Amerigroup

Case management for children and pregnant women

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Today’s discussion

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Who we are

- We are the largest corporation focused solely on meeting the healthcare needs of financially vulnerable Americans.
- We are a leader in managed healthcare services for the public sector, providing healthcare coverage exclusively to low-income families, children, pregnant women, elderly, and disabled individuals.
- We and our affiliate health plans serve approximately 6.5 million Americans in the public sector healthcare market through the following publicly funded programs:
  - Medicaid
  - Medicare
  - Children's Health Insurance Program (CHIP)
- We have proudly served Texas for over 20 years.

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Medicaid programs

Amerigroup offers the following Medicaid managed care programs:

- STAR:
  - The STAR program is for eligible children, pregnant women, and low-income families; it provides members with acute care medical assistance.
- STAR+PLUS:
  - The STAR+PLUS program provides integrated acute care and long-term services and supports in a Medicaid managed care environment for elderly and disabled adults; the program mainly services Supplemental Security Income (SSI)-eligible Medicaid members.
  - The STAR+PLUS program also covers individuals with intellectual disabilities or related conditions who do not qualify for Medicare and who receive services through the Intermediate Care Facilities for Individuals with Intellectual disability (ICF/ID) program or an Intellectual/Developmental Disabilities(IDD) Waiver program; it provides acute care and behavioral health (BH) services only. Long-term services and supports are provided by the Texas Health and Human Services Commission (HHSC).

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Medicaid programs (cont.)

- STAR Kids:
  - STAR Kids is designed specifically for children and young adults with special needs. Most individuals 20 years old and younger who get SSI Medicaid or Home- and Community-Based Waiver services will receive some or all of their Medicaid services through STAR Kids. Children and young adults enrolled in STAR Kids will receive comprehensive service coordination.

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Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan)

Amerigroup was selected by Texas HHSC to participate in a demonstration program to provide both Medicare and Medicaid benefits to dual-eligible members. The goals of Amerigroup STAR+PLUS MMP are to:

- Integrate care and improve quality of care for members by consolidating the responsibility for all the covered services into a single plan.
- Maximize the member's ability to remain safely in their home and community.
- Improve continuity of care across acute care, long-term care, BH, and home- and community-based services using a patient-centered approach.
- This program is currently available to members residing in Bexar, El Paso, Harris, and Tarrant Counties.

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MMP Service Coordination team (SCT)

- Each member has a SCT assigned to assist with developing plans of care, collaborating with other team members, and providing recommendations for the management of the member's care.
  The SCT is person-centered and built on the member's specific preferences and needs, ensuring transparency, individualism, accessibility, respect, and linguistic and cultural competency and dignity.
- Typically, the team can be made up of the member and/or their designee, assigned service coordinator, primary care physician, specialists, BH professional, the member's home care attendant or LTSS provider, and other providers, as applicable.
- The member is an important part of the team and is involved in the planning process. Healthcare practitioners and providers of care in the home or community are also very important members of the team and help to establish and execute the plan of care.

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CPW provider requirements

- CPW providers are Medicaid enrolled advanced practice registered nurses (APRNs), registered nurses (RNs), and social workers. All new CPW Providers must be enrolled with HHSC and go through Amerigroup's contracting process prior to servicing Amerigroup members:
  - Amerigroup does not require a referral from a PCP or physician to provide CPW case management.
  - Amerigroup does not require an authorization to provide CPW case management.
- Amerigroup will conduct CPW claims reviews to ensure the documentation matches the services that were billed.
- Our Case Management team will also review referral information to ensure services are not duplicated.

CPW provider requirements (cont.)

- Supporting documentation should be sent in within 30 days of initiating services. Please email or fax the documentation to our case management team:
  - Referrals for MSHCN/CHSCN should be sent to Amerigroup Case Management via secured email at TXCMCPW@amerigroup.com.
  - Referrals for pregnant MSHCN should be sent to Amerigroup OB Case Management via email at TXCMCPW@amerigroup.com.
  - Referrals for CPW services for STAR Kids members should be sent to sk-service-coordination@amerigroup.com.
- Children fax line: **866-249-1185**
- OB fax line: **866-249-1180**

CPW providers and Amerigroup Case Management will collaborate to meet members' needs for service management.

CPW provider requirements (cont.)

