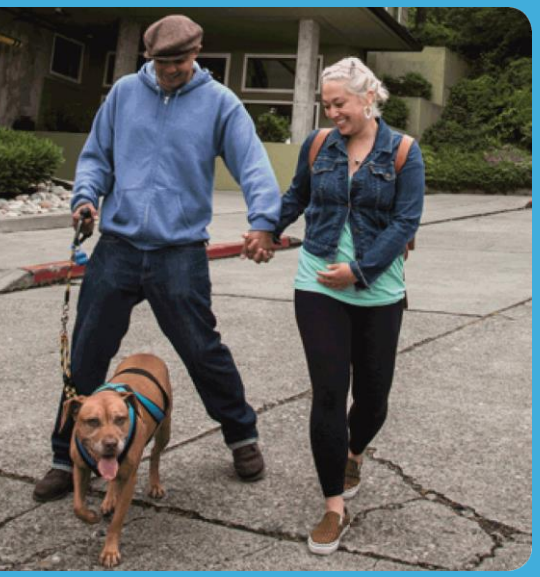

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Federally Qualified Health Centers and Rural Health Clinic orientation

Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.

Your responsibilities

Providers should review both provider and member responsibilities detailed in the provider manual found at https://providers.amerigroup.com/TX.

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Provider demographic updates

Please update us immediately concerning changes in:

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

Please also remember to update your demographic information with the Texas Medicaid & Healthcare Partnership (TMHP).

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Credentialing requirements

Federally Qualified Health Centers (FQHC) and Rural Health Clinic (RHC) facilities must provide the following documents:

- *Letter of Intent – New Facility Form*
- Copy of *W9*

Individual practitioners must be credentialed only if performing services outside of the facility. In those cases, we would need the following:

- *Letter of Intent – New Provider Form*
- Copy of *W9*

All RHC/FQHC facilities must have a valid TPI Texas Medicaid enrollment and NPI. Each location will be credentialed separately based on each location's NPI.

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Credentialing

- RHCs and FQHCs are credentialed as facilities.
- The RHC and FQHC serves as the PCP; Members choose the RHC or FQHC and not the individual provider.
- At this time, we require that the RHC and FQHC (building) have a TPI number Texas Medicaid enrollment requirement.
- RHCs also operating as a group and expecting fee-for-service payment must also be contracted and credentialed at the physician group level and have a TPI number for the group.

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Ongoing credentialing

- Credentialing is for a three-year period.
- Recredentialing efforts begin six months prior to the end of the current credentialing period.
- First notice and second notice letters are faxed/mailed to providers.
- Third notice and final notice letters are mailed to providers.
- Providers who do not respond or submit a complete recredentialing packet will be decredentialed/considered out of network.
- Providers must begin the contracting and credentialing process from the beginning to rejoin the Amerigroup network.
- Notify your Provider Relations representative with changes in licensure, demographics or participation status as soon as possible.

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Medicaid enrollment

MAXIMUS — state enrollment broker:

- Provides education and enrollment services to Texans in Medicaid managed care programs, CHIP and children's dental services.
- Conducts outreach and provides information about the Texas Health Steps program.

Enrollment:

- Enrollment kits are sent to clients by MAXIMUS following receipt of the client's eligibility from the Texas Health and Human Services Commission (HHSC).
- An MCO is automatically assigned if the enrollment process is not completed by client.

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Medicaid enrollment (cont.)

- 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 fax.

Effective dates:

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

Plan changes:

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

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Medicaid enrollment (cont.)

Those who wish to complete the enrollment on their own may submit their applications by mail, online or by fax. The contact information is provided below:

- Enrollment Broker Helpline: **1-800-964-2777**
- Special Populations Helpline: **1-877-782-6440**
- Mail:
  P.O. Box 149023
  Austin, TX 78714-9023
- Online: https://yourtexasbenefits.com
- Fax: **1-855-671-6038**

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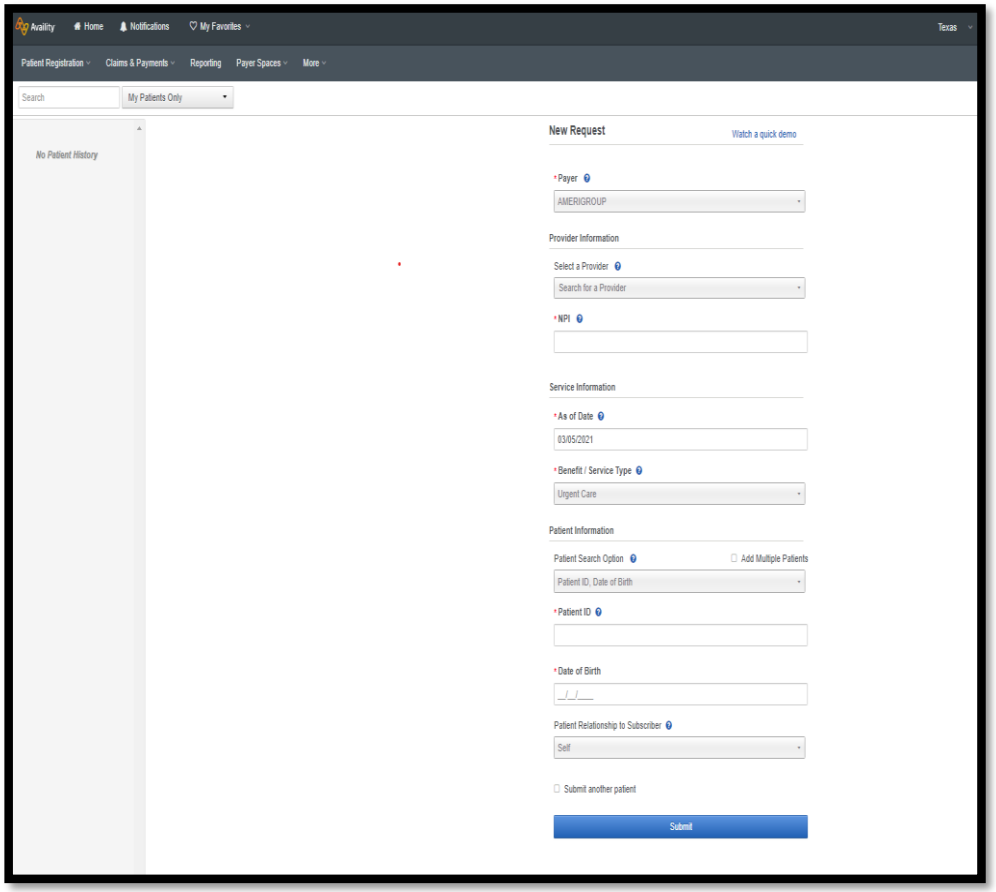
Verifying eligibility

- Check one member or use online batch management to check multiple members from multiple payers.
- Search with either Amerigroup subscriber or Medicaid/CHIP identification number.



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Easy access panel reports

- Providers can access their panel reports from the secure Amerigroup website.
- The user has the option of downloading the listing for the entire TIN or selecting a specific provider. It's that easy!

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Eligibility

Retroenrollment

- Medicaid coverage may be assigned retroactively for a client. For claims for an individual who has been approved for Medicaid coverage but has not been assigned a Medicaid client number, the 95-day filing deadline does not begin until the date the notification of eligibility is received from HHSC and added to the TMHP eligibility file.

