment or the Agreement shall, or shall be construed to, require advance notice, coverage verification, or pre-authorization for Emergency Services, as defined in the ACS, provided in accordance with the federal Emergency Medical Treatment and Labor Act ("EMTALA") prior to Provider's rendering such Emergency Services.

2.8 Hospital Affiliation and Privileges. To the extent required under Amerigroup's credentialing requirements, Provider or any Participating Providers employed by or under contract or subcontract with Provider shall maintain privileges to practice at one or more of Amerigroup's participating hospitals. In addition, in accordance with the Change in Provider Information Section of the Agreement, Provider shall immediately notify Amerigroup in the event any such hospital privileges are revoked, limited, surrendered, or suspended at any hospital or healthcare facility.

2.9 Participating Provider Requirements. If Provider is a group provider, Provider shall require that all Participating Providers employed by or under contract or subcontract with Provider comply with all terms and conditions of the Agreement and this Attachment. Notwithstanding the foregoing, Provider acknowledges and agrees that

Amerigroup is not obligated to accept as Participating Providers all providers employed by or under contract or subcontract with Provider.

2.10 Coordinated and Managed Care. Provider shall participate in utilization management and care management programs designed to facilitate the coordination of services as referenced in the applicable provider manual(s).

2.11 Representations and Warranties. Provider represents and warrants that all information provided to Amerigroup is true and correct as of the date such information is furnished, and that Provider is unaware of any undisclosed facts or circumstances that would make such information inaccurate or misleading. Provider further represents and warrants that Provider: (i) is legally authorized to provide the services contemplated hereunder; (ii) is qualified to participate in all applicable Medicaid Program(s); (iii) is not in violation of any licensure or accreditation requirement applicable to Provider under Regulatory Requirements; (iv) has not been convicted of bribery or attempted bribery of any official or employee of the jurisdiction in which Provider operates, nor made an admission of guilt of such conduct which is a matter of record; (v) is capable of providing all data related to the services provided hereunder in a timely manner as reasonably required by Amerigroup to satisfy its internal requirements and Regulatory Requirements, including, without limitation, data required under the Healthcare Effectiveness Data and Information Set ("HEDIS") and National Committee for Quality Assurance ("NCQA") requirements; and (vi) is not, to Provider's best knowledge, the subject of an inquiry or investigation that could foreseeably result in Provider failing to comply with the representations set forth herein. In accordance with the Change in Provider Information Section of the Agreement, Provider shall immediately provide Amerigroup with written notice of any material changes to such information.

2.11.1 Provider shall conduct criminal background checks and registry checks, which shall include a check of the Tennessee Abuse Registry, National and Tennessee Sexual Offender Registry, in accordance with state law and TennCare policy.

2.12 Third Party Liability. Provider agrees to identify third party liability coverage, including Medicare and long-term care insurance as applicable, and except as otherwise required, seek such third party liability payment before submitting claims to Amerigroup.

2.13 TennCare Kids. If Provider furnishes EPSDT services under the TennCare Kids program, upon request, Amerigroup shall make available to Provider a description of the package of benefits that TennCare Kids offers and require providers to make treatment decisions based upon children's individual medical and behavioral health needs. In furnishing such TennCare Kids services, Provider shall comply with the requirements set forth in the provider manual.

ARTICLE III
COMPENSATION AND AUDIT

3.1 Submission and Adjudication of Medicaid Claims. Unless otherwise instructed, or required by Regulatory Requirements, Provider shall submit Claimsto Amerigroup, using appropriate and current Coded Service Identifier(s), within one hundred twenty (120) days from the date the Health Services are rendered or Amerigroup may refuse payment. If Amerigroup is the secondary payor, the one hundred twenty (120) day period will not begin until Provider receives notification of primary payor's responsibility.

3.1.1 In situations of enrollment in TennCare with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that Amerigroup receives notification from TennCare of the Medicaid Member's eligibility/enrollment. Provider agrees to submit Claims in a format consistent with industry standards and acceptable to Amerigroup either (a) electronically through electronic data interchange ("EDI"), or (b) if electronic submission is not available, utilizing paper forms as defined by the National Uniform Claim Committee ("NUCC").

3.1.2 Provider agrees to provide to Amerigroup, unless otherwise instructed, at no cost to Amerigroup or the Medicaid Member, all information necessary for Amerigroup to determine its payment liability. Such information includes, without limitation, accurate and Clean Claims for Covered Services. If Amerigroup asks for additional information in order to process the Claim, Provider must provide that information within sixty (60) days, or before the expiration of the one hundred twenty (120) day period referenced in section 3.1 above, whichever is longer.

3.1.3 Amerigroup will provide for prompt payment to the Provider upon receipt of a Clean Claim properly submitted by the Provider within the required time frames as specified in TCA 56-32-126. All Clean Claims will be adjudicated in accordance with the terms and conditions of a Medicaid Member's

Health Benefit Plan, the ACS, the provider manual(s), and the Regulatory Requirements applicable to Amerigroup's Medicaid Program(s).

3.2 This provision intentionally left blank.

3.3 Audit for Compliance with CMS Guidelines. Notwithstanding any other terms and conditions of the Agreement, this Attachment, or the ACS, Amerigroup has the same rights as CMS, to review and/or Audit and, to the extent necessary recover payments on any claim for Medicaid Covered Services rendered pursuant to this Attachment and the Agreement to ensure compliance with CMS Regulatory Requirements.

3.4 State Audit Requirements. Provider shall maintain books, records, documents, and other evidence pertaining to Medicaid Covered Services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to this Attachment as well as medical information relating to the individual Medicaid Members, as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with State Agency requirements regarding the reporting and investigation of fraud and abuse. Records other than medical records may be kept in an original paper state or preserved on micromedia or electronic format. Medical records shall be maintained in their original form or may be converted to electronic format as long as the records are readable and/or legible. As a condition of participation in TennCare, enrollees and providers shall give TennCare or its authorized representative, DIDD, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, TBI MFCU, DHHS Office of Inspector General (DHHS OIG), and DOJ, and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request by the provider in either paper or electronic form, at no cost to the requesting party, for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of Amerigroup, TennCare or authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to DIDD, the OIG, the TBI MFCU, the DHHS OIG and the DOJ. Said records are to be provided by the Provider at no cost to the requesting agency; records, books, documents, etc., shall be made immediately available for any authorized federal, state agency, including, but not limited to TennCare, or its designees, Comptroller of the Treasury, the Office of the Inspector General (OIG), the Medicaid Fraud Control Unit (MFCU), the Department of Health and Human Services, Office of Inspector General (DHHS, OIG) and the Department of Justice (DOJ) personnel during the Attachment period and ten (10) years thereafter, unless an audit, administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are yet unresolved in which case records shall be kept until all tasks or proceedings are completed. Said records are to be provided by Provider at no cost to the requesting agency. During the Attachment period, Provider agrees to make these records available at a location in Tennessee as agreed upon by the parties subject to the approval State Agency. If the records need to be sent to State Agency or Amerigroup, Provider shall bear the expense of duplication and delivery of the medical records. Prior approval of the disposition of Provider's records must be requested and approved by State Agency. Without in any way limiting the foregoing, as a condition of receiving any amount of Amerigroup or TennCarepayment, Provider shall comply with the fraud and abuse requirements set forth in the Contract Risk Agreement and the Provider Manual.

ARTICLE IV
COMPLIANCE WITH FEDERAL REGULATORY REQUIREMENTS

4.1 Federal Funds. Provider acknowledges that payments Provider receives from Amerigroup to provide Medicaid Covered Services to Medicaid Members are, in whole or part, from federal funds. Therefore, Provider and any of his/her/its subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds, which may include but are not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 80; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973 as implemented by 45 CFR part 84, lobbying restrictions as implemented by 45 CFR Part 93 and 31 USC 1352, Title IX of the Education Amendments of 1972, as amended (20 U.S.C. sections 1681, 1865-1866, and 1783) and any other regulations applicable to recipients of federal funds.

4.2 Surety Bond Requirement. If Provider provides home health services or durable medical equipment, Provider shall comply with all applicable provisions of Section 4724(b) of the Balanced Budget Act of 1997, including, without limitation, any applicable requirements related to the posting of a surety bond.

4.3 Laboratory Compliance. If Provider renders lab services in the office, it must maintain a valid Clinical Laboratory Improvement Amendments ("CLIA") certificate for all laboratory testing sites and comply with CLIA

regulations at 42 CFR Part 493 for all laboratory testing sites performing Health Services pursuant to this Attachment.