- Amerigroup will conduct quality assurance audits every 30 days to ensure receipt of supporting clinical documentation. Per HHSC, CPW providers have 10 days to submit case management documentation when it's requested by the managed care organization (MCO):
  - *Referral Intake* form
  - Service plan

CPW covered services

CPW services include a comprehensive visit, face-to-face follow-ups, and/or telephonic follow-ups:

- These services are limited to one contact per day per person. Additional contacts on the same day will be denied.
- CPW services are not billable when a person is admitted to an inpatient hospital or other treatment facility.
- All services require documentation to support the medical necessity of the service rendered. These services are subject to retrospective reviews to ensure the documentation supports the services rendered.

Procedure codes and billing requirements:

- Face-to-face or telephonic visits
- Total of three visits
- One comprehensive visit (face-to-face)
- Two follow-up visits (face-to-face or telephonic)

Procedure code	Description	Modifiers
G9012	Comprehensive visit (in-person)	U2 and U5
G9012	Comprehensive visit (telehealth)	U2, U5, and 95
G9012	Follow-up visit (in-person)	U5 and TS
G9012	Follow-up visit (telehealth)	U5, TS, and 95
G9012	Follow-up visit (audio only)	TS and 93

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Member Medicaid enrollment

MAXIMUS:

- MAXIMUS, HHSC's contracted enrollment broker, provides education and enrollment services to Texans in Medicaid managed care programs, CHIP, and children's dental services. They conduct outreach and provide information about the Texas Health Steps program.

Enrollment:

- Enrollment kits are sent to clients following receipt of their eligibility from the Texas HHSC. An MCO is automatically assigned if the enrollment process is not completed by the client. Assistance is available with the enrollment process, including:
  - Personalized assistance at enrollment assistance sites and during enrollment events. Visit www.txmedicaidevents.com.
  - Home visits scheduled through the Enrollment Broker Helpline.
  - Submission of enrollment forms online, by mail, or by fax.

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Member Medicaid enrollment (cont.)

Effective dates:

- Before the 15th of the month — effective the first day of following month (for example, enroll January 10 — effective February 1)
- After the 15th of the month — effective the first day of next full month (for example, enroll January 20 — effective March 1)

Plan changes:

- Must contact MAXIMUS for plan changes
- Same effective date rules apply

Contact:

- Enrollment Broker Helpline: **800-964-2777**
- Special Populations Helpline: **877-782-6440**
- Mail: P.O. Box 149023, Austin, TX 78714-9023
- Online: https://yourtexasbenefits.com
- Fax: **855-671-6038**

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Member ID cards

Members who choose to enroll in a plan from Amerigroup will receive a member ID card containing the member's name, member number, and basic information about the member's plan. Amerigroup members should present their member ID card when receiving services.

Sample ID cards can be found in the Amerigroup provider manuals. These manuals are accessible at https://provider.amerigroup.com/texas-provider/resources/manuals-and-guides.

Marketing activities

- **Sanctioned marketing activities:**
  - Attendance at MAXIMUS-sponsored member enrollment events
  - Approved MCO-sponsored health fairs and community events
  - Radio, television, and print advertisements
- **In Texas, the following activities are prohibited:**
  - Conducting direct-contact marketing, except through the HHSC-sponsored enrollment events
  - Making any written or oral statement containing material that misrepresents facts or laws relating to Amerigroup or the STAR, STAR+PLUS, STAR Kids, and CHIP programs
  - Promoting one MCO over another if contracted with more than one MCO

Consult the Amerigroup provider manual at https://provider.amerigroup.com/TX for more details on HHSC marketing guidelines.

Early Childhood Intervention

- Early Childhood Intervention (ECI) is a federally mandated program for infants and toddlers under the age of 3 who are at risk for developmental delays and/or disabilities.
- The federal ECI regulations are found at *34 C.F.R. § 303.1 et seq*.
- The state ECI rules are found within the *Texas Administrative Code, Title 26, Part 1, Chapter 350*.
- Amerigroup must ensure network providers are educated regarding the federal laws on child-find and referral procedures (for example, *20 U.S.C. § 1435(a)(5), 34 C.F.R. § 303.303*).
- Amerigroup must require network providers to identify and refer any member under the age of 3 who is suspected of having a developmental delay or disability (or otherwise meets eligibility criteria for ECI services in accordance with *Texas Administrative Code, Title 26, Part 1, Chapter 350*) to the designated ECI program for screening and assessment within seven calendar days from the day the provider identifies the member.
- Amerigroup must use written educational materials developed or approved by HHSC for ECI services for these child-find activities. Materials are located at https://hhs.texas.gov/services/disability/early-childhood-intervention-services.

