Amerigroup

Provider Quick Reference Guide

Precertification/notification requirements
Important phone numbers ■ Revenue codes

Tennessee

https://provider.amerigroup.com/TN
800-454-3730
866-840-4991 (Long-term services and support)

TNAGP-CD-018488-23-CPN18476

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

For additional information about benefits and services, see your provider manual. The most recent, full version of the provider manual is located at **https://provider.amerigroup.com/TN** > Resources > Policies, Guidelines and Manuals. If you have questions about this Quick Reference Card (QRC) or have a recommendation to improve it, please call your local Provider Relations representative. We want to hear from you and improve our service so you can focus on serving your patients.

Precertification or prior authorization: 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. If a service requires precertification, the provider must contact Amerigroup Community Care via phone, facsimile or electronic communication to obtain approval prior to the rendering of services. All relevant clinical information needed to determine medical necessity must be included in the request for prior authorization.

Concurrent review: This review is conducted for admissions which initially did not obtain prior authorization due to emergent status and for reviews during the length of stay. Notification with supporting clinical is required to be submitted within one business day of admission and is subject to medical necessity review. Clinical reviews will continue intermittently during the length of the stay.

Notification: 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 for services classified as notification only. 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. Give us notification prior to rendering services outlined in this document.

Precertification/notification instructions and definitions:

When is it appropriate to use urgent, STAT or ASAP on a request?

Under *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:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment
- Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request

Request precertification and give us notification:

- **Online using our preferred method at: https://provider.amerigroup.com/TN**
- **By phone: 800-454-3730**
- **By fax: 800-964-3627**
  - Fax behavioral health information to the following numbers:
    - Inpatient: **1-877-434-7578**
    - Outpatient: **1-800-964-3627**
- For emergency or urgent services, give us notification within 24 hours or the next business day.

For code-specific requirements for all services, visit **https://providers.amerigroup.com/TN** > Resources > Precertification Lookup Tool.

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

Cardiac rehabilitation

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* from the *Quick Tools* menu on our website.
- Precertification is required for coverage of inpatient chemotherapy.

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.

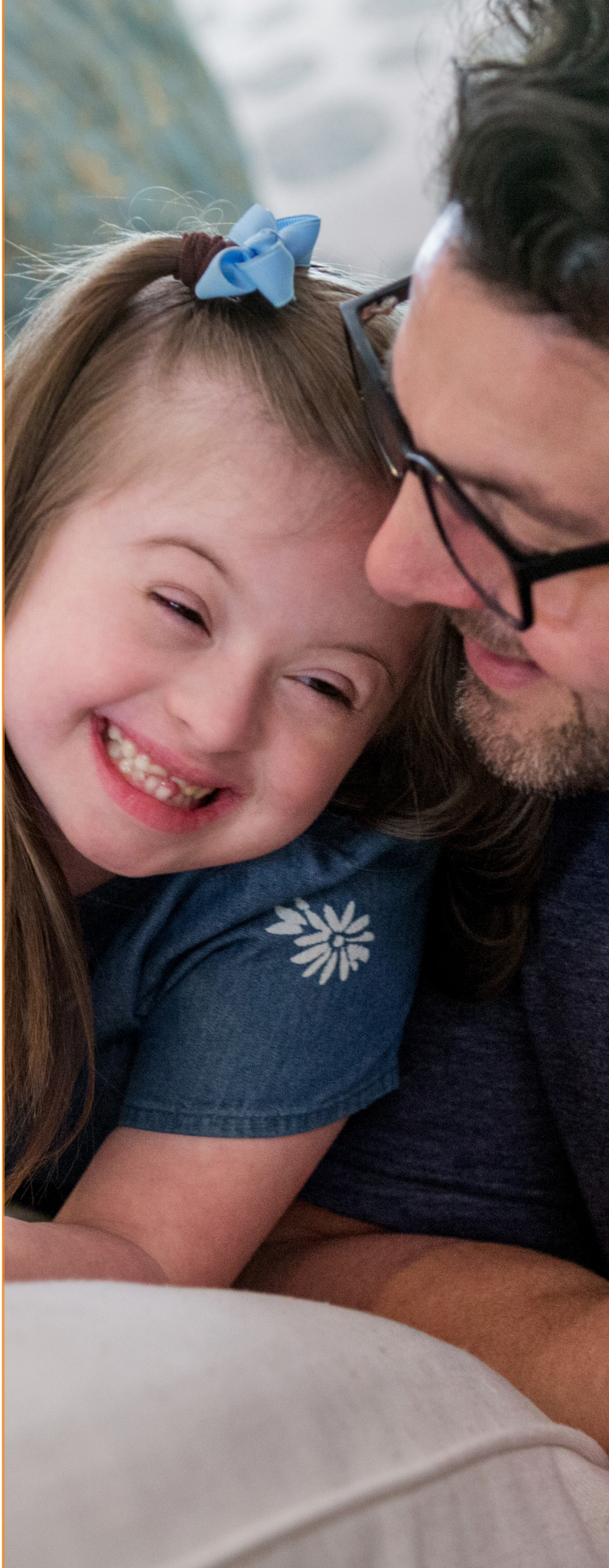
Mandatory Outpatient Treatment: Amerigroup will provide mandatory outpatient treatment for members found not guilty by reason of insanity following a 30- to 60-day inpatient evaluation or for other reasons. Treatment can be terminated only by the court.

