Amerigroup





Provider Manual

Amerigroup

STAR	Bexar, Dallas, Harris, Jefferson, Lubbock and Tarrant Counties and the Central, Northeast and West Rural Service Areas
STAR Kids	Dallas, El Paso, Harris and Lubbock Counties and the West Rural Service Area
STAR+PLUS	Bexar, El Paso, Harris, Jefferson, Lubbock, Tarrant and Travis Counties and the West Rural Service Area
CHIP	Bexar, Dallas, Harris, Jefferson and Tarrant Counties

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800-454-3730

https://provider.amerigroup.com/tx

CHIP | TEXAS STAR Your Health Plan ★ Your Choice | TEXAS STAR Kids Your Health Plan ★ Your Choice | TEXAS STAR PLUS Your Health Plan ★ Your Choice | TEXAS Health and Human Services

Amerigroup retains the right to add to, delete from and otherwise modify this provider manual. Contracted providers must acknowledge this provider manual and any other written materials provided by Amerigroup as proprietary and confidential.

Please note: Material in this provider manual is subject to change. Please visit **https://provider.amerigroup.com/TX** for the most up-to-date information.

TABLE OF CONTENTS

1 Introduction

Welcome to the Amerigroup provider family. We're pleased you're part of our network, which represents some of the finest health care providers in the state. As a leader in managed health care services for the public sector, we believe hospitals, physicians and other providers play a pivotal role in managed care. We can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, high-quality provider network. This manual contains information about our STAR, STAR Kids, STAR+PLUS and CHIP programs, and is designed to assist you with providing quality care to our members. The information in this manual may be updated periodically and changed as needed. Information on other programs offered by Amerigroup is included in the next section.

1.1 Who is Amerigroup?

Amerigroup refers to both Amerigroup Texas, Inc. and Amerigroup Insurance Company. Amerigroup members in the Medicaid Rural Service Area (RSA) and the STAR Kids program are served by Amerigroup Insurance Company. All other Amerigroup members in Texas are served by Amerigroup Texas, Inc.

Amerigroup Texas, Inc., doing business as Amerigroup is a licensed health maintenance organization (HMO). Amerigroup Insurance Company is a licensed indemnity plan. As a leader in managed health care services for the public sector, the Amerigroup health plans provide health care coverage exclusively to low-income families, children, pregnant women, elderly and disabled persons. Amerigroup also offers Medicare Advantage Plans, including Medicare Special Needs Plans, and participates in the Medicare-Medicaid Dual Demonstration Program (MMP). Amerigroup administers the following programs in Texas:

Program	Program objectives
STAR	The STAR program is a Medicaid managed care program for children, pregnant women and low-income families providing clients with acute care medical assistance. The objectives of the program are to: • Improve access to care for clients enrolled in the program. • Increase quality and continuity of care for clients. • Decrease inappropriate use of the health care delivery system, such as using emergency rooms (ERs) for nonemergencies. • Achieve cost effectiveness and efficiency for the state. • Promote provider and client satisfaction.
STAR+PLUS	The STAR+PLUS program is a Medicaid managed care program providing integrated acute and long-term services and supports in a Medicaid managed care environment for elderly and disabled adults (mainly Supplemental Security Income [SSI]-eligible Medicaid clients). 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 ICF-IID program or an IDD Waiver program (acute care and behavioral health services only — long-term services and supports are provided by the Texas Health and Human Services Commission [HHSC]). In addition to the objectives of the STAR program, the STAR+PLUS program aims to: • Integrate acute and long-term services and supports. • Coordinate Medicare services for clients who are dual-eligible.

Program	Program objectives
STAR Kids	STAR Kids is a Medicaid managed care program designed specifically for children and young adults with special needs. Most individuals 20 years old and younger who get Supplemental Security Income (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. Objectives of the STAR Kids program include: • Provide Medicaid benefits customized to meet the health care needs of recipients through a defined system of care. • Better coordination of care for recipients. • Improve health outcomes. • Improve access to health services. • Achieve cost containment and cost efficiency. • Reduce administrative complexity. • Reduce potentially preventable events, including out-of-home residential care, through provision of care management and appropriate services.
CHIP	The Children's Health Insurance Program (CHIP) provides health coverage for children age 18 and younger in families that earn too much to qualify for Medicaid but cannot afford private health care coverage. A child must be age 18 or younger, a Texas resident, and a U.S. citizen or legal permanent resident. Objectives of the CHIP program are to: • Increase the number of insured children in Texas. • Ensure children have access to a medical home, a physician or health care provider who serves the physical, mental and developmental health care needs of a growing child through a continuous and ongoing relationship. Texas residents who are pregnant, uninsured and not able to obtain Medicaid may be eligible for CHIP Perinatal benefits. Coverage starts before the child is born and lasts 12 months from the date the unborn child is enrolled. The objectives of CHIP Perinatal are to improve health status and birth outcomes by ensuring pregnant women who are ineligible for Medicaid due to income or immigration status receive prenatal care.
Medicare Advantage	We have contracted with the Centers for Medicare & Medicaid Services (CMS) to provide a Medicare Advantage dual-eligible Special Needs Plan (SNP) as well as traditional Medicare Advantage health plans. All plans offer full Medicare Part D prescription drug coverage as well as extra benefits covering other health care services beyond what traditional Fee-For-Service (FFS) Medicare may offer. The Amerigroup Amerivantage (Medicare Advantage) Special Needs Plans (SNPs) are for Medicare beneficiaries entitled to Medicare Part A, enrolled in Medicare Part B and Medicaid (either as a full-benefit, dual-eligible or qualified-Medicare beneficiary). There are some copays for prescription drugs. The Amerigroup Amerivantage traditional Medicare Advantage plans are for Medicare beneficiaries who are entitled to Medicare Part A and are enrolled in Medicare Part B. The plans have copays for most services. The objectives of all these plans are to: • Enhance the coordination of a member's primary and acute care, long-term care, and prescription drug benefits through a unified case management program. • Improve the health status and outcomes of members.
Medicare-Medicaid Dual Demonstration Program (MMP)	Amerigroup was selected by the Texas Health and Human Services Commission (HHSC) to participate in a demonstration program to provide both Medicare and Medicaid benefits to dual-eligibles. The goals of this program 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, behavioral health, and home- and community-based services using a patient-centered approach.

We offer these programs in the following service areas (SAs) across Texas:

Service area	STAR	STAR+PLUS	STAR Kids	CHIP	Medicare Advantage*	MMP*
Bexar	X	X		X	X	X
Dallas	X		X	X	X	
El Paso		X	X		X	X
Harris	X	X	X	X	X	X
Jefferson	X	X		X	X	
Lubbock	X	X	X		X	
Tarrant	X	X		X	X	X
Travis		X			X	
Central Texas Rural	X				X	
Northeast Texas Rural	X				X	
West Texas Rural	X	X	X		X	

* Selected counties.

For more information on the programs Amerigroup offers in Texas, please refer to the other provider manuals available on the provider website:

- STAR+PLUS Nursing Facility Provider Manual
- Medicare Advantage Provider Manual
- STAR+PLUS Medicare-Medicaid Plan (MMP) Provider Manual

You can also call **866-805-4589** for more information about Medicare Advantage or **855-878-1785** for more information about the Medicare-Medicaid Dual Demonstration Program.

1.2 Our mission and goals

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

Our goals are to:

- Improve access to preventive primary care services by ensuring the selection of a primary care provider (PCP) who will serve as provider, care manager and coordinator for all basic medical services.
- Improve the health status and outcomes of our members.
- Educate members about their benefits, responsibilities, and the appropriate use of health care services.
- Encourage stable, long-term relationships between providers and members.
- Discourage medically inappropriate use of specialists and emergency rooms.

- Commit to community-based enterprises and community outreach.
- Facilitate the integration of physical and behavioral health care.
- Foster quality improvement mechanisms that actively involve providers in re-engineering health care delivery.
- Encourage a customer service orientation with regular measurement of member and provider satisfaction.

1.3 Role of primary care providers (medical home)

The role of the primary care physician or primary care provider (PCP) is to provide a medical home for STAR, STAR Kids, STAR+PLUS and CHIP members. The PCP is also responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

Members who are eligible for both Medicare and Medicaid will receive primary care from their Medicare plan and will not select a Medicaid primary care provider.

Additional information is available in the ***Provider Rights and Responsibilities*** chapter of this manual.

1.4 Role of a Health Home

A Health Home is a provider practice that manages all of the health care a person needs — physical, mental, and social. The range of Health Home services and supports is more than is normally offered by a primary care provider. This type of care can be of great benefit to persons with one or more serious and ongoing mental or health conditions. The provider practice can be a primary care practice or, in some cases, a specialty care practice. A Health Home uses a team-based approach to care to improve access, coordination among providers and quality of care.

We will provide access to a Health Home for any member who asks for this service and for any member who would benefit from this type of care. Some of the main kinds of Health Home services are:

- Comprehensive case management.
- Care coordination.
- Patient self-management education and health promotion.
- Transitional care from inpatient or emergency room.
- Patient and family-centered care with patient and family support.
- Referral to community and social support services.
- Use of health information to link services.

1.5 Role of specialty care providers

The role of the specialty care provider is to meet the medical specialty needs of STAR, STAR Kids, STAR+PLUS, and CHIP members and provide all medically necessary covered services. Specialty care providers, including behavioral health providers, coordinate care with the member's medical home provider.

Additional information is available in the ***Provider Rights and Responsibilities*** chapter of this manual under ***Specialty Care Providers' Roles and Responsibilities***. Additional information for behavioral health providers is available in the ***Behavioral Health Program*** chapter of this manual.

1.6 Role of CHIP Perinatal providers

The role of the CHIP Perinatal provider, usually an OB/GYN, is to meet the prenatal, delivery and postpartum needs of the CHIP Perinate unborn child by providing all medically necessary covered services.

The role of the CHIP Perinatal provider caring for the CHIP Perinate newborn has the same functions as primary care and specialty providers listed above.

Additional information is available in the ***Provider Rights and Responsibilities*** chapter of this manual.

1.7 Role of long-term services and supports providers

The responsibilities of long-term services and supports (LTSS) providers include but are not limited to:

- Verifying member eligibility.
- Obtaining prior authorization for services prior to provision of those services.
- Coordinating Medicaid and Medicare benefits.
- Notifying us of changes in members' physical condition or eligibility.
- Collaborating with the Amerigroup service coordinator in managing members' health care.
- Managing continuity of care for STAR Kids and STAR+PLUS members.

Additional responsibilities and information are available in the ***Long-Term Services and Supports*** chapter of this manual.

1.8 Role of Amerigroup service coordinator

Service coordination means specialized care management services performed by a licensed, certified, and/or experienced person called a service coordinator. This includes but is not limited to:

- Identifying a member's needs through an assessment.
- Documenting how to meet the member's needs in a care plan.
- Arranging for delivery of the needed services.
- Establishing a relationship with the member and being an advocate for the member in coordinating care.
- Helping with coordination between different types of services.
- Making sure the member has a primary care provider.

A service coordinator works as a team with the member and the primary care provider to arrange all the services the member needs to receive, including services from specialists and behavioral health providers (if needed). A service coordinator helps make sure all of the member's different health care needs are met.

1.9 Role of Amerigroup transition specialist

A transition specialist is an Amerigroup employee who works with adolescent and young adult members and their support network to prepare the member for a successful transition out of STAR Kids and into adulthood. A transition specialist is wholly dedicated to counseling and educating members and others in their support network about issues and resources for transitioning out of STAR Kids after the member's 21st birthday. A transition specialist will work with the member's service coordinator to conduct ongoing transition planning activities starting at age 15.

1.10 Role of pharmacy

Our pharmacy benefit provides coverage for medically necessary medications from licensed prescribers for: saving lives in emergency situations, treatment of short-term illness, sustaining life in chronic or long-term illness, or limiting the need for hospitalization. Members have access to most national pharmacy chains and many independent retail pharmacies.

Pharmacy providers are responsible for but not limited to:

- Filling prescriptions in accordance with the benefit design.
- Adhering to the Vendor Drug Program (VDP) formulary and *Preferred Drug List (PDL)*.
- Coordinating with the prescribing physician.
- Ensuring members receive all medication for which they are eligible.
- Coordinating benefits when a member also receives Medicare Part D services or other insurance benefits.
- Providing a 72-hour emergency supply of prescribed medication when a prior authorization (PA) cannot be resolved within 24 hours for a medication on the Texas Vendor Drug Program (VDP) formulary that is appropriate for the member's medical condition or if the prescribing provider cannot be reached or is unable to request a PA because it is after the prescriber's office hours. The pharmacy should submit an emergency 72-hour prescription if the dispensing pharmacist determines it is an emergency situation. Emergency situations include cases in which, based on the dispensing pharmacist's judgement, a member may experience a detrimental change in health status within 72 hours from when the pharmacy receives the prescription due to the inability to obtain the medication. Pharmacies should not dispense 72-hour emergency supplies on a routine basis.

1.11 Role of main dental home

A member of a managed care dental plan (DMO) may choose a main dental home. A dental plan will assign each member to a main dental home if they do not timely choose one. Whether chosen or assigned, each member of a DMO who is six months or older must have a designated main dental home.

A main dental home serves as the member's main dentist for all aspects of oral health care. The main dental home has an ongoing relationship with that member to provide comprehensive, continuously accessible, coordinated and family-centered care. The main dental home provider also makes referrals to dental specialists when appropriate. Federally qualified health centers (FQHCs) and individuals who are general dentists and pediatric dentists can serve as main dental homes.

1.12 Role of nursing facilities

The role of the nursing facility is to provide the necessary care and services for residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being, as defined by and in accordance with the comprehensive assessment and plan of care.

In addition, nursing facility responsibilities include but are not limited to:

- Verifying member eligibility.
- Obtaining prior authorization for services prior to provision of those services.
- Coordinating Medicaid and Medicare benefits.
- Notifying us of changes in members' physical condition or eligibility within one business day of identification.
- Collaborating with the Amerigroup service coordinator in managing members' health care.
- Managing continuity of care for members.
- Allowing Amerigroup service coordinators and other key personnel access to Amerigroup members in the facility and to requested medical record information.

Nursing facility providers should refer to the separate *Nursing Facility Provider Manual* available at **https://provider.amerigroup.com/TX** for information specific to nursing facilities.

1.13 Network limitations

Providers with the following specialties can apply for enrollment with us as PCPs:

- General practice
- Family practice
- Internal medicine
- Pediatrics
- Obstetrics/gynecology (OB/GYN)
- Advanced practice registered nurses (APRNs) and physician assistants (PAs), when APRNs and PAs are practicing under the supervision of a physician specializing in family practice, internal medicine, pediatrics, or obstetrics/gynecology who also qualifies as a PCP
- Federally qualified health centers (FQHCs)
- Rural health clinics (RHCs) and similar community clinics
- Physicians serving members residing in nursing facilities
- Indian Health Care Providers (IHCP) for American Indian members

Providers must be enrolled with Texas Medicaid in one of the specialties listed above to serve as a PCP.

Specialist physicians may be willing to provide a medical home to selected members with special needs and conditions. Information regarding the circumstances in which a specialist can be designated as a PCP is available under the ***Specialist as a PCP*** section of this manual.

1.14 Nondiscrimination statement

Amerigroup does not engage in, aid, or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color, or national origin in providing aid, benefits, or services to beneficiaries. Amerigroup does not utilize or administer criteria having the effect of discriminatory practices on the basis of gender or gender identity. Amerigroup does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of, or subjecting them to discrimination on the basis of gender or gender identity. In addition, in compliance with the *Age Act*, Amerigroup may not discriminate against any person on the basis of age, or aid or perpetuate age discrimination by providing significant assistance to any agency, organization or person that discriminates on the basis of age. Amerigroup provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, physical or mental disability, or type of illness or condition.

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

Members are also advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

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

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

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

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

- Mail: 2505 N. Highway 360, Suite 300, Grand Praire, TX 75050
- Phone: **800-600-4441**/STAR Kids: **844-756-4600 (TTY 711)**, and ask for a member advocate
- Email: dl-txmemberadvocates@anthem.com

Equal program access on the basis of gender
Amerigroup provides individuals with equal access to health programs and activities without discriminating on the basis of gender. Amerigroup must also treat individuals in a manner consistent with their gender identity and is prohibited from discriminating against any individual or entity on the basis of

a relationship with, or association with, a member of a protected class (race, color, national origin, gender, gender identity, age, or disability).

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

2 Quick reference information

Quick reference topic	Description
Provider Services/Inquiry Line	Phone: **800-454-3730** Fax: **800-964-3627**
Amerigroup website	**https://provider.amerigroup.com/TX** Availity Essentials* at **Availity.com** These sites feature tools for real-time eligibility inquiry, claims submission/status/appeals and prior authorization requests/status/appeals. In addition, the sites offer general information and various tools that are helpful to the provider such as: • *Preferred Drug List* • List of drugs requiring prior authorization • Provider manuals • Referral directories • Provider newsletters • Precertification Lookup Tool • Electronic remittance advice and electronic funds transfer information • Health plan and industry updates • *Clinical Practice Guidelines* • Downloadable forms
Prior Authorizations	Requests for prior authorizations may be submitted as indicated below: • Digital submission (preferred method): **Availity.com** • Inpatient/Outpatient surgeries and other general requests: ○ Fax: **800-964-3627** ○ Phone: **800-454-3730** • Inpatient Discharge Planning (fax only): ○ Physical Health: **888-708-2599** ○ Behavioral Health: **844-430-6805** • Specialized Care Services (fax only): ○ Back and spine procedures: **800-964-3627** ○ Durable Medical Equipment (DME): **866-249-1271** ○ Home Health nursing (PDN, SNV, HHA): **866-249-1271** ○ Medical injectable/infusible drugs: **844-512-8995** (for other services, refer to pharmacy section of this manual) ○ Pain management injections and wound care: **866-249-1271** ○ Therapy (physical, occupational, speech): **844-756-4608** • Behavioral Health Services: ○ Digital submission (preferred method) at **Availity.com** ○ Behavioral Health — inpatient: **844-430-6805** (fax) ○ Behavioral Health — outpatient: **844-442-8010** (fax) • Carelon Medical Benefits Management, Inc.* (formerly known as AIM Specialty Health®): **833-342-1260** (phone); **careloninsights.com** (online) ○ Cardiology ○ Genetic testing ○ Radiation oncology ○ Radiology (high-tech) ○ Sleep studies • Superior Vision of Texas* (medical/surgical): ○ Fax: **855-313-3106** ○ Email: ecs@superiorvision.com • Nursing Facility: **844-206-3445** (fax) • Ambulance Transportation (nonemergency): ○ Physical health (nonurgent): **866-249-1271** (fax) ○ Behavioral health (nonurgent): **844-442-8010** (fax) ○ Urgent: **800-454-3730** (phone) ○ For additional information, refer to the ambulance transportation services (nonemergent) section of this manual.