4.4 Gratuities. Provider certifies that no member or delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the United States General Accounting Office, United States Department of Health and Human Services, CMS, or any other federal agency has or will benefit financially or materially due to influence in obtaining Agreement. This Agreement may be terminated by Amerigroup at the discretion of TennCare if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the Provider or the Provider's agent or employees.

4.5 Reassignment of Payment. Any reassignment of payment must be made in accordance with 42 CFR 447.10 and all tax-reporting entities must execute a billing agent or alternative payee assignment agreement in order to assign TennCare funds/payments. Billing agents and alternative payees are subject to monthly federal exclusion and debarment screenings while the assignment is ongoing.

4.6 Federal 340B Program. If Provider participates in the federal 340B program, Provider shall give Amerigroup the benefit of Provider's 340B pricing. This requirement shall be enforced in accordance with the guidance as provided by TennCare.

4.7 Exclusion and Debarment Screening. Provider shall comply with all federal requirements (42 C.F.R. § 1002) on exclusion and debarment screening. Providers that bill and/or receive TennCare funds as the result of this Participation Agreement shall screen its owners and employees against the General Services Administration (GSA) System for Award Management (SAM) and the HHS-OIG List of Excluded Individuals/Entities (LEIE). In addition, Provider shall screen its owners and employees against the Social Security Master Death File. Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or Amerigroup dependent upon the entity that identifies the payment of unallowable funds to excluded individuals

4.7.1 Provider shall screen its employees and contractors initially and on an ongoing, monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) or 1156 of the Social Security Act and 42 CFR 455.101) and not employ or contract with an individual or entity that has been excluded or debarred. The Provider shall be required to immediately report to Amerigroup any exclusion information discovered. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare Members.

4.8 Referral Incentive/Kickbacks. Provider agrees to abide by the Medicaid laws, regulations and program instructions that apply to the Provider. Provider understands that payment of a claim by Amerigroup is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. The Provider understands and agrees that each claim the Provider submits to Amerigroup constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), in connection with such claims and the services provided therein.

ARTICLE V
COMPLIANCE WITH STATE REGULATORY REQUIREMENTS

5.1 Indemnification of State. In addition to the Indemnification provision of the Agreement, Provider shall, at all times, indemnify and hold harmless the State, its agencies, officers, and employees (hereinafter the "Indemnified Parties") from all claims and suits, including court costs, attorney's fees, and other expenses, brought against the Indemnified Parties, because of injuries or damages received or sustained by any person, persons, or property that is caused by any act or omission of Provider.

5.1.1 The Provider shall indemnify and hold harmless the State of Tennessee and its Indemnified Parties from all claims, losses or suits incurred by or brought against the Indemnified Parties as a result of the failure of the Provider to comply with the terms of this Attachment. The State of Tennessee shall give the Provider written notice of each such claim or suit and full right and opportunity to conduct Provider's own defense thereof, together with full information and all reasonable cooperation; but the State of Tennessee does not hereby accord to the Provider, through its attorneys, any right(s) to

represent the State of Tennessee or Amerigroup in any legal matter, such right being governed by TCA 8-6-106.

5.1.2 The Provider shall indemnify and hold harmless the Indemnified Parties from all claims or suits which may be brought against the Indemnified Parties for infringement of any laws regarding patents or copyrights which may arise from the Provider's or Indemnified Parties performance under this Attachment. In any such action, brought against the Indemnified Parties, the Provider shall satisfy and indemnify the Indemnified Parties for the amount of any final judgment for infringement. The State of Tennessee shall give the Provider written notice of each such claim or suit and full right and opportunity to conduct the Provider's own defense thereof, together with full information and all reasonable cooperation; but the State of Tennessee does not hereby accord to the Provider, through its attorneys, any right(s) to represent the State of Tennessee or Amerigroup in any legal matter, such right being governed by TCA 8-6-106.

5.1.3 While the State of Tennessee will not provide a contractual indemnification to the Provider; such shall not act as a waiver or limitation of any liability for which the State of Tennessee may otherwise be legally responsible to the Provider. The Provider retains all of its rights to seek legal remedies against the State of Tennessee for losses the Provider may incur in connection with the furnishing of services under this Agreement or for the failure of the State of Tennessee to meet its obligations under the Agreement.

5.1 This provision intentionally left blank.

5.2 Medicaid Hold Harmless. Provider shall accept payment or appropriate denial made by Amergroup (or, if applicable, payment by Amerigroup that is supplementary to the member's third party payer) plus the amount of any applicable TennCare cost sharing responsibilities, as payment in full for Medicaid Covered Services provided to Medicaid Members. Provider agrees that in no event, including, but not limited to non-payment by Amerigroup, Amerigroup insolvency, or breach of this Attachment, shall Provider solicit or accept any surety or guarantee of payment from a Medicaid Member for Medicaid Covered Services in excess of the amount of applicable TennCare cost sharing responsibilities. Provider agrees it shall not seek payment from the Medicaid Member, his/her representative or the State for any Health Services rendered pursuant to this Attachment, with the exception of Cost Shares, if any, or payment for non-Medicaid Covered Services otherwise requested by, and provided to, the Medicaid Member if the Medicaid Member agrees in writing to pay for the service prior to the service being rendered. Medicaid Member shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the Member being served. The form of agreement must specifically state the admissions, services or procedures that are non-Medicaid Covered Services and the approximate amount of out of pocket expense to be incurred by the Medicaid Member. Provider agrees not to bill Medicaid Members for missed appointments while enrolled in the Medicaid Programs. This provision shall remain in effect even in the event Amerigroup becomes insolvent.

5.3 State Agency Government Contract. Provider shall comply with the terms applicable to providers set forth in the Government Contract, including incorporated documents, between Amerigroup and TennCare, which applicable terms are incorporated herein by reference. Amerigroup agrees to provide Provider with a description of the applicable terms upon request. For the purposes of this Attachment all references to Government Contract shall mean and refer to TennCare Contractor Risk Agreement ("CRA") regarding requirements for operation and administration of the managed care TennCare program, including CHOICES and I/DD MLTSS Programs.

5.4 Performance Within the U.S. Provider agrees that all services to be performed herein shall be performed in the United States of America. Breach, or anticipated breach, of the foregoing shall be a material breach of this Attachment and, without limitation of remedies, shall be cause for immediate termination of the Agreement and this Attachment.

5.5 No Payment Outside the United States. Provider agrees that Amerigroup shall not provide any payments for items or services provided under the Agreement to any financial institution or entity located outside the United States of America.

5.6 Overpayments. Notwithstanding Provider's obligation to return an overpayment upon notification from Amerigroup, Provider must comply with TennCare policies and procedures regarding requirement to report, including written notification, provider initiated refunds of overpayments to Amerigroup and the TennCare

Office of Program Integrity (OPI) and, when it is applicable, returning overpayments to Amerigroup within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may be a violation of state or federal law.

5.7 Use of Independent Review. Provider shall have the right to avail itself of the TennCare Provider Independent Review of Disputed Claims process to resolve claims denied in whole or in part by Amerigroup, as provided at TCA 56-32-126(b).

5.8 Care to Pregnant Women. Any unreasonable delay in providing care to a pregnant Medicaid Member seeking prenatal care will be considered a material breach of this Attachment. "Unreasonable delay" in providing care for pregnant Medicaid Members shall mean the following: (a) for Medicaid Members in their first trimester of pregnancy, in excess of three (3) weeks from the date of the Medicaid Member's request for regular appointments and 48 hours from the date of the Medicaid Member's request for urgent care; and (b) for Medicaid Members past their first trimester of pregnancy, on the day they are determined to be eligible a first prenatal care appointment shall occur no later than fifteen (15) calendar days from the day they are determined to be eligible.

5.9 No Conflict with Government Contract. If any requirement in this Attachment is determined by TennCare to conflict with the Government Contract provision), such requirement shall be deemed null and void, but all other provisions of this Attachment shall remain in full force and effect.

5.10 Care Coordination for CHOICES Members. Provider shall facilitate notification of the Medicaid Member's care coordinator by notifying the Amerigroup, in accordance with the Amerigroup's processes, as expeditiously as warranted by the Medicaid Member's circumstances, of any known significant changes in the Medicaid Member's condition or care, hospitalizations, or recommendations for additional services.

5.11 Cooperation with CHOICES Nursing Facility Diversion Plan. If Provider is a hospital (including a psychiatric hospital), Provider shall cooperate with Amerigroup in developing and implementing protocols as part of Amerigroup's nursing facility diversion plan, which shall include, at a minimum, the hospital's obligation to promptly notify Amerigroup upon admission of an Medicaid Member regardless of payor source for the hospitalization; how the hospital will identify members who may need home health, private duty nursing, nursing facility, or CHOICES HCBS upon discharge, and how the hospital will engage Amerigroup in the discharge planning process to ensure that Medicaid Members receive the most appropriate and cost-effective Medically Necessary services upon discharge.