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ECI (cont.)

- The local ECI program will determine eligibility for ECI services using the criteria contained in *Texas Administrative Code*, Chapter 350.
- ECI providers must submit claims for all physical, occupational, speech, and language therapy to Amerigroup.
- ECI-targeted case management services and ECI specialized skills training are noncapitated services:
  - ECI providers should bill Texas Medicaid & Healthcare Partnership (TMHP) for these services.
- Amerigroup must contract with qualified ECI providers to provide ECI-covered services to members under the age of 3 who are eligible for ECI services.
- Amerigroup must permit members to self-refer to local ECI service providers without requiring a referral from the member's PCP.

ECI (cont.)

- The Individual Family Service Plan (IFSP) is the authorization for the program-provided services (for example, services provided by the ECI contractor) included in the plan.
- Preauthorization is not required for the initial ECI assessment or for the services in the plan after the IFSP is finalized.
- All medically necessary health and BH program-provided services contained in the IFSP must be provided to the member in the amount, duration, scope, and service setting established in the IFSP.

Provider demographic updates

Update us immediately concerning changes in your:

- Address
- Phone number
- Fax number
- Office hours
- Access and availability
- Panel status

The demographic update form can be found on the provider website at https://provider.amerigroup.com/TX > Resources > Forms.

Contact your Healthcare Networks consultants for assistance with updating your demographics and remember to update your demographic information with TMHP.

Provider website

- The provider website is available to all providers, regardless of participation status, and can be accessed at https://provider.amerigroup.com/TX.
- Online tutorials, forms, trainings, user guides, and other resources are on the Amerigroup website to help.
- Network providers should register with Availity to access secure content. Register at www.availity.com.

Availity Essentials

- Use Availity Essentials* to review patient eligibility and benefit information, and to submit, track, and appeal claims.
- Patient360 allows you to view secure member demographic and care management details.
- Registration for the secured content on Availity is easy:
  - Begin by navigating to www.availity.com and selecting **Register**.
- There are multiple resources and trainings available to support navigation of the Availity and Amerigroup websites.

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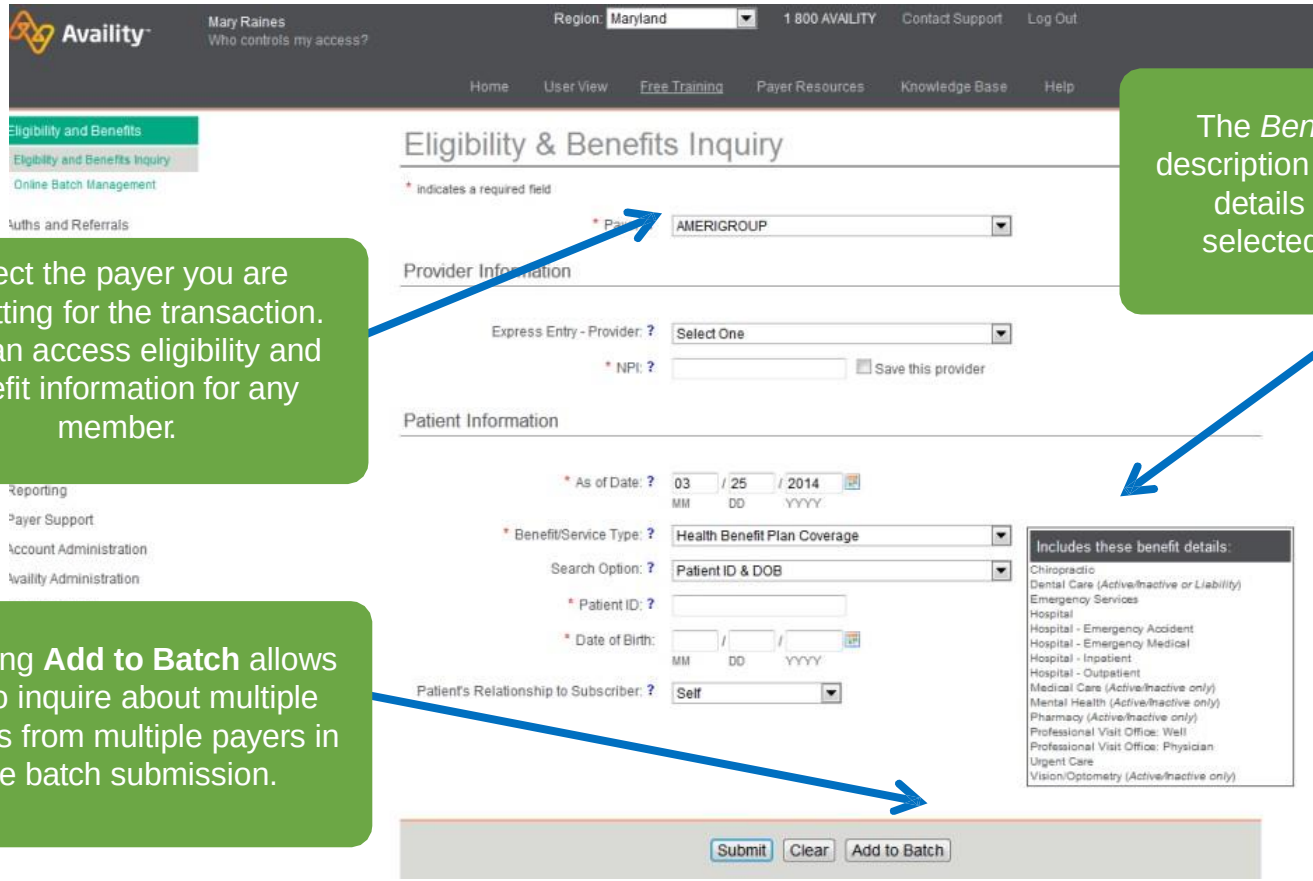
Eligibility and benefits