Retrodisenrollment

- If TMHP finds that the member did not meet eligibility guidelines after application or if the member does not complete the necessary paperwork to complete the application, then the member's temporary initial enrollment can be reversed. If this occurs, the state will request funds back from the MCO who will subsequently request those funds back from the provider.

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Eligibility and benefits

	STAR	STAR+PLUS	STAR Kids	CHIP	CHIP Perinatal
Eligibility	Temporary Assistance for Needy Families (TANF), pregnant women, children receiving Medicaid assistance only, AAPCA services	SSI adult population including dual-eligible clients, Non-SSI adults who qualify for home- and community-based service (HCBS) STAR+PLUS waiver services, MBCC services	Children age 20 and younger who have Medicaid through SSI or 1915(c) waiver programs, AAPCA services	Uninsured children ages 18 and below in families with incomes too high to qualify for Medicaid	Unborn children of pregnant women who do not have health insurance and do not qualify for Medicaid
Covered services	Inpatient and outpatient hospital, emergency, physician services, lab, X-ray, home health, family planning, behavioral health services, pharmacy, Texas Health Steps	Inpatient and outpatient hospital, emergency, physician services, lab, X-ray, home health, family planning, behavioral health services, pharmacy, long-term services and supports (LTSS), service coordination	Inpatient and outpatient hospital, emergency, physician services, lab, X-ray, home health, family planning, behavioral health services, pharmacy, service coordination, LTSS, Texas Health Steps	Inpatient and outpatient hospital, emergency, physician, lab, X-ray, home health, behavioral health services, pharmacy, well-child visits	Care related to pregnancy only, including prenatal visits, labor and delivery, postpartum visits

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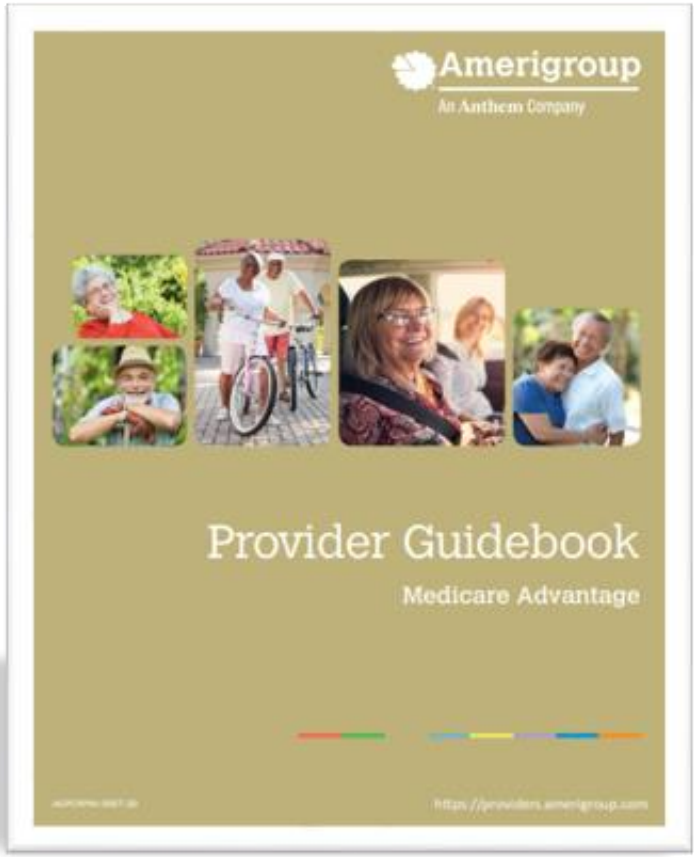
Medicare resources

- For additional information about the various Medicare Advantage plans from Amerigroup, please visit https://providers.amerigroup.com/TX and check out our provider guidebook.



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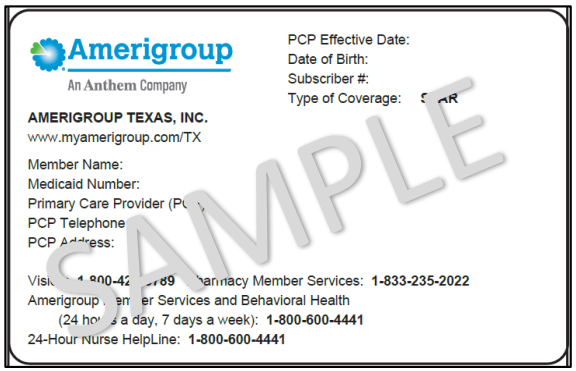
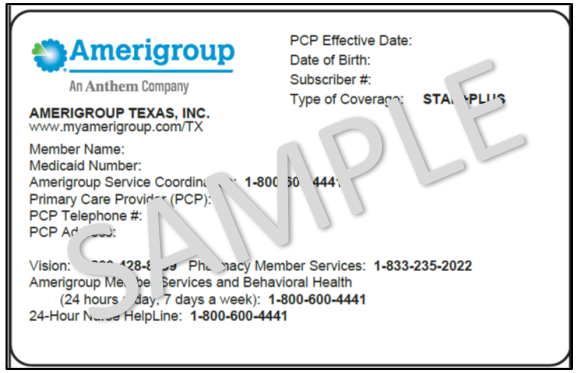
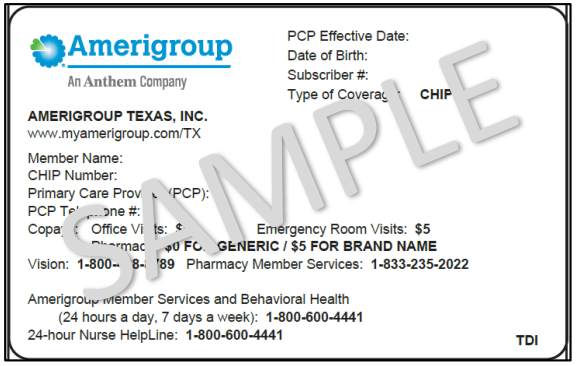
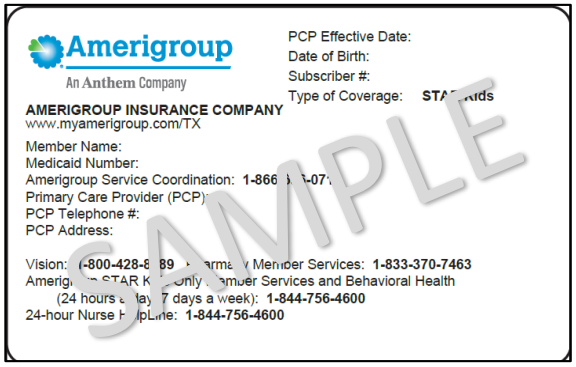
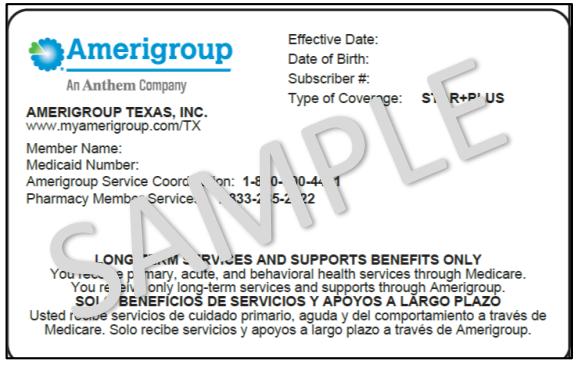
Member sample ID cards — Medicaid