Dermatology services

- No precertification is required for Evaluation and Management (E&M, testing and most procedures).
- Services considered cosmetic in nature or related to previous cosmetic procedures are not covered.
- See the *Diagnostic Testing* section of this QRC for more information.

Diagnostic testing

- No precertification is required for routine diagnostic testing.
- Precertification is required for coverage of video EEG.
- Precertification through Carelon Medical Benefits Management, Inc. is required for coverage of CTA, MRA, MRI, CAT scan, nuclear cardiology, stress echocardiography, transesophageal echocardiography, echocardiogram and PET scan. Contact Carelon Medical Benefits Management, Inc. by phone at **800-714-0040** or online at **www.carelon.com**. Carelon Medical Benefits Management, Inc. will locate a preferred imaging facility from the Amerigroup network of radiology service providers.
- No precertification is required for tests performed in conjunction with an inpatient stay.



Genetic testing

- If precertification is required, services will be provided through Carelon Medical Benefits Management, Inc.
- Clinical criteria used to determine medical necessity of these services can be found on our provider website at **https://providers.amerigroup.com/QuickTools/Pages/MedicalPolicies.aspx**.
- The ordering provider is responsible for obtaining a health services review authorization. To obtain this authorization, you can access Carelon Medical Benefits Management, Inc. at **https://providerportal.com** or **https://www.availity.com**. You can also can contact Carelon Medical Benefits Management, Inc. toll free at **800-714-0040**, Monday to Friday, 7 a.m. to 7 p.m. Central time.
- The **Provider***Portal*℠ is the fastest, easiest way to contact Carelon Medical Benefits Management, Inc. An online application, **Provider***Portal* offers a convenient way to enter your order requests or check on the status of your previous orders. Go to **https://providerportal.com** to begin; registration is required.

Durable medical equipment (DME)

Coordinate all DME referrals through Amerigroup Utilization Management (UM) at **800-454-3730**. You can fax referral requests to **877-423-9958**. Medical necessity is required for all services. All referral requests must contain, at a minimum, the following information:

- First and last name of patient
- Address where 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
- Diagnosis and documentation to support requested service(s) or equipment (for example, sat levels for O2)
- Allergies, disability status, height, weight or diabetic status
- Desired start of care date
- Services or equipment required including size, quantity, frequency, brand, etc.
- Ordering physician name and phone number
- Amerigroup subscriber ID

Educational consultation

No notification or precertification is required for diabetic/nutritional or weight management counseling.

Emergency services

- Members may self-refer.
- No notification is required for emergency care given in the emergency room. If emergency care results in admission, notification to Amerigroup is required within 24 hours or the next business day.
- For observation precertification requirements, see the *Observation* section of this QRC.

ENT services (otolaryngology)

- No precertification is required for network provider E&M testing and most procedures.
- Precertification is required for tonsillectomy and/or adenoidectomy, nasal/sinus surgery and cochlear implant surgery and services.
- See the *Diagnostic testing* section of this QRC for more information.