Select the payer you are submitting for the transaction. You can access eligibility and benefit information for any member.

The *Benefit/Service Type* description box lists the benefit details included for the selected benefit/service.

Selecting **Add to Batch** allows you to inquire about multiple patients from multiple payers in one batch submission.

Claims submission

- Claims may be submitted through:
  - Availity
  - Batch 837
  - Claims clearinghouses to the Availity EDI Gateway
  - Mailing directly to Amerigroup

Claims submission (cont.)

- Claims must be received within 95 calendar days from the date of service or discharge.
- Claims can be submitted electronically or by paper:

Paper submission	Electronic submission payers
Amerigroup P.O. Box 61010 Virginia Beach, VA 23466-1010	**Availity**: • **800-282-4548** • Payer ID 26375 • https://apps.availity.com/web/welcome/#/edi

For assistance with electronic transmission of claims, call Availity at **800-Availity** (**282-4548**).

Rejected vs. denied claims

If you receive a notice that your claim was rejected or denied, this is what each status means:

Rejected	Denied
Does not enter the adjudication system due to missing or incorrect information	Goes through the adjudication process, but is denied for payment
Claim will be returned	Provider will receive an *Explanation of Payment (EOP)*

Billing members

Our agreement with the state indicates that our members should not be burdened with any non-approved, out-of-pocket expenses for services covered under the Medicaid program:

- This fundamental principle does not change when the member has other insurance.
- Members should receive the best benefits available from both coverage plans.

Members should not be billed:

- When claims are denied or reduced for services that are within the amount, duration, and scope of benefits under the Medicaid program.
- For services not submitted for payment, including claims not received.
- When claims are denied for timely filing (95 days).
- For failure to submit corrected claims within 120 days.
- For failure to appeal claims within the 120-day appeal period.
- For failure to appeal a medical denial.
- For submission of unsigned or otherwise incomplete claims.