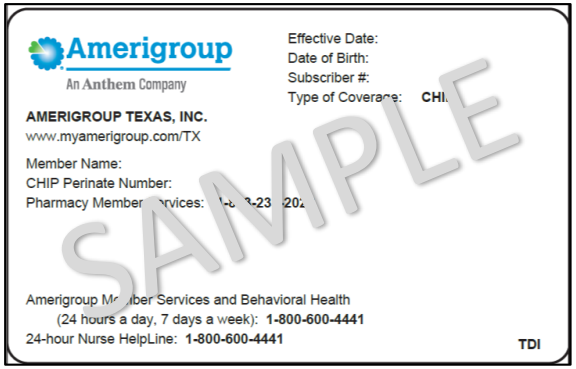












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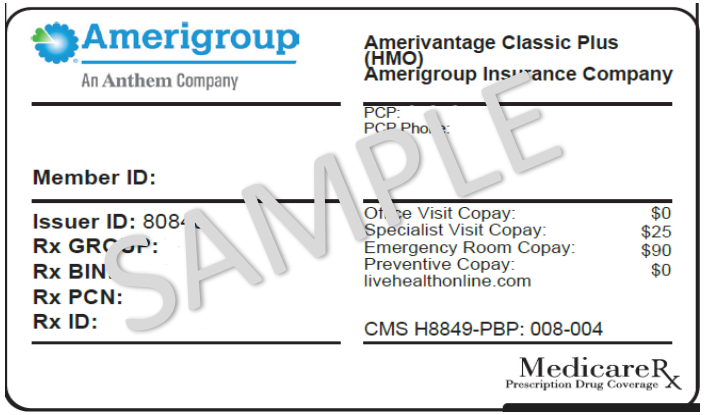
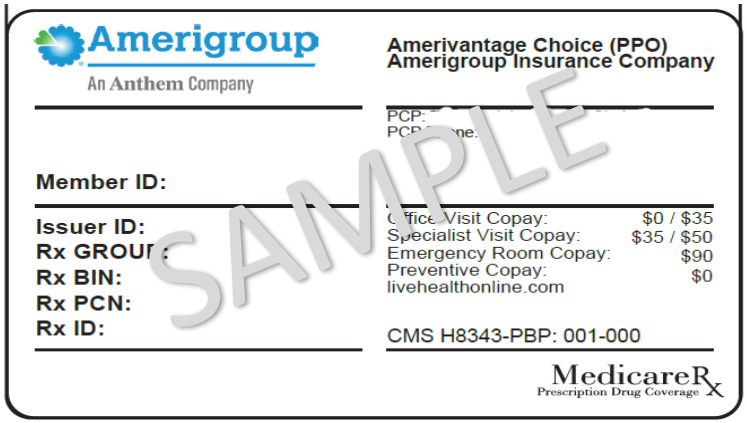
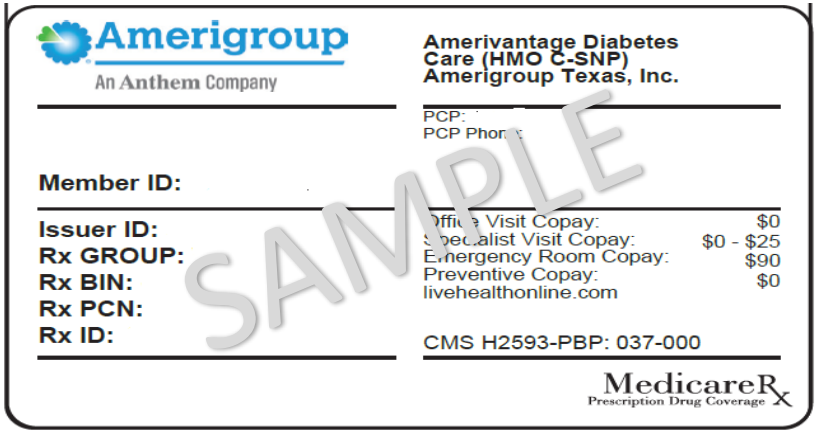
Member sample ID cards — Medicare







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Patient360

- Patient360 is a tool in Availity* that provides an in-depth view of the treatment and care your patient is receiving. This tool allows all providers to view information regarding patient demographics, pharmacy details, authorizations on file, claim summaries (such as what other providers the patient is seeing). Sharing relevant case information in a timely, useful and confidential manner is an Amerigroup requirement.
- Improving provider-to-provider communication will help to eliminate barriers when coordinating member care, improve the quality of care a member receives and improve the member's experience.
- To access Patient360, log in to https://www.availity.com, select **Amerigroup** under *Payer Spaces* and it will appear under the *Applications* tab on the bottom portion of the screen.

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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.

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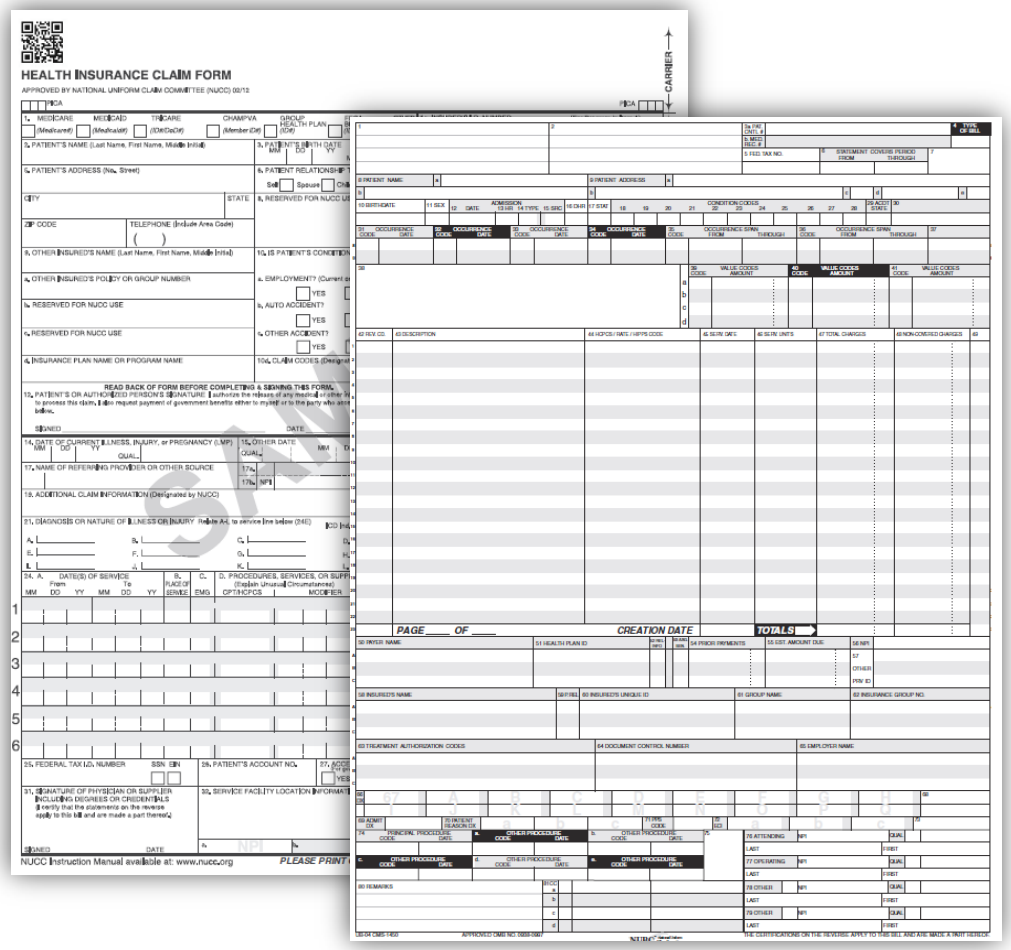
Billing format



Paper claims should be submitted on *CMS-1500*, *UB-04* or successor forms as applicable to the provider contract.