5.12 Ethical and Religious Directives ("ERDs"). Should an issue arise at the time of service, the Provider shall inform TennCare members that Amerigroup has additional information on providers and procedures that are covered by TennCare. The Provider is not required to make specific recommendations or referrals.

5.13 Pharmacy Services. Provider shall coordinate with TennCare Pharmacy Benefit Management (PBM) regarding authorization and payment for pharmacy services.

5.14 Reporting Abuse and Neglect. Provider shall report suspected abuse, neglect, and exploitation of adults in accordance with TCA 71-6-103 and shall report suspected brutality, abuse, or neglect of children in accordance with TCA 37-1-403 and TCA 37-1-605.

5.15 Encounter Data Requirements. Provider shall submit complete and accurate utilization and/or encounter data for any services provided that are reimbursed under a global, e.g., global procedures codes for obstetric care, or capitated payment arrangement. Provider shall submit utilization and/or encounter data as specified by Amerigroup in a timely manner to support individual services provided, so as to ensure Amerigroup's ability to submit encounter data to TennCare that meets the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims.

5.16 Provider Change of Ownership. In the event Provider has a change of ownership, the new owner/provider shall provide to TennCare a bill of sale (or equivalent) and documentation from the appropriate State of Tennessee licensing entity stating that the new owner is allowed to operate under the existing license until such time as a new license is issued. TennCare shall issue a new Medicaid ID based on this provider-submitted documentation, and Amerigroup shall reimburse the new provider based on rates provided by TennCare to Amerigroup on the next weekly rate file following Tenncare's receipt of the new provider's documentation. Notwithstanding this foregoing, any assignment of the Attachment shall be consistent with the Assignment provision of the Agreement.

5.17 Permitted Sanctions. In the event Provider fails to meet any performance standard or other requirement or rule of the TennCare, or any standard or rule existing under applicable law pertaining to the services provided hereunder including, without limitation, Section 1200-13-13-.08 of TennCare's Rules and regulations, or fails to perform its obligations hereunder in accordance with the terms of this Attachment, Amerigroup may assess liquidated damages, sanctions or reductions in payment in an amount equal to any penalty assessed by TennCare, or under applicable law, against Amerigroup, due to such performance standard not having been met or due to the breach of such requirement, rule or obligation under this Attachment. Liquidated damages, sanctions or payment reductions for selected failures of performance will be specifically set forth in the provider manual.

5.18 Non-Discrimination. In addition to the Provider Non-discrimination provision of the Agreement. No person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws shall be excluded from participation in, except as specified in Section A.2.3.5, of the Government Contract, or be denied benefits of, or be otherwise subjected to discrimination in the performance of Provider's obligation under its agreement with Amerigroup or in the employment practices of the Provider. Provider will cooperate with TennCare and/or CMS, and Amerigroup, as applicable, during discrimination complaint investigations and report discrimination complaints and allegations to Amerigroup including allegations of discrimination as set forth in the CRA, i.e., any instance of disrespectful or inappropriate communication, e.g., humiliation harassment, threats of punishment or deprivation, intimidation or demeaning or derogatory communication (vocal, written, gestures) or any other acts pertaining to a person supported that is not directed to or within eyesight or audible range of the person supported and does not meet the definition of emotional or psychological abuse. Provider will assist any Medicaid Covered Person in obtaining discrimination complaint forms and contact information for Amerigroup's nondiscrimination office. Provider shall, upon request, show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees, TennCare applicants, and enrollees.

5.19 Records Availability and Retention. In addition to the Amerigroup Access to and Requests for Provider Records provision of the Agreement, Provider shall immediately make available to Amerigroup, TennCare, or its authorized representatives, federal or state personal, including but not limited to, OIG, TBI MFCU, DOJ and the DHHS OIG, and Office of the Comptroller of the Treasury ("Representatives"), in a usable form, any or all records, whether medical or financial, related to Provider's activities undertaken pursuant to this Attachment and the services provided to Medicaid Members. Provider shall have an adequate record system and maintain all records for ten (10) years from the termination of the Agreement or retained until all evaluations, audits reviews, investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the Agreement and administrative, civil or criminal investigations and prosecutions).

5.19.1 Provider shall make all records (including, but not limited to, financial and medical records) pertaining to services rendered under this Attachment available at Provider's expense for administrative, civil and/or criminal review, audit, evaluation, inspection, investigation and/or prosecution by authorized federal and state personnel, including TennCare, its Representatives and Amerigroup or any duly authorized state or federal designee. Access will be either through on-site review of records or mailed copies at TennCare's or the State Agency's discretion and during normal business hours, unless there are exigent circumstances, in which case access will be at any time at TennCare's or the State Agency's discretion Requested records shall be provided at no expense to TennCare or State Agency, its Representative, Amerigroup, or any duly authorized state or federal designee. Paper records must be signed by rendering provider; electronic records must have capability of affixing an electronic signature to notes added by rendering provider.

5.19.2 Provider shall make all records, including, but not limited to, financial, administrative and medical records available to the State Agency, its Representatives, Amerigroup, or any duly authorized state or federal designee. The State Agency, its Representatives, Amerigroup, or any duly authorized state or federal designee or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means, any record pertinent to this Attachment, including but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution, and such evaluation, inspection, review or request, when performed or requested, shall be performed with the immediate cooperation of the Provider. Such records are to be provided at no charge to the

requesting agency. Upon request, the Provider shall assist in such reviews, and provide complete copies of medical records. Any authorized federal or State government agency, TennCare, its Representative, Amerigroup, or any duly authorized state or federal designee, may use these records to carry out their authorized duties, reviews, audits, administrative, civil and/or criminal investigations and/or prosecutions.

5.19.3 Amerigroup and Provider recognize that in the event of termination of the CRA between Amerigroup and TennCare for any reason(s) described therein, Provider shall immediately make available, to TennCare, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to this Agreement. The provision of such records shall be at no expense to TennCare.

5.19.4 Provider acknowledges that HIPAA regulations do not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to, the Comptroller of the Treasury, OIG, MFCU, DHHS OIG and DOJ.

5.19.5 TennCare, State Agency, CMS, or their Representatives shall, at all reasonable times, have the right to enter into the Provider's premises, or such other places where duties of this Attachment are being performed, to inspect, monitor, or otherwise evaluate including periodic audits of the work being performed. The Provider shall supply reasonable access to all facilities and assistance for federal, TennCare, or State Agency's representatives.

5.20 Medical Records. Provider shall maintain medical records in a manner that is current, detailed and organized, and that permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions.

5.20.1 Provider shall have medical record keeping practices that are consistent with 42 CFR 456 and current NCQA standards for medical record documentation, in accordance with Amerigroup policies and procedures regarding confidentiality of medical records, medical record documentation standards and standards for the availability of medical records. Provider shall obtain all necessary releases, consents and authorizations from Medicaid Members with respect to their medical records to permit Amerigroup access to such records. Records related to appeals shall be forwarded within the timeframes specified in the appeal process section of the provider manual. Such requests made by Amerigroup or TennCare shall not be unreasonable.

5.20.2 Medical records shall be maintained and be available at the site where Medicaid Covered Services are rendered. Medicaid Members (including individuals age 16 or older for behavioral health records and including individuals age 14 or older for non-behavioral health records), and their legally appointed representatives shall be given access to the Medicaid Member's medical records, to the extent and in the manner provided by TCA 63-2-101, 63-2-102 and 33-3-104 et seq., and, subject to reasonable charges as defined in TCA 63-2-102, (except as provided section 5.20.3 below) may be given copies thereof upon request and to request that they be amended or corrected.

5.20.3 In the event a patient-provider relationship with a Medicaid Program primary care provider ends and the Medicaid Member requests that medical records be sent to a second Medicaid Program provider who will be the Medicaid Member's primary care provider, the first provider shall not charge the Medicaid Member or the second provider for providing one set of medical records.

5.20.4 If Provider furnishes Behavioral Health Care Services, Provider shall maintain medical records in conformity with TCA 33-3-101 et seq. for persons with serious emotional disturbance or mental illness. If Provider furnishes Behavioral Health Care Services, Provider shall maintain medical records of persons whose confidentiality is protected by 42 CFR Part 2 in conformity with that rule or TCA 33-3-103, whichever is more stringent. . Provider shall maintain Behavioral Health Records at the Provider level for ten (10) years from the termination of the Agreement **or retained until all** evaluations, audits reviews, investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the Agreement and administrative, civil or criminal investigations and prosecutions).