Quick reference topic	Description

	• STAR Kids:
	  ○ Long-Term Services and Supports (LTSS)/Personal Attendant Services (PAS): **844-756-4604** (fax)
	• STAR+PLUS LTSS/PAS requests are to be submitted by service area (fax only):
	  ○ Austin: **877-744-2334**
	  ○ El Paso: **888-822-5790**
	  ○ Houston/Beaumont: **888-220-6828**
	  ○ Lubbock: **888-822-5761**
	  ○ San Antonio: **877-820-9014**
	  ○ Tarrant/West RSA : **888-562-5160**
	• Urgent Services: **800-454-3730** (phone)
	
	Documentation and forms required for prior authorization requests are available on the Amerigroup provider website.

National Provider Identifier (NPI)	The *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* requires the adoption of a standard, unique provider identifier for health care providers. All Amerigroup participating providers must have a NPI number. The NPI is a 10-digit, intelligence-free numeric identifier. Intelligence-free means the numbers do not carry information about health care providers such as the states in which they practice or their specialties. For more information about the NPI and the application process, please visit **https://nppes.cms.hhs.gov**. You can complete the application online (estimated time to complete the NPI application is 20 minutes) or complete a paper application by downloading one online or calling **800-465-2003** to request an application.
Claims information	Electronic Data Interchange (EDI): To submit transactions directly to Availity or use a clearinghouse or billing company to submit your claims to the Availity EDI Gateway. Contact Availity Client Services with any questions at **800-Availity (282-4548)** Online claims submission: Use our free online claim submission tool at **Availity.com**. Log into **Availity.com** and navigate to *Claims & Payments*, select professional or institutional, and manually enter your claim. Submit paper claims to: Amerigroup P.O. Box 61010 Virginia Beach, VA 23466-1010 Timely filing is within 95 days from the date of service or per the terms of the provider agreement. We provide an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status and prior authorization status. Visit **Availity.com**. If you are unable to access the internet, you may receive claims, eligibility, and prior authorization status over the phone at any time by calling our automated Provider Inquiry Line at **800-454-3730**.
Member medical appeal information	Member medical appeals can be initiated by the member or the provider on behalf of the member with the member's signed consent (signed consent is not required for CHIP members). An appeal request must be submitted within 60 calendar days from the date of an adverse determination. Be sure to include medical charts or other supporting information. Member medical appeals may be submitted in writing to: Amerigroup — Appeals P.O. Box 62429 Virginia Beach, VA 23466-2429

Quick reference topic	Description
	Member medical appeals may also be requested by calling Member Services at **800-600-4441**/STAR Kids: **844-756-4600 (TTY 711)**.
Payment disputes	A provider has 120 days from the date of an *Explanation of Payment (EOP)* to file a payment dispute. Providers can utilize the online payment dispute tool at **Availity.com** (locate the claim you want to dispute using **Claim Status** from the *Claims & Payments* menu). If available, select **Dispute Claim** to initiate the dispute. Go to **Request** to navigate directly to the initiated dispute in the appeals dashboard, add the documentation, and submit. Or fax the dispute request to **844-756-4607** or mail it to: Provider Payment Disputes Amerigroup P.O. Box 61599 Virginia Beach, VA 23466-1599
Complaints	Provider complaints should be faxed to **844-664-7179** or mailed to: Amerigroup P.O. Box 61789 Virginia Beach, VA 23466-1789 Providers can also email complaints at **https://provider.amerigroup.com/TX**.
Amerigroup Member Services	Phone: **800-600-4441**/STAR Kids: **844-756-4600 (TTY 711)**
24-hour Nurse HelpLine	Phone: **800-600-4441**/STAR Kids: **844-756-4600 (TTY 711)**
Behavioral health services	Phone: **800-454-3730** Prior authorization: Digital submission (preferred method) at **Availity.com** Fax: • Behavioral Health — inpatient: **844-430-6805** • Behavioral Health — outpatient: **844-442-8010**
Case managers/service coordinators	Our case managers and service coordinators are available from 8 a.m. to 5 p.m. local time at **800-454-3730** or the local health plan (see the ***Long-Term Services and Supports*** chapter for health plan service coordination telephone numbers). For urgent issues, assistance is available after normal business hours, during weekends, and on holidays through Provider Services at **800-454-3730**.
Interpreter services	Telephonic services for those who are deaf or hard of hearing: **711** Non-English telephonic services: **800-454-3730** (language line available) In-person interpretation: **800-454-3730**
Carelon Behavioral Health, Inc.*	National Provider Service Line: **800-397-1630**, Monday through Friday, 7 a.m. to 7 p.m. Central time
Carelon Medical Benefits Management, Inc. (cardiology, genetic testing, radiation oncology, hi-tech radiology, and sleep studies prior authorizations)	Phone: **833-342-1260** Website: **careloninsights.com** Prior authorization: **833-342-1260** (phone); **careloninsights.com** (online)
Dental services	Members under age 21 receive dental services through one of the following dental maintenance organizations: • DentaQuest:* **800-508-6775** (CHIP), **800-516-0165** (Medicaid) • MCNA Dental: **800-494-6262** • UnitedHealthcare: **877-901-7321** For STAR+PLUS Waiver dental benefits: Members should contact their service coordinator either directly or through Member Services at **800-600-4441 (TTY 711)**.
Pharmacy services	Online pharmacy prior authorization via CoverMyMeds:* **covermymeds.com** Pharmacy prior authorization fax: **844-474-3341** Phone: **800-454-3730** (Amerigroup Pharmacy) Medical injectable/infusible drugs prior authorization fax: **844-512-8995**
Vision services (Superior Vision of Texas)	Providers call: **866-819-4298** Members call: **800-428-8789** Medical/surgical prior authorization: **855-313-3106** (fax); ecs@superiorvision.com (email)

Quick reference topic	Description
Access2Care* (nonemergent transportation other than ambulance)	Members and providers call the number below for their membership type: • STAR: **833-721-8184 (TTY 711)** • STAR+PLUS: **844-867-2837 (TTY 711)** • STAR Kids: **844-864-2443 (TTY 711)**
Availity Essentials (for claim filing, claim status inquiries and disputes, member eligibility and benefits information, prior authorizations, and demographic updates)	Website: **Availity.com** Phone: **800-Availity (282-4548)**
Electronic Data Interchange	Contact Availity Client Services with any questions at **800-Availity (282-4548)**. If you use a clearinghouse or vendor, please work with them. EDI Payer ID - 26375
Enrollment/disenrollment Medicaid and CHIP	Phone: **800-964-2777** for STAR and CHIP **877-782-6440** for STAR+PLUS and STAR Kids
Medicaid and CHIP HelpLine	Phone: **800-964-2777** or **211**
Texas Health Steps Program	Phone: **877-847-8377**

3 Member eligibility

Eligibility for Medicaid (STAR, STAR Kids, and STAR+PLUS) and CHIP is determined by the Texas Health and Human Services Commission. Once eligible, members select enrollment in a managed care organization in their area through the administrative services contractor.

3.1 Verifying member Medicaid eligibility and MCO Enrollment

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the patient has current Medicaid coverage. Providers should verify the patient's Medicaid eligibility and MCO enrollment for the date of service prior to services being rendered. There are several ways to do this:

- Use TexMedConnect on the TMHP website at **tmhp.com**.
- Log into your TMHP user account and access the Medicaid Client Portal for providers.
- Call the TMHP Contact Center or the Automated Inquiry System (AIS) at **800-925-9126** or **512-335-5986**.
- Call Provider Services at the patient's medical or dental plan.

Important: Do not send patients who forgot or lost their cards to an HHSC benefits office for a paper form. They can request a new card by calling **800-252-8263**. Medicaid members also can go online to order new cards or print temporary cards.

Important: Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by patients. A copy is required during the appeal process if the patient's eligibility becomes an issue.

Providers access to Medicaid medical and dental health information
Medicaid providers can log into their TMHP user account and access the Medicaid Client Portal for providers. This portal aggregates data (provided from TMHP) into one central hub — regardless of the plan (FFS or Managed Care). This information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details if need be.

The specific functions available are:

- Access to a Medicaid patient's medical and dental health information including medical diagnosis, procedures, prescription medicines, and vaccines on the Medicaid Client Portal through My Account.
- Enhances eligibility verification available on any device, including desktops, laptops, tablets, and smart phones with print functionality.
- Texas Health Steps and benefit limitations information.
- A viewable and printable Medicaid card.
- Display of the Tooth Code and Tooth Service Code for dental claims or encounters.
- Display of the Last Dental Anesthesia Procedure Date.

Additionally, an online portal is available to patients at **YourTexasBenefits.com** where they can:

- View, print, and order a Your Texas Benefits Medicaid card.
- See their medical and dental plans.
- See their benefit information.
- See Texas Health Steps Alerts.
- See broadcast alerts.
- See diagnosis and treatments.
- See vaccines.
- See prescription medicines.
- Choose whether to let Medicaid doctors and staff see their available medical and dental information.

Note: The **YourTexasBenefits.com** Medicaid Client Portal displays information for active patients only. Legally Authorized Representatives can view anyone who is part of their case.

3.1.1 Your Texas Benefits Medicaid card

A person approved for Medicaid will get a Your Texas Benefits Medicaid card. A member will only be issued one card and will only receive a new card in the event of the card being lost or stolen. If the card is lost or stolen, a member can get a new one by calling toll free at **800-252-8263**.

The Your Texas Benefits Medicaid card has the following printed on the front:

- Member's name and Medicaid ID number
- The date the card was sent to the member
- The name of the Medicaid program if the member gets:
    - Medicare (QMB, MQMB)
    - Healthy Texas Women Program
    - Hospice
    - STAR Health
    - Emergency Medicaid
    - Presumptive Eligibility for Pregnant Women (PE)
- Facts a drugstore will need to bill Medicaid
- The name of the member's doctor and drugstore if the member is in the Medicaid Lock-In Program

The back of the Your Texas Benefits Medicaid card has a website the member can visit **YourTexasBenefits.com** and a phone number they can call toll free **800-252-8263** if there are questions about the card.

3.1.2 Temporary ID verification form

If the member has lost or does not have access to the Your Texas Benefits Medicaid card and needs a temporary Medicaid ID card, a temporary verification form (*Form 1027-A*) can be obtained by calling the local HHSC benefits office. Providers must accept this form as proof of Medicaid eligibility, but current coverage should be verified as described in ***Verifying Member Medicaid Eligibility***. Members can also go online at **YourTexasBenefits.com** to order a new card or print a temporary card.

3.1.3 Additional documentation and verification

In addition to the procedures in ***Verifying Member Medicaid Eligibility***, we suggest you:

- Photocopy the member's eligibility identification and retain copies in the member's file.
- Review the current monthly roster/panel of patients assigned to your practice to determine if the patient's name and Medicaid number appear on the list (for PCPs only).

3.2 Amerigroup member identification card

Amerigroup member identification cards are available in ***Appendix A*** for the STAR, STAR Kids (non-dual and dual), STAR+PLUS (non-dual and dual), and CHIP programs. We now offer members the option of downloading a free digital version of their member ID card to their Apple iOS or Android-based smartphones and tablets. Members may now show their mobile ID card as proof of coverage. Providers should treat the digital version the same as the original plastic card.

For dual-eligible STAR Kids and STAR+PLUS members who have Medicare, a PCP is not listed on the Amerigroup ID card. Instead, the phrase *Long-Term Services and Supports Benefits Only* is listed. Medicare is responsible for primary, acute, and behavioral health care services; therefore, the PCP's name, address and telephone number are not listed. The member receives long-term services and supports through Amerigroup.

3.2.1 STAR newborns

Newborns are presumed Medicaid-eligible and enrolled in the mother's health care plan for at least 90 days from the date of birth. Newborns who have not received a state-issued Medicaid ID number will automatically receive an Amerigroup-assigned number effective on their date of birth.

3.2.2 STAR Kids and STAR+PLUS newborns

If a newborn is born to a Medicaid-eligible mother enrolled in STAR Kids or STAR+PLUS, the HHSC administrative service contractor will enroll the newborn into the STAR program in the same health plan as the mother (if available in the service area). All rules related to STAR newborn enrollment will apply to the newborn. If the mother's health plan does not offer a STAR plan in the service area, the newborn will be placed in Medicaid FFS until the mother chooses a STAR plan.

3.2.3 STAR+PLUS members in the Medicaid for Breast and Cervical Cancer Program

Effective September 1, 2017, women enrolled in the Medicaid for Breast and Cervical Cancer Program were transitioned from Medicaid FFS to the STAR+PLUS program. These members are not limited to cancer treatment only; they have full STAR+PLUS benefits.

3.2.4 STAR+PLUS ICF-IID Program and IDD Waiver services members

STAR+PLUS members with intellectual disabilities or related conditions who do not qualify for Medicare and who receive services through the ICF-IID program or an IDD Waiver will be covered for acute care services only under STAR+PLUS. Long-term services and supports will be provided through HHSC. The ICF-IID program is the Medicaid program serving individuals with intellectual disabilities or related conditions who receive care in intermediate care facilities other than a state supported living center. The

IDD Waivers are the Community Living Assistance and Support Services Waiver program (CLASS), the Deaf-Blind with Multiple Disabilities Waiver program (DBMD), the Home- and Community-Based Services Waiver program (HCBS), or the Texas Home Living Waiver program (TxHmL). A personal service coordinator will be assigned to each of these members.

3.2.5 CHIP

Dependent upon the member's CHIP category, the copays may vary. Preventive health care services, such as well-child exams and immunizations and pregnancy-related services, are exempt from cost sharing.

We will issue a new ID card for those members who have notified the state of Texas they've met the out-of-pocket annual maximum. The new member ID card will display zero dollars for copays.

3.3 Service responsibility

3.3.1 STAR Service Exception Table

We will cover authorized services for all periods for which we have received payment for our members, except as indicated in the following table:

Service category	Description
Newborns	If the mother was enrolled with Amerigroup on the date of birth, Amerigroup is responsible for coverage of all covered services for 90 days after birth, including hospital, provider, and nonhospital services costs attributed to the care of a newborn.
Hospital transfers	Discharge from one hospital and readmission or admission to another hospital within 24 hours for continued treatment will not be considered a discharge under this section. For instance, if a member is hospitalized at the time of the plan change, the old plan will be responsible for the hospital services, and the new plan will be responsible for the physician services only. This will not change if a member is discharged and readmitted within 24 hours of the discharge. Once the member is discharged, the new health plan is responsible for covering all managed care services.

3.3.2 STAR Kids and STAR+PLUS Responsibility Table

Service category	Medicaid coverage only	Medicaid and Medicare coverage (dual-eligible)
Medical and behavioral health	Amerigroup	Medicare fee-for-service (FFS) or Medicare HMO
Long-term services and supports	Amerigroup and/or waiver program*	Amerigroup or Medicare FFS/Medicare HMO and/or waiver program
Prescription drugs	Amerigroup	Member's chosen Part D prescription drug vendor
Transportation coverage	Amerigroup	Amerigroup or Medicare FFS/Medicare HMO
Medicare copays and deductibles	Not applicable	State's fiscal agent (TMHP) for FFS; Medicare HMO
Medicaid wrap-around services	Not applicable	State's fiscal agent (TMHP)

* See the ***Long-Term Services and Supports*** chapter of this manual for specific responsibility information.

STAR+PLUS members with intellectual disabilities or related conditions who do not qualify for Medicare and who receive services through the ICF-IID program or an IDD Waiver will be covered for acute care services only under STAR+PLUS. Long-term services and supports will be provided through HHSC.

3.3.3 CHIP Responsibility Table

CHIP-eligible members receive coverage for up to 12 consecutive months and must apply for Medicaid if they are eligible. Please note, there is no spell-of-illness limitation for CHIP members.

Service category	Description
Pregnant members (including pregnant teens)	We require network providers to notify the plan immediately upon identifying a pregnant CHIP member (excluding CHIP Perinate). Pregnant CHIP members may be referred for a Medicaid eligibility determination. Those pregnant CHIP members who are determined to be Medicaid-eligible will be disenrolled from CHIP. Medicaid coverage will be coordinated to begin when CHIP enrollment ends to avoid gaps in health care coverage. If we remain unaware of a member's pregnancy until delivery, the delivery will be covered by CHIP. The member's eligibility expiration date will be the later of: • The end of the second month following the month of the baby's birth. • The member's original eligibility expiration date.
Newborns	Most newborns born to CHIP members or CHIP heads-of-household will be Medicaid-eligible. Eligibility of newborns must be determined for CHIP before enrollment can occur. For newborns determined to be CHIP eligible, the baby will be covered from the beginning of the month of birth for the period.

3.3.4 CHIP Perinatal Responsibility Table

The CHIP program provides certain prenatal and birth benefits to unborn children of pregnant women (adults or teens) not otherwise eligible for Medicaid due to income limits or their immigration status. The program also provides eligibility to the CHIP Perinate newborn child.

CHIP Perinatal provides for 12 months of continuous coverage from the month of the eligibility determination. The mother of the unborn child receives coverage in the prenatal period and through the month of delivery. The child then picks up the remaining months of eligibility. The CHIP Perinate mother has no eligibility following the child's birth but two postpartum visits within 60 days of delivery are covered benefits. See the ***CHIP Perinatal Postpartum Billing*** section of this manual for information on claims for postpartum visits.

Under CHIP Perinatal, the unborn child is enrolled prior to birth and remains eligible for benefits for 12 continuous months from the date of eligibility determination. Subsequent enrollment in traditional CHIP will be subject to the same eligibility and enrollment standards established in traditional CHIP rules.

Once the child is born, the family can submit an application for Medicaid for the newborn if they choose. If eligible, disenrollment from CHIP Perinatal will be coordinated with enrollment in Medicaid.

Children born to CHIP Perinate mothers whose family income is above the Medicaid eligibility threshold will have the same newborn benefits as those children enrolled in the regular CHIP program after the

initial CHIP Perinate newborn admission. Children born into families whose income falls at or below the Medicaid eligibility threshold will be enrolled in Medicaid. There is no spell-of-illness limitation for CHIP Perinate newborn members. Copays/cost sharing does not apply to CHIP Perinate mothers or CHIP Perinate newborns.

Service category	Description
Families with income at or below the Medicaid eligibility threshold	Amerigroup is not financially responsible for any claims with effective dates of coverage occurring while the child is confined in a hospital. These claims should be submitted to the Texas Medicaid & Healthcare Partnership for processing.
Families with income above the Medicaid eligibility threshold	Amerigroup is responsible for the costs of covered services beginning on the effective date. If a CHIP Perinate newborn is disenrolled while confined in a hospital, our responsibility for the costs of covered services terminates on the date of disenrollment.

3.4 Member enrollment and disenrollment from Amerigroup

3.4.1 Medicaid enrollment

STAR, STAR Kids, and STAR+PLUS members may enroll in or disenroll from Amerigroup at any time. If a member asks how to enroll in or disenroll from Amerigroup, the provider can direct the member to either method below:

- Call the state enrollment broker, MAXIMUS, at **800-964-2777** for STAR and CHIP or call **877-782-6440** for STAR+PLUS and STAR Kids.
- Write to MAXIMUS at P.O. Box 149219, Austin, TX 78714-9965.