The taxonomy in 24J shaded should correspond with the NPI in the unshaded portion and the taxonomy in 33B should match the NPI in 33A respectively.

On the new *UB-04* form, NPI should be in box 56 and taxonomy in box 57. Claims without a verifiable ID number will be denied or rejected.

To ensure timely adjudication of a claim, please use the NPI/ taxonomy attested with TMHP.

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Who can bill at an FQHC or RHC?

An encounter is considered an in-person visit between a patient and a/an:

- Physician.
- Physician assistant.
- Nurse practitioner.
- Certified nurse-midwife (CNM).
- Visiting nurse.
- Other health visits (OHV) (See note below).

OHV may include a qualified clinical psychologist, clinical social worker, dentist, dental hygienist, optometrist, Texas Health Steps medical checkup, other health professionals for mental health, etc.

What cannot be billed?

- Hospital services are not considered for reimbursement to FQHC/RHC providers and cannot be billed using the facility provider number assigned to the FQHC/RHC.
- Exceptions are qualified credentialed providers performing outside of the FQHC/RHC facility. The claim would be submitted using the individual or group physician provider identifier.
- Amerigroup will reimburse the FQHC/RHC at the fee-for-service rate versus at the encounter rate.

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FQHC claims submission guidelines — medical services

All services incidental to the encounter are considered inclusive and are not reimbursed separately.

Incidental services cannot be billed as a separate encounter but are included in the total cost of the encounter.

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Claims submission guidelines — medical services

Encounters must be billed using procedure code T1015, except for:

- Family planning services.
- Texas Health Steps medical and dental services.
- Immunizations.
- Vision services.
- Mental health services.
- Case management for high-risk pregnant women and infants.

- Services provided by healthcare professionals require AH, AM, SA, TD, TE, or a U7 modifier.
- All FQHC claims will need to be submitted with POS 50
- All RHC claims will need to be submitted with POS 72

Please reference TMHP or CMS for appropriate billing requirements for FQHC/RHC facilities.

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General service modifiers

Modifier	Service performed
AH	AH services performed by psychologist
AJ	Services performed by social worker
AM	Services performed by physician, team member services
SA	Services performed by nurse practitioner in collaboration with physician
TD	Services performed by registered nurse
TE	Services performed by LPN or LVN
U7	Services performed by physician assistant other than assistant at surgery

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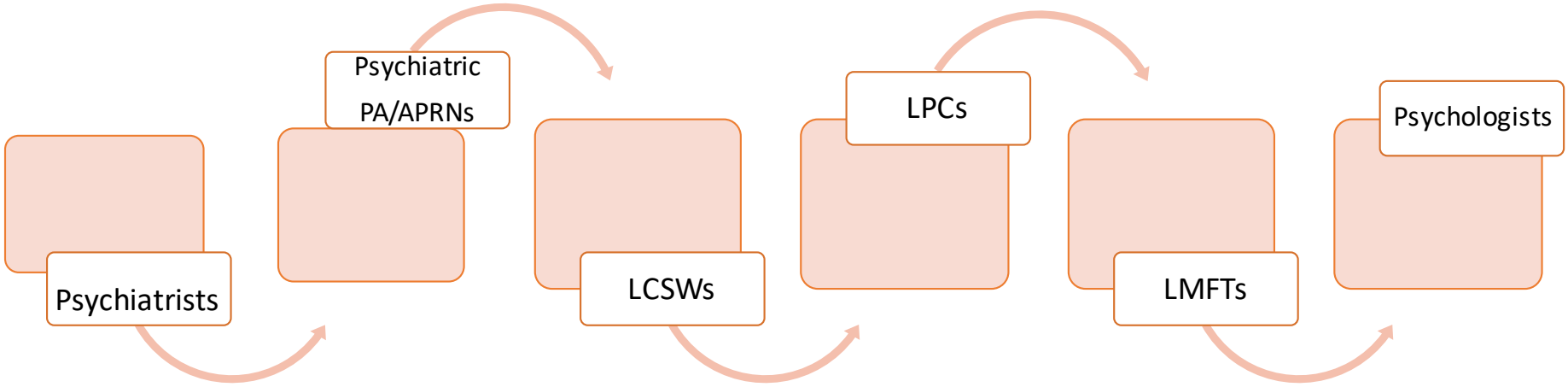
Claims submission guidelines — behavioral services

- Behavioral health providers include:



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FQHC claims submission guidelines — behavioral services

Mental health services codes:

Mental Health Services									
90791	90792	90832	90833*	90834	90836*	90837	90838*	90846	90847
90853	90899	96116	96130	96132	96136				
* Procedures cannot be performed by Psychologist. Mental health services must be submitted using one of the appropriate modifiers AH, AJ, AM, U1, or U2.									

Only appropriate behavioral health services that are within the scope of the providers' practice should be rendered.

For more information regarding Mental Health Services please visit:
http://bit.ly/Txoutpatientservs

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FQHC behavioral health services — authorization process

To identify whether a service requires precertification, please visit the Amerigroup website and search under Precertification Lookup Tool or Quick Reference Card at https://providers.amerigroup.com/TX for specific code requirements. We recommend using Availity as a preferred method to submit precertification request via www.Availity.com; however, you may submit a precertification request via fax. For more information, please check out the specific fax numbers on the precertification fax page.

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Incidental services

- All services incidental to the encounter are considered inclusive and are not reimbursed separately.
- Freestanding RHCs — All lab services provided in the RHC's laboratory are included in the encounter. If the laboratory is a certified Medicare laboratory, is enrolled in Medicaid as an independent laboratory and has a laboratory contract with Amerigroup, the claim should be filed under their laboratory identifier.
- Incidental services cannot be billed as a separate encounter but are included in the total cost of the encounter.

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Claims submission guidelines — multiple services/visits

An FQHC or RHC can bill up to five encounters in one day.

- Example of billing encounters in one day:
  - One general medical visit
  - OHV:
    - One Texas Health Steps checkup
    - One family planning visit
    - One mental health visit
    - One vision care visit

Based on the State's language, multiple encounters that occur on the same day at one location with the same or several different health professionals constitute a single visit.

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Claims submission guidelines — exception to multiple services/visits

An exception to the encounter per day may occur when the following is presented:

- After the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment
- The patient has both a medical visit and another health visit.

The second exception allows the provider to bill more than one encounter per day.

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Claims submission guidelines — family planning services

RHC:

- RHCs may be reimbursed for family planning services using their RHC National Provider Identifier (NPI) with the appropriate benefit code.
- Family planning services performed in the RHC setting must be billed with the appropriate modifier: AM, SA, or U7.

FQHC:

- An annual family planning examination is allowed once per state fiscal year, per patient, per provider.
- Up to three family planning encounters may be reimbursed per provider, per patient, per year.
- Only the annual family planning examination requires the FP modifier; all other family planning visits do not require the FP modifier.