5.21 Monitoring. Provider acknowledges that Amerigroup may monitor the quality of services delivered by Provider hereunder and may initiate corrective action when necessary to improve quality of care in accordance with

that level of medical or behavioral health care which is recognized as acceptable professional practice in the respective community in which Provider practices and/or the standards established by TennCare. Provider shall comply with corrective action plans initiated by Amerigroup. Provider acknowledges that Amerigroup has the right to monitor Medicaid Covered Services rendered by Provider to Medicaid Members in accordance with this Attachment and Amerigroup Policies and procedures that are made known to Provider, and that such monitoring may be announced or unannounced. Provider shall participate and cooperate in any internal and external QM/QI, monitoring, utilization review, peer review and/or appeal procedures established by Amerigroup and/or TennCare.

5.22 Services to TennCare Children. Provider shall not encourage or suggest in any way that State Agency children be placed in state custody in order to receive medical, behavioral, or long-term care services covered by the Medicaid Program.

5.23 Non-Covered Services. Provider acknowleges that any services not listed in the State of Tennessee TennCare Program Rules and Regulations Chapter 1200-13-13-.04 (or 1200-13-14-.04, as applicable) and the Government Contract at Section A.2.6 BENEFITS/SERVICES REQUIREMENTS AND LIMITS or TennCare Bureau policies and procedures as "Covered Services" must receive prior approval in writing by TennCare and CMS.

5.24 Reports, Provider Manual and Member Handbook. Amerigroup shall provide to Provider such utilization profiles or other reports, if any, that Amerigroup is required to provide to Provider under Regulatory Requirements. In addition, Amerigroup shall provide its Tennessee Provider Directory to Provider. Pursuant to TCA 63-51-110, Amerigroup posts an updated provider network directory on its website every twenty-one (21) business days. Provider shall timely submit all reports and clinical information required by Amerigroup. Amerigroup shall provide a copy of the applicable provider manual and Member Handbook, whether by its website or otherwise.

5.25 Conflict of Interest and Lobbying. Provider provides assurance that no part of the total Agreement amount received by Provider under this Agreement shall be paid directly, indirectly or through a parent organization, subsidiary or an affiliated organization to any state or federal officer or employee of the State of Tennessee or any immediate family member of a state or federal officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to the Provider in connection with any work contemplated or performed relative to this Agreement unless otherwise disclosed to the Commissioner, Tennessee Department of Finance and Administration. For purposes of this section, "immediate family member" shall mean a spouse or minor child(ren) living in the household. Provider shall ensure that it maintains adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of its organization. Provider further provides assurance that no part of the total Agreement amount received by Provider have been used, directly or indirectly, for any Lobbying activities.

5.26 Provider-Preventable Conditions. Provider understands and agrees that no payment will be made to Provider by Amerigroup for any provider-preventable conditions which have been identified by TennCare or pursuant to Regulatory Requirements. In addition, Provider shall identify provider-preventable conditions that are associated with claims for services provided under the Medicaid Program hereunder or with courses of treatment furnished to Medicaid Members for which payment under the Medicaid Program would otherwise be available.

5.27 Language and Translation Services. Provider shall have written procedures for the provision of language assistance services to Medicaid Members and/or the Medicaid Member's representative. Language assistance services include interpretation and translation services and effective communication assistance in alternative formats for any Medicaid Member and/or Medicaid Member's representative who requires such services including, but not limited to, Medicaid Members with limited English proficiency and individuals with disabilities or who are hearing impaired. Provider shall provide interpreter and translation services, and employ appropriate auxiliary aids and services, free of charge to Medicaid Members and furnish a copy of such procedures to Amerigroup upon request.

5.28 Capitation Arrangement. In the event Provider and Amerigroup enter into a capitated payment arrangement for Medicaid Covered Services and Provider becomes aware for any reason that he or she is not entitled to a capitation payment for a particular enrollee (a Medicaid Member dies, for example), the Provider shall immediately notify both Amerigroup and TennCare by certified mail, return receipt requested.

5.29 Alternative Claims Processing. In the event that TennCare deems Amerigroup unable to timely process and reimburse Claims and requires Amerigroup to submit Provider Claims for reimbursement to an alternative

claims processor to ensure timely reimbursement, Provider shall agree to accept reimbursement at Amerigroup's contracted reimbursement rate or the rate established by TennCare, whichever is greater.

5.30 Informal Resolution of Disputes. Notwithstanding the Dispute Resolution and Arbitration provisions of the Agreement, in the event of a dispute arising out of this Attachment that is not resolved and Provider has exhausted any other applicable provider appeal and/or provider dispute resolution procedures under the Agreement, the parties shall seek good faith informal resolution of the dispute prior to pursuing any external remedies, subject to applicable law. Any party may initiate the informal resolution process by sending a written description of the dispute to the other parties by certified or registered mail or personal delivery. The description shall explain the nature of the dispute in detail and set forth a proposed resolution, including a specific time frame within which the parties must act. The party receiving the letter must respond in writing within thirty (30) days with a detailed explanation of its position and a response to the proposed resolution. Within thirty (30) days of the initiating party receiving this response, principals of the party who have authority to settle the dispute will meet to discuss the resolution of the dispute. The initiating party shall initiate the scheduling of the meeting. In the event the parties are unable to resolve the dispute following exhaustion of the grievance and appeal process and the negotiation or mediation, a party shall pursue remedies at law or equity.

5.31 Provider Insurance.

5.31.1 If the Provider is State owned and/or operated: The State of Tennessee, including the University of Tennessee, is prohibited by law from agreeing to provide indemnity. In addition, the General Assembly for the State of Tennessee does not authorize the State agencies or employees to provide, carry, or maintain commercial General Liability Insurance or Medical, Professional or Hospital Liability Insurance. Claims against the State of Tennessee, or its employees, for injury, damages, expenses or attorney's fees are heard and determined by the Tennessee Claims Commission or the Tennessee Board of Claims in the manner prescribed by law. See Tenn. Code Ann. §§ 8-42-101 et seq., 9-8-101 et seq., 9-8-301 et seq., and 9-8-410 et seq. Provider as a governmental entity is not required to provide workers compensation insurance. It does, however, provide a fully funded injured on duty benefit program for its employees.

5.31.2 If the Provider is a local government owned and operated: The Provider, being a Tennessee local governmental entity (such as a county or municipality), is governed by the provisions of the Tennessee Government Tort Liability Act, Tennessee Code Annotated, Sections 29-20-101 et seq., for causes of action sounding in tort. Further, no contract provision requiring a Tennessee political entity to indemnify or hold harmless the State beyond the liability imposed by law is enforceable because it appropriates public money and nullifies governmental immunity without the authorization of the General Assembly. Provider as a governmental entity is not required to provide workers compensation insurance. If the Provider does not maintain workers compensation insurance it does, however, provide a fully funded injured on duty benefit program for its employees.

5.31.3 If the Provider is a non-profit corporation duly existing and organized under the laws of the State of Tennessee which is a Federally Qualified Health Center as defined in 42 C.F.R. §405.2401, Provider is an entity to which the Federal Tort Claims Act may apply. For so long as Provider qualifies as an "employee" in accordance with Section 224 (g) of the Public Health Service Act ("PHS"), located at 42 U.S.C. § 223(g), as amended, Provider shall have its liability limits defined by Section 224(a) of the Federal Tort Claims Act. As an employee under the PHS, Provider carries no professional liability insurance; however, it is insured for general liability. This general liability insurance is for the benefit of the Provider only and provides no indemnification for any other entity whatsoever. The Provider agrees to produce proof of adequate professional liability insurance for the Provider's professional employees who perform any professional services under this Agreement and are not covered by the Federal Tort Claims Act. To the extent required by Regulatory Requirements, Provider shall maintain workers' compensation insurance for Provider's employees. In the event that Provider loses its status as an "employee" pursuant to Section 224(g) of the PHS, Provider shall maintain professional liability insurance, including maintaining such tail or prior acts coverage necessary to avoid any gap in coverage for claims arising from incidents occurring during the term of this Agreement. Such insurance shall (i) be obtained from a carrier authorized to issue coverage in the jurisdiction in which Provider operates, except for permitted self-insurance; and (ii) maintain minimum policy limits equal to $1,000,000.00 per occurrence and $3,000,000.00 in the aggregate, or such other coverage amounts as prescribed by applicable Regulatory Requirements and consented to by Amerigroup. Provider shall maintain general liability insurance covering Provider's premises, insuring Provider against any claim of loss, liability, or damage caused by or arising out of the

condition or alleged condition of said premises, or the furniture, fixtures, appliances, or equipment located therein, and if Provider operates motor vehicles in connection with Provider's services, with liability protection against any loss, liability or damage resulting from the operation of such motor vehicles by Provider, Provider's employees or agents. Such general liability insurance shall contain commercially reasonable coverage limits, or such limits as prescribed by Regulatory Requirements.