Family planning/STD care

- 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 (for example, intrauterine device [IUD]).
- Infertility services and treatment are not covered.

Gastroenterology services

No precertification is required for network provider for E&M, testing and most procedures.

- Precertification is required for upper endoscopy and bariatric surgery, including insertion, removal and/or replacement of adjustable gastric restrictive devices and subcutaneous port components.
- See the *Diagnostic testing* section of this QRC for more information.

Hearing aids

- Precertification is required for digital hearing aids for members under 21 years of age.
- Hearing aids, including prescribing, fitting or changing of hearing aids, for members over 21 years of age are not a covered benefit.

Hearing screening

- No notification or precertification is required for coverage of diagnostic and screening tests, hearing aid evaluations and counseling.
- Audiological therapy, training or cochlear implants are not covered for members over 21 years of age.

Home health care

- Precertification is required and can take up to 14 days for a decision. For continuing home care services, the requested should be received at least two weeks prior to the end of the authorization period. In order for home care services to be reviewed, the initial requests must have a current MD order, clinical documentation to include the nurse and/or therapy evaluation. For concurrent home care services, documentation shall include the most current signed 485, nurses/therapy/home health aide notes.
- Covered services include skilled nursing, home health aide, physical, occupational and speech therapy services, and physician-ordered supplies.
- Precertification is required for the following covered services: skilled nursing, home health aide, therapy, home infusion.
- Rehabilitation therapy, drugs and DME require separate precertification.
- Fax number for home health is: **866-920-6003**.

Hospital admission

- Elective admissions require precertification.
- 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.
- No coverage for rest cures, personal comfort and convenience items, services, and supplies not directly related to the care of the patient (such as telephone charges, take-home supplies and similar costs).
- For normal newborn nursery and non-normal newborn admission, please refer to the *Newborn admissions* section.

Laboratory services (outpatient)

All outpatient laboratory tests must be sent to participating outpatient laboratory providers Quest Diagnostics* or LabCorp* or be performed at a CLIA-certified physician's office with the following exceptions:

- Lab services rendered in an emergency room setting
- Lab services rendered in conjunction with hospital observation services: RV0760-V0769
- Lab services required for pre-admission testing for hospital inpatient admission
- Lab services rendered in conjunction with ambulatory surgery services: RV0360-RV0369, RV0481, RV0490-RV0499, RV0720-RV0729, RV0750-RV0759 and RV0790-RV0799

Laboratory services (outpatient) (cont.)

- Lab services that are billed with the following diagnosis codes:
  - Obstetric: O00-O08, O09, O10-O16, O20-O29, O30-O48, O60-O77, O80-O82, O85-O92, O94-O9A, Z30-Z39
  - Chemotherapy: Z51.11, Z92.21, Z01.818
  - Neoplasms: C00-C14, C15-C26, C30-C39, C40-C41, C43-C44, C45-C49, C50, C51-C58, C60-C63, C64-C68, C69-C72, C73-C75, C7A, C7B, C76-C80, C81-C96, D00-D09, D10-D36, D3A, D37-D48, D49
  - Sickle cell: D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.3, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, D57.819
  - Any laboratory services not on the STAT lab list below, performed by a Tennessee hospital or nonparticipating laboratory, will be denied with the following: Service billed not on Amerigroup approved STAT lab list.
  - STAT labs identified by CPT code in Table below:

CPT®	Description
80048	Basic metabolic panel
80051	Electrolyte panel
80076	Hepatic function panel
80156	Carbamazepine; total
80162	Digoxin
81001	Urinalysis by dipstick or tablet reagent; auto with micro
81003	Urinalysis by dipstick or tablet reagent; without micro auto
81025	Urine preg-nancy test visual color compare methods
80329, 80321, 80322	Acetaminophen
80320, 80321, 80322	Alcohol; any specimen except breath
82140	Ammonia
82150	Amylase
82247	Bilirubin; total
82310	Calcium; total
82375	Carbon monoxide; quantitative
82550	Creatine kinase; total
82565	Creatinine; blood
80164	Dipropylacetic acid
80178	Lithium
80184	Phenobarbital
80185	Phenytoin; total
80192	Procainamide; with metabolites
82670	Estradiol
82947	Glucose; quanti-tative blood
83045	Hemoglobin; methemoglobin qualitative
83050	Hemoglobin; methemoglobin quantitative
83690	Lipase
83735	Magnesium
84132	Potassium; serum
84520	Urea nitrogen; quantitative
84702	Gonadotropin chorionic; quantitative
84703	Gonadotropin chorionic; qualitative
85025	Blood count; complete auto and auto differential white blood cell count
85031	Blood count; Hemogram manual complete CBC
80194	Quinidine
80329, 80330, 80331	Salicylate
80198	Theophylline
80200	Tobramycin
81000	Urinalysis by dipstick or tablet reagent for bilirubin, glucose, etc.; nonautomated, with microscopy
85044	Blood count; reticulocyte manual
85045	Blood count; reticulocyte automated
85384	Fibrinogen; activity
85032	Platelet; manual count
85049	Platelet; automated count
85610	Prothrombin time
85384	Fibrinogen; activity
85590	Platelet; manual count
85651	Sedimentation rate erythrocyte; nonautomated
85730	Thromboplastin time par-tial; plasma/whole blood
86308	Heterophile antibodies; screening
87205	Smear, primary source with interpretation; Gram/Giemsa Stain

Medical supplies

Coordinate all medical supply referrals through Amerigroup Utilization Management (UM) at **800-454-3730**. You can fax referral requests to **877-423-9958**. No precertification is required for coverage of disposable medical supplies. Disposable medical supplies are disposed of after use by a single individual. Over-the-counter (OTC) disposable medical supplies are not covered.

All referral requests must contain, at a minimum, the following information:

- First and last name of patient
- Address where 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
- Diagnosis and documentation to support requested service(s) or equipment (for example, sat levels for O2)
- Therapist evaluation for wheelchairs
- Allergies, disability status, height, weight or diabetic status
- Desired start of care date
- Services or equipment required, including size, quantity, frequency, brand, etc.
- CPT codes with the number of units requesting (indicate if the equipment will be a rental or a purchase)
- Ordering physician name and phone number
- Amerigroup subscriber ID

Neurology

- No precertification is required for network providers for E&M and most procedures.
- Precertification is required for neurosurgery, spinal fusion and artificial intervertebral disc surgery.
- See the *Diagnostic testing* section of this QRC for more information.

Newborns

- Newborns with high care needs, which refers to newborns who require a higher level of care associated with the more complex newborn DRG, and those admitted to the Neonatal Intensive Care Unit (NICU) require authorization.
- If a newborn with high care needs admission does not have an approved authorization on file, the claim will be paid at the normal newborn rate if the mother's authorization is on file.
- Normal newborns will be paid using the mother's approved authorization.
- If no authorization is on file for the mother or the newborn, the claim will deny for *No Authorization*.

Observation

- No precertification or notification is required for in-network observation.
- If observation results in admission, notification to Amerigroup is required within 24 hours or one business day.

Obstetrical care

- No precertification is required for coverage of obstetrical (OB) services, including OB 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 newborn information including date of birth, gestational age, birth weight, number of births, and sex.
- OB case management programs are available.
- See the *Diagnostic testing* section of this QRC for more information.

Ophthalmology

- No precertification is required for E&M, testing and most procedures.
- Precertification is required for repair of eyelid defects.
- Services considered cosmetic in nature are not covered.
- See the *Diagnostic testing* section of this QRC for more information.

Oral maxillofacial

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

Otolaryngology (ENT services)

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

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

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

Outpatient/ambulatory surgery

- Precertification requirement is based on the service performed.
- For procedure-specific requirements, see the *Precertification Lookup Tool* on our website.

Pharmacy

Outpatient pharmacy benefits are covered by TennCare through OptumRx.* Bill OptumRx for injectable drugs obtained directly from a pharmacy provider. Some of these drugs require precertification through TennCare to ensure clinical criteria are met. For full details, please refer to the TennCare program.

The injectable drugs covered under the pharmacy benefit, located at **https://www.optumrx.com/oe_tenncare/prescription-drug-list**, are available by having the member obtain the drug through his or her local or specialty pharmacy.