View the *Texas Medicaid Provider Procedures Manual* and your contract for the required family planning procedure codes and diagnosis codes.

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RHC claims submission guidelines — Texas Health Steps services

- RHC facility providers may be reimbursed for Texas Health Steps medical services using their RHC NPI with the appropriate benefit code.
- View the *Texas Medicaid Provider Procedures Manual* and your contract for the required procedure codes and diagnosis codes.
- If the appropriate benefit code is not included, the service will process as informational only and will not be reimbursed.

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FQHC claims submission guidelines — (Texas Health Steps) services

- FQHCs must enroll in the Texas Vaccines for Children Program.
- Immunizations are not considered an encounter if this is the only reason for the visit.
- EP modifier must be used for Texas Health Steps for an FQHC. In addition, the appropriate modifier must be used to identify the healthcare provider rendering the service.
- Registered nurses may not be the sole provider of a medical checkup in an FQHC.

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FQHC vision and dental care services

- Any services provided as emergency and therapeutic treatment are billed services to Amerigroup.
- For nontherapeutic or nonemergency services, please refer members to their dental health plan for members younger than 21, or Superior Vision* of Texas (for vision services).
- For additional information, please visit the TMHP website at www.tmhp.com for a list of billable vision or dental care services.

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Payment methodology

- FQHCs and RHCs are paid an all-inclusive encounter rate.
- FQHCs are reimbursed provider-specific prospective payment system encounter rates in accordance with 1 TAC §355.8261.
- Freestanding and hospital-based RHCs are reimbursed provider-specific per-visit rates calculated in accordance with 1 TAC §355.8101.

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Encounter rate determination

- Medicaid provider-specific prospective payment system (PPS) visit rates for RHCs are calculated in accordance with 1 TAC §355.8101, and those for FQHCs are calculated in accordance with 1 TAC §355.8261.

Providers are no longer required to supply a copy of encounter notice. Amerigroup will update the encounter rate based on the published date received from HHSC or CMS as applicable.

https://rad.hhs.texas.gov/hospitals-clinic/clinic-facility-services/federally-qualified-health-centers or
https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center

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After hours care rate

- As an FQHC/RHC, Amerigroup will reimburse at 100% of the Medicaid fee schedule for providing after hours visit care services.
- After hours visit care services are defined as care provided on weekends, holidays or before 8 a.m. and after 5 p.m.

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FQHC wrap payment reminder

- All claims will need to be submitted with POS 50. Servicing and billing taxonomies must be 261QF0400X.
- We need simple billing on the first two lines of a claim that will trigger your wrap payment and flat rate payment. Every claim must have T1015 on line 1 with one of the applicable codes published in the TMPPM on line 2.
- Wrap payments only apply to FQHCs. The process of wrapping the encounter payment does not apply to RHCs.

You must also bill an applicable appropriate modifier in conjunction with these codes as outlined in the TMPPM. Any other code submitted (for example, lab, radiology), except those designated as paid outside the encounter, will still need to be submitted.

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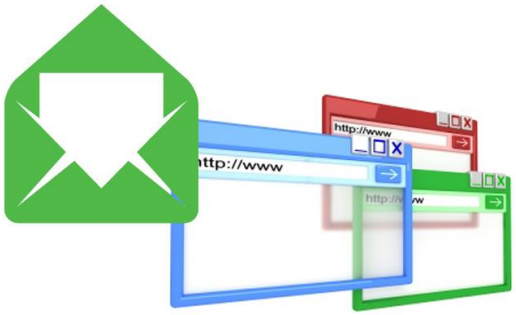
Claim submission options



- Availity Portal
- Batch 837
- Via clearinghouse
- By mail
- Timely filing is within 95 days from the date of service.

Paper submissions	Electronic submission payer
Amerigroup P.O. Box 61010 Virginia Beach, VA 23466-1010	• Availity: **1-800-282-4548** — 26375 • Email: Support@Availity.com • Website: https://www.Availity.com

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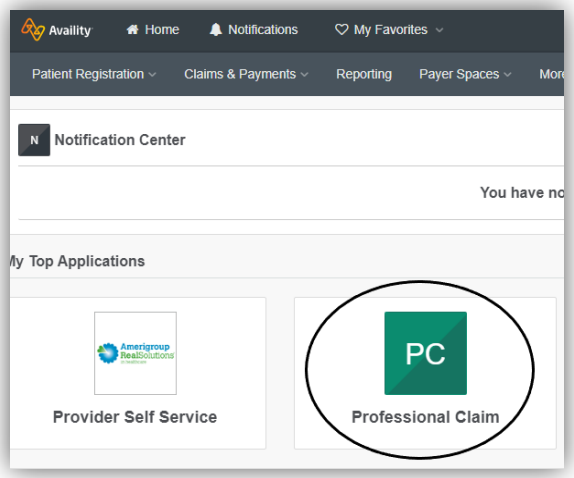
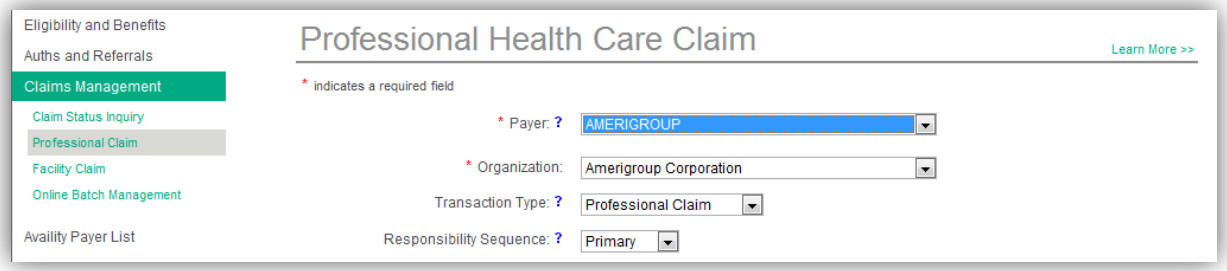
Availity claim submission

Amerigroup has designated Availity to operate and service your EDI entry point (EDI gateway).

Online claims submission:
Use our free online claim submission tool at https://www.availity.com.

Please refer to the *Quick Reference Card and* provider manual for additional information.