ARTICLE VI
TERMINATION

6.1 Termination of Medicaid Participation Attachment. Either party may terminate this Attachment without cause by giving at least one hundred eighty (180) days prior written notice of termination to the other party.

6.2 Termination of Government Contract. If a Government Contract between TennCare and Amerigroup terminates, expires or ends for any reason or is modified to eliminate a Medicaid Program, this Attachment shall have no further force or effect with respect to the applicable Medicaid Program. In the event of said termination, Provider shall immediately make available to TennCare, or its designees, in a usable form, any or all records, whether medical or financial, related to Provider's activities undertaken pursuant to the Government Contract. The provision of such records shall be at no expense to TennCare or its designees.

6.3 Effect of Termination. Following termination of this Attachment, the remainder of the Agreement shall continue in full force and effect, if applicable. In addition, upon termination of this Attachment but subject to the Continuation of Care provision(s) and applicable Regulatory Requirements, any references to services, reimbursement, or participation in Networks related to the Medicaid Program are hereby terminated in full and shall have no further force and effect.

ARTICLE VII
GENERAL PROVISIONS

7.1 Regulatory Amendment. Notwithstanding the Amendment provision in the Agreement, this Attachment shall be automatically modified to conform to required changes to Regulatory Requirements related to Medicaid Programs without the necessity of executing written amendments. TennCarereserves the right to direct Amerigroup to terminate or modify this Attachment when TennCare determines it to be in the best interest of the State of Tennessee.

7.2 Inconsistencies. In the event of an inconsistency between terms and conditions of this Attachment and the terms and conditions as set forth in the Agreement, the terms and conditions of this Attachment shall govern. Except as set otherwise forth herein, all other terms and conditions of the Agreement remain in full force and effect.

7.3 Disclosure Requirements. In accordance with Regulatory Requirements, Provider agrees to disclose complete ownership, control and relationship information ("Disclosures") in accordance with 42 CFR 455.100 through 455.106. Provider further agrees to notify Amerigroup within fourteen (14) days of any changes to the Disclosures. Providers that bill and/or receive TennCare funds as the result of the Agreement/contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B, Amerigroup and TennCare policies and procedures, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form or disclosing entity, at least once every three (3) years, and at any time upon request. Providers may satisfy this requirement may be satisfied through TennCare's provider registration process. Failure to provide Disclosures as required under Regulatory Requirements shall be deemed a material breach of this Attachment and the Agreement.

7.4 Subcontracting Requirements. In addition to the Use of Subcontractors provision in the Agreement, Provider shall obtain written approval from Amerigroup prior to execution of all Subcontracts for the provision of services to Amerigroup Medicaid Members, subject to Amerigroup's submission and receipt of approval of such Subcontracts by the Tennessee Department of Commerce and Insurance. The word "subcontract" here has its usual legal meaning not the defintion used in the CRA. Failure by Provider to obtain written approval from Amerigroup for a Subcontract may lead to the contract being declared null and voidby Amerigroup. Claims submitted by the Subcontractor or by Provider for services furnished by the unapproved subcontractor are considered to be improper payments and may be considered false claims. Any such improper payments may be subject to action under federal and state false claims statutes or be subject to be recouped by Amerigroup and/or Tenncare as overpayment.

7.5 Survival of Attachment. Provider further agrees that: (1) the hold harmless and continuation of care sections shall survive the termination of this Attachment or disenrollment of the Medicaid Member; and (2) these provisions supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and a Medicaid Member or persons acting on their behalf that relates to liability for payment for, or continuation of, Medicaid Covered Services provided under the terms and conditions of these provisions.

Medicare Participation Attachment

MEDICARE ADVANTAGE
PARTICIPATION ATTACHMENT TO THE
AMERIGROUP
PROVIDER AGREEMENT

This is a Medicare Advantage Participation Attachment ("Attachment") to the Amerigroup Provider Agreement ("Agreement"), entered into by and between Amerigroup and Provider and is incorporated into the Agreement.

ARTICLE I
DEFINITIONS

The following definitions shall apply to this Attachment. Terms not otherwise defined in this Attachment shall carry the meaning set forth in the Agreement.

All references to "Amerigroup" under this Medicare Advantage Participation Attachment shall mean and refer to AMERIGROUP Texas, Inc.

"Clean Claim" means a Claim that has no defect or impropriety, including a lack of required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payment from being made on the Claim. A Claim is clean even though Amerigroup refers it to a medical specialist within Amerigroup for examination. If additional documentation (e.g., a medical record) involves a source outside Amerigroup, then the Claim is not considered clean.

"CMS" is defined as set forth in Article I of the Agreement.

"Downstream Entity(ies)" means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between Amerigroup and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

"Emergency Condition" is defined as set forth in the ACS.

"Emergency Services" is defined as set forth in the ACS.

"First Tier Entity(ies)" means any party that enters into a written agreement, acceptable to CMS, with Amerigroup to provide administrative services or health care services for a Medicare eligible Member under the Medicare Advantage Program.

"Medically Necessary" or "Medical Necessity" means care for which CMS determines is reasonable and necessary under Medicare for services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of MA Member's medical condition and meet accepted standards of medical practice.

"Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Act, as then constituted or later amended.

"Medicare Advantage Covered Services ("MA Covered Services")" means, for purposes of this Attachment, only those Covered Services provided under Amerigroup's Medicare Advantage Program.

"Medicare Advantage Member ("MA Member")" means, for purposes of this Attachment, a Member who is covered under a Medicare agreement between CMS and Amerigroup under Part C of Title XVIII of the Social Security Act ("Medicare Advantage Program") and for Amerigroup's DSNP Medicare Program, the beneficiary is also entitled to Medicaid under Title XIX of the Social Security Act, see 42 USC §1396 et seq..

"Medicare Advantage Network" means Network of Providers that provides MA Covered Services to MA Members.

"Related Entity(ies)" means any entity that is related to Amerigroup by common ownership or control and (1) performs some of Amerigroup's management functions under contract or delegation; (2) furnishes services to MA Member under an oral or written agreement; or (3) leases real property or sells materials to Amerigroup at a cost of more than twenty-five hundred dollars ($2,500) during a contract period.

"Urgently Needed Care" means MA Covered Services provided when a MA Member is either: (1) temporarily absent from Amerigroup's Medicare Advantage service area and such MA Covered Services are Medically Necessary and immediately required: (a) as a result of an unforeseen illness, injury, or condition; and (b) it was not reasonable, given the circumstances, to obtain the services through Amerigroup's Medicare Advantage Network; or (2) under unusual and extraordinary circumstances, the MA Member is in the service area but Amerigroup's Network is temporarily unavailable or inaccessible and such MA Covered Services are Medically Necessary and immediately required: (a) as a result of an unforeseen illness, injury, or condition; and (b) it was not reasonable, given the circumstances, to obtain the services through Amerigroup's Medicare Advantage Network.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Participation-Medicare Advantage. As a participant in Amerigroup's Medicare Advantage Network, Provider will render MA Covered Services to MA Members enrolled in Amerigroup's Medicare Advantage Program in accordance with the terms and conditions of the Agreement and this Attachment. Except as set forth in this Attachment, or in the ACS, all terms and conditions of the Agreement will apply to Provider's participation in Amerigroup's Medicare Advantage Program(s). The terms and conditions set forth in this Attachment are limited to the provision of and payment for Health Services provided to MA Members. This Agreement does not apply to any of Amerigroup's Medicare Advantage Private Fee for Service or Medical Savings Account Programs. If Amerigroup contracts with a third party to manage all or any portion of its Medicare Advantage Network, then Provider shall be required to contract separately with such third party to maintain its status as a Participating Provider for such Network(s).

2.1.1 New Programs. Provider acknowledges that Amerigroup has or may develop Medicare Advantage Networks that support certain products, programs or plans with specific participation criteria that may include but are not limited to, quality and/or cost of care metrics. Pursuant to this Agreement, Provider shall be a Participating Provider in any such Network unless Amerigroup notifies Provider in writing to the contrary. Amerigroup shall notify Provider sixty (60) days in advance of any specific Network participation criteria. Any notice of non-inclusion in any of Amerigroup's Medicare Advantage Network(s) shall be provided in writing sixty (60) days in advance.