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Billing members for non-covered services

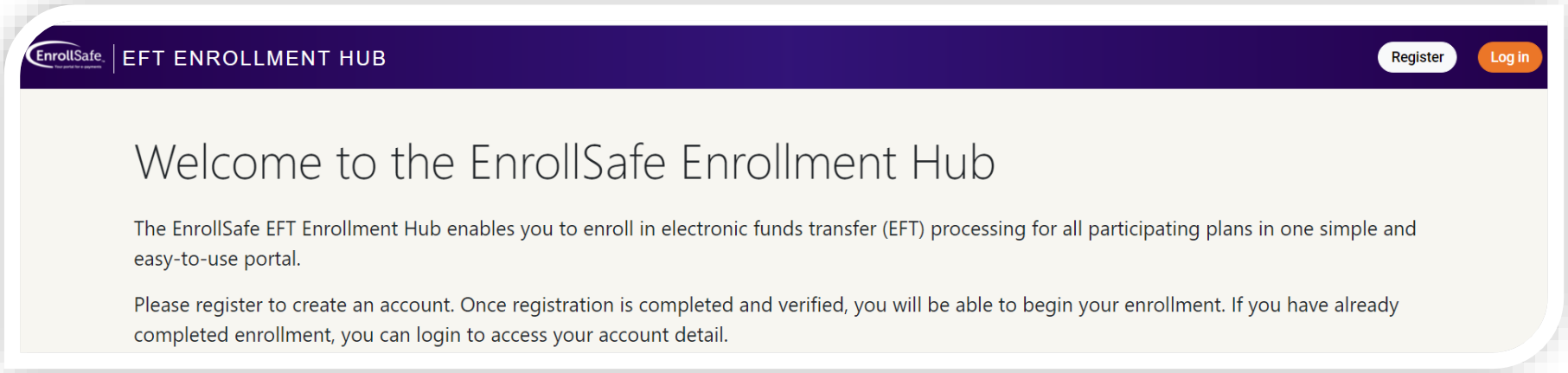
Before billing members for services not covered, providers must:

- Inform the member in writing of the cost of the service.
- Inform the member that the service is not covered by Amerigroup.
- Inform the member that they can be charged.
- Obtain the member's signature on a *Client Acknowledgment* form before providing the service.

Electronic remittance advice (ERA) and electronic funds transfer (EFT) enrollment

You should register to receive your ERAs through Availity at https://www.availity.com.

Enroll in EFT through EnrollSafe* at https://enrollsafe.payeehub.org.



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Grievances and appeals

- We track all provider grievances until they are resolved.
- The provider manual details filing and escalation processes and contact information.
- Examples of grievances include:
  - Issues with eligibility.
  - Contract disputes.
  - Authorization process difficulties.
  - Member/associate behavior concerns.

Appeals process

Payment disputes:

- There is a 120-day filing deadline from the date of *EOP.*
- Providers may use the payment dispute tool at www.availity.com. Supporting documentation can be uploaded using the attachment feature.
- Providers can also submit a *Provider Payment Dispute* form and relevant supporting documentation, including the original *EOP*, corrected claim, invoices, medical records, reference materials, etc.
  - **Verbally (for reconsiderations only):** Call Provider Services.
  - **Mail to:**

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

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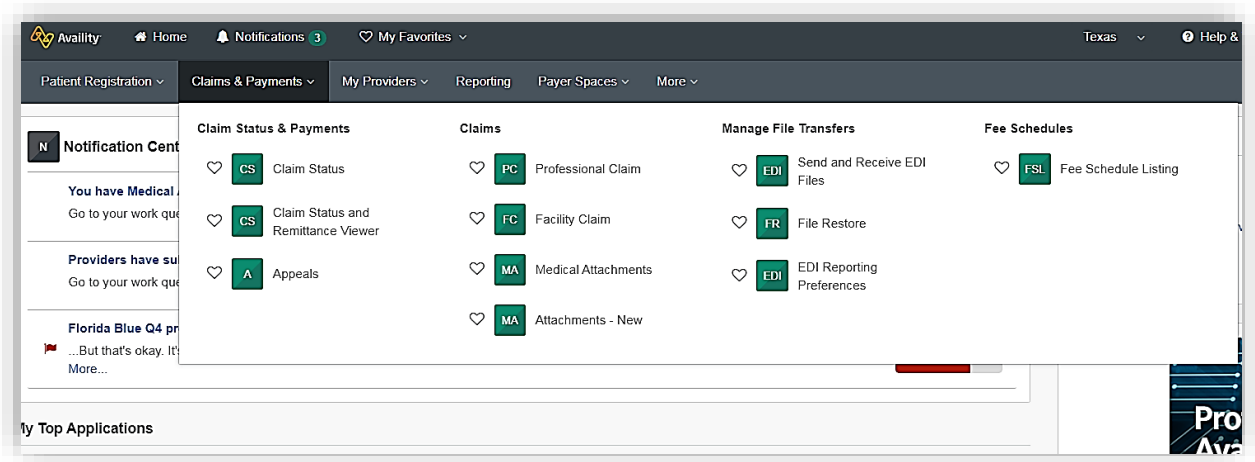
Availity claims dispute tool

Claims payment disputes can be filed when the provider believes the claim was incorrectly adjudicated. They must be filed within 120 days of the adjudication date on your *EOP*.