The TennCare pharmacy benefits manager for both TennCare and CoverKids members is OptumRx. Please note the TennCare program has a *Preferred Drug List* and an *Auto Exempt List*. You can access information about the TennCare Pharmacy program at **https://www.optumrx.com/oe_tenncare/landing**.

Products considered non-self-administered and obtained in an office/clinic setting are to be billed to Amerigroup. We reimburse 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.

Specialty pharmacy:
CVS Caremark Medical Specialty,* Monroeville, PA

- To help prevent delays in shipment, the provider will need to remind patients Caremark will contact them prior to dispensing.
- Medical injectables requiring a prior authorization must have an approved prior authorization for Caremark to dispense the medication. Once approval is received, the provider must fax the approval letter and order form to CVS Caremark Medical Specialty.
- Members are not required to pay copays.

Contact information:

- Phone: **800-326-3477**
- Fax: **866-336-8479**

Physical medicine and rehabilitation

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

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 or related to previous cosmetic procedures are not covered (e.g., scar revision, keloid removal resulting from pierced ears).
- Reduction mammoplasty requires medical director's review.
- 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 TMJ.

Podiatry

No precertification is required for coverage of E&M testing and procedures when provided by a participating podiatrist.

Prosthetics and orthotics

- Precertification and Certificate of Medical Necessity (CMN) are required.
- No precertification is required for the coverage of orthotics for arch support, heels, lifts, shoe inserts and wedges by a network provider.
- 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*.
- All prosthetics and orthotics billed with an RR modifier (rental) require precertification.
- You can request precertification by completing a CMN —available on our website — or by submitting a physician order and *Amerigroup Referral and Authorization Request* form. Amerigroup and the provider must agree on HCPCS and/or other codes for billing covered services.

Radiation therapy

- Precertification requirement is based on the service performed.
- For procedure-specific requirements, see the *Precertification Lookup Tool* on our website.
- If required, precertification services will be provided through Carelon Medical Benefits Management, Inc. Contact Carelon Medical Benefits Management, Inc. by phone at **800-714-0040** or online at **www.carelon.com**.

Radiology

See the *Diagnostic testing* section of this QRC.

Rehabilitation therapy (short-term): PT, OT, RT and ST

- No precertification is required for initial evaluation.
- No precertification is required for members under 21 years of age.
- Precertification from Amerigroup is required for coverage of treatment. 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 is required for coverage.

Sleep study

Precertification is required.

Carelon Medical Benefits Management, Inc. manages sleep study reviews. Contact Carelon Medical Benefits Management, Inc. at **800-714-0040**.

www.carelon.com

Sterilization

- 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.
- A sterilization consent form is required for claims submission.
- Reversal of sterilization is not a covered benefit.

TennCare Kids/Early and Periodic Screening, Diagnostic and Treatment office visits
(not covered under CoverKids)

CoverKids Well-Child visits
(covered under CoverKids)

- Members may self-refer.
- Use TennCare Kids schedule and document visits.
- As long as Amerigroup is the primary payer, and the screening is medically necessary, there is no limit to the number of well-child screenings a child can have.
- If a child presents for a problem-oriented visit and is behind/due for their well-child exam, it is appropriate to perform and report a well child exam (99381-99395) in addition to the acute visit (99201-99215) if all evaluation and management requirements are met. Modifier 25 should be appended to the problem-oriented visit (99201-99215) when reported in conjunction with the preventive visit (99381-99385) on the same day.

Transportation

All nonemergency medical transportation, including facility discharges, should be coordinated through Tennessee Carriers (not covered under CoverKids).

Urgent care center

No notification or precertification is required for participating facilities, routine, preventive care or back up for PCP office.

Weight management services

No precertification is required for weight management services at the below locations. 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**
- Davidson:
  - Matthew Walker Comprehensive Health Center: **615-327-9400**
  - United Neighborhood Health Services: **615-226-1695** (Nutritionist available by 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.
- Members should contact their local health department or FQHC for an appointment.

Well-woman exam

One exam is covered per calendar year for self-referral. This includes testing for chlamydia, PAP tests and breast cancer screenings.