The effective date of an enrollment or disenrollment is generally no later than the first day of the second month following the month in which a completed enrollment or disenrollment form was received by MAXIMUS. The examples below illustrate how to determine the effective date of an enrollment or disenrollment:

Example 1:	MAXIMUS receives the enrollment or disenrollment form by January 15; the effective date is February 1.
Example 2:	MAXIMUS receives the enrollment or disenrollment form between January 16 and January 31; the effective date is March 1.

3.4.2 Medicaid expedited enrollment of pregnant women

Female members eligible for Medicaid under the Type Program 40 (TP40) Pregnant Woman category are eligible for an expedited enrollment as follows:

Certification date	Enrollment standard
Certified from the 1st through the 10th of the month	Member will be enrolled on the first day of the month of certification.
Certified from the 11th through the end of the month	Member will be enrolled on the first day of the month following the month of certification.
Certified at any time during their estimated month of delivery	Member will be enrolled the first day of the following month (prospective enrollment).

Certification date	Enrollment standard
Certified in their actual month of delivery (if known by the Department of State Health Services prior to certification)	Member will be enrolled the first day of the following month (prospective enrollment).

The Texas Health and Human Services Commission (HHSC) may retroactively assign an eligible member to us. If a claim is denied, the provider should appeal the claim and include documentation regarding the member's exact enrollment date. Refer to the ***Provider Appeal Process to HHSC (Related to Claim Recoupment due to Member Disenrollment)*** section of this manual for additional information on how to submit an appeal.

3.4.3 Medicaid automatic re-enrollment

Members who are disenrolled because they're temporarily ineligible for Medicaid are automatically re-enrolled in the same HMO. The member may elect to change HMOs at any time. Temporary loss of eligibility is defined as a period of six months or less. We notify our members of this procedure through our member handbooks.

3.4.4 Medicaid managed care program disenrollment

Members who request disenrollment from the mandated managed care program to move back into FFS require medical documentation from the PCP and/or specialist. HHSC renders a final decision on these types of requests. Providers cannot take retaliatory action against a member who decides to disenroll from Amerigroup.

3.4.5 Medicaid enrollment changes due to SSI status

When an adult STAR member becomes qualified for SSI, the member will move to STAR+PLUS or the Dual Demonstration. When a child STAR member becomes qualified for SSI, the member will move to STAR Kids.

3.4.6 Medicaid enrollment changes with custom durable medical equipment (DME) and augmentative device prior authorization

The following table describes payment responsibility for Medicaid enrollment changes that occur when a prior authorization exists for custom DME before the delivery of the product.

	Scenario	Custom DME	All other covered services
1	Member moves between STAR, STAR Kids, STAR+PLUS, or STAR Health MCO	Former MCO	New MCO
2	Member moves from FFS to STAR, STAR Kids, STAR+PLUS, or STAR Health MCO	New MCO	New MCO

3.4.7 Medicaid enrollment changes with home modification

The following table describes payment responsibility for Medicaid enrollment changes that occur during a minor home modification service provided to an HCBS STAR+PLUS Waiver or MDCP STAR Kids Waiver member before completion of the modification.

	Scenario	Minor home modification	All other covered services
	Member moves between STAR Kids or STAR+PLUS MCOs	Former MCO	New MCO

3.4.8 Members enrolled in HHSC Hospice Program

When a STAR member becomes enrolled in the HHSC Medicaid Hospice Program, the member will receive Medicaid services through Fee-for-Service (FFS) and will be disenrolled from Amerigroup. HHSC will notify Amerigroup of the enrollment in the HHSC Medicaid Hospice Program and will initiate prospective disenrollment from managed care and transition the member to FFS.

When a STAR Kids or STAR+PLUS member becomes enrolled in the HHSC Medicaid Hospice Program, the member will remain enrolled in managed care with Amerigroup. We will cover services unrelated to the member's terminal illness and furnish case management coordination.

3.4.9 CHIP enrollment

Children who enroll in CHIP receive 12 months of continuous coverage. Members must re-enroll annually.

If members need assistance with re-enrollment, direct them to call:

- Amerigroup Member Services at **800-600-4441 (TTY 711)**.
- CHIP at **800-964-2777**.

3.4.10 CHIP disenrollment

CHIP members are allowed to make health plan changes under the following circumstances:

- For any reason within 90 days of enrollment in CHIP
- For cause at any time
- If the member moves to a different service delivery area
- During the member's annual re-enrollment period

HHSC will make the final decision. Providers cannot take retaliatory action against a member who decides to disenroll from CHIP.

3.4.11 CHIP Perinatal enrollment and disenrollment

CHIP Perinate mothers have 15 calendar days from the time the enrollment packet is sent by the vendor to enroll in a managed care organization (MCO). If the mother of the CHIP Perinate member lives in an area with more than one CHIP MCO and does not select an MCO within 15 calendar days of receiving the enrollment packet, the CHIP Perinate member is defaulted into an MCO, and the mother is notified of the plan choice. When this occurs, the mother has 90 days to select another MCO.

3.4.12 CHIP Perinatal plan change

A CHIP Perinate unborn child who lives in a family with an income at or below the Medicaid eligibility threshold will be deemed eligible for Medicaid and will receive 12 months of continuous Medicaid coverage (beginning on the date of birth) after the birth is reported to HHSC's enrollment broker.

A CHIP Perinate mother in a family with an income at or below the Medicaid eligibility threshold may be eligible to have the costs of the birth covered through Emergency Medicaid. Clients under the Medicaid eligibility threshold will receive *Form H3038* with their enrollment confirmations. *Form H3038* must be filled out by the provider at the time of birth and returned to HHSC's enrollment broker.

A CHIP Perinate unborn child will continue to receive coverage through the CHIP program as a CHIP Perinate newborn if born to a family with an income above the Medicaid eligibility threshold and the birth is reported to HHSC's enrollment broker.

A CHIP Perinate newborn is eligible for 12 months continuous CHIP enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate newborn will maintain coverage in their CHIP Perinatal health plan.

In the tenth month of the CHIP Perinate newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form that is prepopulated to include the CHIP Perinate newborn's and the CHIP member's information.

CHIP Perinate members may request to change health plans for any reason within 90 days of enrollment in the CHIP Perinatal program, for cause at any time, and if the member moves into a different service delivery area.

3.4.13 CHIP Perinatal disenrollment

HHSC makes final decisions on member enrollment and disenrollment. Providers cannot take retaliatory action against a member who decides to disenroll from the CHIP Perinatal program.

3.4.14 Enrollments and disenrollments while hospital confined

If a CHIP or CHIP Perinate program member's effective date of coverage occurs while the member is confined in a hospital, Amerigroup is responsible for the member's costs of covered services as of the effective date of coverage. If a member is disenrolled while confined in a hospital, our responsibility for the member's costs of covered services terminates on the date of disenrollment.

3.4.15 Effective date of SSI status

The Social Security Administration notifies HHSC of a member's SSI status. HHSC will update their eligibility system within 45 days of receiving notice of SSI status for a member. The member will then be able to choose to either:

- Prospectively move to STAR+PLUS (if the member is an adult).
- Prospectively move to STAR Kids (if the member is a child).

HHSC will not retroactively disenroll a member from the STAR, CHIP, or CHIP Perinatal programs.

4 Covered services and extra benefits

4.1 Medicaid covered services for STAR, STAR Kids, and STAR+PLUS

Our coverage of Medicaid members (STAR, STAR Kids, and STAR+PLUS) includes medically necessary services as outlined for the Medicaid FFS program in the *Texas Medicaid Provider Procedures Manual (TMPPM)*, enhanced pharmacy and inpatient coverage, and extra benefits. The table below compares covered services of STAR, STAR Kids, and STAR+PLUS to traditional FFS Medicaid.

Covered services	STAR	STAR+PLUS	STAR Kids	Traditional Medicaid FFS
Core Medicaid benefits as outlined in the Medicaid FFS program (listed below in ***Acute Care Covered Services (Core Medicaid Services Covered by Amerigroup)***)	X	X	X	X
Waiver of the three prescription per month limit (unlimited prescriptions for adults are only available for members not covered by Medicare)	X	X	X	
Waiver of the 30-day spell-of-illness limitation under FFS	X	See notes below	X	
Extra or value-added benefits	X	X	X	

Notes:

- STAR Kids and STAR+PLUS dual-eligible members receive their acute care services coverage through Medicare.
- The $200,000 annual limit on inpatient services does not apply for STAR, STAR Kids, and STAR+PLUS members.
- For STAR+PLUS, waiver of the 30-day spell-of-illness limitation applies only to members under age 21 and to non-dual members with a diagnosis from the categories of bipolar disorder (F31), major depressive disorder (F32), recurrent depressive disorder (F33), schizophrenia (F20), or schizoaffective disorder (F25) as defined by the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)*. Unspecified diagnosis codes are not exempt from the limitation.

STAR+PLUS members with intellectual disabilities or related conditions who do not qualify for Medicare and who receive services through the ICF-IID program or an IDD Waiver will be covered for acute care services only under STAR+PLUS. Long-term services and supports will be provided through HHSC.

Covered services are subject to change in accordance with Texas Medicaid requirements. Modifications to covered services are communicated through the provider website, mailings, faxes, emails, newsletters, and/or provider contractual amendments. Medicaid members do not have deductibles or copays for Medicaid covered services, and providers are prohibited from balance billing for Medicaid covered services.

4.1.1 Acute care covered services (core Medicaid services covered by Amerigroup)

Medicaid covered acute care services include but are not limited to medically necessary:

- Ambulance services — emergency and nonemergency transportation
- Audiology services (including hearing aids for adults and children)
- Behavioral health services including:
    - Inpatient mental health services for adults and children
    - Outpatient mental health services for adults and children
    - Psychiatry services
    - Mental health rehabilitative services
    - Counseling services for adults (21 years of age and over)
    - Outpatient substance use disorder treatment services including:
        - Assessment
        - Detoxification services
        - Counseling treatment
        - Medication assisted therapy
    - Residential substance use disorder treatment services including:
        - Detoxification services
        - Room and board
- Birthing services provided by a physician and certified nurse-midwife in a licensed birthing center
- Birthing services provided by a licensed birthing center
- Cancer screening, diagnostic, and treatment services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Early childhood intervention (ECI) services
- Emergency services
- Family planning services
- Home health care services
- Hospital services (inpatient and outpatient)
- Laboratory services
- Mastectomy, breast reconstruction, and external breast prosthesis-related follow-up procedures including:
    - Inpatient services, outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate, physician and professional services provided in an office, inpatient or outpatient setting for:
        - All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed
        - Surgery and reconstruction on the other breast to produce symmetrical appearance
        - Treatment of physical complications from the mastectomy and treatment of lymphedemas
        - Prophylactic mastectomy to prevent the development of breast cancer
    - External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed; surgery and reconstruction on the other breast to produce symmetrical appearance

- Medical checkups and Comprehensive Care Program (CCP) services for children (birth through age 20) through the Texas Health Steps program
- Mental health targeted case management
- Nonemergency medical transportation services
- Nursing facility services under the STAR+PLUS program
- Oral evaluation and fluoride varnish in the medical home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age
- Podiatry
- Prenatal care
- Prenatal care provided by a physician, certified nurse midwife, nurse practitioner, clinical nurse specialist, or physician assistant in a licensed birthing center
- Prescription drugs, medications, and biologicals including pharmacy-dispensed and provider-administered outpatient drugs and biologicals
- Primary care services
- Preventive services including an annual adult well-check for patients 21 years of age and older
- Radiology, imaging, and X-rays
- Specialty physician services
- Telehealth
- Telemedicine
- Telemonitoring
- Therapies (physical, occupational, and speech)
- Transplantation of organs and tissues
- Vision services including optometry and glasses (Contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses.)

4.1.2 Medicaid program exclusions

The following services are not covered by Amerigroup or traditional FFS Medicaid:

- All services not medically necessary
- All services not provided, approved, or arranged by a network provider or preauthorized by a nonparticipating provider with the exception of emergency, Texas Health Steps, and family planning services
- Cosmetic surgery, except when medically necessary
- Experimental organ transplants
- Infertility treatments and drugs
- Rest cures, personal comfort and convenience items, and services and supplies not directly related to the care of the patient
- Services provided in federally operated facilities
- Other services listed in the *TMPPM* as noncovered benefits (located at **tmhp.com**)

4.1.3 Coordination with non-Medicaid managed care covered services

In addition to MCO coverage, STAR, STAR Kids, and STAR+PLUS members are eligible for the services described below. Amerigroup and our network providers are expected to refer to and coordinate with

these programs. These services are described in the *Texas Medicaid Provider Procedures Manual (TMPPM)*:

- Texas Health Steps dental (including orthodontia)
- Texas Health Steps environmental lead investigation (ELI)
- Early Childhood Intervention (ECI) case management/service coordination
- Early Childhood Intervention Specialized Skills Training
- Texas School Health and Related Services (SHARS)
- Department of Assistive and Rehabilitative Services Blind Children's Vocational Discovery and Development Program
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- For STAR Kids and STAR+PLUS, HHSC hospice services
- For STAR, Texas Health Steps personal care services for members birth through age 20
- For STAR, Community First Choice (CFC) services
- For STAR Kids and STAR+PLUS, PASRR screenings, evaluations, and specialized services
- HHSC contracted providers of long-term services and supports for STAR+PLUS members who have intellectual or developmental disabilities
- HHSC contracted providers of case management or service coordination services for STAR+PLUS members who have intellectual or developmental disabilities
- Mental Health Targeted Case Management and Mental Health Rehabilitative Services for STAR Kids and STAR+PLUS dual-eligible members
- For STAR Kids, nursing facility services and intermediate care facility (ICF) services
- For STAR Kids, HHSC or DSHS HCBS waiver programs authorized under *Social Security Act §1915(c)*, including Youth Empowerment Services (YES), Community Living Assistance and Support Services (CLASS), Deaf-Blind with Multiple Disabilities (DBMD), Texas Home Living (TxHmL), and home- and community-based services (HCBS)
- For members who are prospectively enrolled in STAR, STAR Kids, or STAR+PLUS from Medicaid FFS during an inpatient stay, hospital facility charges associated with the inpatient stay are noncapitated services, except for a stay in a chemical dependency treatment facility for STAR and STAR+PLUS members

4.1.4 Dental services

STAR, STAR Kids, and STAR+PLUS members age 20 and younger are covered for dental services through their core Medicaid benefits. Members select a dental maintenance organization though HHSC's enrollment broker to provide these services.

Home- and Community-Based Services (HCBS) STAR+PLUS Waiver members are eligible for services provided by a dentist to preserve teeth and meet the medical needs of the member. Allowable services include:

- Emergency dental treatment necessary to control bleeding, relieve pain, and eliminate acute infection.
- Preventive procedures required to prevent the imminent loss of teeth.
- The treatment of injuries to teeth or supporting structures.

- Dentures and the cost of preparation and fitting.
- Routine procedures necessary to maintain good oral health.

Dental services for HCBS STAR+PLUS Waiver members are limited to $5,000 per waiver plan year. This limit may be exceeded upon approval by Amerigroup up to an additional $5,000 per waiver plan year when medically necessary treatment requires the services of an oral surgeon. Amerigroup may also approve other dental services above the $5,000 waiver plan year limit on a case-by-case basis due to medical necessity, functional necessity, or the potential for improved health of the member. Amerigroup must review and approve any treatment in excess of the waiver plan year limit prior to services being rendered.

4.1.4.1 Nonemergency dental services

Medicaid nonemergency dental services
Amerigroup is **not responsible** for paying for routine dental services provided to Medicaid members except as allowed for HCBS STAR+PLUS Waiver members. These services are paid through dental managed care organizations.

Amerigroup **is responsible** for paying for treatment and devices for craniofacial anomalies and for oral evaluation and fluoride varnish benefits (OEFV) provided as part of a Texas Health Steps medical checkup for members aged 6 months through 35 months old.

Medical providers for Texas Health Steps must complete training and become certified to provide the intermediate oral evaluation and fluoride varnish application before providing these services. Federally qualified health center (FQHC) providers will be certified at the facility level. Training for certification is available as a free continuing education course on the Texas Health Steps website at **txhealthsteps.com**.

The OEFV benefit includes (during a visit) intermediate oral evaluation, fluoride varnish application, dental anticipatory guidance, and assistance with a main dental home choice.

- OEFV is billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup (99381, 99382, 99391, or 99392 medical checkup procedure code).
- OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT® code 99429 with U5 modifier and diagnosis code Z00.121 or Z00.129.
- Documentation must include all components of the OEFV.
- Texas Health Steps providers must assist members with establishing a main dental home and document the member's main dental home choice in the member's file.

A maximum of six services may be billed per member lifetime by any provider. There is no additional reimbursement for OEFV services for FQHCs.

For more information, see **https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/medical-providers/oral-evaluation-fluoride-varnish-medical-home**.

CHIP nonemergency dental services
Amerigroup is **not responsible** for paying for routine dental services provided to CHIP and CHIP Perinate members. These services are paid through dental managed care organizations. Amerigroup **is responsible** for paying for treatment and devices for craniofacial anomalies.

Amerigroup will provide coverage for fluoride varnish for CHIP members in accordance with American Academy of Pediatrics (AAP) guidelines.

4.1.4.2 Emergency dental services

Medicaid emergency dental services
Amerigroup is responsible for emergency dental services provided to Medicaid members in a hospital, freestanding emergency room, or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (for example, anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts
- Treatment of oral abscess of tooth or gum origin

CHIP emergency dental services
Amerigroup is responsible for emergency dental services provided to CHIP members and CHIP Perinate newborn members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (for example, anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts
- Treatment of oral abscess of tooth or gum origin

4.1.5 Family planning services

Family planning services are a covered benefit of the Medicaid program. We cover family planning services, including medically necessary medications, contraceptives, and supplies not covered by the Vendor Drug Program (VDP). We reimburse out-of-network family planning providers in accordance with HHSC administrative rules. Except as otherwise noted, no prior authorization is required for family planning services.

STAR, STAR Kids, and STAR+PLUS members must be allowed:

- The freedom to choose medically appropriate contraceptive methods.
- The freedom to accept or reject services without coercion.
- To receive services without regard to age, marital status, sex, race or ethnicity, parenthood, handicap, religion, national origin, or contraceptive preference.
- To self-refer for family planning services to any Texas Health and Human Services-approved family planning provider listed on the web at **healthytexaswomen.org/family-planning-program**.

Only members receiving family planning services, not their parents, spouse, or any other individual, may consent to the provision of family planning services. Providers cannot require parental consent for minors to receive family planning services and must keep family planning use confidential in accordance with applicable privacy laws. However, counseling should be offered to adolescents to encourage them to discuss their family planning needs with a parent, an adult family member, or other trusted adult.

4.1.6 Pharmacy

Our pharmacy benefit provides coverage for medically necessary prescriptions from any licensed prescriber for legend and nonlegend medications that appear in the latest revision of the *Texas Drug Code Index* for Medicaid and CHIP members. Members have access to most national pharmacy chains and many independent retail pharmacies that are contracted with us. Members may obtain their medications at any network pharmacy unless HHSC has placed the member in the Office of Inspector General (OIG) Lock-In Program.