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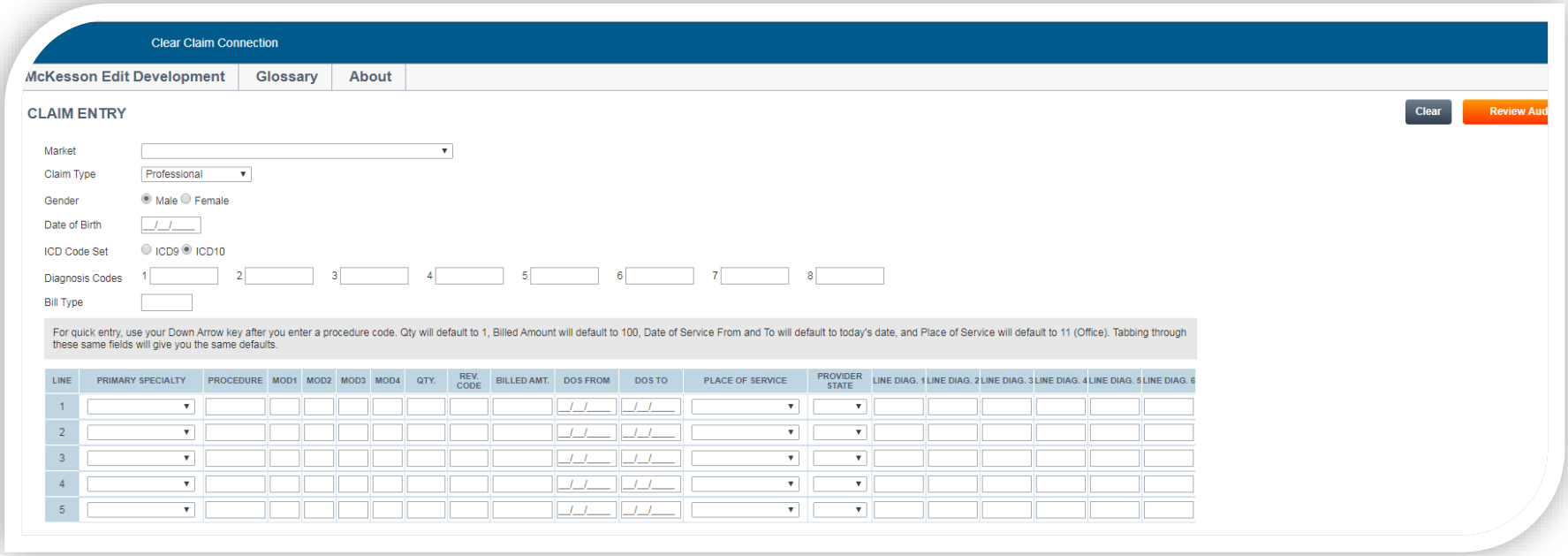
Clear Claim Connection™



- Provides guidance for code combinations and modifiers.
- Does not guarantee payment.

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Rejected versus denied claims

What is the difference between a rejected and a denied claim?

Rejected:

- Does not enter the adjudication system due to missing or incorrect information.
- Resubmission subject to 95-day timely filing deadline.

Denied:

- Does go through the adjudication process, but is denied for payment.
- Appeal deadline of 120 days from the *Explanation of Payment* (*EOP*) date applies.

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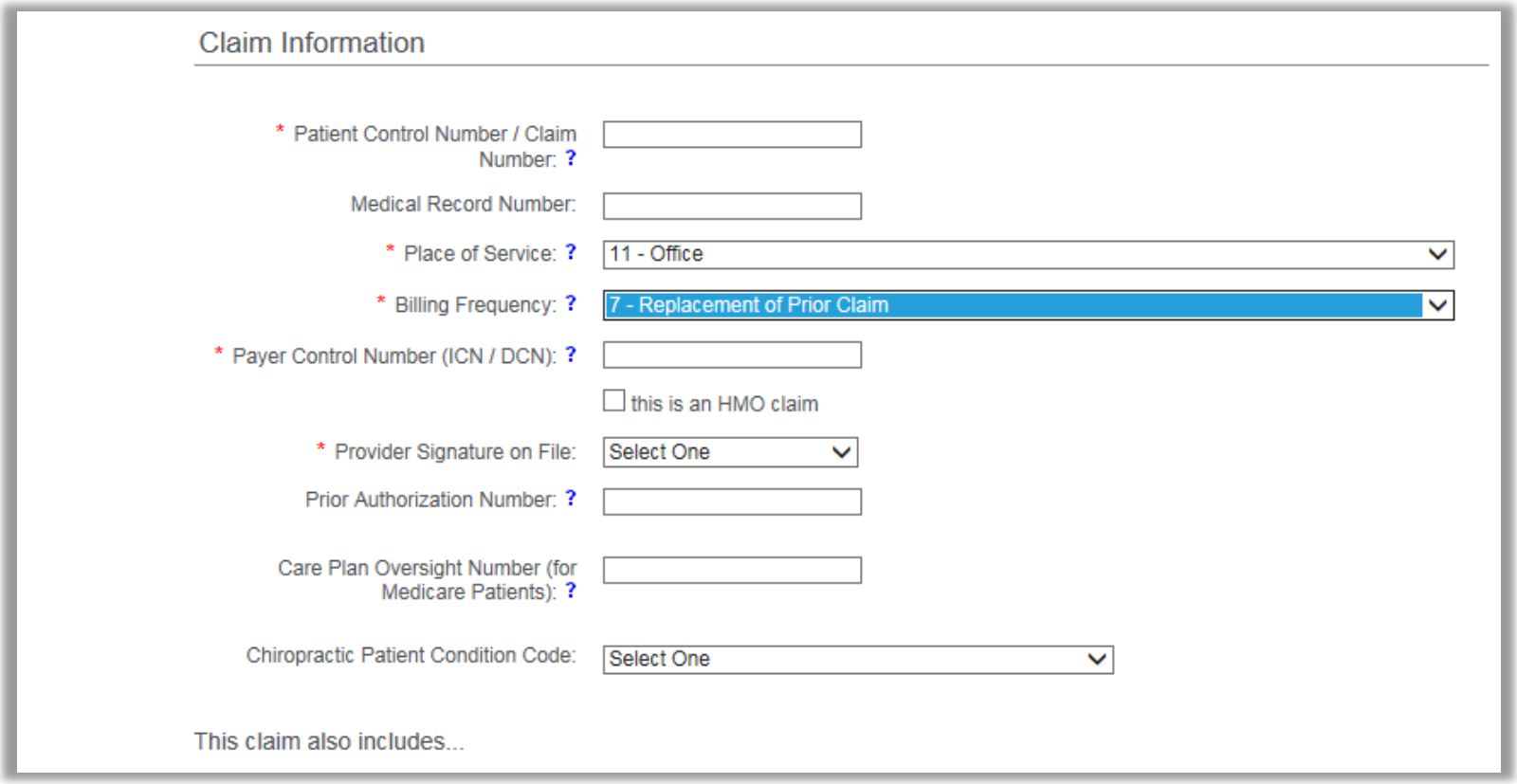
Submitting a corrected claim



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Payment dispute process

- There is a 120-day filing deadline from the date of the *EOP.*
- Providers may use the payment dispute tool at https://www.availity.com. Supporting documentation can be uploaded using the attachment feature.
- Providers can submit the *Provider Payment Dispute* form and relevant supporting documentation including the original *EOP*, corrected claim, invoices, medical records, reference materials, etc.:
- **Fax: 1-844-756-4607**
- **Mail:** Amerigroup
  Payment Dispute Unit
  P.O. Box 61599
  Virginia Beach, VA 23466-1599


Amerigroup RealSolutions in healthcare

Claim Payment Appeal– Submission Form

This form should be completed by providers for payment appeals only.

Member Information:

Member First/Last Name: _____ Member Date of Birth: _____

Member Coverage: ☐ Medicaid ☐ Medicare

Member ID: _____

Provider/Provider Representative Information:

Provider First/Last Name: _____ NPI Number: _____

Provider Street Address: _____

City: _____ State: _____ ZIP Code: _____

☐ I am a participating provider. ☐ I am a nonparticipating provider.*

*If filing for a Medicare member and the member has potential financial liability, you must include a completed Centers for Medicare & Medicaid Services Waiver of Liability form.