A reconsideration can be requested as a first option; if the issue us not resolved, a formal appeal can be requested. See the provider manual for details.

Member complaints and appeals

- Medicaid members or their representatives may contact a member advocate or their service coordinator for assistance with writing or filing a complaint or appeal (including an expedited appeal). The member advocate or service coordinator also works with the member to monitor the process through resolution.
- Refer to the provider manual for complaint/appeal timelines.

Case Management program

- Available for members with complex medical conditions
- Focuses on members who have experienced a critical event or diagnosis
- Super Utilizer program
- Members with special healthcare needs
- Social workers available

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Disease management

We offer programs for members living with:

- Asthma
- Bipolar disorder
- Congestive heart failure
- Chronic obstructive pulmonary disease (COPD)
- HIV/AIDS
- Hypertension
- Major depressive disorder
- Schizophrenia
- Substance use disorder and more

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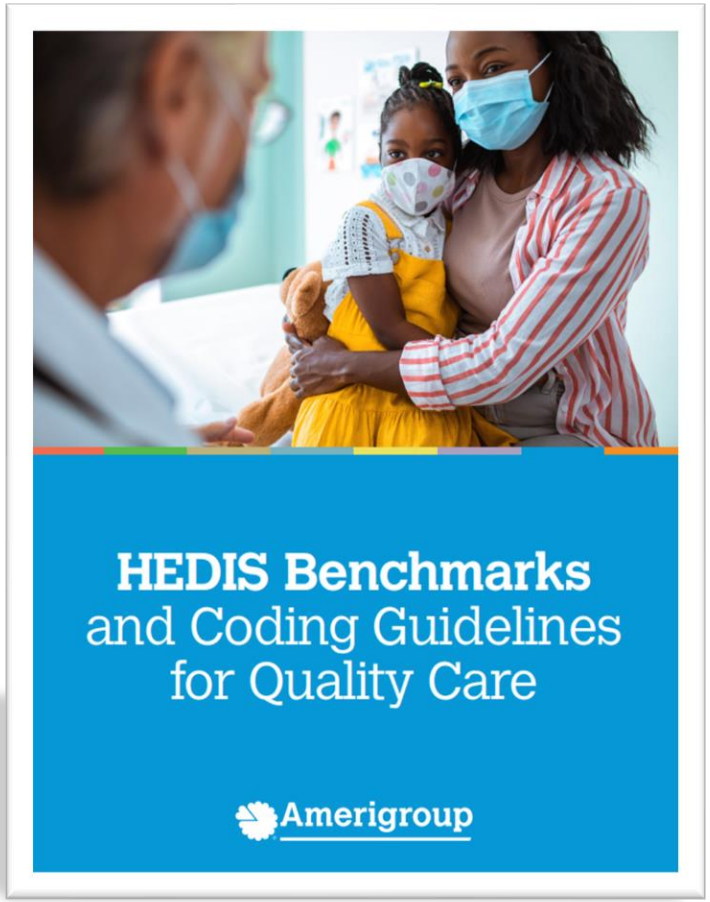
Pharmacy program

- The Texas Vendor Drug Program formulary and *Preferred Drug List* are available on our website.
- Prior authorization is required for:
  - Brand-name medications when generics are available.
  - High-cost injectable and specialty drugs.
  - Any other drugs identified in the formulary as needing prior authorization.
- Detailed information is available on our website at https://provider.amerigroup.com/TX.

Note: This list is not all-inclusive and is subject to change.

Quality Management team

Our Quality Management team continually analyzes provider performance and member outcomes for improvement opportunities.



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Fraud, waste and abuse

Help us prevent it and tell us if you suspect it:

- Verify patient identity.
- Ensure services are medically necessary.
- Document medical records completely.
- Bill accurately.