We process prescription drug claims using a computerized point-of-sale (POS) system. This system gives participating pharmacies online, real-time access to beneficiary eligibility, drug coverage (to include prior authorization requirements), prescription limitations, pricing and payment information, and prospective drug utilization review.

Prescription limits
All prescriptions are limited to a maximum 34-day supply per fill except for CHIP members. All prescriptions for noncontrolled substances are valid only for 11 refills or 12 months from the date the prescription was written, whichever is less.

CHIP member prescriptions
CHIP members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 90-day supply of a drug.

OIG Lock-In Program
The HHSC OIG Lock-In Program restricts, or locks in, a Medicaid member to a designated pharmacy if HHSC finds the member used drugs covered by Medicaid at a frequency or in an amount that is duplicative, excessive, contraindicated, or conflicting or that the member's actions indicate abuse, misuse, or fraud. Some circumstances allow a member to be approved to receive medications from a pharmacy other than the lock-in pharmacy; a pharmacy override occurs when Amerigroup approves a member's request to obtain medication at an alternate pharmacy other than the lock-in pharmacy. In order to request a pharmacy override, the member or pharmacy should call Pharmacy Member Services at **833-235-2022**/STAR Kids: **833-370-7463 (TTY 711)**.

The following are allowable circumstances for pharmacy override approval:

- The member moved out of the geographical area (more than 15 miles from the lock-in pharmacy).
- The lock-in pharmacy does not have the prescribed medication, and the medication will not be available for more than 2 to 3 days.
- The lock-in pharmacy is closed for the day, and the member needs the medication urgently.

Covered drugs
The Amerigroup Pharmacy program utilizes the Texas Medicaid/CHIP Vendor Drug Program (VDP) formulary and Medicaid *Preferred Drug List (PDL)* at **txvendordrug.com**. The *PDL* is a list of the preferred drugs within the most commonly prescribed therapeutic categories for Medicaid; it does not apply to CHIP. The *PDL* is comprised of drug products reviewed and approved by the Texas Drug Utilization Review Board. Over-the-counter (OTC) medications specified in the Texas State Medicaid plan are included in the

formulary and are covered if prescribed by a licensed prescriber. OTC medications are generally not covered for CHIP members; however, exceptions exist. **To prescribe medications listed as nonpreferred on the *PDL*, call Amerigroup Pharmacy at 800-454-3730** for prior authorization.

Only those drugs listed in the latest edition of the Texas Drug Code Index (TDCI) are covered. Venosets, catheters, and other medical accessories are not covered and are not included when submitting claims for intravenous and irrigating solutions.

Except for vitamins K and D3, prenatal vitamins, fluoride preparations, and products containing iron in its various salts, we do not reimburse for vitamins and legend and nonlegend multiple-ingredient anti-anemia products. There are some additional exceptions in the VDP formulary based on the age of the member.

We may limit coverage of drugs listed in the TDCI per the VDP. Procedures used to limit utilization may include prior approval, cost containment caps or adherence to specific dosage limitations according to FDA-approved product labeling. Limitations placed on the specific drugs are indicated in the TDCI.

The following are examples of covered items:

- Legend drugs
- Insulin
- Disposable insulin needles/syringes
- Disposable blood/urine glucose/acetone testing agents
- Lancets and lancet devices
- Compounded medication of which at least one ingredient is a legend drug listed on the VDP formulary
- Any other drug, which under the applicable state law, may only be dispensed upon the written prescription of a physician or other lawful prescriber and is listed on the VDP formulary
- Legend contraceptives (Exception: Injectable contraceptives may be dispensed up to a 90-day supply.)

Prior authorization drugs

Providers are strongly encouraged to write prescriptions for preferred products as listed on the *PDL*. If, for medical reasons, a member cannot use a preferred product, providers are required to contact Amerigroup Pharmacy at **800-454-3730** to obtain prior authorization.

Examples of medications that require prior authorization are listed below (**Note:** This list is not all-inclusive and is subject to change.):

- Drugs listed as nonpreferred on the *PDL* or drugs that require clinical prior authorization
- Select self-administered injectable products
- Drugs that exceed certain cost and/or dosing limits (for information on these limits, call Amerigroup Pharmacy at **800-454-3730**)

Obtaining prior authorization
To prescribe medications that require prior authorization, submit a request online at **covermymeds.com**, by fax to **844-474-3341**, or by phone at **800-454-3730**. For requests by fax, submit a *Pharmacy Prior Authorization Form* available on the provider website at **https://provider.amerigroup.com/TX**.

Providers must be prepared to supply relevant clinical information regarding the member's need for a nonformulary or nonpreferred product or a medication requiring prior authorization. Only the prescribing physician or one of their staff representatives can request prior authorization. Decisions are based on medical necessity and are determined according to VDP-established medical criteria. Most approved requests for prior authorization will be valid for one year, although some medications may require review more often.

Emergency prescription supply
A 72-hour emergency supply of a prescribed drug can be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a prior authorization (PA), either because they are nonpreferred drugs on the *Preferred Drug List* or because they are subject to clinical edits.

A 72-hour emergency supply may be dispensed when a PA cannot be resolved within 24 hours for a medication on the Texas Vendor Drug Program (VDP) formulary that is appropriate for the member's medical condition or if the prescribing provider cannot be reached or is unable to request a PA because it is after the prescriber's office hours. The pharmacy should submit an emergency 72-hour prescription if the dispensing pharmacist determines it is an emergency situation. *Emergency situation* includes a case in which, based on the dispensing pharmacist's judgement, a member may experience a detrimental change in health status within 72 hours from when the pharmacy receives the prescription due to the inability to obtain the medication. Pharmacies should not dispense 72-hour emergency supplies on a routine basis.

A pharmacy can dispense a product packaged in a dosage form that is fixed and unbreakable (for example, an albuterol inhaler) as a 72-hour emergency supply.

To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit the following information:

- "8" in "Prior Authorization Type Code" (Field 461-EU)
- "801" in "Prior Authorization Number Submitted" (Field 462-EV)
- "3" in "Days Supply" (in the Claim segment of the billing transaction) (Field 405-D5)
- The quantity submitted in "Quantity Dispensed" (Field 442-E7) should not exceed the quantity necessary for a three-day supply according to the directions for administration given by the prescriber. If the medication is a dosage form that prevents a three-day supply from being dispensed (for example, an inhaler), it is still permissible to indicate that the emergency prescription is a three-day supply and enter the full quantity dispensed

Call the Pharmacy Help Desk at **833-252-0329** for more information about the 72-hour emergency prescription supply policy.

Dispensing limitations
Several drugs have dispensing limitations to ensure appropriate use. The following is an example of some limitations. For a complete list of limitations, refer to the Texas VDP formulary and *PDL* at **txvendordrug.com**:

- Prenatal vitamins limitation is for females younger than the age of 50 only.
- Family planning drugs prescribed for contraception are not covered by CHIP.
- Anti-fungal limitation is a 180-day supply per calendar year.
- Stadol limitation is 10 ml per calendar month (four bottles).
- Migraine medications limitations are across strengths per calendar month for each drug.

Excluded drugs
The following drugs are excluded from the pharmacy benefit:

- In accordance with Section 1927 of the *Social Security Act, 42 U.S.C. §1396r-8*, any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program
- Drug products that have been classified as less-than-effective by the Food and Drug Administration (FDA) Drug Efficacy Study Implementation (DESI)
- Drugs excluded from coverage following Section 1927 of the *Social Security Act, 42 U.S.C. §1396r-8*, such as:
    - Weight control products (except Xenical, which requires prior authorization)
    - Drugs used for cosmetic reasons or hair growth
    - Experimental or investigational drugs
    - Drugs used for experimental or investigational indication
    - Infertility medications
    - Erectile dysfunction drugs to treat impotence

Specialty Drug Program
We cover most specialty drugs under the pharmacy benefit, which may be obtained at any specialty pharmacy in our network. For information on specialty pharmacies, call Amerigroup Pharmacy at **800-454-3730**.

The following conditions are typically treated with specialty injectable drugs: growth hormone deficiency, cancer, multiple sclerosis, hemophilia, rheumatoid arthritis, hepatitis, and cystic fibrosis.

Texas Prescription Monitoring Program
The Texas Prescription Monitoring Program (PMP) is used to collect and monitor prescription data for all Schedule II, III, IV, and V Controlled Substances dispensed by a pharmacy in Texas or to a Texas resident from a pharmacy located in another state. The PMP also provides a database for monitoring patient prescription history for practitioners and the ordering of Schedule II Texas Official Prescription Forms.

Pharmacists and prescribers are required to check the patient's PMP history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol. The requirement applies to all Schedule II, III, IV, and V controlled substances. The PMP must be utilized to help eliminate duplicate and overprescribing of controlled substances, as well as to obtain critical controlled substance history information.

Information on how to access the Texas PMP, including FAQs and a User Support Manual, is available on the Texas State Board of Pharmacy website at: **pharmacy.texas.gov/PMP/aware.asp**.

Durable medical equipment and other products normally found in a pharmacy

Amerigroup reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy. For all qualified members, this includes medically necessary items such as nebulizers, ostomy supplies or bedpans, and other supplies and equipment. For items both Medicare and Medicaid cover, Medicare will pay first, and we will pay second. For children and young adults (birth through age 20), Amerigroup also reimburses for items typically covered under the Texas Health Steps Program, such as prescribed over-the-counter drugs, diapers, disposable or expendable medical supplies, and some nutritional products.

To be reimbursed for DME or other products normally found in a pharmacy for children and young adults (birth through age 20), a pharmacy must be in the pharmacy network or enrolled with us as a DME provider. Pharmacies that want to join the network should call Network Enrollment at **866-488-4708**. Pharmacies may obtain information about becoming a DME provider with us by sending an email to TXCredentialing@amerigroup.com.

Network pharmacies that are not Amerigroup DME providers should submit claims through the pharmacy benefit. Refer to the pharmacy provider manual for information on the claim submission process and call the Pharmacy Help Desk at **833-252-0329** for information about DME and other covered products commonly found in a pharmacy for children and young adults (birth through age 20).

Pharmacies enrolled with us as a DME provider should submit medical (*CMS-1500*) claims in accordance with our standard claims submissions guidelines in the ***Billing and Claims Administration*** chapter of this manual and subsequent updates. DME providers should call Provider Services at **800-454-3730** for information about DME and other covered products commonly found in a pharmacy for children and young adults (birth through age 20).

Pharmacies enrolled in both the pharmacy and the Amerigroup DME networks have the option to bill these specific DME supplies through either the pharmacy benefit or the medical benefit, but not both. Claims for these supplies may be subject to postpayment desk reviews to ensure claims from DME providers and pharmacies do not result in a member exceeding the maximum quantity or a duplicate payment for the same member and supply.

Preferred blood glucose testing strips

We have selected the Trividia Health TRUE METRIX® brand as our single preferred line of test strips for blood glucose testing. Pharmacies can provide Trividia Health TRUE METRIX meters to our members who have prescriptions. Our clinical policy has several standard exceptions to our preferred product, which allows access to other brands. These exceptions include visual or dexterity impairment and use of insulin pumps not compatible with the preferred brand. We evaluate other requests for exceptions on a case-by-case basis for medical necessity. If a member needs a nonpreferred brand of test strips, a prior authorization request should be submitted by faxing a completed prior authorization form to **844-474-3341**. If you have questions about prior authorization, call Amerigroup Pharmacy at

800-454-3730. Pharmacies can provide three-day supplies (limited to the smallest package size, typically 25 test strips) of any VDP formulary test strips while a prior authorization review is pending. Blood glucose test strips and monitors are not covered through DME providers.

4.1.7 Texas Health Steps

Texas Health Steps is the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Under Texas Health Steps, medical and dental preventive care and dental treatment services are available through Medicaid providers to Medicaid-enrolled children and young adults from birth through age 20. The program provides payment for comprehensive, periodic evaluations of a child's health, development, and nutritional status, including vision, hearing, dental, and case management services. For information regarding Texas Health Steps requirements, providers can refer to the resources listed below:

Resource	Link
Texas Medicaid Provider Procedures Manual	**tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx**
Texas Health Steps website	**https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps**

Information includes:

- Periodicity schedule
- State and federally mandated elements of the Texas Health Steps exam
- State provider enrollment requirements
- Dental varnish provider participation requirements
- Advisory Committee on Immunization Practice (ACIP) immunization schedule
- Vaccines for Children program description
- ImmTrac2 (immunization registry)
- Submission of laboratory specimens
- Referrals
- Comprehensive Care Program services, including private duty nursing, prescribed pediatric extended care centers and therapies

Texas Health Steps medical providers (participating and nonparticipating) may perform Texas Health Steps medical checkups on any Amerigroup member, regardless of panel assignment. Claims for these services should be submitted to us. Please fax or mail a copy of the Texas Health Steps record to the member's PCP. Texas Health Steps network providers are reimbursed according to their contracts with us. Nonparticipating providers will be paid in accordance with the state's out-of-network rules.

4.1.7.1 Prescribed pediatric extended care centers (PPECC) and private duty nursing (PDN)

A member has a choice of PDN, PPECC, or a combination of both PDN and PPECC for ongoing skilled nursing. PDN and PPECC are considered equivalent services and must be coordinated to prevent duplication. A member may receive both in the same day but not simultaneously (for example, PDN may be provided before or after PPECC services are provided). The combined total hours between PDN and PPECC services are not anticipated to increase unless there is a change in the member's medical

condition, or the authorized hours are not commensurate with the member's medical needs. Per *1 TAC §363.209(c)(3)*, PPECC services are intended to be a one-to-one replacement of PDN hours unless additional hours are medically necessary.

4.1.7.2 Texas Health Steps and newly enrolled STAR, STAR Kids, and STAR+PLUS members age 20 and younger

STAR, STAR Kids, and STAR+PLUS members age 20 and younger who are newly enrolled in Amerigroup are informed through welcome calls and new member information of the need to receive a medical checkup within 90 days of enrollment. For newborns, in no case should the medical checkup occur later than 14 days from the date of enrollment. Throughout the year, we remind members of the need to obtain their periodic Texas Health Steps medical checkups, diagnoses, and treatment for routine and acute care through:

- The member handbook.
- Telephone calls.
- Welcome information in the new member packet.
- Member newsletters.
- Preventive health reminders.

The Texas Health Steps annual medical checkup for an existing member age 36 months and older is due on the child's birthday. The annual medical checkup is considered timely if it occurs no later than 364 calendar days after the child's birthday. A checkup for an existing member from birth through 35 months of age is timely if received within 60 days beyond the periodic due date in the *Texas Medicaid Provider Procedures Manual*, based on the member's birth date. If a member misses a Texas Health Steps medical checkup appointment, the provider and office staff must:

- Document the missed appointment and efforts to contact the member in the member's medical record.
- Contact the member to reschedule the appointment.

4.1.7.3 Children of migrant farm workers

Children of migrant farm workers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service but should be billed as a checkup.

Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity or an accelerated service. It is considered a late checkup.

4.1.8 Ambulance transportation services (emergent)

Ambulance transportation service is a benefit when the member has an emergency medical condition. See the ***Emergency Services*** section in this manual for the definition of emergency medical condition.

Facility-to-facility transport may be considered an emergency if emergency treatment is not available at the first facility and the member still requires emergency care. The transport must be to an appropriate

facility, meaning the nearest medical facility equipped in terms of equipment, personnel, and the capacity to provide medical care for the illness or injury of the member.

Transports to out-of-locality providers (one-way transfers of 50 or more miles from the point of pickup to the point of destination) are covered if a local facility is not adequately equipped to treat the condition. Transports may be cut back to the closest appropriate facility.

4.1.9 Ambulance transportation services (nonemergent)

Nonemergency ambulance transport is a benefit when provided for a member to or from a scheduled medical appointment, to or from a licensed facility for treatment, or to the member's home after discharge from a hospital if the member has a medical condition such that the use of an ambulance is the only appropriate means of transportation (in other words, alternate means of transportation are medically contraindicated). In this circumstance, contraindicated means that the member cannot be transported by any other means from the origin to the destination without endangering the individual's health. Nonemergency ambulance transports between a member's home and a prescribed pediatric extended care center (PPECC) is not a covered benefit.

A physician, nursing facility, health care provider or other responsible party is required to obtain authorization before an ambulance is used to transport a client in circumstances not involving an emergency. Requests can be faxed, submitted at **Availity.com** or called into Amerigroup via the contact numbers shown in the table below. All requests require clinical information to support the need for the member to be transported by nonemergent ambulance transportation. The ambulance provider may not submit an authorization request.

Transports must be limited to those situations where the transportation of the client is less costly than bringing the service to the client.

Some requests for nonemergent ambulance transportation will occur after business hours. Authorizations that meet medical necessity will be authorized retrospectively if the request is received the next business day. The request can be called in or faxed the next business day to the numbers listed in the table below.

Request type	Behavioral health facilities/ behavioral health provider and IDD members	All other members for discharge from facility to home or from home to a provider/facility
Urgent same day	Call **800-454-3730**	Call **800-454-3730**
Nonurgent requests	Fax request to **844-442-8010**	Fax request to **866-249-1271**

4.1.10 Nonemergency Medical Transportation (NEMT) services

What are NEMT services?
NEMT services provide transportation to covered health-care services for Medicaid members who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, and other places an individual receives Medicaid services. NEMT services do NOT include ambulance trips.

What services are part of NEMT services?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb service transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health-care service. The ITP can be the member, the member's family member, friend, or neighbor.
- Members 20 years old or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain a covered health-care service. The daily rate for meals is $25 per day for the member and $25 per day for an approved attendant.
- Members 20 years old or younger may be eligible to receive the cost of lodging associated with a long-distance trip to obtain a covered health-care service. Lodging services are limited to the overnight stay and do not include any amenities or incidentals, such as phone calls, room service, or laundry service.
- Members 20 years old or younger may be eligible to receive funds in advance of a trip to cover authorized NEMT services.

If you have a member needing assistance while traveling to and from his or her appointment with you, NEMT services will cover the costs of an attendant. You may be asked to provide documentation of medical necessity for transportation of the attendant to be approved. The attendant must remain at the location where covered health-care services are being provided but may remain in the waiting room during the member's appointment.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years of age must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adult on file to travel alone. Parental consent is not required if the covered health-care service is confidential in nature.

If you have a member you think would benefit from receiving NEMT services, please refer him or her to Amerigroup at the number below for their membership type for more information:

- STAR: **833-721-8184 (TTY 711)**
- STAR+PLUS: **844-867-2837 (TTY 711)**
- STAR Kids: **844-864-2443 (TTY 711)**

4.1.11 Vision services

Coverage for STAR, STAR Kids, and STAR+PLUS nondual members may be obtained by calling Superior Vision of Texas at **866-819-4298**. Services are available for member self-referral to a network vision provider for all vision benefits. Members can call **800-428-8789**.