Provider Representative: ☐ Self ☐ Billing Agency ☐ Law Firm ☐ Other: _____

Representative Contact Name: _____ Contact Phone: (___) _____

Representative Street Address: _____ Email: _____

City: _____ State: _____ ZIP Code: _____

Claim Information:**

Claim Number: _____ Billed Amount $_____ Amount Received $_____

Start Date of Service _____ End Date of Service _____ Authorization Number _____

** If you have multiple claims related to the same issue, you can use one form and attach a listing of the claims with each supporting document following behind.

Payment Appeal

A payment appeal is defined as a request from a health care provider to change a decision made by Amerigroup related to claim payment for services already provided. A provider payment appeal is not a member appeal (or a provider appeal on behalf of a member) of a denial or limited authorization as communicated to a member in a notice of action.

☐ First-level Appeal ☐ Second-level Appeal

To ensure timely and accurate processing of your request, please complete the Payment Dispute section below by checking the applicable determination provided on the Amerigroup determination letter or Explanation of Payment.

☐ Untimely filing
☐ No authorization
☐ Denied for Other Health Insurance (OHI), but member doesn't have OHI
☐ Experimental/investigational procedure denial
☐ Claim code editing denial
☐ Retrospective authorization issue
☐ Disagree that you were paid according to your contract
☐ Data elements on the claim on file does not match the claim originally submitted
☐ Denied as duplicate
☐ Denial related to provider data issue
☐ Member retro-eligibility issue
☐ Other: _____

Mail this form, a listing of claims (if applicable) and supporting documentation to:

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

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Appointment availability and after hours standards

- We are dedicated to arranging access to care for our members. Our ability to provide quality access depends on the accessibility of network providers. We evaluate HHSC, Texas Department of Insurance and National Committee for Quality Assurance (NCQA) requirements and follow the most stringent standards among the three sources.
- Providers are required to adhere to access standards that apply to both Medicaid and CHIP unless specified. Standards are measured from the date of presentation or request, whichever occurs first.

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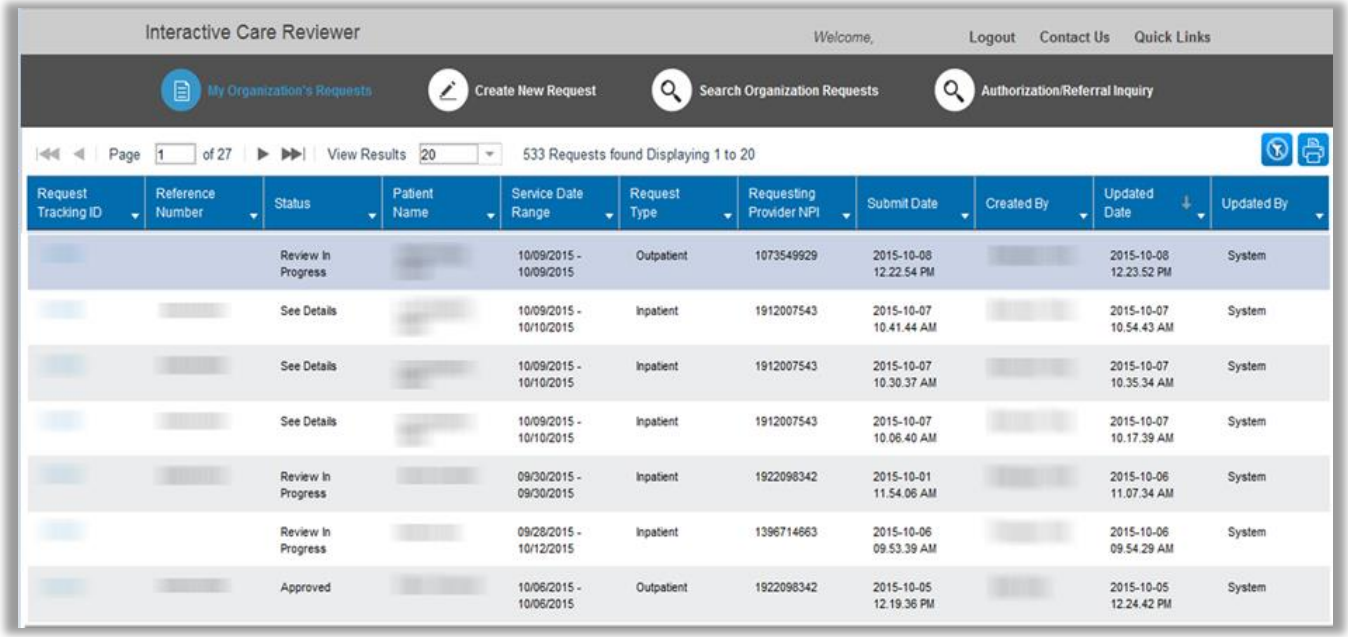
Interactive Care Reviewer

- The Interactive Care Reviewer (ICR) offers a streamlined process to request inpatient and outpatient prior authorization through Availity.



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Healthy Rewards Program

- Increase your **HEDIS®** quality scores while members earn rewards by ensuring your members receive health screenings, exams and any needed tests.

Healthy Rewards incentive chart
(does not apply to STAR+PLUS or STAR Kids members with Medicare or CHIP Perinate members)

Program	For children	Ages	Reward	Limit
STAR, STAR Kids and CHIP	Well-child visits/Texas Health Steps checkups	0 to 15 months	$120	Must complete a total of 6 visits during baby's first 15 months according to the well-child visit/Texas Health Steps schedule to earn reward
	Well-child visits/Texas Health Steps checkups	18 to 30 months	$20 per visit	Must complete a timely well-child visit/Texas Health Steps checkup at 18, 24 or 30 months
	Well-child visits/Texas Health Steps checkups	3 to 18 years of age (CHIP) or 3 to 20 years of age (STAR and STAR Kids) or 18 to 20 years of age (STAR+PLUS)	$20	Once every 12 months
	Rotavirus vaccination	42 days after birth to 24 months	$20	Complete a full series of the rotavirus vaccinations, 2 to 3 vaccinations on different days
	Human Papillomavirus (HPV) Vaccination	9 through 12 years	$20	Complete a full series of the Human Papillomavirus (HPV) Vaccination, 2 to 3 vaccinations on different days.

Healthy Rewards incentive chart (cont.)
(does not apply to STAR+PLUS or STAR Kids members with Medicare or CHIP Perinate members)

Program	For pregnant or new mothers	Ages	Reward	Limit
STAR, STAR+PLUS, STAR Kids and CHIP	Prenatal checkup	–	$25	Complete a prenatal checkup in the first trimester or within 42 days of enrollment with Amerigroup
	Postpartum checkup	–	$50	Complete a postpartum checkup 7 to 84 days after giving birth
Program	**For patients with diabetes**	**Ages**	**Reward**	**Limit**
STAR, STAR+PLUS and STAR Kids	Blood sugar test (A1C)	Age 18 years or older (STAR and STAR+PLUS) or 18 to 20 years of age (STAR Kids)	$20	Once every 6 months
	Blood sugar (HbA1c) control < 8	Age 18 years or older (STAR and STAR+PLUS) or 18 to 20 years of age (STAR Kids)	$20	Once every 6 months
Program	**Seasonal**	**Ages**	**Reward**	**Limit**
STAR, STAR Kids and CHIP	Flu vaccination	6 months to 24 months	$20	Complete a full series of the flu (influenza) vaccinations, 2 vaccinations on different days
STAR, STAR+PLUS, STAR Kids and CHIP	Flu vaccination	Ages 3 and older	$20	Once every 12 months
Program	**For women**	**Ages**	**Reward**	**Limit**
STAR+PLUS	Cervical Cancer Screening	21 to 64 years of age	$50	Once every 3 to 5 years
Program	**For behavioral health patients**	**Ages**	**Reward**	**Limit**
STAR+PLUS	Diabetes Screening for Antipsychotic Medications (SSD)	18 to 64 years of age	$20	Members diagnosed with schizophrenia or bipolar disorder and prescribed antipsychotic medication must complete a glucose or HbA1c test annually. Members already diagnosed with diabetes are excluded from this reward.
STAR, STAR+PLUS, STAR Kids and CHIP	Follow-Up after Hospitalization for Mental Illness (FUH)	–	$20	Members who complete a follow-up outpatient visit with a mental health provider within 7 days of discharge from the hospital for a mental health stay, up to 4 times per year
STAR, STAR Kids and	Follow-Up Care for Children Prescribed	6 to 12 years of age	$20	Newly diagnosed members with ADHD who have a follow-up visit with the prescribing provider within 30 days after starting their medication treatment