Reporting fraud, waste, and abuse is required. If you suspect or witness it, tell us immediately by calling:

- The Special Investigations Fraud Hotline at **866-847-8247**. (Reporting can be anonymous.)
- Medicaid Provider Services at **800-454-3730**.
- MMP Provider Services at **855-878-1785**.

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Caring for diverse populations

Everyone approaches illness as a result of their own experiences, including education, social conditions, economic factors, cultural background, and spiritual traditions, among others. In our increasingly diverse society, patients may experience illness in ways that are different from their health professional's experience. Sensitivity to a patient's view of the world enhances the ability to seek and reach mutually desirable outcomes. If these differences are ignored, unintended outcomes could result, such as misunderstanding instructions and poor compliance. Subconscious stereotyping and untested generalizations can lead to disparities in access to service and quality of care.

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Cultural competency and patient engagement

- Amerigroup believes that we must recognize and thoroughly understand the role that culture and ethnicity play in the lives of our members in order to ensure everyone receives equitable and effective healthcare.
- We expect our providers and their staff to share our commitment to cultural competency.
- Resources, training materials and information can be found online, including:
  - The *Cultural Competency Plan*.
  - Cultural competency tool kit.
  - Cultural competency training.
  - *Improving the Patient Experience CME*.

Children of migrant farmworkers

- HHSC defines a migrant farm worker as “a migratory agriculture worker whose principal employment is in agriculture on a seasonal basis, who has been employed in the last 24 months and who establishes for the purpose of such employment a temporary abode.”
- Texas traveling farmworker children face higher proportions of dental, nutritional, and chronic health problems than other children.
- Amerigroup assists children of migrant farmworkers in receiving accelerated services while they are in the area.
- We ask PCPs to assist Amerigroup in identifying a child of a migrant farmworker by asking the child or parent about the parent’s occupation during an office visit.
- Call Amerigroup if you identify a child of a migrant farmworker. Call Provider Services at **800-454-3730**.

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Interpreter services

- 24 hours a day, 7 days a week
- Supports over 170 languages
- Medicaid and CHIP Provider Services phone number: **800-454-3730**
- MMP Provider Services phone number: **855-878-1785**

Member records and documentation requirements

The records must reflect all aspects of patient care, including ancillary services. The use of electronic medical records must conform to *HIPAA* requirements and other federal and state laws. Some requirements listed may not be applicable to your specialty.

Documentation of each visit must include the following as applicable:

- Date of service
- Complaint or purpose of visit
- Diagnosis or medical impression
- Objective finding
- Assessment of patient's findings
- Plan of treatment, diagnostic tests, therapies, and other prescribed regimens
- Medications prescribed
- Health education provided
- Signature or initials and title of the provider rendering the service (If more than one person documents in the medical record, there must be a record on file as to which signature is represented by which initials.)

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Medical record standards

- **Patient identification information:** Each page or electronic file in the record must contain the patient's name or patient ID number.
- **Personal/biographical data:** The record must include the patient's age, sex, address, employer, home telephone number, work telephone number, and marital status.
- **Date and corroboration**: All entries must be dated and author-identified.
- **Legibility**: Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
- **Allergies**: Medication allergies and adverse reactions must be prominently noted on the record. Absence of allergies (no known allergies [NKA]) must be noted in an easily recognizable location.

Medical record standards (cont.)

- **Past medical history for patients seen three or more times:** Past medical history must be easily identified, including serious accidents, operations, and illnesses. For children, the history must include prenatal care of the mother and birth.
- **Physical examination:** A record of physical examination(s) appropriate to the presenting complaint or condition must be noted.
- **Immunizations:** For pediatric records of members ages 13 and younger, a completed immunization record or a notation of prior immunization must be recorded. This should include vaccines and their dates of administration when possible.
- **Diagnostic information:** Documentation of clinical findings and evaluation for each visit should be noted.

Medical record standards (cont.)

- **Medication information**: This notation includes medication information and instruction(s) to the patient.
- **Identification of current problems:** Significant illnesses, medical and BH conditions, and health maintenance concerns must be identified in the medical record. A current problem list must be included in each patient record.
- **Instructions:** The record must include evidence that the patient was provided with basic teaching/instructions regarding physical/BH condition.
- **Smoking/alcohol/substance abuse**: A notation concerning cigarettes and alcohol use and substance use must be stated if present for patients aged12 and older. Abbreviations and symbols may be appropriate.
- **Preventive services/risk screening**: The record must include consultation and provision of appropriate preventive health services and appropriate risk screening activities.