Category	Benefits	Contact
STAR, STAR Kids, and STAR+PLUS members age 20 and younger	One eye exam every 12 months. Medically necessary frames and lenses or contact lenses once every 24 months.	Coverage may be obtained by calling Superior Vision of Texas at **866-819-4298** for providers and **800-428-8789** for members.
STAR and STAR+PLUS nondual adult members (age 21 and older)	One eye exam and medically necessary frames and lenses or contact lenses once every 24 months.	Coverage may be obtained by calling Superior Vision of Texas at **866-819-4298** for providers and **800-428-8789** for members.
STAR+PLUS dual adult members (age 21 and older)	Vision services are not covered under Medicaid managed care.	Not applicable

4.1.12 Breast pump coverage in Medicaid and CHIP

Texas Medicaid and CHIP cover breast pumps and supplies when medically necessary after a baby is born. A breast pump may be obtained under an eligible mother's Medicaid or CHIP client number; however, if a mother is no longer eligible for Texas Medicaid or CHIP and there is a need for a breast pump or parts, then breast pump equipment must be obtained under the infant's Medicaid client number.

Coverage in prenatal period	Coverage at delivery	Coverage for newborn	Breast pump coverage and billing
STAR	STAR	STAR	STAR covers breast pumps and supplies when medically necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)[1]	Emergency Medicaid	Medicaid fee-for-service (FFS) or STAR[2]	Medicaid FFS and STAR cover breast pumps and supplies when medically necessary for newborns when the mother does not have coverage under CHIP. Breast pumps and supplies must be billed under the newborn's Medicaid ID.
CHIP Perinatal, with income above 198% FPL	CHIP Perinatal	CHIP Perinatal	CHIP covers breast pumps and supplies when medically necessary for CHIP Perinate newborns. Breast pumps and supplies must be billed under the newborn's CHIP Perinatal ID.
STAR Kids	STAR Kids	Medicaid FFS or STAR[2]	Medicaid FFS, STAR and STAR Health cover breast pumps and supplies when medically necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
STAR+PLUS	STAR+PLUS	Medicaid FFS or STAR[2]	
STAR Health	STAR Health	STAR Health	
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR[2]	Medicaid FFS and STAR cover breast pumps and supplies when medically necessary for the newborn when the mother does not have coverage. Breast pumps and supplies must be billed under the newborn's Medicaid ID.

1 CHIP Perinate members with household incomes at or below 198% FPL must apply for Emergency Medicaid coverage for labor and delivery services. The Texas Health and Human Services Commission (HHSC) mails the pregnant woman an Emergency Medicaid application 30 days before her reported due date. When Emergency Medicaid covers a birth, the newborn is certified for 12 months of Medicaid coverage, beginning on the date of birth.

2 These newborns will be in FFS Medicaid until they are enrolled with a STAR MCO. Claims should be filed with Texas Medicaid & Healthcare Partnership (TMHP) using the newborn's Medicaid ID if the mother does not have coverage.

4.1.13 Case Management for Children and Pregnant Women

The Case Management for Children and Pregnant Women (CPW) benefit assists eligible Medicaid members in accessing medically necessary medical, social, educational, and other services.

CPW is a Medicaid benefit that provides health-related case management services to children birth through 20 years of age with a health condition and to high-risk pregnant women of any age.

Amerigroup will contract with HHSC enrolled CPW providers to supply these services. CPW case managers assess a person's need for these services and then develop a service plan to address those needs. Case managers can help members:

- Get medical and dental services.
- Get medical supplies or equipment.
- Work on school or education issues.
- Work on other problems.

Prior authorization is not required for these services. Members will still have access to an Amerigroup case manager for all other case management services.

For additional benefit details and requirements, refer to the *Texas Medicaid Provider Procedures Manual Behavioral Health and Case Management Services Handbook* at **tmhp.com/resources/provider-manuals/tmppm**.

To refer an Amerigroup member for CPW services, providers should call Provider Services at **800-454-3730**.

4.2 CHIP covered services

We cover CHIP program services including well-child exams, immunizations, provider office visits, hospital care, prescription drugs, and ancillary services, such as labs and X-rays. We do not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provide coverage to any CHIP member.

4.2.1 CHIP Covered Services Table

CHIP services must meet the CHIP definition of medically necessary to be covered. There is no lifetime maximum on benefits; however, there is a 12-month enrollment period, and lifetime limitations do apply to certain services as specified in the following chart. Copays for certain services apply until a family reaches its specific enrollment period copay maximum. The benefits in the table below apply to traditional CHIP members and CHIP Perinate newborns. For information about covered services for CHIP Perinate members, see the ***CHIP Perinatal Covered Services*** section of this manual.

CHIP benefit	CHIP benefit description

Inpatient general acute and inpatient rehabilitation hospital services	Services include the following:
	• Hospital-provided physician or provider services
	• Semi-private room and board (or private if medically necessary as certified by attending physician)
	• General nursing care
	• Special duty nursing when medically necessary
	• Intensive care unit (ICU) and services
	• Patient meals and special diets
	• Operating, recovery, and other treatment rooms
	• Anesthesia and administration (facility technical component)
	• Surgical dressings, trays, casts, and splints
	• Drugs, medications, and biologicals
	• Blood or blood products that are not provided free-of-charge to the patient or for their administration
	• X-rays, imaging, and other radiological tests (facility technical component)
	• Laboratory and pathology services (facility technical component)
	• Machine diagnostic tests (EEGs, EKGs, etc.)
	• Oxygen services and inhalation therapy
	• Radiation and chemotherapy
	• Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care
	• In-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section
	• Hospital, physician, and related medical services, such as anesthesia, associated with dental care
	• Inpatient services associated with a miscarriage or a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) including but not limited to:
	  ○ Dilation and curettage (D&C) procedures
	  ○ Appropriate provider-administered medications
	  ○ Ultrasounds
	  ○ Histological examination of tissue samples
	• Presurgical or postsurgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat cleft lip and/or palate; or severe traumatic, skeletal and/or congenital craniofacial deviations; or severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment
	• Surgical implants
	• Other artificial aids, including surgical implants

CHIP benefit	CHIP benefit description

	• Inpatient services for a mastectomy and breast reconstruction, including:
	  ○ All stages of reconstruction on the affected breast
	  ○ External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed
	  ○ Surgery and reconstruction on the other breast to produce symmetrical appearance
	  ○ Treatment of physical complications from the mastectomy and treatment of lymphedemas
	• Implantable devices covered under inpatient and outpatient services; this benefit does not count towards the DME 12-month period limit

Birthing center services provided by a licensed birthing center	Coverage is limited to facility services (for example, labor and delivery) and does not apply to CHIP Perinate newborn members.
Services rendered by a certified nurse midwife or physician in a licensed birthing center	CHIP members: Coverage includes prenatal services and birthing services rendered in a licensed birthing center. CHIP Perinate newborn members: Coverage includes services rendered to a newborn immediately following delivery.
Skilled nursing facilities (includes rehabilitation hospitals)	Services include but are not limited to the following: • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility There is a 60-day per 12-month period limit.

Outpatient hospital, comprehensive outpatient rehabilitation hospital, clinic (including health center), and ambulatory health care center	Services include but are not limited to the following services provided in a hospital clinic or emergency room, a clinic or health center, a hospital-based emergency department, or an ambulatory health care setting:
	• X-ray, imaging, and radiological tests (technical component)
	• Laboratory and pathology services (technical component)
	• Machine diagnostic tests
	• Ambulatory surgical facility services
	• Drugs, medications, and biologicals
	• Casts, splints, and dressings
	• Preventive health services
	• Physical, occupational, and speech therapy
	• Renal dialysis
	• Respiratory services
	• Radiation and chemotherapy
	• Blood or blood products that are not provided free-of-charge to the patient and the administration of these products
	• Facility and related medical services, such as anesthesia, associated with dental care when provided in a licensed ambulatory surgical facility
	• Outpatient services associated with a miscarriage or a nonviable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero) include but are not limited to:
	  ○ Dilation and curettage (D&C) procedures
	  ○ Appropriate provider-administered medications
	  ○ Ultrasounds
	  ○ Histological examination of tissue samples

CHIP benefit	CHIP benefit description

	• Presurgical or postsurgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat cleft lip and/or palate; or severe traumatic, skeletal and/or congenital craniofacial deviations; or severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions, and/or tumor growth or its treatment
	• Surgical implants
	• Other artificial aids, including surgical implants
	• Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, including:
	  ○ All stages of reconstruction on the affected breast
	  ○ External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed
	  ○ Surgery and reconstruction on the other breast to produce symmetrical appearance
	  ○ Treatment of physical complications from the mastectomy and treatment of lymphedemas
	• Implantable devices covered under inpatient and outpatient services; this benefit does not count towards the DME 12-month period limit

Physician/physician extender professional services	Services include but are not limited to the following:
	• American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations)
	• Physician office visits, and inpatient and outpatient services
	• Laboratory, X-rays, imaging, and pathology services, including technical component and/or professional interpretation
	• Medications, biologicals and materials administered in the physician's office
	• Allergy testing, serum and injections
	• Professional component (inpatient/outpatient) of surgical services, including:
	  ○ Surgeons and assistant surgeons for surgical procedures, including appropriate follow-up care
	  ○ Administration of anesthesia by a physician (other than surgeon) or certified registered nurse anesthetist (CRNA)
	  ○ Second surgical opinions
	  ○ Same-day surgery performed in a hospital without an over-night stay
	  ○ Invasive diagnostic procedures such as endoscopic examinations
	• Hospital-based physician services (including physician-performed technical and interpretive components)
	• Physician and professional services for a mastectomy and breast reconstruction, including:
	  ○ All stages of reconstruction on the affected breast
	  ○ External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed
	  ○ Surgery and reconstruction on the other breast to produce symmetrical appearance
	  ○ Treatment of physical complications from the mastectomy and treatment of lymphedemas
	• In-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section

CHIP benefit	CHIP benefit description

	• Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation
	• Physician services associated with a miscarriage or a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) including but not limited to:
	  ○ Dilation and curettage (D&C) procedures
	  ○ Appropriate provider-administered medications
	  ○ Ultrasounds
	  ○ Histological examination of tissue samples
	• Presurgical or postsurgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:
	  ○ Cleft lip and/or palate
	  ○ Severe traumatic, skeletal and/or congenital craniofacial deviations
	  ○ Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions, and/or tumor growth or its treatment

Prenatal care and pre-pregnancy family services and supplies	Covered, unlimited prenatal care and medically necessary care related to diseases, illness or abnormalities related to the reproductive system, and limitations and exclusions to these services are described under inpatient, outpatient, and physician services. Primary and preventive health benefits do not include pre-pregnancy family reproductive services and supplies, or prescription medications prescribed only for the purpose of primary and preventive reproductive health care.
Durable medical equipment (DME), prosthetic devices and disposable medical supplies	There is a $20,000 per 12-month period limit for DME, prosthetic devices, and disposable medical supplies (implantable devices, diabetic supplies and equipment are not counted against this cap). Covered services include DME (equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness, injury or disability; and is appropriate for use in the home), including devices and supplies that are medically necessary and needed for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including but not limited to: • Orthotic braces and orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Other artificial aids, including surgical implants • Hearing aids • Implantable devices covered under inpatient and outpatient services; these devices do not count towards the DME 12-month period limit • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements **CHIP Perinate unborn child:** This is not a covered benefit with the exception of a limited set of disposable medical supplies, published at **txvendordrug.com**, and only when they are obtained from a CHIP-enrolled pharmacy provider. For a complete list of CHIP-covered DME and supplies, view the CHIP member handbook at **myamerigroup.com/TX**.

CHIP benefit	CHIP benefit description
Home and community health services	Services that are provided in the home and community, including but not limited to: • Home infusion • Respiratory therapy • Visits for private duty nursing (RN, LVN) • Skilled nursing visits as defined for home health purposes (may include RN or LVN) • Home health aide when included as part of a plan of care during a period that skilled visits have been approved • Speech, physical, and occupational therapies These services are not intended to replace the child's caretaker or to provide relief for the caretaker. Skilled nursing visits are provided on an intermittent level and are not intended to provide 24-hour skilled nursing services; services are not intended to replace 24-hour inpatient or skilled nursing facility services.
Inpatient mental health services	Services include but are not limited to: • Mental health services, including services for serious mental illness, furnished in a freestanding psychiatric hospital, psychiatric units of general acute-care hospitals and state-operated facilities • Neuropsychological and psychological testing When inpatient psychiatric services are ordered by a court of competent jurisdiction pursuant to the *Texas Health and Safety Code* Chapter 573, Subchapters B and C, Chapter 574, Subchapter D, or as a condition of probation, the court order serves as binding determination of medical necessity. Refer to the ***Court-Ordered Services*** section of this manual for more information.
Outpatient mental health services	Services include but are not limited to: • Mental health services, including services for serious mental illness provided on an outpatient basis • Neuropsychological and psychological testing • The visits can be furnished in a variety of community-based settings (including school- and home-based) or in a state-operated facility • Medication management • Rehabilitative day treatments • Residential treatment services • Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) • Skills training (psycho-educational skill development) • Qualified mental health providers – community services (QMHP-CS), which are defined by the Texas Department of State Health Services (DSHS) in *Title 25 T.A.C., §412.303(48)*; QMHP-CSs shall be providers working through a DSHS-contracted local mental health authority or a separate DSHS-contracted entity; QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards; those services include individual and group-skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services When outpatient psychiatric services are ordered by a court of competent jurisdiction pursuant to the *Texas Health and Safety Code* Chapter 573, Subchapters B and C, Chapter 574, Subchapters A through G, *Texas Family Code* Chapter 55, Subchapter D, or as a condition of probation, the court order serves as binding determination of medical necessity. Refer to the ***Court-Ordered Services*** section of this manual for more information.

CHIP benefit	CHIP benefit description
Inpatient and residential substance use treatment services	Services include but are not limited to inpatient and residential substance use treatment services including detoxification, crisis stabilization, and 24-hour residential rehabilitation programs. When inpatient and residential substance use disorder treatment services are required by a court order consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code, or as a condition of probation, the court order serves as a binding determination of medical necessity. Refer to the "*Court-Ordered Services"* section of this manual for more information.
Outpatient substance use treatment services	Services include but are not limited to: • Prevention and intervention services that are provided by physician and nonphysician providers such as screening, assessment, and referral for chemical dependency disorders • Intensive outpatient services, which are defined as organized nonresidential services providing structured group and individual therapy, educational services, and life-skills training; these services consist of at least 10 hours per week for 4 to 12 weeks but less than 24 hours a day • Outpatient treatment services provided at least 1 to 2 hours per week; these services include structured group and individual therapy, educational services, and life skills training • Partial hospitalization When outpatient substance use disorder treatment services are required by a court order consistent with Chapter 462, Subchapter D of the *Texas Health and Safety Code*, or as a condition of probation, the court order serves as a binding determination of medical necessity. Refer to the ***Court-Ordered Services*** section of this manual for more information.
Rehabilitation services	Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include but are not limited to: • Physical, occupational, and speech therapy • Developmental assessment
Hospice care services	Services include but are not limited to: • Palliative care, including medical and support services for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death; treatment for unrelated conditions is unaffected • Services apply to the hospice diagnosis and are covered for a maximum of 120 days for those children with a six-month life expectancy
Emergency services, including emergency hospitals, physicians, and ambulance services	The health plan cannot require authorization as a condition for payment for emergency conditions or labor and delivery. Covered services include: • Emergency services based on the prudent layperson definition of emergency health condition • Hospital emergency department room and ancillary services, and physician services 24 hours a day, 7 days a week both by in-network and out-of-network providers • Medical screening examination • Stabilization services • Access to DSHS-designated Level I and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air, and water transportation
Emergency dental services	Covered services include:

CHIP benefit	CHIP benefit description
	• Treatment of a fractured or dislocated jaw • Traumatic damage to teeth • Removal of cysts • Treatment of oral abscess of tooth or gum origin
Transplants	Covered services include using up-to-date FDA guidelines; all nonexperimental human organ and tissue transplants; and all forms of nonexperimental corneal, bone marrow, and peripheral stem cell transplants including donor medical expenses.
Vision benefit	Covered services include: • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period without authorization • One pair of nonprosthetic eyewear per 12-month period
Chiropractic services	Covered services do not require a physician prescription and are limited to spinal subluxation.
Tobacco Cessation program	Covered up to $100 for a 12-month period if the program has been approved
Case management and care coordination	These services include outreach informing, case management, care coordination and community referral.
Drug benefits	Services include but are not limited to: • Outpatient drugs and biologicals including pharmacy-dispensed and provider-administered outpatient drugs and biologicals • Drugs and biologicals provided in an inpatient setting

4.2.2 CHIP exclusions from covered services

These services are excluded from coverage:

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses or abnormalities related to the reproductive system
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (in other words, cannot be prescribed for family planning)
- Personal comfort items including personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical, or other health care procedures or services that are not generally employed or recognized within the medical community; this exclusion is an adverse determination and is eligible for review by an independent review organization
- Treatment or evaluations required by third parties including but not limited to those for schools, employment, flight clearance, camps, insurance, or court other than a court of competent jurisdiction pursuant to the *Texas Health and Safety Code* Chapter 573, Subchapters B and C, Chapter 574, Subchapter D, or Chapter 462, Subchapter D and *Texas Family Code* Chapter 55, Subchapter D
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility
- Mechanical organ replacement devices, including an artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise preauthorized by the health plan
- Prostate and mammography screening
- Elective surgery to correct vision

- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Dental devices solely for cosmetic purposes
- Out-of-network services not authorized by the health plan, except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the health plan
- Medications prescribed for weight loss or gain
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses, and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses, or ingrown toenails)
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse, or loss when confirmed by the member or the vendor
- Corrective orthopedic shoes
- Over-the-counter medications
- Convenience items
- Orthotics primarily used for athletic or recreational purposes
- Custodial care that assists a child with daily living activities, such as assisting with walking, getting in and out of bed, bathing, dressing, feeding, toileting, preparing a special diet, and supervising medication that is usually self-administered or provided by a parent; this care does not require the continuing attention of trained medical or paramedical personnel; exclusion does not apply to hospice services
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse that do not require the skill and training of a nurse
- Vision training and vision therapy
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services when ordered by a physician/PCP
- Donor nonmedical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan

4.2.3 Coordination with non-CHIP covered services

We will enlist the involvement of community organizations that may not provide CHIP-covered services but are otherwise important to the health and well-being of members. We will make a best effort to establish relationships with these community organizations to make referrals. CHIP members who meet the criteria for children with complex special health care needs (CSHCN) have access to community

organizations for assistance with referrals and services for their complex health care needs. These organizations may include:

- Texas agency-administered programs and case management services.
- Essential public health services.

Our service coordinators can offer assistance with coordination of care for these members.

4.2.4 Preventive care

CHIP members receive preventive care services in accordance with the AAP recommendations for preventive pediatric health care. To bill preventive visits for CHIP members, use CPT codes 99381-99385 and 99391-99395 with diagnosis code Z00.121 or Z00.129.

4.3 CHIP Perinatal covered services

Covered CHIP Perinatal services must meet the definition of medically necessary covered services. There is no lifetime maximum on benefits; however, a 12-month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart.

Copays do not apply to CHIP Perinate members. CHIP Perinate unborn members are eligible for 12 months of continuous coverage following enrollment in the program. Copays, cost sharing and enrollment fees still apply to other children in the family enrolled in the CHIP program.