2.2 This provision intentionally left blank.

2.3 Accountability/Oversight. Amerigroup delegates to Provider its responsibility under its Medicare Advantage contract with CMS to provide the services as set forth in this Attachment to MA Members. Amerigroup may revoke this delegation, including, if applicable, the delegated responsibility to meet CMS reporting requirements, and thereby terminate this Attachment if CMS or Amerigroup determine that Provider has not performed satisfactorily. Such revocation shall be consistent with the termination provisions of the Agreement and this Attachment. Performance of Provider shall be monitored by Amerigroup on an ongoing basis as provided for in this Attachment. Provider further acknowledges that Amerigroup shall oversee and is accountable to CMS for the functions and responsibilities described in the Medicare Advantage Regulatory **Requirements and ultimately responsible to CMS for the performance of all services. Further, Provider** acknowledges that Amerigroup may only delegate such functions and responsibilities in a manner consistent with the standards as set forth in 42 CFR § 422.504(i)(4).

2.4 Accountability/Credentialing. Both parties acknowledge that accountability shall be in a manner consistent with the requirements as set forth in 42 CFR § 422.504(i)(4). Therefore the following are acceptable for purposes of meeting these requirements:

2.4.1 The credentials of medical professionals affiliated with Amerigroup or Provider will be either reviewed by Amerigroup, if applicable; or

2.4.2 The credentialing process will be reviewed and approved by Amerigroup and Amerigroup must audit Provider's credentialing process and/or delegate's credentialing process on an ongoing basis.

2.5 Medicare Provider. Provider must have a provider and/or supplier agreement, whichever is applicable, with CMS that permits Provider to provide services under original Medicare.

ARTICLE III
ACCESS: RECORDS/FACILITIES

3.1 Inspection of Books/Records. Provider acknowledges that Amerigroup, Health and Human Services Department ("HHS"), the Comptroller General, or their designees have the right to timely access to inspect, evaluate and audit any books, contracts, medical records, patient care documentation, and other records of Provider, or his/her/its First Tier, Downstream and Related Entities, including but not limited to subcontractors or transferees involving transactions related to Amerigroup's Medicare Advantage contract through ten (10) years from the final date of the contract period or from the date of the completion of any audit, or for such longer period provided for in 42 CFR § 422.504(e)(4) or other Regulatory Requirements, whichever is later. For the purposes specified in this section, Provider agrees to make available Provider's premises, physical facilities and equipment, records relating to Amerigroup's MA Member, including access to Provider's computer and electronic systems and any additional relevant information that CMS may require. Provider acknowledges that failure to allow HHS, the Comptroller General or their designees the right to timely access under this section can subject Provider to a fifteen thousand dollar ($15,000) penalty for each day of failure to comply.

3.2 Confidentiality. In addition to the confidentiality requirements under the Agreement, each party agrees to abide by all Regulatory Requirements applicable to that party regarding confidentiality and disclosure for mental health records, medical records, other health information, and MA Member information. Provider agrees to maintain records and other information with respect to MA Member in an accurate and timely manner; to ensure timely access by MA Member to the records and information that pertain to him/her; and to safeguard the privacy of any information that identifies a particular MA Member. Information from, or copies of, records may be released only to authorized individual. Provider must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released only in accordance with Regulatory Requirements, court orders or subpoenas. Both parties acknowledge that Amerigroup, HHS, the Comptroller General or its designee have the right, pursuant to section 3.1 above, to audit and/or inspect Provider's premises to monitor and ensure compliance with the CMS requirements for maintaining the privacy and security of protected health information ("PHI") and other personally identifiable information ("PII") of MA Member.

ARTICLE IV
ACCESS: BENEFITS AND COVERAGE

4.1 Non-Discrimination. Provider shall not deny, limit, or condition the furnishing of Health Services to MA Member of Amerigroup on the basis of any factor that is related to health status, including, but not limited to medical condition; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; or disability.

4.2 Direct Access. Provider acknowledges that MA Member may obtain covered mammography screening services and influenza vaccinations from a participating provider without a referral and that MA Member who are women may obtain women's routine and preventive Health Services from a participating women's health specialist without a referral.

4.3 No Cost Sharing. Provider acknowledges that covered influenza vaccines and pneumococcal vaccines are not subject to MA Member Cost Share obligations.

4.4 Timely Access to Care. Provider agrees to provide MA Covered Services consistent with Amerigroup's: (1) standards for timely access to care and member services; (2) policies and procedures that allow for MA Member Medical Necessity determinations; and (3) policies and procedures for Provider's consideration of MA Member input in the establishment of treatment plans.

4.5 Accessibility to Care. A Provider who is a primary care provider, or a gynecologist or obstetrician, shall provide Health Services or make arrangements for the provision of Health Services to MA Member on a twenty-four (24) hour per day, seven (7) day a week basis to assure availability, adequacy and continuity of care to MA Member. In the event Provider is not one of the foregoing described providers, then Provider shall provide Health Services to MA Member on a twenty-four (24) hour per day, seven (7) day a week basis or at such times as Health Services are typically provided by similar providers to assure availability, adequacy, and continuity of care to MA Member. If Provider is unable to provide Health Services as described in the previous sentence, Provider will arrange for another Participating Provider to cover Provider's patients in Provider's absence.

ARTICLE V

BENEFICIARY PROTECTIONS

5.1 Cultural Competency. Provider shall ensure that MA Covered Services rendered to MA Members, both clinical and non-clinical, are accessible to all MA Members, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, the homeless, and MA Members with physical and mental disabilities. Provider must provide information regarding treatment options in a cultural-competent manner, including the option of no treatment. Provider must ensure that MA Members with disabilities have effective communications with participants throughout the health system in making decisions regarding treatment options.

5.2 Health Assessment. Provider acknowledges that Amerigroup has procedures approved by CMS to conduct a health assessment of all new MA Members within ninety (90) days of the effective date of their enrollment. Provider agrees to cooperate with Amerigroup as necessary in performing this initial health assessment.

5.3 Identifying Complex and Serious Medical Condition. Provider acknowledges that Amerigroup has procedures to identify MA Members with complex or serious medical conditions for chronic care improvement initiatives; and to assess those conditions, including medical procedures to diagnose and monitor them on an ongoing basis; and establish and implement a treatment plan appropriate to those conditions, with an adequate number of direct access visits to specialists to accommodate the treatment plan. To the extent applicable, Provider agrees to assist in the development and implementation of the treatment plans and/or chronic care improvement initiatives.

5.4 Advance Directives. Provider shall establish and maintain written policies and procedures to implement MA Members' rights to make decisions concerning their health care, including the provision of written information to all adult MA Members regarding their rights under Regulatory Requirements to make decisions regarding their right to accept or refuse medical treatment and the right to execute an advance medical directive. Provider further agrees to document or oversee the documentation in the MA Members' medical records whether or not the MA Member has an advance directive, that Provider will follow state and federal requirements for advance directives and that Provider will provide for education of his/her/its staff and the community on advance directives.

5.5 Standards of Care. Provider agrees to provide MA Covered Services in a manner consistent with professionally recognized standards of health care.

5.6 Hold Harmless. In addition to the hold harmless provision in the Agreement, Provider agrees that in no event, including but not limited to non-payment by Amerigroup, insolvency of Amerigroup or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a MA Member or persons other than Amerigroup acting on their behalf for MA Covered Services provided pursuant to this Attachment. This section does not prohibit the collection of supplemental charges or Cost Shares on Amerigroup's behalf made in accordance with the terms of the MA Member's Health Benefit Plan or amounts due for services that have been correctly identified in advance as a non-MA Covered Service, subject to medical coverage criteria, with appropriate disclosure to the MA Member of their financial obligation. This advance notice must be provided in accordance with the CMS regulations for Medicare Advantage organizations. CMS regulations require that a coverage determination be made with a standard denial notice (Notice of Denial of Medical Coverage (or Payment)/CMS-10003) for a non-Covered Service when such Health Service is typically not covered, but could be covered under specific conditions. If prior to rendering the non-Covered Service, Provider obtains, or instructs the MA Member to obtain, a coverage determination of a non-Covered Service(s), the MA Member can be held financially responsible for non-Covered Services. However, if a service or item is never covered by Amerigroup, such as a statutory exclusion, and the MA Member's Evidence of Coverage ("EOC") clearly specifies that the service or item is never covered, the Provider does not have to seek a coverage determination from Amerigroup in order to hold the MA Member responsible for the full cost of the service or item. Additional information, related requirements and the process to request a coverage determination can be found in the Provider Guidebook. Both Parties agree that failure to follow the CMS regulations can result in Provider's financial liability.

5.6.1 Dual Eligibles. Provider further agrees that for MA Members who are dual eligible beneficiaries for Medicare and Medicaid, that Provider will ensure he/she/it will not bill the MA Member for Cost Sharing that is not the MA Member's responsibility and such MA Members will not be held liable for Medicare Parts A and B Cost Sharing when the State is liable for the Cost Sharing. In addition, Provider agrees to accept Amerigroup payment as payment in full or Provider should bill the appropriate state source.