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Medical record standards (cont.)

- **Consultations, referrals, and specialist reports:** Notes from any referrals and consultations must be in the record. Consultation, lab, and X-ray reports filed in the chart must have the ordering physician's initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results must have an explicit notation in the record of follow-up plans.
- **Emergencies:** All emergency care provided directly by the contracted provider or through an emergency room and the hospital discharge summaries for all hospital admissions while the patient is part of the PCP's panel must be noted.
- **Hospital discharge summaries:** Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the patient is enrolled and for prior admissions as appropriate. Prior admissions pertaining to admissions that may have occurred prior to the patient being enrolled may be pertinent to the patient's current medical condition.

Medical record standards (cont.)

- **Advance directive:** Medical records of adult patients must document whether the individual has executed an advance directive. An advance directive is a written instruction, such as a living will or durable power of attorney, which directs healthcare decision-making for individuals who are incapacitated.
- **Security:** Providers must maintain a written policy to ensure that medical records are safeguarded against loss, destruction or unauthorized use. Physical safeguards require records to be stored in a secure manner that allows access for easy retrieval by authorized personnel only. Staff receives periodic training in member information confidentiality.
- **Release of information**: Written procedures are required for the release of information and obtaining consent for treatment.

Medical record standards (cont.)

- **Documentation:** Documentation is required setting forth the results of medical, preventive, and BH screening and of all treatment provided and results of such treatment.
- **Multidisciplinary teams:** Documentation of the team members involved in the multidisciplinary team of a patient needing specialty care is required.

Medical record standards (cont.)

- **Integration of clinical care**: Documentation of the integration of clinical care in both the physical and BH records is required. Such documentation must include the following:
  - Notation of screening for BH conditions (including those that may be affecting physical healthcare and vice versa) and referral to BH providers when problems are indicated
  - Notation of screening and referral by BH providers to PCPs when appropriate
  - Notation of receipt of BH referrals from physical medicine providers and the disposition and outcome of those referrals
  - A summary (at least quarterly or more often if clinically indicated) of the status/progress from the BH provider to the PCP
  - A written release of information that will permit specific information sharing between providers
  - Documentation that BH professionals are included in primary and specialty care service teams when a patient with disabilities, or chronic or complex physical or developmental conditions, and has a co-occurring behavioral disorder.

Reference tools and key resources

For the most up-to-date provider manual, go to **https://provider.amerigroup.com/TX**. To check claims status, eligibility and authorizations, visit the Availity Portal at **https://www.availity.com**.

Medicaid and CHIP Provider Services • Available Monday-Friday, 8 a.m. to 5 p.m. CT	**800-454-3730**
MMP Provider Services	**855-878-1785**
24-hour Nurse HelpLine — Clinical services available 24 hours a day, 7 days a week. TTY services are available for members who are deaf or hard of hearing by calling 711. Language translation services are also available.	**800-600-4441**
24-hour Nurse HelpLine for STAR Kids members	**844-756-4600**
24-hour Nurse Helpline for MMP members	**855-878-1784**
Medicaid and CHIP Member Services	**800-600-4441**
STAR Kids Member Services	**844-756-4600**
MMP Member Services	**855-878-1784**
Access2Care Nonemergency Transportation Services: • STAR • STAR+PLUS • STAR Kids • MMP	**833-721-8184** **844-867-2837** **844-864-2443** **844-869-2767**

For additional training resources, go to our Provider Training Academy located at:
https://provider.amerigroup.com/texas-provider/resources/training-academy

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Healthcare Networks

You can contact your Provider Experience Consultant by using our online webform at https://provider.amerigroup.com/TX > Contact Us.

Email a Provider Experience associate
Did you know that most question and issues can be resolved by using the Amerigroup provider self-service tools? Use Availity for inquiries like payment disputes, provider data updates, claims status, member eligibility, etc. You can also chat live with an Amerigroup associate from within the Availity Portal.

For other issues, you can message the Healthcare Networks team. Your Provider Experience representative will respond, usually within two business days.

* Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup. EnrollSafe is a tool developed by Zelis Payments, an independent organization offering electronic fund transfer services on behalf of Amerigroup.

https://provider.amerigroup.com