Note that CHIP Perinate unborn members in families with incomes at or below the Medicaid eligibility threshold are not covered for facility charges related to labor and delivery. These members should apply for Medicaid coverage to cover these services. HHSC has structured CHIP Perinatal with the expectation that members in this income bracket will be eligible for emergency Medicaid to cover these facility charges. The emergency Medicaid coverage would include both labor and delivery charges and the newborn's facility charges until discharge. Professional services are covered under the CHIP program for this population.

4.3.1 CHIP Perinatal Covered Services Table

CHIP Perinate newborns have the same benefits as CHIP members as outlined in the ***CHIP Covered Services*** section of this manual. Covered services for CHIP Perinate unborns (mother) are outlined in the following table.

Covered benefit	CHIP Perinate unborn (mother)
Inpatient general acute and inpatient rehabilitation hospital services	For CHIP Perinates in families with incomes at or below the Medicaid eligibility threshold, the facility charges are not a covered benefit; however, professional service charges associated with labor and delivery are a covered benefit. For CHIP Perinates in families with incomes above the Medicaid eligibility threshold, benefits are limited to professional service charges and facility charges associated with labor and delivery until birth. Services include:

Covered benefit	CHIP Perinate unborn (mother)
	• Covered medically necessary hospital-provided services • Operating, recovery, and other treatment rooms • Anesthesia and administration (facility technical component) • Medically necessary surgical services, limited to services that directly relate to the delivery of the unborn child and services related to miscarriage or nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) • Inpatient services associated with a miscarriage or a nonviable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero) including but not limited to dilation and curettage (D&C) procedures, appropriate provider-administered medications, ultrasounds, and histological examination of tissue samples
Birthing center services provided by a licensed birthing center	Coverage is limited to facility services related to labor with delivery.
Services rendered by a certified nurse midwife or physician in a licensed birthing center	Prenatal and birthing services rendered in a licensed birthing center are covered. Prenatal services are limited to an initial visit and subsequent prenatal (antepartum) care visits that include: • One visit every four weeks for the first 28 weeks of pregnancy • One visit every 2-3 weeks from 28-36 weeks of pregnancy • One visit per week from 36 weeks to delivery More frequent visits are allowed as medically necessary. Benefits are limited to 20 prenatal visits and two postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review. Visits after the initial visit must include: • Interim history (problems, marital status, fetal status) • Physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) • Laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple-marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh-negative women at 28 weeks followed by Rho[D] immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client)
Skilled nursing facilities (includes rehabilitation hospitals)	Not a covered benefit

Covered benefit	CHIP Perinate unborn (mother)
Outpatient hospital, comprehensive outpatient rehabilitation hospital, clinic (including health center), and ambulatory health care center	Services include the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department, or an ambulatory health care setting: • X-ray, imaging and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Drugs, medications and biologicals that are medically necessary prescription and injection drugs • Outpatient services associated with a miscarriage or a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero); outpatient services associated with a miscarriage or nonviable pregnancy, including but not limited to D&C procedures, appropriate provider-administered medications, ultrasounds, and histological examination of tissue samples • Laboratory and radiological services, limited to services that directly relate to antepartum care and/or the delivery of the covered CHIP Perinate until birth • Ultrasound of the pregnant uterus when medically indicated; an ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational-age conformation, or miscarriage or nonviable pregnancy • Amniocentesis, cordocentesis, fetal intrauterine transfusion (FIUT) and ultrasonic guidance for cordocentesis; a FIUT is a covered benefit of the CHIP Perinatal program with an appropriate diagnosis • Laboratory tests, limited to nonstress testing, contraction stress testing, and hemoglobin or hematocrit repeated once a trimester and at 32 to 36 weeks of pregnancy; or complete blood count (CBC), urinalysis for protein and glucose every visit, and blood type and RH antibody screen; repeat antibody screen for RH negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple-marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by the medical condition of the client • Surgical services associated with a miscarriage or nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are covered

Physician/physician extender professional services	Services include but are not limited to the following:
	• Medically necessary physician services, limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth
	• Physician office visits, inpatient and outpatient services
	• Laboratory, X-rays, imaging, and pathology services, including technical component and/or professional interpretation
	• Medically necessary medications, biologicals and materials administered in physician's office
	• Professional component (inpatient/outpatient) of surgical services including:
	  ○ Surgeons and assistant surgeons for surgical procedures directly related to labor with delivery of the covered unborn child until birth
	  ○ Administration of anesthesia by physician (other than surgeon) or CRNA
	  ○ Invasive diagnostic procedures directly related to labor with delivery of the unborn child

Covered benefit	CHIP Perinate unborn (mother)
	○ Surgical services associated with a miscarriage or a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) • Hospital-based physician services (including physician-performed technical and interpretive components) • Professional component associated with a miscarriage or a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) including but not limited to D&C procedures, appropriate provider-administered medications, ultrasounds and histological examination of tissue samples • Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age conformation • Professional component of amniocentesis, cordocentesis, fetal intrauterine transfusion (FIUT), and ultrasonic guidance for amniocentesis, cordocentesis,and FIUT
Prenatal care and prepregnancy family services and supplies	Services are limited to an initial visit and subsequent prenatal (antepartum) care visits that include: • One visit every four weeks for the first 28 weeks of pregnancy • One visit every 2 to 3 weeks from 28-36 weeks of pregnancy • One visit per week from 36 weeks to delivery More frequent visits are allowed as medically necessary. Benefits are limited to 20 prenatal visits and two postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies; high-risk prenatal visits are not limited to 20 visits per pregnancy; documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review. Visits after the initial visit must include: • Interim history (problems, marital status, fetal status) • Physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) • Laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32 to 36 weeks of pregnancy; multiple-marker screen for fetal abnormalities offered at 16 to 20 weeks of pregnancy; repeat antibody screen for RH negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24 to 28 weeks of pregnancy; and other lab tests as indicated by medical condition of client)
Durable medical equipment (DME), prosthetic devices, and disposable medical supplies	Not a covered benefit with the exception of a limited set of disposable medical supplies published at **txvendordrug.com** and only when they are obtained from a CHIP-enrolled pharmacy provider.
Home and community health services	Not a covered benefit
Inpatient mental health services	Not a covered benefit
Outpatient mental health services	Not a covered benefit
Inpatient substance use treatment services	Not a covered benefit
Outpatient substance use treatment services	Not a covered benefit
Rehabilitation services	Not a covered benefit

Covered benefit	CHIP Perinate unborn (mother)
Hospice care services	Not a covered benefit
Emergency services, including emergency hospitals, physicians, and ambulance services	The health plan cannot require authorization as a condition for payment for emergency conditions related to labor with delivery. Covered services are limited to those emergency services that are directly related to the delivery of the covered unborn child until birth; services include: • Emergency services based on prudent layperson definition of emergency health condition • Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child • Stabilization services related to the labor and delivery of the covered unborn child • Emergency ground, air, and water transportation for labor and threatened labor • Emergency services associated with a miscarriage or a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) Postdelivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.
Transplants	Not a covered benefit
Vision benefit	Not a covered benefit
Chiropractic services	Not a covered benefit
Tobacco Cessation program	Not a covered benefit
Case management and care coordination services	Covered benefit
Drug benefits	Not a covered benefit unless identified elsewhere in this table

4.3.2 CHIP Perinatal — exclusions from covered services for CHIP Perinates

These services are excluded from coverage:

- Inpatient facility charges for the initial CHIP Perinate newborn admission for CHIP Perinate mothers in families with incomes at or below the Medicaid eligibility threshold (initial CHIP Perinate newborn admission refers to the hospitalization associated with the birth)
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, services related to a miscarriage, a nonviable pregnancy, and postpartum care related to the covered unborn child until birth
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (in other words, cannot be prescribed for family planning)
- Inpatient mental health services
- Outpatient mental health services
- DME or other medically related remedial devices
- Disposable medical supplies
- Home- and community-based health care services
- Nursing care services
- Dental services
- Inpatient substance use treatment services and residential substance use treatment services
- Outpatient substance use treatment services

- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- Hospice care
- Skilled nursing facility and rehabilitation hospital services
- Emergency services other than those directly related to the labor with delivery of the covered unborn child
- Transplant services
- Tobacco cessation programs
- Chiropractic services
- Medical transportation not directly related to labor or threatened labor, miscarriage or nonviable pregnancy, and/or delivery of the covered unborn child
- Personal comfort items, including:
    - Personal care kits provided on inpatient admission
    - Telephone
    - Television
    - Newborn infant photographs
    - Meals for guests of patient
    - Other articles not required for the specific treatment related to labor with delivery or postpartum care
- Experimental and/or investigational medical, surgical, or other health care procedures or services that are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties, including those for schools, employment, flight clearance, camps, insurance, or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility
- Mechanical organ replacement devices, including an artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor with delivery
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by the health plan, except for emergency care related to labor with delivery of the covered unborn child
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity
- Medications prescribed for weight loss or gain
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses, and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses, or ingrown toenails)
- Corrective orthopedic shoes
- Convenience items

- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes
- Custodial care that assists with the activities of daily living, such as:
    - Assisting with walking
    - Getting in and out of bed
    - Bathing
    - Dressing
    - Feeding
    - Toileting
    - Preparing special diets
    - Supervising medication that is usually self-administered or provided by a caregiver; this care does not require the continuing attention of trained medical or paramedical personnel
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse that do not require the skill and training of a nurse
- Vision training, vision therapy or vision services
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services
- Donor nonmedical expenses
- Charges incurred as a donor of an organ

4.3.3 CHIP Perinatal exclusions from covered services for CHIP Perinate newborns

With the exception of the item below, all CHIP Perinate newborn exclusions match those of CHIP.

For CHIP Perinate newborns in families with incomes at or below the Medicaid eligibility threshold, inpatient facility charges are not a covered benefit for the initial CHIP Perinate newborn admission. Initial CHIP Perinate newborn admission means the hospitalization associated with the birth.

4.3.4 Coordination with non-CHIP covered services

We will coordinate with public health entities to provide essential public health care (noncapitated) services to CHIP Perinate members. Our primary role in this collaboration is to:

- Report to public health entities regarding communicable diseases and/or diseases that are preventable by immunization as defined by state law.
- Notify the local public health entity, as defined by state law, of communicable disease outbreaks involving members.
- Educate members and providers regarding WIC services available to members.
- Coordinate with local public health entities that have a child lead program, or with DSHS regional staff when the local public health entity does not have a child lead program, for follow-up of suspected or confirmed cases of childhood lead exposure.

In addition to coordinating with public health entities, we will work with other state HHS programs to provide essential public health care services. In this role, we will:

- Notify providers of the availability of vaccines through the Texas Vaccines for Children program.
- Work with HHSC and providers to improve the reporting of immunizations to the statewide ImmTrac2 registry.
- Cooperate with activities required of state and local public health authorities necessary to conduct the annual population and community-based needs assessment.
- Report all blood lead results to the Childhood Lead Poisoning Prevention Program unless the test was performed at the DSHS state laboratory, and coordinate and follow up on suspected or confirmed cases of childhood lead exposure with local public health entities that have a child lead program or with the Childhood Lead Poisoning Prevention Program in DSHS when the local public health entity does not have a program; additionally, follow the Centers for Disease Control and Prevention guidelines for testing children for lead and follow-up actions for children with elevated blood levels located at **dshs.texas.gov/blood-lead-surveillance-group/for-providers** and coordinate with the Texas Health Steps Outreach and Informing Unit.

4.3.5 Breast pump coverage for CHIP Perinate members

Refer to the ***Breast Pump Coverage in Medicaid and CHIP*** section of this manual.

4.4 Referrals to health-related services — all products

We will enlist the involvement of community organizations that may not provide Medicaid or CHIP covered services but are otherwise important to the health and well-being of members. We will make a best effort to establish relationships with these community organizations to make referrals. These organizations may include:

- Texas ECI Program
- Texas Department of Mental Health and Mental Retardation (MHMR)
- Texas Department of Health Title V Program
- Local school district special education
- Other state and local agencies and programs with jurisdiction over children's services including food stamps and the Women, Infants, and Children program
- Texas information and referral network
- Texas Commission for the Blind
- Child-service civic and religious organizations, and consumer and advocacy groups, such as United Cerebral Palsy, that also work on behalf of the CSHCN population; service coordinators can offer assistance with coordination of care for these members.

4.5 Value-added services — all products

We cover extra health care benefits for our members. These extra benefits are also called value-added services. The kinds of benefits vary by product and age of member, but the following are examples of the various services available:

- 24-Hour Nurse HelpLine
- Transportation assistance
- Healthy Rewards program — gift cards for completion of healthy activities
- Cellphone and monthly minutes, texts, and data

- Taking Care of Baby and Me® program
- Pest control services
- Mental and emotional well-being program
- Respite services
- Boys & Girls Club
- Sports physicals
- Home-delivered meals after discharge from a hospital or nursing facility

Value-added services are subject to change on September 1 of each year. Complete details of the extra benefits and how a member can access are in our member handbooks at **myamerigroup.com/TX**. If you have questions or need help finding the information, call Provider Services at **800-454-3730**.

5 Prior authorization and utilization management

5.1 Utilization Management Program

Our utilization management (UM) program facilitates the delivery of the most appropriate medically necessary care, benefits, and services to our eligible members in the most appropriate setting while ensuring our members receive clinically appropriate care and services in the most efficient manner possible.

For services that require prior authorization, we make case-by-case determinations that consider the individual's health care needs and medical history in conjunction with nationally recognized standards of care and medical necessity criteria.

The UM program includes activities related to inpatient and ambulatory care. Through collaboration with other programs such as care coordination, discharge planning, case management and community programs, we ensure we meet the physical, behavioral, and social needs of our members.

We provide medically necessary covered services to all members beginning on the member's date of enrollment, regardless of pre-existing conditions, prior diagnosis and/or receipt of any prior health care services. For STAR Kids and STAR+PLUS members, we also provide functionally necessary community long-term services and supports beginning on the member's date of enrollment, regardless of health status, pre-existing conditions, prior diagnosis, receipt of any prior health care services, confinement in a health care facility, and/or previous coverage, if any, or the reason for termination of such coverage. We do not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provide coverage to any member.

Regarding UM issues, staff are available at least eight hours a day Monday through Friday during normal business hours for inbound collect or toll-free calls and can receive inbound communication by fax after normal business hours. Messages will be returned within one business day. Our staff will identify themselves by name, title and organization name when initiating or returning calls. TDD/TTY services and language assistance services are available for members as needed, free of charge.

Medical policies and UM criteria can be viewed and downloaded on **https://provider.amerigroup.com/TX** by selecting Resources > Medical Policies and Clinical UM Guidelines.

For questions about the UM process, including requesting a free copy of our UM criteria, call Provider Services at 800-454-3730.

5.2 Utilization management decision-making affirmative statements

As a corporation and as individuals involved in UM decisions, the health plan is governed by the following statements:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.

- The health plan does not reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting, or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denials of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.

5.3 Medical policies, clinical UM guidelines, and medical drug benefit clinical criteria

There are several factors that impact whether a service or procedure is covered under a member's benefit plan. Medical policies, clinical UM guidelines and medical drug benefit clinical criteria are resources that help us determine if a procedure is medically necessary. These guidelines are available to you as a reference when interpreting prior authorization and claim decisions through the following websites:

Medical Policies & Clinical UM Guidelines

Medical Drug Benefit Clinical Criteria

In addition, the following criteria/guidelines may be used:

- *Texas Medicaid Provider Procedures Manual (TMPPM)*
- MCG Care Guidelines (based on specific provider contracts, McKesson InterQual® Level of Care criteria) are also used when no specific health plan medical policies exist.
- Carelon Medical Benefits Management, Inc. (formerly known as AIM Specialty Health) guidelines are utilized for the following types of services:
    - Cardiology
    - Genetic testing
    - Radiation oncology
    - Radiology (high-tech)
    - Sleep studies

  Please refer to their website, **careloninsights.com**, for additional information.
- Behavioral Health utilizes the American Society for Addiction Medicine Patient Placement Criteria (ASAM) for substance use treatment authorizations, with the exception of detoxification which uses MCG.
- Superior Vision of Texas utilizes health plan criteria and guidelines for medical/surgical reviews.

Federal law, state law, contract language, including definitions and specific contract provisions/ exclusions, Centers for Medicare & Medicaid (CMS) requirements as well as the Texas Medicaid Provider Procedures Manual (TMPPM), tmhp.com/resources/provider-manuals/tmppm, are used when determining eligibility for coverage and supersede any other UM criteria.

5.4 Prior authorization process

Determine if specific outpatient procedures and/or services require prior authorization through the Precertification Look Up Tool, which can be found on Availity Essentials through Payer Spaces or the health plan provider website through the following link:

Precertification Lookup Tool: https://provider.amerigroup.com/texas-provider/resources/prior-authorization-requirements/precertification-lookup

A completed prior authorization request is required to eliminate delays in processing, which includes all required documentation, current clinical information, and a signed authorization form by the requesting provider. Documentation and forms required for prior authorization requests are located on our provider website.

Prior authorization requests or notifications can be submitted digitally through Availity Essentials and is the preferred method.

Availity Essentials: Availity.com

Additional information regarding the process to submit prior authorization requests is located in the ***Quick Reference Information*** section of this manual.

Information needed for a member that is hospitalized

For services or equipment that will be necessary for the care of the hospitalized member immediately after discharge, ensure all required documentation is submitted with the request along with any required signatures to eliminate delays in processing. For additional information, please refer to the ***Discharge Planning*** section of this manual.

Submission timelines

Initial requests for prior authorization with all supporting documentation is recommended to be submitted a minimum of three business days prior to the start of care.

For timeline exceptions, please refer to the provider website for prior authorization requirements.

Failure to comply with notification rules may result in an administrative denial. Additional information is available in the ***Administrative Denials*** section of this manual.

Prior authorization review

Upon receipt of a request for prior authorization, an assistant verifies eligibility and benefits prior to forwarding to the nurse or other qualified reviewer. The reviewer examines the request and supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures using criteria/guidelines. When the clinical information received meets medical necessity criteria, we issue a reference number to the requesting provider.

Prior authorization not required

If a request is submitted for a service for which prior authorization is not required, the provider will receive a response stating that prior authorization is not required. This is not an approval or a guarantee of payment. Claims for services are subject to all plan provisions, limitations and patient eligibility at the time services are rendered.

Incomplete documentation

If the prior authorization documentation is incomplete or inadequate, the reviewer is unable to process the request. In such instances, the health plan will notify the provider and member to submit the additional documentation necessary to make a decision. If no additional information is received within the designated time frame, the medical director will make a determination based on the information previously received.

Additionally, if the request does not meet criteria for approval, the requesting provider will be afforded the opportunity to discuss the case with the medical director prior to issuing the denial. For information on this process, refer to the ***Peer-to-Peer Review Process*** section of this manual.

5.5 Prior authorization recertification process

A physician or health care provider can submit a medical prior authorization recertification request at least 60 calendar days prior to the expiration of the current authorization of service(s) on file.