Patients can inquire about the Healthy Rewards program by calling **1-888-990-8681 (TTY 711)** or logging into their account at **www.myamerigroup.com/TX** to get to the Healthy Rewards site from the *Benefits* page.

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Precertification fax information

Inpatient/outpatient surgeries/general requests fax:	**1-800-964-3627**
Therapy fax (PT/ST/OT):	**1-844-756-4608**
Durable medical equipment fax:	**1-866-249-1271**
Home health nursing/pain management/wound care fax:	**1-866-249-1271**
STAR+PLUS: LTSS and personal attendant services (PAS) fax by service area:	
Austin:	**1-877-744-2334**
El Paso:	**1-888-822-5790**
Houston/Beaumont:	**1-888-220-6828**
Lubbock:	**1-888-822-5761**
San Antonio:	**1-877-820-9014**
Tarrant/RSA West:	**1-888-562-5160**
Behavioral health services:	
Using Preferred Electronic Method via www.availity.com	
Medicaid/CHIP plans:	
Behavioral health fax — inpatient:	**1-844-430-6805**
Behavioral health fax — outpatient:	**1-844-442-8010**
Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan):	
Behavioral Health fax – inpatient:	**1-844-451-2825**
Behavioral Health fax – outpatient:	**1-844-430-6804**
Specialized diagnostic testing:	
AIM Specialty Health®*	
(cardiology, radiology (high-tech), genetic testing, radiation oncology, sleep studies)	**1-800-714-0040**
www.aimspecialtyhealth.com/goweb	

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Telehealth and telemedicine services

Telemedicine medical services are defined as healthcare services delivered by a physician licensed in Texas or health professional who acts under the delegation and supervision of a health professional licensed in Texas and within the scope of the health professional's license to a patient at a different physical location using telecommunications or information technology.

Telehealth services are a benefit of Texas Medicaid. Telehealth services are defined as healthcare services, other than telemedicine medical services, delivered by a health professional licensed, certified or otherwise entitled to practice in Texas and acting within the scope of the health professional's license, certification or entitlement to a patient at a different physical location other than the health professional using telecommunications or information technology.

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Telehealth and telemedicine guidelines

- Amerigroup follows the guidelines set forth by TMHP regarding telemedicine and telehealth services.
- TMHP publishes the *Texas Medicaid Provider Procedures Manual – Telecommunication Services Handbook* on their website. The handbook offers information regarding telemedicine and telehealth services, provider types, billing guidelines, procedure codes and modifiers, and documentation requirements for the services.
- The handbook can be located at: http://www.tmhp.com/Manuals_PDF/TMPPM/TMPPM_Living_Manual_Current/2_Telecommunication_Srvs.pdf.

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Telehealth and telemedicine notifications to PCPs

- The use of telemedicine and telehealth services is intended to promote and support patient-centered medical homes and care coordination.
- As outlined in *Senate Bill 670* from the 86th Legislature, Medicaid telemedicine and telehealth providers are required to notify the Medicaid member's PCP or provider of the telemedicine or telehealth service, provided the member or their parent/legal guardian consents to the notice. This includes a summary of the telemedicine or telehealth service rendered, exam findings, a list of prescribed or administered medications, and patient instructions.

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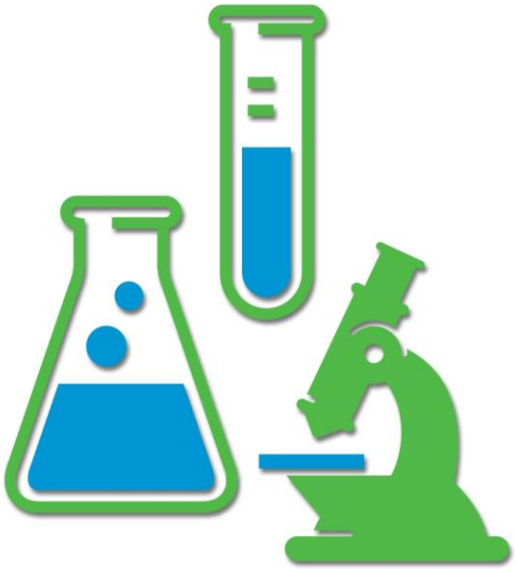
Laboratory services

- Notification or precertification is not required if laboratory work is performed in a physician's office, participating hospital outpatient department (if applicable) or by one of our laboratory vendors.
- Visit https://providers.amerigroup.com/TX for a complete listing of participating vendors.



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CAHPS and systems survey

CAHPS® is an annual survey to assess consumers' experience with their health and healthcare services from a patient's perspective. Here are a few reasons why Amerigroup conducts this type of survey.

Why focus on patient experience

- There is a strong correlation between patient experience and healthcare outcomes.
- Patients with chronic conditions demonstrate greater self-management skills and quality of life.
- Patient retention is greater when there is a high quality relationship with the provider.
- Decreased malpractice risk.
- Efforts to improve patient experience have resulted in decreased employee turnover.

How to improve patient experience

- Ensure all office staff are courteous and empathetic.
- Respect cultural differences and beliefs.
- Demonstrate active listening by asking questions and making confirmatory statements.
- Spend enough time with the patient to address all of their concerns.
- Provide clear explanation of treatments and procedures.
- Obtain and review records from hospitals and other providers.

Additional resource:
What Matters Most: Improving the Patient Experience www.patientexptraining.com. For a full CAHPS overview, visit https://providers.amerigroup.com/TX.

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Provider Satisfaction Survey

- Amerigroup sends out a *Provider Satisfaction Survey* annually to engage our provider network to provide feedback to improve and strengthen our processes and operations.
- We use your survey responses to better understand your experiences and continue to improve our programs. You can complete the survey online by obtaining a unique password/username or you may choose to mail back your response. Please remember to complete the survey!

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Coding disclaimer

- The information in this presentation does not guarantee reimbursement or payment for services.
- Coding guidance in this presentation is not intended to replace official coding guidelines or professional coding expertise.
- Amerigroup providers are expected to ensure documentation supports all codes submitted for conditions and services.
- If you have questions regarding billed claims and reimbursement, call Provider Services at **1-800-454-3730** or your designated Provider Relations Representative.

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Questions/comments

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* Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup. AIM Specialty Health is an independent company providing some utilization review services on behalf of Amerigroup. Superior Vision is an independent company providing vision services on behalf of Amerigroup.

https://provider.amerigroup.com