5.7 Continuation of Care-Insolvency. Provider agrees that in the event of Amerigroup's insolvency, termination of the CMS contract or other cessation of operations, MA Covered Services to MA Members will continue through the period for which the premium has been paid to Amerigroup, and services to MA Members confined in an inpatient hospital on the date of termination of the CMS contract or on the date of insolvency or other cessation of operations will continue until their discharge.

5.8 Out of Network Referrals and Transfers. In addition to the Cost Effective Care provision in the Agreement, Provider shall seek authorization from Amerigroup prior to referring or transferring an MA Member to a non-Participating Provider. For Amerigroup's HMO Medicare Advantage Network, if a Participating Provider is not accessible or available for a referral or transfer, then Provider shall call Amerigroup for an authorization. If, however, a Participating Provider is accessible and available for a referral or transfer, then Provider shall transfer or refer the MA Member to such Participating Provider. For Amerigroup's PPO MA Members, Provider shall advise the MA Member that an out of network referral is being made, and shall ensure that the MA Member understands and agrees to be financially responsible for any additional costs related to such out of network service.

ARTICLE VI
COMPENSATION AND AUDIT

6.1 Submission and Adjudication of Medicare Advantage Claims. Unless otherwise instructed in the provider manual(s) or Policies applicable to Amerigroup's Medicare Advantage Program, or unless required by Regulatory Requirements, Provider shall submit Claims to Amerigroup, using appropriate and current Coded Service Identifier(s), within ninety (90) days from the date the Health Services are rendered or Amerigroup will refuse payment. If Amerigroup is the secondary payor, the ninety (90) day period will not begin until Provider receives notification of primary payor's responsibility.

6.1.1 Provider agrees to provide to Amerigroup, unless otherwise instructed, at no cost to Amerigroup the MA Member, all information necessary for Amerigroup to determine its payment liability. Such information includes, without limitation, accurate and Clean Claims for MA Covered Services. Once Amerigroup determines Amerigroup has any payment liability, all Clean Claims will be paid in accordance with the terms and conditions of a MA Member's Health Benefit Plan, the ACS, and the provider manual(s).

6.1.2 Provider agrees to submit Claims in a format consistent with industry standards and acceptable to Amerigroup either (a) electronically through electronic data interchange ("EDI"), or (b) if electronic submission is not available, utilizing paper forms as defined by the National Uniform Claim Committee ("NUCC").

6.1.3 If Amerigroup asks for additional information so that Amerigroup may process the Claim, Provider must provide that information within sixty (60) days, or before the expiration of the ninety (90) day period referenced in section 6.1 above, whichever is longer.

6.2 Prompt Payment. Amerigroup agrees to make best efforts to pay a majority of Clean Claims for MA Covered Services submitted by or on behalf of MA Members, within forty-five (45) days of receipt by Amerigroup. Amerigroup agrees to make best efforts to pay all remaining Clean Claims for MA Covered Services submitted by or on behalf of MA Members, within sixty (60) days of receipt by Amerigroup. Amerigroup agrees to make best efforts to pay all non-Clean Claims for MA Covered Services submitted by or on behalf of MA Members within sixty (60) days of receipt by Amerigroup of the necessary documentation to adjudicate the Clean Claim.

6.3 Audit for Compliance with CMS Guidelines. Notwithstanding any other terms and conditions of the Agreement, Amerigroup has the same rights as CMS, to review and/or Audit and, to the extent necessary recover payments on any claim for MA Covered Services rendered pursuant to this Agreement to insure compliance with CMS Regulatory Requirements.

ARTICLE VII
REPORTING AND DISCLOSURE REQUIREMENTS

7.1 Risk Adjustment Documentation and Coding Reviews and Audits. Provider is required in accordance with 42 CFR § 422.310(e) to submit medical records for MA Members for the purpose of validation of Risk Adjustment Data (as defined below in section 7.2) as requested by Amerigroup. Provider is also required to comply with

all other medical record requests from Amerigroup for other governmental (e.g., CMS, Office of Inspector General (OIG)) and/or Amerigroup documentation and coding review and audit activities. Accordingly, Amerigroup, or its designee, shall have the right, as set forth in section 3.4 of the Agreement to obtain copies of such documentation on at least an annual basis or otherwise as Amerigroup may reasonably require. Provider agrees to provide copies of the requested medical records to Amerigroup or its designee, within fourteen (14) calendar days from Amerigroup's, or its designee's, and/or any Agency's written request, unless sooner required by CMS or such other Agency. Such records shall be provided to Amerigroup or its designee, or a governmental agency, at no additional cost to Amerigroup, its designee or such Agency. Provider also agrees to participate in education and/or remediation, as required by Amerigroup, based on the outcome of any documentation and coding reviews and/or audits.

7.2 Data Reporting Requirements. Provider shall provide to Amerigroup all information necessary for or requested by Amerigroup to enable Amerigroup to meet its data reporting and submission obligations to CMS, including but not limited to, data necessary to characterize the context and purpose of each encounter between a MA Member and the Provider ("Risk Adjustment Data"), and data necessary for or requested by Amerigroup to enable Amerigroup to meet its reporting obligations under 42 CFR §§ 422.516 and 422.310 or under any subsequent or additional regulatory provisions or CMS guidance. In accordance with CMS Regulatory Requirements, Amerigroup reserves the right to assess Provider for any penalties resulting from Provider's submission of false data.

7.3 Risk Adjustment Data Submission. Provider shall submit all diagnosis data generated in connection with this Agreement by way of filing a Claim with Amerigroup. Where Provider identifies supplemental diagnosis data through retrospective medical chart review or other processes, Provider shall file an amended Claim containing the supplemental diagnosis data. If an amended Claim cannot be filed and Provider wants to submit supplemental diagnosis data, then Provider shall ensure that a Claim (i.e., the associated encounter data record) has already been submitted for the original MA Member/Provider encounter. This Claim must be (i) from the same date of service, (ii) having the same Provider identification number, (iii) with the same MA Member information, and (iv) containing the same procedural information as the supplemental data identified through the retrospective medical chart review or other processes. Amerigroup requires submission of the original Claim prior to the submission of supplemental data to ensure the two (2) can be linked.

Supplemental diagnosis data shall be submitted in a format specified by Amerigroup. If Provider reasonably determines that a Provider is unable to meet these requirements, then Provider must inform Amerigroup within a reasonable time, but no later than thirty (30) days after receiving knowledge, actual or constructive of such inability, and Amerigroup shall have the right to validate the data by auditing medical records and/or data generation processes, or by requesting additional data and/or documentation from Provider to confirm the acceptability of the data. For purposes of clarity, Provider shall cooperate with any such requests by Amerigroup or on Amerigroup's behalf, as set forth in this Agreement. If Provider identifies data corrections (e.g., prior data submissions not supported in the medical record), then Provider shall promptly inform Amerigroup and submit data corrections to Amerigroup in a format specified by Amerigroup as soon as reasonably possible, but in no event later than thirty (30) days after identifying.

7.4 Risk Adjustment Data. Provider's Risk Adjustment Data shall include all information necessary for or requested by Amerigroup to enable Amerigroup to submit such data to CMS as set forth in 42 CFR § 422.310 or any subsequent or additional regulatory provisions or CMS guidance. If Provider fails to submit accurate, complete, and truthful Risk Adjustment Data in the format described in 42 CFR § 422.310 or any subsequent or additional regulatory provisions or CMS guidance, then this may result in denials and/or delays in payment of Provider's Claims. Amerigroup will make best efforts to work with Provider to resolve Risk Adjustment Data format and/or processing issues.

7.5 Accuracy of Risk Adjustment Data. Risk Adjustment Data submitted by Provider must be accurate, complete, and truthful. By submitting Risk Adjustment Data to Amerigroup, Provider is certifying and attesting to the accuracy, completeness, and truthfulness of such Risk Adjustment Data. If requested by Amerigroup, Provider shall execute such further certifications or attestations as to the accuracy, completeness, and truthfulness of such Risk Adjustment Data as Amerigroup may require.

ARTICLE VIII
QUALITY ASSURANCE/QUALITY IMPROVEMENT REQUIREMENTS

8.1 Independent Quality Review Organization. Provider agrees to comply and cooperate with an independent quality review and improvement organization's activities pertaining to the provision of MA Covered Services for MA Member.

8.2 Compliance with Amerigroup Medical Management Programs. Provider agrees to comply with Amerigroup's medical policies, quality improvement and performance improvement programs, and medical management programs to the extent provided to or otherwise made available to Provider in advance.