Exception: The health plan requires that the following prior authorization recertification requests be received up to 30 calendar days before the expiration of the current authorized service(s):

a) Physical, Occupational, and Speech Therapy
b) Private Duty Nursing (PDN)
c) Prescribed Pediatric Extended Care Centers (PPECC)

5.6 Determination timelines

Utilization review timeliness standards are as follows:

Program	Authorization type	Decision timeframe
Medicaid	Routine/non-urgent	3 business days
CHIP	Routine/non-urgent	2 business days (approval)
		3 business days (adverse determination)
Medicaid & CHIP	Urgent/expedited	3 calendar days
Medicaid & CHIP	Concurrent	1 business day
Medicaid & CHIP	Post-service	30 calendar days

Medicaid notifications:

- A written notice of final determination will be provided no later than the next business day following a prior authorization request determination.

CHIP notifications:

- For routine and urgent approvals, written/letter notification is required no later than the second business day after the date of the request.
- For a member that is not hospitalized at the time of an adverse determination, notification will be provided within three business days in writing to the requesting provider and the member.

Medicaid/CHIP:

- For a member who is hospitalized at the time of the request, within one business day of receiving the request for services or equipment that will be necessary for the care of the member immediately after discharge, including if the request is submitted by an out-of-network provider, provider of acute care inpatient services, or a member.
- Within one hour of receiving the request for post-stabilization or life-threatening conditions, except for Emergency Medical conditions and Emergency Behavioral Health conditions where a prior authorization is not required.
- Providers can confirm that an authorization is on file by accessing Availity Essentials, **Availity.com**, or by calling Provider Services at **800-454-3730**. If coverage of an admission has not been approved, the facility should contact Provider Services to resolve the issue.

Expedited requests

A member or physician may request to expedite a determination when the member, or member's physician, believes that waiting for a decision under the standard time frame could cause any of the following:

- Serious jeopardy to the life, health, or safety or the member's ability to regain maximum function, based on a prudent layperson's judgement.
- Serious jeopardy to the life, health, or safety of the member or others, due to the member's psychological state.
- 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.
- In the case of a pregnant woman, serious jeopardy to the life, health, or safety of the fetus.
- In the opinion of a practitioner with knowledge of a member's medical condition, subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. The practitioner must be allowed to act as the authorized representative of that member.

The following situations are examples that do not meet criteria for an expedited request:

- The date of service is greater than one week from the request date
- Clinical documentation does not support criteria for an expedited request as defined above
- Any request for therapy (occupational, speech, or physical therapy) greater than two days from the request date

Request for services as "Urgent", "Expedited" or "STAT" are processed as non-urgent if the request does not meet Expedited/urgent care/STAT as defined above.

5.7 Peer-to-peer review process

If you receive a notification that a case is under review and would like to discuss the case with our medical director, please contact the applicable department shown below.

Contact Numbers:

- Physical Health: **817-861-7768**
- Behavioral Health: **844-719-1806**

Be prepared to provide the following information:

- Name of person/physician our medical director needs to call
- Contact number
- Convenient time for a return call
- Authorization/reference number for the case
- Member's name, DOB, and the health plan ID number

If you or your office staff reach our voicemail, leave the name of the best contact person and their phone number so we can reach out for additional information. The medical director will make every effort to return calls within one business day.

If the notification received indicates the case was denied, you may contact us within two business days of receipt of the notification to set up a peer-to-peer review for possible reconsideration. After two business days, the case will need to follow the appeal process outlined in the copy of the member denial letter received.

5.8 Administrative denials

An administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, failure to obtain a prior authorization, or benefit limitations.

If the health plan overturns its administrative decision, the case will be reviewed and, if approved, the claim will be reprocessed, or the requestor will be notified of the action that needs to be taken.

5.9 Discharge planning

Discharge planning is designed to assist the provider in the coordination of the member's discharge when acute care (hospitalization) is no longer necessary to ensure a seamless transition from the inpatient setting to outpatient services to improve health outcomes for our members. Our UM clinician will help coordinate discharge planning needs with the hospital utilization review staff and attending physician. The attending physician is expected to coordinate with the member's provider(s) regarding follow-up care

after discharge and the provider is responsible for contacting the member to schedule all necessary follow-up care.

In the case of a behavioral health discharge, the attending facility is also responsible for ensuring the member has secured an appointment for a follow-up visit with a HEDIS qualified behavioral health provider. The follow-up visit must occur within seven calendar days of discharge.

When additional or ongoing care is necessary after discharge, we work with the provider to plan the member's discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital facility such as a:

- Hospice facility
- Convalescent facility
- Home health care program (for example, home I.V. antibiotics) or skilled nursing facility

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

For prior authorization requests for a member who is hospitalized at the time of the request, please clearly document at the top of the request to indicate that the member is hospitalized and has discharge planning needs. To eliminate delays in processing, please ensure all required documentation is submitted with the request along with any required signatures to the applicable department shown below.

Contact Numbers (fax):

- Inpatient Discharge Planning — Physical Health: **888-708-2599**
- Inpatient Discharge Planning — Behavioral Health: **844-430-6805**

Discharge plan authorizations for ongoing outpatient care follow nationally recognized standards of care and medical necessity criteria. Authorizations include but are not limited to transportation, home health, durable medical equipment (DME), pharmacy, follow-up visits to practitioners, and outpatient procedures.

6 Long-term services and supports (LTSS)

The STAR Kids and STAR+PLUS programs provide an integrated approach to health care delivery that addresses those services members may require in the acute, behavioral, functional, social, and environmental areas. The programs administer acute and long-term services and supports to the eligible populations through a managed-care system.

Service coordination is a major feature of STAR Kids and STAR+PLUS and involves specialized, person-centered thinking for members. Service coordinators provide assistance to members, family members, member representatives, and providers to develop a detailed service plan and provide the following services according to the member's needs:

- Acute care
- Behavioral health
- Environmental care
- Functional care
- Home- and community-based care

For information specific to STAR+PLUS members residing in nursing facilities, refer to the *STAR+PLUS Nursing Facility Provider Manual* located at **https://provider.amerigroup.com/TX** on the *Provider Manuals and Guides* page under *Resources*.

6.1 Eligibility

6.1.1 Eligibility verification

Providers must verify member eligibility by:

- Checking **Availity.com**. To verify member eligibility, log on to Availity Essentials at **Availity.com**. From the homepage, select **Patient Registration** > **Eligibility & Benefits**.
- Calling our automated Provider Inquiry Line at **800-454-3730**.
- Calling the Texas Medicaid & Healthcare Partnership (TMHP) Automated Inquiry Line at **800-925-9126**.
- Using TexMedConnect on the TMHP website at **tmhp.com**.
- Calling the Your Texas Benefits Provider Helpline at **855-827-3747**.

Note: It's the provider's responsibility to ensure eligibility is verified before delivering services.

6.1.1 STAR+PLUS eligibility

Texas requires enrollment in managed care for the adult Supplemental Security Income (SSI) population, including those clients with Medicaid and those dually eligible with Medicare and Medicaid. SSI members age 20 and younger are enrolled in the STAR Kids program.

STAR+PLUS members with intellectual disabilities or related conditions who do not qualify for Medicare and who receive services through the ICF-IID program or an IDD Waiver will be covered for acute care

services only under STAR+PLUS. Long-term services and supports will be provided through HHSC. A personal service coordinator will be assigned to each of these members.

Women enrolled in STAR+PLUS through eligibility for the Medicaid Breast and Cervical Cancer Program have full STAR+PLUS benefits. These members are not limited to cancer treatment only.

6.1.2 STAR Kids eligibility

Medicaid populations that must participate in STAR Kids include children and young adults aged 20 and younger who:

- Receive Supplemental Security Income (SSI)
- Receive SSI and Medicare
- Receive Medically Dependent Children Program (MDCP) waiver services
- Receive Youth Empowerment Services (YES) waiver services
- Receive IDD waiver services (for example, CLASS, DBMD, HCBS or TxHmL)
- Reside in a community-based ICF/IID or in a nursing facility (state plan services and service coordination only; long-term services and supports will continue to be provided through the appropriate institution)

Children and young adults enrolled in STAR Health, receiving adoption assistance or adoption services, or who reside in the Truman Smith Children's Care Center are not eligible to participate in STAR Kids.

6.2 Member identification cards

Sample member identification cards can be found in the ***Appendix A — ID Cards*** section of this manual.

6.3 The role of long-term services and supports providers

Long-term services and supports providers are responsible for but not limited to the following:

- Verifying member eligibility
- Obtaining authorizations for services prior to provision of those services
- Notifying us immediately if unable to render authorized services to the full extent authorized
- Initiating services within seven days from the start date on the Individual Service Plan (ISP) or the eligibility effective date for non-HCBS STAR+PLUS Waiver members, unless the referring provider or member requests or the STAR+PLUS handbook states otherwise
- Initiating community-based services within seven days of authorization for non-MDCP STAR Kids members; for STAR Kids MDCP members, services must be initiated by the start date of the ISP Tracker
- Coordinating Medicaid/Medicare benefits
- Notifying us of changes in a member's physical condition or eligibility
- Partnering with our service coordinator in managing a member's health care
- Managing continuity of care
- Reporting any suspicion or allegation of member abuse, neglect, or exploitation in accordance with Texas Human Resources Code §48.051, Texas Health and Safety Code §260A.002, and Texas Family Code §261.101

- For Employment Assistance providers: Developing and updating quarterly a plan for delivering Employment Assistance Services
- For Supported Employment providers: Developing and updating quarterly a plan for delivering Supported Employment Services

All Home and Community Support Services Agency (HCSSA) providers, adult day care providers, and residential care facility providers must notify Amerigroup if a member experiences any of the following:

- A significant change in the member's physical or mental condition or environment
- Hospitalization
- An emergency room visit
- Two or more missed appointments

6.3.1 Community First Choice (CFC) Program provider responsibilities

- The CFC services must be delivered in accordance with the member's service plan.
- The program provider must have current documentation, which includes the member's service plan, ID/RC (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable), and nursing assessment (if applicable).
- The HCS or TxHmL program provider must ensure that the rights of the members are protected (for example, privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).
- The program provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies, and any other needs specific to the member that are required to ensure the member's health, safety, and welfare. The program provider must maintain documentation of this training in the member's record.
- The program provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation. The program provider must also show documentation regarding required actions that must be taken from the time they are notified that an Adult Protective Services investigation has begun through the completion of the investigation (for example, providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc.). The program provider must also provide the member/legally authorized representative (LAR) with information on how to report acts or suspected acts of abuse, neglect, and exploitation and the Adult Protective Services hotline (**800-252-5400**).
- The program provider must address any complaints received from a member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the member/LAR with the appropriate contact information for filing a complaint.
- The program provider must not retaliate against a staff member, service provider, member (or someone on behalf of a member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.

- The program provider must ensure that the service providers meet all of the personnel requirements (age, high school diploma/GED or competency exam and three references from non-relatives, current Texas driver's license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC emergency response services (ERS), the program provider must ensure that the provider of ERS has the appropriate licensure.
- For CFC ERS, the program provider must have the appropriate licensure to deliver the service.
- Per the *CFR §441.565* for CFC, the program provider must ensure that any additional training requested by the member/LAR of CFC personal assistance services (PAS) or habilitation (HAB) service providers is procured.
- The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints, must be maintained, including any necessary behavior support plans.
- The program provider must adhere to the MCO financial accountability standards.
- The program provider must prevent conflicts of interest between the program provider, a staff member, or a service provider and a member, such as the acceptance of payment for goods or services from which the program provider, staff member or service provider could financially benefit.
- The program provider must prevent financial impropriety toward a member, including unauthorized disclosure of information related to a member's finances and the purchase of goods that a member cannot use with the member's funds.

6.4 Personal attendant wage requirements in community settings

Facilities and agencies providing personal attendant services must pay attendants at least $10.60 per hour for the following types of services provided to members:

STAR+PLUS:

- Day Activity Health Care Services (DAHS)
- Primary Home Care (PHC)
- Personal Assistance Services (PAS)
- Personal Assistance Services (CFC)
- Acquisition, maintenance, and enhancement of skills in CFC
- Texas Health Steps Personal Care Services (PCS)

STAR Kids:

- Personal Care Services (PCS)
- Personal Care Services (CFC)
- Acquisition, maintenance, and enhancement of skills in CFC
- MDCP attendant services

These wage requirements apply to personal attendants working as either employees or contractors of a provider or as employees or contractors of a subcontractor, regardless of whether the member chooses

to self-direct these services. Newly employed or contracted attendants must be notified of the required base wages within three days of being hired.

This requirement does not apply to attendant services provided by noninstitutional facilities such as assisted living, adult foster care, residential care, and nursing facilities.

6.5 Electronic visit verification (EVV)

General information about EVV

1. What is EVV?
EVV is a computer-based system that electronically documents and verifies the occurrence of a visit by a Service Provider or CDS Employee, as defined in Chapter 8.7.1 of the UMCM, to provide certain services to a member. The EVV System documents the following:

- Type of service provided (Service Authorization Data).
- Name of the member to whom the service is provided (Member Data).
- Date and times the visit began and ended.
- Service delivery location.
- Name of the Service Provider or CDS Employee who provided the service (Service Provider Data).
- Other information HHSC determines is necessary to ensure the accurate adjudication of Medicaid claims.

2. Is there a law that requires the use of EVV?
Yes. In December of 2016, the federal *21st Century Cures Act* added *Section 1903(l)* to the *Social Security Act (42 USC. § 1396b(l))* to require all states to implement the use of EVV. *Texas Government Code, Section 531.024172*, requires HHSC to implement an EVV System to electronically verify certain Medicaid services in accordance with federal law. To comply with these statutes, HHSC required the use of EVV for all Medicaid personal care services requiring an in-home visit, effective January 1, 2021. HHSC plans to require the use of EVV for Medicaid home health care services requiring an in-home visit, effective January 1, 2023.

3. Which services must a Service Provider or CDS Employee electronically document and verify using EVV?
The EVV required services that must be electronically documented and verified through EVV are listed on the HHSC EVV website. Refer to the *Programs, Services, and Service Delivery Options Required to Use Electronic Visit Verification*.

Check the **EVV Service Bill Codes Table** on the HHSC EVV website for up-to-date information and specific HCPCS code(s) and modifiers for EVV-required services at **Electronic Visit Verification | Texas Health and Human Services**.

4. Who must use EVV?
The following must use EVV:

- Provider: An entity that contracts with an MCO to provide an EVV service

- Service Provider: A person who provides an EVV required service and who is employed or contracted by a Provider or a CDS Employer
- CDS Employee: A person who provides an EVV required service and who is employed by a CDS Employer.
- Financial Management Services Agency (FMSA): An entity that contracts with an MCO to provide financial management services to a CDS Employer as described in *Texas Administrative Code, Title 40, Part 1, Chapter 41, Subchapter A, §41.103(25), Consumer Directed Services Option*
- CDS Employer: A member or LAR who chooses to participate in the CDS option and is responsible for hiring and retaining a Service Provider who delivers a service

EVV Systems

5. Do Providers and FMSAs have a choice of EVV Systems?
Yes. A Provider or FMSA must select one of the following two EVV Systems:

- EVV vendor system. An EVV vendor system is an EVV System provided by an EVV vendor selected by the HHSC Claims Administrator, on behalf of HHSC, that a Provider or FMSA may opt to use instead of an EVV proprietary system. More information about EVV vendors and their systems is available on the **TMHP EVV Vendors** webpage.
- EVV proprietary system. An EVV proprietary system is an HHSC-approved EVV System that a Provider or FMSA may choose to use instead of an EVV vendor system. An EVV proprietary system:
    - Is purchased or developed by a Provider or a FMSA.
    - Is used to exchange EVV information with HHSC or an MCO.
    - Complies with the requirements of *Texas Government Code Section §531.024172* or its successors.

Additional information is available on the TMHP Proprietary System webpage at **EVV Proprietary Systems | TMHP**.

6. Does a CDS Employer have a choice of EVV Systems?
No. A CDS Employer must use the EVV System selected by the CDS Employer's FMSA.

7. What is the process for a Provider or FMSA to select an EVV System?

- To select an EVV vendor from the state vendor pool, a Provider or FMSA, signature authority and the agency's appointed EVV System administrator must complete, sign, and date the *EVV Provider Onboarding Form* located on the EVV vendor's website. More information about EVV vendors and their systems is available on the **TMHP EVV Vendors** webpage.
- To use an EVV proprietary system, a Provider or FMSA, signature authority, and the agency's appointed EVV System administrator, must visit the TMHP Proprietary System webpage to review the EVV Proprietary System Operator (PSO) Onboarding process and HHSC EVV Proprietary System approval process. Additional information is available on the TMHP Proprietary System webpage at **EVV Proprietary Systems | TMHP**.

8. What requirements must a Provider or FMSA meet before using the selected EVV System?
Before using a selected EVV System:

- The Provider or FMSA must submit an accurate and complete form directly to the selected EVV vendor. EVV vendor information is available on the **TMHP EVV Vendors** webpage.
- Providers or FMSAs must submit the PSO Request Packet to enter the EVV PSO Onboarding Process which includes:
    - An *EVV Proprietary System Request Form*
    - *EVV PSO Detailed Questionnaire (DQ)*
    - TMHP Interface Access Request
- A program provider or FMSA must complete the EVV PSO Onboarding Process and receive written approval from HHSC to use an EVV proprietary system to comply with HHSC EVV requirements.
- If selecting either an EVV vendor or an EVV Proprietary System, a Provider or FMSA must:
    - Complete all required EVV training as described in the answer to **Question #18**.
    - Complete the EVV System onboarding activities:
        - Manually enter or electronically import identification data.
        - Enter or verify member service authorizations.
        - Set up member schedules (if required).
        - Create the CDS Employer profile for CDS Employer credentials to the EVV System.

9. Does a Provider or FMSA pay to use the selected EVV System?
If a Provider or FMSA selects an EVV vendor system, the Provider or FMSA uses the system free of charge.

If a Provider or FMSA elects to use an EVV proprietary system, the Provider or FMSA is responsible for all costs for development, operation, and maintenance of the system.

10. Can a Provider or FMSA change EVV Systems?
Yes. A Provider or FMSA may:
- Transfer from an EVV vendor to another EVV vendor within the state vendor pool.
- Transfer from an EVV vendor to an EVV proprietary system.
- Transfer from an EVV proprietary system to an EVV vendor.
- Transfer from one EVV proprietary system to another EVV proprietary system.

11. What is the process to change from one EVV System to another EVV System?
To change EVV Systems, a Provider or FMSA must request a transfer as follows:
- To request a transfer to an EVV vendor, a Provider or FMSA must submit an *EVV Provider Onboarding Form* to the new EVV vendor.
- To request a transfer to an EVV proprietary system, a Provider or FMSA must submit the PSO Request packet and complete the EVV PSO Onboarding Process.
- A Provider or FMSA must submit an EVV Provider Onboarding Form to the newly selected EVV vendor or an EVV PSO Request packet to TMHP at least 120 days before the desired effective date of the transfer.
- If a Provider or FMSA is transferring to an EVV vendor, the effective date of the transfer may be earlier than the desired effective date of the transfer if the Provider or FMSA and the newly selected EVV vendor agree on an earlier date.