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

The TennCare Reference Link for Exclusion List

The TennCare Reference Link for Exclusion List is a list of general exclusions for services that shall not be considered covered services by TennCare. You can find this list by going to the State of Tennessee website at **https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13.htm** and clicking on **Chapter 1200-13-13 TennCare Medicaid**. For CoverKids, you can find the list by clicking on **Chapter 1200-13-21 CoverKids**.

Precertification/Notification Coverage Guidelines 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:		
M.D. Services (Psychiatry)	No	Yes
Outpatient Non-M.D. Services	No	Yes
Partial Hospitalization	No	Yes
Intensive Outpatient	No	Yes
I/DD Systems of Support Services	Yes	Yes
Inpatient, Residential and Outpatient Substance Abuse Services:		
Inpatient Facility Services (including detoxification)	Yes	Yes
Residential Treatment Services	Yes	Yes
Partial Hospital	No	Yes
Intensive Outpatient	No	Yes
Outpatient Treatment Services	No	Yes
Ambulatory Detoxification	Yes	Yes
Intensive Community-Based Treatment Services (ICTBS), Continuous Treatment Team (CTT), Comprehensive Child and Family Treatment (CCFT), and Program of Assertive Community Treatment (PACT)	Yes	Yes
Medication Assisted Treatment Program	No	Yes
Tennessee Health Link (THL)	No	No
Psychiatric Rehabilitation Services (includes psychosocial rehabilitation, supported employment, Peer Recovery Services, Family Support Services, illness management and recovery, and supported housing)	No	Yes
Supported Housing	Yes	Yes
Applied Behavioral Analysis	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	Yes	Yes
Electroconvulsive Therapy	Yes	Yes
Transcranial Magnetic Stimulation	Yes	Yes
Emergency Room Services	No	No
Court-Ordered Services	Yes	Yes
Transportation, Nonemergency for Medically Necessary Treatment	Yes	Yes

Our service partners

EyeQuest* (vision services)	**800-526-9202**
Tennessee Carriers* (nonemergency transportation)	**866-680-0633**
Carelon Medical Benefits Management, Inc. (radiology precertification)	**800-714-0040**
DentaQuest (for TennCare members)	**855-418-1622**
DentaQuest (for CoverKids members)	**888-291-3766**

Provider Experience Program

Our Provider Services department offers precertification, care management, automated member eligibility, health education materials, outreach and more. Call **800-454-3730** Monday through Friday from 7 a.m. to 7 p.m. Central time.

Local Provider Relations

We also offer local Provider Relations representatives who will help your office with ongoing education, contract and fee issues, procedural issues and more. Your office will have a designated representative you can reach at **615-316-2400, ext. 22160**.

Provider self-service site and inquiry line available 24/7/365

To verify eligibility, check claims and referral authorization status, and look up precertification/notification requirements, visit https://provider.amerigroup.com/TN.

Can't access the internet? Call Provider Services and simply say your NPI number when prompted by the recorded voice. It's easy! The recording guides you through a menu of options. Just select the information or materials you need when you hear it.

Population Health

Our Population Health program is part of a comprehensive Health Care Management (HCM) services program that offers a continuum of services, including Wellness, Low- and High-Risk Maternity, Health Risk Management, Care Coordination, Chronic Care Management and Complex Case Management.

Our case managers are registered nurses available from 8:30 a.m. to 5:30 p.m. local time, Monday through Friday. If calling after hours, we have a confidential voicemail box available 24 hours a day. The Nurse HelpLine at **800-600-4441** is also available for our members 24 hours a day, 7 days a week.

All requests for skilled nursing facilities (SNF), acute inpatient rehab (AIR) and long term acute care (LTAC) should be faxed to **866-920-6005**.

Please call **888-830-4300** to reach a case manager. Members can get information about our Population Health program by visiting **www.myamerigroup.com/TN** or calling **888-830-4300**.

Amerigroup will pay participating providers a $10 administrative fee per code, per eligible member when they report select CPT Category II codes on claims once per calendar year. Please visit **https://providers.amerigroup.com** to see the provider update regarding CPT Category II Payment Opportunity.