8.3 Consulting with Participating Providers. Amerigroup agrees to consult with Participating Providers regarding its medical policies, quality improvement program and medical management programs and ensure that practice guidelines and utilization management guidelines: (1) are based on reasonable medical evidence or a consensus of health care professionals in the particular field; (2) consider the needs of the enrolled population; (3) are developed in consultation with participating physicians; (4) are reviewed and updated periodically; and (5) are communicated to providers and, as appropriate, to MA Member. Amerigroup also agrees to ensure that decisions with respect to utilization management, MA Member education, coverage of Health Services, and other areas in which the guidelines apply are consistent with the guidelines.

ARTICLE IX
COMPLIANCE

9.1 Compliance: Medicare Laws/Regulations. Provider agrees to comply, and to require any of his/her/its subcontractors to comply, with all applicable Medicare Regulatory Requirements and CMS instructions. Further, Provider agrees that any MA Covered Services provided by Provider or his/her/its subcontractors to or on the behalf of Amerigroup's MA Member will be consistent with and will comply with Amerigroup's Medicare Advantage contractual obligations.

9.2 Compliance: Exclusion from Federal Health Care Program. Provider may not employ, or subcontract with an individual, or have persons with ownership or control interests, who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, or social services programs under Title XX of the Social Security Act, and thus have been excluded from participation in any federal health care program under §§1128 or 1128A of the Act (or with an entity that employs or contracts with such an individual) for the provision of any of the following: healthcare, utilization review, medical social work, or administrative services.

9.3 Compliance: Appeals/Grievances. Provider agrees to comply with Amerigroup's policies and procedures in performing his/her/its responsibilities under the Agreement. Provider specifically agrees to comply with Medicare Regulatory Requirements regarding MA Member appeals and grievances and to cooperate with Amerigroup in meeting its obligations regarding MA Member appeals, grievances and expedited appeals, including the gathering and forwarding of information in a timely manner and compliance with appeals decisions.

9.4 Compliance: Policy and Procedures. Provider agrees to comply with Amerigroup's policy and procedures in performing his/her/its responsibilities under the Agreement and this Attachment including any supplementary documents that pertain to Amerigroup's Medicare Advantage Program such as the provider manual(s).

9.5 Illegal Remunerations. Both parties specifically represent and warrant that activities to be performed under this Agreement are not considered illegal remunerations (including kickbacks, bribes or rebates) as defined in 42 USCA § 1320(a)-7b.

9.6 Compliance: Training, Education and Communications. In accordance with CMS requirements, Provider agrees and certifies that it, as well as its employees, subcontractors, Downstream Entities, Related Entities and agents who provide services to or for Amerigroup's Medicare Advantage and/or Part D MA Members or to or for Amerigroup itself shall conduct general compliance and fraud, waste and abuse training, education and/or communications annually or as otherwise required by Regulatory Requirements, and must be made a part of the orientation for a new employee, new First Tier Entities, Downstream Entities, or Related Entities, and for all new appointments of a chief executive, manager, or governing body member who performs leadership and/or oversight over the service provided under the Agreement. Provider or its subcontractors or Downstream Entities shall ensure that their general compliance and fraud, waste and abuse training and education is comparable to the elements, set forth in Amerigroup's Standards of Ethical Business Conduct and shall provide documentation to demonstrate compliance prior to execution of the Agreement and annually thereafter. In addition, Provider is responsible for documenting applicable employee's, subcontractor's, Downstream Entity's, Related Entity's and/or agent's attendance and completion of such training on an annual

basis. Provider shall provide such documentation to Amerigroup and as required to support a Amerigroup or CMS audit. If necessary and upon request, Amerigroup or its designee can make such compliance training, education and lines of communication available to Provider in either electronic, paper or other reasonable medium.

9.7 Federal Funds. Provider acknowledges that payments Provider receives from Amerigroup to provide MA Covered Services to MA Members are, in whole or part, from federal funds. Therefore, Provider and any of his/her/its subcontractors are subject to certain Regulatory Requirements that are applicable to Members and entities receiving federal funds, which may include but is not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 80; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973 as implemented by 45 CFR Part 84, lobbying restrictions as implemented by 45 CFR Part 93 and 31 USC 1352 and any other regulations applicable to recipients of federal funds.

ARTICLE X
MARKETING

10.1 Approval of Materials. Both parties agree to comply, and to require any of his/her/its subcontractors to comply, with all applicable Regulatory Requirements, CMS instructions, and marketing activities under this Agreement, including but not limited to, the Medicare Marketing Guidelines for Medicare Managed Care Plans and any requirements for CMS prior approval of materials. Any printed materials, including but not limited to letters to Amerigroup MA Members, brochures, advertisements, telemarketing scripts, packaging prepared or produced by Provider or any of his/her/its subcontractors pursuant to this Agreement must be submitted to Amerigroup for review and approval at each planning stage (i.e., creative, copy, mechanicals, blue lines, etc.) to assure compliance with Regulatory Requirements. Amerigroup agrees its approval will not be unreasonably withheld or delayed.

ARTICLE XI
TERMINATION

11.1 Notice Upon Termination. If Amerigroup decides to terminate this Attachment, Amerigroup shall give Provider written notice, to the extent required under CMS regulations, of the reasons for the action, including, if relevant, the standards and the profiling data the organization used to evaluate Provider and the numbers and mix of Participating Providers needs. Such written notice shall also set forth Provider's right to appeal the action and the process and timing for requesting a hearing.

11.2 Effect of Termination. Following termination of this Attachment, the remainder of the Agreement shall continue in full force and effect, if applicable. In addition, upon termination of this Attachment but subject to the Continuation of Care provision(s) and applicable Regulatory Requirements, any references to services, reimbursement, or participation in Networks related to the Medicare Advantage Program are hereby terminated in full and shall have no further force and effect.

11.3 Termination Without Cause. Either party may terminate this Attachment without cause by giving at least one hundred twenty (120) days prior written notice of termination to the other party.

ARTICLE XII
GENERAL PROVISIONS

12.1 Inconsistencies. In the event of an inconsistency between terms of this Attachment and the terms and conditions as set forth in the Agreement, the terms and conditions of this Attachment shall govern. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

12.2 Interpret According to Medicare Laws. Provider and Amerigroup intend that the terms of the Agreement and this Attachment as they relate to the provision of MA Covered Services under the Medicare Advantage Program shall be interpreted in a manner consistent with applicable requirements under Medicare Regulatory Requirements.

12.3 Subcontractors. In addition to the Use of Subcontractors provision of the Agreement, Provider agrees that if Provider enters into subcontracts to perform services under the terms of this Attachment, Provider's subcontracts shall include: (1) an agreement by the subcontractor to comply with all of Provider's obligations

in the Agreement and this Attachment; (2) a prompt payment provision as negotiated by Provider and the subcontractor; (3) a provision setting forth the term of the subcontract (preferably one (1) year or longer); and (4) dated signatures of all the parties to the subcontract.

12.4 Delegated Activities. If Amerigroup has delegated activities to Provider, then Amerigroup will provide the following information to Provider and Provider shall provide such information to any of its subcontracted entities:

12.4.1 A list of delegated activities and reporting responsibilities;

12.4.2 Arrangements for the revocation of delegated activities;

12.4.3 Notification that the performance of the contracted and subcontracted entities will be monitored by Amerigroup;

12.4.4 Notification that the credentialing process must be approved and monitored by Amerigroup; and

12.4.5 Notification that all contracted and subcontracted entities must comply with all applicable Medicare Regulatory Requirements and CMS instructions.

12.5 Delegation of Provider Selection. In addition to the responsibilities for delegated activities as set forth herein, to the extent that Amerigroup has delegated selection of providers, contractors, or subcontractor to Provider, Amerigroup retains the right to approve, suspend, or terminate any such arrangement.

12.6 Survival of Attachment. Provider further agrees that: (1) the hold harmless and continuation of care sections shall survive the termination of this Attachment or disenrollment of the MA Member; and (2) these provisions supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and an MA Member or persons acting on their behalf that relates to liability for payment for, or continuation of, MA Covered Services provided under the terms and conditions of these clauses.

12.7 Attachment Amendment. Notwithstanding the Amendment provision in the Agreement, this Attachment shall be automatically modified to conform to required changes to Regulatory Requirements related to Medicare Advantage Programs without the necessity of executing written amendments. For amendments not required by Regulatory Requirements related to Medicare Advantage Programs, Amerigroup shall make a good faith effort to provide notice to Provider at least thirty (30) days in advance of the effective date of the amendment.

12.8 References to Regulatory Requirements. All references in this Attachment to any Regulatory Requirement shall mean and refer to the existing law, regulation or guidance as of the Effective Date of the Agreement and any subsequent, successor or additional Regulatory Requirements related to the same subject matter.