Amerigroup On Call • Contact clinical staff at 866-864-2544 (Spanish 866-864-2545)

24-hour Nurse HelpLine (800-600-4441)

24-hour Nurse HelpLine is a telephonic, 24-hour triage service your Amerigroup patients can call to speak with a registered nurse who can help them:

- Find doctors when your office is closed, whether after hours or on weekends
- Schedule appointments with you or other network doctors
- Get to urgent care centers or walk-in clinics
- Speak directly with a doctor or a member of the doctor's staff to talk about their health care needs

Our Member Services Line at **800-600-4441** offers free translation services for 170 languages and the use of a TDD line for members with difficulty hearing.

We encourage you to tell your Amerigroup patients about this service and share with them the advantages of avoiding the emergency room when a trip there isn't necessary or the best alternative.

Claims services

Timely filing is 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.

We require all submitters of institutional claims to use the *CMS-1450 (UB04)* form and submitters of professional claims to use the *CMS-1500 (08-05)* form approved by the National Uniform Claim Committee (NUCC). If a claim is received on any other form but the *CMS-1450* or the *CMS-1500 (08-05)* form, the claim will be returned to the submitter and will not be processed. We also offer free electronic claims submission via our provider self-service site.

Electronic data interchange (EDI)

Effective January 1, 2019, Availity is our designated Electronic Data Interchange (EDI) gateway and E-Solutions Service Desk.

How to register with Availity Essentials:

If you wish to submit directly, you can connect to the Availity EDI Gateway at no cost for you: go to **https://www.availity.com** and select **REGISTER**. If you have any questions or concerns, please contact Availity at **800-AVAILITY (800-282-4548)**.

ICR tool via Availity Essentials:

- Your practice can initiate online precertification requests for TennCare members more efficiently and conveniently with our ICR tool, available through Availity Essentials.
- The ICR offers a streamlined process to request inpatient and outpatient procedures through Availity Essentials.
- For questions on accessing our tool via Availity, call Availity Client Services at **800-AVAILITY**. Availity Client Services is available Monday to Friday from 8 a.m. to 7 p.m. Eastern time (excluding holidays) to answer your registration questions.

Electronic claim payment reconsideration:

Providers have the ability to submit claim reconsideration requests through Availity Essentials with more robust functionality, including:

- Filing a claim payment reconsideration.
- Sending supporting documentation.
- Checking the status of your claim payment reconsideration.
- Viewing your claim payment reconsideration history.

Electronic data interchange (EDI) (cont.)

Availity Essentials functionality includes:

- Acknowledgement of submission at the time of submission.
- Email notification when a reconsideration has been finalized by Amerigroup.
- A worklist of open submissions to check a reconsideration status.

Paper claims

Submit claims on original claim forms (*CMS 1500* or *CMS-1450*) with dropout red ink, printed or typed (not handwritten) in a large, dark font.

Mail paper claims to:

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

Please note: AMA and CMS-approved modifiers must be used appropriately based on the type of service and procedure code.

Payment disputes

Payment disputes must be received at Amerigroup within 365 days of the date of the explanation of payment.

Forms for provider disputes are located on our website and should be sent to the following address:

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

Medical appeals

Members and their representative(s), including a member's provider, have 60 calendar days from the date of the Notice of 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 can file an appeal of an adverse benefit determination with the TennCare Solutions Unit (TSU):

TennCare Member Medical Appeals or
CoverKids Member Medical Appeals
P.O. Box 593
Nashville, TN 37202-0593

- Fax: **888-345-5575**
- Phone: **800-878-3192**
- TTY/TDD: **800-772-7647**
- Español: **800-254-7568**

All appeals filed by the provider will require the member's written consent to move forward in the process. TSU will forward any valid factual disputes to Amerigroup for reconsideration. An *On Request Report* will be faxed to Amerigroup by TSU requesting reconsideration of the member's appeal.

* Quest Diagnostics is an independent company providing laboratory testing services on behalf of the health plan. Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan. Lab Corp is an independent company providing laboratory testing services on behalf of the health plan. CVS Specialty Pharmacy is a company providing specialty pharmacy services on behalf of the health plan. OptumRx is an independent company providing pharmacy services on behalf of the health plan. EyeQuest is an independent company providing vision benefit management services on behalf of the health plan. Tennessee Carriers is an independent company providing nonemergency transportation services on behalf of the health plan.

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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