- If a Provider or FMSA is transferring to an EVV proprietary system, the Provider or FMSA, TMHP, and HHSC will establish an effective date of transfer for the proprietary system that may be different than the desired effective date of the transfer.
- A FMSA must notify CDS Employers 60 days in advance of the planned Go-Live date to allow time for the FMSA to train CDS Employers and CDS Employees on the new EVV System.
- A Provider or FMSA must complete all required EVV System training before using the new EVV System.
- A Provider or FMSA who transfers to a new EVV vendor or proprietary system:
    - Will not receive a grace period and will be subject to all EVV policies including those related to compliance and enforcement.
    - May have EVV claims denied or recouped if there are no matching accepted EVV visit transactions in the EVV Aggregator.
- After a Provider or FMSA begins using a new EVV System, the Provider or FMSA must return all alternative devices supplied by the previous EVV vendor to the previous EVV vendor, if applicable.

12. Are the EVV Systems accessible for people with disabilities?

The EVV vendors provide accessible systems, but if a CDS Employer, Service Provider, or CDS Employee needs an accommodation to use the EVV System, the vendor will determine if an accommodation can be provided. However, vendors will not provide a device or special software if the system user needs this type of accommodation.

If the Provider or FMSA is using a proprietary system, the Service Provider, CDS Employer, or CDS Employee must contact the Provider or FMSA to determine accessibility features of the system and if an accommodation can be provided.

EVV service authorizations

13. What responsibilities do Providers and FMSAs have regarding service authorizations issued by an MCO for an EVV required service?

A Provider and FMSA must do the following regarding service authorizations issued by a MCO for an EVV-required service:

- Manually enter into the EVV System the most current service authorization for an EVV required service, including:
    - Name of the MCO.
    - Name of the Provider or FMSA.
    - Provider or FMSA Tax Identification Number.
    - National Provider Identifier (NPI) or Atypical Provider Identifier (API).
    - Member Medicaid ID.
    - Healthcare Common Procedural Coding System (HCPCS) code and Modifier(s).
    - Authorization start date.
    - Authorization end date.
- Perform Visit Maintenance if the most current service authorization is not entered into the EVV System.
- Manually enter service authorization changes and updates into the EVV System as necessary.

EVV clock-in and clock-out methods

14. What are the approved methods a Service Provider or CDS Employee may use to clock in and to clock out to begin and to end service delivery when providing services to a member in the home or in the community?

A Service Provider or CDS Employee must use one of the three approved electronic verification methods described below to clock in to begin service delivery and to clock out to end service delivery when providing services to a member in the home or in the community. A Service Provider or CDS Employee may use one method to clock in and a different method to clock out:

1. Mobile method:

- A Service Provider must use one of the following mobile devices to clock in and clock out:
    - The Service Provider's personal smart phone or tablet.
    - A smart phone or tablet issued by the Provider.
- A Service Provider must not use a member's smart phone or tablet to clock in and clock out.
- A CDS Employee must use one of the following mobile devices to clock in and clock out:
    - The CDS Employee's personal smart phone or tablet.
    - A smart phone or tablet issued by the FMSA.
    - The CDS Employer's smart phone or tablet if the CDS Employer authorized the CDS Employee to use their smart phone or tablet.
- To use a mobile method, a Service Provider or CDS Employee must use an EVV application provided by the EVV vendor or the PSO that the Service Provider or CDS Employee has downloaded to the smart phone or tablet.
- The mobile method is the only method that a Service Provider or CDS Employee may use to clock in and clock out when providing services in the community.

2. Home phone landline:

- A Service Provider or CDS Employee may use the member's home phone landline, if the member agrees, to clock in and clock out of the EVV System.
- To use a home phone landline, a Service Provider or CDS Employee must call a toll-free number provided by the EVV vendor or the PSO to clock in and clock out.
- If a member does not agree to a Service Provider's or CDS Employee's use of the home phone landline or if the member's home phone landline is frequently not available for the Service Provider or CDS Employee to use, the Service Provider or CDS Employee must use another approved clock in and clock out method.
- The Provider or FMSA must enter the member's home phone landline into the EVV System and ensure that it is a landline phone and not an unallowable landline phone type.

3. Alternative device:

- A Service Provider or CDS Employee may use an HHSC-approved alternative device to clock in and clock out when providing services in the member's home.
- An alternative device is an HHSC-approved electronic device provided at no cost by an EVV vendor or EVV PSO.
- An alternative device produces codes or information that identifies the precise date and time service delivery begins and ends.
- The alternative device codes are active for only seven days after the date of service and must be entered into the EVV system before the code expires.
- The Service Provider or CDS Employee must follow the instructions provided by the Provider or CDS Employer to use the alternative device to record a visit.
- An alternative device must always remain in the member's home even during an evacuation.

15. What actions must the Provider or FMSA take if a Service Provider or CDS Employee does not clock in or clock out or enters inaccurate information in the EVV System while clocking in or clocking out?

- If a Service Provider does not clock in or clock out of the EVV System or an approved clock-in or clock-out method is not available, then the Provider must manually enter the visit in the EVV System.
- If a Service Provider makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the Provider must perform Visit Maintenance to correct the inaccurate service delivery information in the EVV System.
- If a CDS Employee does not clock in or clock out for any reason, the FMSA or CDS Employer must create a manual visit by performing Visit Maintenance in accordance with the CDS Employer's selection on *Form 1722* to manually enter the clock-in and clock-out information and other service delivery information, if applicable.
- If a CDS Employee makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the FMSA or CDS Employer must perform Visit Maintenance in accordance with the CDS Employer's selection on *Form 1722* to correct the inaccurate service delivery information in the EVV System.
- After the Visit Maintenance timeframe has expired, the EVV System locks the EVV visit transaction and the program provider, FMSA or CDS Employer may only complete Visit Maintenance if the MCO approves a *Visit Maintenance Unlock Request*.
- The *EVV Policy Handbook* requires the Provider, FMSA or CDS Employer to ensure that each EVV visit transaction is complete, accurate, and validated.

EVV Visit Maintenance

16. Is there a timeframe in which Providers, FMSAs, and CDS Employers must perform Visit Maintenance?

In general, a Provider, FMSA, or CDS Employer must complete any required Visit Maintenance after a visit prior to the end of the Visit Maintenance timeframe as set in the HHSC *EVV Policy Handbook.*

Note: The standard Visit Maintenance timeframe as set in the *EVV Policy Handbook* may be changed by HHSC to accommodate Providers impacted by circumstances outside of their control.

17. **Are Providers, FMSAs, and CDS Employers required to include information in the EVV System to explain why they are performing Visit Maintenance?**
Yes. Program providers, FMSAs, or CDS Employers must select the most appropriate **Reason Code Number(s)**, **Reason Code Description(s)**, and must enter any required free text when completing Visit Maintenance in the EVV System:

- **Reason Code Number(s)** describe the purpose for completing Visit Maintenance on an EVV visit transaction.
- **Reason Code Description(s)** describe the specific reason Visit Maintenance is necessary.
- Free text is additional information the program provider, FMSA or CDS Employer enters to further describe the need for Visit Maintenance.

Reason Codes information is located on the home page of the HHSC EVV website at **Electronic Visit Verification | Texas Health and Human Services**.

EVV training

18. What are the EVV training requirements for each EVV System user?

- Providers and FMSAs must complete the following training:
    - EVV System training provided by the EVV vendor or EVV PSO
    - EVV Portal training provided by TMHP
    - EVV Policy training provided by HHSC or the MCO
- CDS Employers must complete training based on delegation of Visit Maintenance on *Form 1722*, **CDS Employer's Selection for Electronic Visit Verification Responsibilities**:
    - Option 1: CDS Employer agrees to complete all Visit Maintenance and approve their employee's time worked in the EVV System:
        - EVV System training provided by the EVV vendor or EVV PSO
        - Clock-in and clock-out methods
        - EVV Policy training provided by HHSC, the MCO, or FMSA.
    - Option 2: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf; however, CDS Employer will approve their employee's time worked in the system:
        - EVV System training provided by EVV vendor or EVV PSO
        - EVV Policy training provided by HHSC, the MCO, or FMSA
    - Option 3: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf:
        - Overview of EVV Systems training provided by EVV Vendor or EVV PSO
        - EVV policy training provided by HHSC, the MCO or FMSA
- Providers and CDS Employers must train Service Providers and CDS Employees on the EVV methods used to clock in when an EVV required service begins and clock out when the service ends.

Amerigroup EVV training requirements and information is available on the Amerigroup EVV website at **Electronic Visit Verification (EVV) | Amerigroup Texas**.

Compliance Reviews

19. What are EVV Compliance Reviews?

- EVV Compliance Reviews are reviews conducted by the MCO to ensure Providers, FMSAs, and CDS Employers are in compliance with EVV requirements and policies.
- The MCO will conduct the following reviews and initiate contract or enforcement actions if Providers, FMSAs, or CDS Employers do not meet any of the following EVV compliance requirements:
    - EVV Usage Review — meet the minimum EVV Usage Score.
    - EVV Required Free Text Review — document EVV required free text.
    - EVV Landline Phone Verification Review — ensure valid phone type is used.

Information about Amerigroup EVV Compliance Reviews is available on the Amerigroup EVV website at **Electronic Visit Verification (EVV) | Amerigroup Texas**.

EVV claims

20. Are Providers and FMSAs required to use an EVV System to receive payment for EVV required services?

Yes. All EVV claims for services required to use EVV must match to an accepted EVV visit transaction in the EVV Aggregator before reimbursement of an EVV claim by the MCO. The MCO may deny or recoup an EVV claim that does not match an accepted visit transaction.

21. Where does a Provider or FMSA submit an EVV claim?

Providers and FMSAs must submit all EVV claims to the HHSC Claims Administrator in accordance with the MCO's submission requirements.

EVV claims and billing information is located on both the Amerigroup EVV website at **Electronic Visit Verification (EVV) | Amerigroup Texas** and the HHSC EVV website in the *Electronic Visit Verification Policy Handbook*, *Section 12000 EVV Claims* including all sub-sections, at **12000 EVV Claims | Texas Health and Human Services**.

22. What happens if a Provider or FMSA submits an EVV claim to the MCO instead of the HHSC Claims Administrator?

If a Provider or FMSA submits an EVV claim to the MCO instead of the HHSC Claims Administrator, the MCO will reject or deny the claim and require the Provider or FMSA to submit the claim to the HHSC Claims Administrator.

23. What happens after the HHSC Claims Administrator receives an EVV claim from a Provider or FMSA?

The HHSC Claims Administrator will forward the EVV claims to the EVV Aggregator for the EVV claims matching process. The EVV Aggregator will return the EVV claims and the EVV claims match result code(s) back to the HHSC Claims Administrator for further claims processing. After completing the EVV claims matching process, the HHSC Claims Administrator forwards the claim to the MCO for final processing.

24. How does the automated EVV claims matching process work?

The claims matching process includes:

- Receiving an EVV claim line item.
- Matching data elements from each EVV claim line item to data elements from one or more accepted EVV transactions in the EVV Aggregator.
- Forwarding an EVV claim match result code to the MCO once the claims matching process is complete.

The following data elements from the claim line item and EVV transaction must match:

- Medicaid ID
- Date of service
- National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Healthcare Common Procedure Coding System (HCPCS) code
- HCPCS modifiers
- Billed units to units on the visit transaction, if applicable

Note: No unit match is performed on CDS EVV claims and unit match is not performed on visit transactions against the billed units on the claim line item for specific services. Refer to the *EVV Service Bill Codes Table* for the specific services that bypass the units matching process.

Based on the result of the EVV claims matching process, the EVV Portal displays an EVV claims match result code. After the EVV claims matching process, the EVV Aggregator returns an EVV claims match result code to the claims management system for final claims processing.

EVV claim match codes viewable in the EVV Portal are:

- EVV01 — EVV Successful Match
- EVV02 — Medicaid ID Mismatch
- EVV03 — Visit Date Mismatch
- EVV04 — Provider Mismatch (NPI/API) or Attendant ID Mismatch
- EVV05 — Service Mismatch (HCPCS and Modifiers, if applicable)
- EVV06 — Units Mismatch
- EVV07 — Match Not Required
- EVV08 — Natural Disaster

If the EVV Aggregator identifies a mismatch between an accepted EVV visit transaction and an EVV claim line item, the EVV claims matching process will return one of the EVV claim match result codes of EVV02, EVV03, EVV04, EVV05, or EVV06. The MCO will deny the EVV claim line item if it receives an EVV claim match result code of EVV02, EVV03, EVV04, EVV05, or EVV06.

When HHSC implements a bypass of the claims matching process for disaster or other temporary circumstance:

- The EVV claims matching process will return a match result code of EVV07 or EVV08.
- The MCO will not immediately deny an EVV claim with either of these claims match result codes for an unsuccessful EVV match.

- The MCO may still deny an EVV claim if other claim requirements fail the claims adjudication process.
- If allowed by HHSC, the MCO may complete a retrospective review of a paid EVV claim line item with a match result code of EVV07 or EVV08 to ensure the paid claim line item has a successful EVV match.

25. How can a Provider and FMSA see the results of the EVV claims matching process?
Providers and FMSAs may view the results of the EVV claims matching process in the EVV Portal. The EVV Portal contains a claim identifier for both the TMHP system and the MCO system. The MCO's Provider Portal also provides additional claims status information, such as whether the MCO has paid or denied the claim. In addition, the MCO provides an Explanation of Payment (EOP) to Providers and FMSAs to inform them of whether the MCO paid or denied the claim, and if denied, the reason for denial.

Detailed information including job aids is located on the TMHP EVV Training webpage at **EVV Training | TMHP**.

26. Could an MCO deny payment of an EVV claim even if the EVV claim successfully matches the EVV visit transaction?
Yes. An MCO may deny payment for an EVV claim for a reason unrelated to EVV requirements, such as a member's loss of program eligibility or the Provider's or FMSA's failure to obtain prior authorization for a service.

6.6 STAR+PLUS covered services

The services we cover under STAR+PLUS differ according to a member's eligibility for Medicare.

STAR+PLUS long-term services and supports (LTSS) include both custodial nursing home care and community-based services. The HCBS STAR+PLUS Waiver provides community LTSS to Medicaid-eligible adults with disabilities and elderly persons as a cost-effective alternative to living in a nursing facility. Individuals who reside in a nursing facility must be age 21 or older, enrolled in Medicaid or otherwise financially eligible for Waiver services to qualify for STAR+PLUS.

All LTSS services must be authorized. Coverage of these services is limited to members who need assistance with activities of daily living. Some services are limited to members who meet the nursing home level of care. If you have an Amerigroup patient who needs these services, please direct him or her to contact Member Services at **800-600-4441 (TTY 711)** or the health plan toll-free numbers given in the ***Service Coordination*** section of this chapter. Our service coordinators will assess the member's needs and develop a service plan.

6.6.1 Nondual-eligible members

STAR+PLUS covers acute care and LTSS for members who are not eligible for Medicare (Medicaid-only members). The ***Covered Services and Extra Benefits*** chapter has information on acute care benefits.

6.6.2 Dual-eligible members

Acute care for dual-eligible members is covered by Medicare or a Medicare HMO. STAR+PLUS members dually eligible for Medicare will receive most prescription drug services through Medicare rather than Medicaid. Dual-eligible members are eligible to receive coverage for LTSS covered by Amerigroup under the STAR+PLUS program.

6.6.3 STAR+PLUS coverage table

STAR+PLUS members get benefits for acute care such as doctor visits, hospitalizations, prescriptions, and behavioral health services, and they can also get long-term services and supports. A member may not need long-term services and supports right now, but they can get those benefits if needed in the future. If a member does need long-term services and supports benefits, the kind of benefits they can get is based on their category of Medicaid eligibility. There are three Medicaid eligibility levels:

- Other Community Care (OCC): basic coverage
- Community First Choice (CFC): mid-level coverage
- Home- and Community-Based Services (HCBS) STAR+PLUS Waiver (SPW): highest level of coverage for members with complex needs

Service types	Nondual (Medicaid only) + OCC	Nondual (Medicaid only) + CFC	Nondual (Medicaid only) + SPW	Dual-eligibles (Medicaid and Medicare) + OCC	Dual-eligibles (Medicaid and Medicare) + CFC	Dual-eligibles (Medicaid and Medicare) + SPW
Medical (such as doctor's visits and hospital services) and behavioral health services	Amerigroup	Amerigroup	Amerigroup	Medicare or Medicare HMO	Medicare or Medicare HMO	Medicare or Medicare HMO
Prescription drugs	Amerigroup	Amerigroup	Amerigroup	Member's chosen Part D prescription drug vendor	Member's chosen Part D prescription drug vendor	Member's chosen Part D prescription drug vendor
Medicare coinsurance and deductibles	Not applicable	Not applicable	Not applicable	State's fiscal agent (TMHP) for regular Medicare; Medicare HMO	State's fiscal agent (TMHP) for regular Medicare; Medicare HMO	State's fiscal agent (TMHP) for regular Medicare; Medicare HMO
Transportation assistance	Amerigroup	Amerigroup	Amerigroup	Amerigroup	Amerigroup	Amerigroup
Long-term services and supports						
Primary home care/ personal assistance services	Amerigroup*	Amerigroup*	Amerigroup*	Amerigroup*	Amerigroup*	Amerigroup*
Day activity and health services (DAHS)	Amerigroup*	Amerigroup*	Amerigroup*	Amerigroup*	Amerigroup*	Amerigroup*
Consumer-directed attendant care (including financial	Amerigroup*	Amerigroup*	Amerigroup*	Amerigroup*	Amerigroup*	Amerigroup*

Service types	Nondual (Medicaid only) + OCC	Nondual (Medicaid only) + CFC	Nondual (Medicaid only) + SPW	Dual-eligibles (Medicaid and Medicare) + OCC	Dual-eligibles (Medicaid and Medicare) + CFC	Dual-eligibles (Medicaid and Medicare) + SPW
management services)						
Nursing services (in home)	N/A	N/A	Amerigroup*	Medicare/ Medicare HMO	Medicare/ Medicare HMO	Amerigroup* or Medicare/ Medicare HMO
Acquisition, maintenance, and enhancement of skills services	N/A	Amerigroup*	Amerigroup*	N/A	Amerigroup*	Amerigroup*
Emergency response services (emergency call button)	N/A	Amerigroup*	Amerigroup*	N/A	Amerigroup*	Amerigroup*
Dental services	N/A	N/A	Amerigroup*	N/A	N/A	Amerigroup*
Home-delivered meals	N/A	N/A	Amerigroup*	N/A	N/A	Amerigroup*
Minor home modifications	N/A	N/A	Amerigroup*	N/A	N/A	Amerigroup*
Adaptive aids	N/A	N/A	Amerigroup*	N/A	N/A	Amerigroup*
Durable medical equipment	N/A	N/A	Amerigroup*	Medicare/ Medicare HMO	Medicare/ Medicare HMO	Amerigroup*
Medical supplies	N/A	N/A	Amerigroup*	N/A	N/A	Amerigroup*
Physical, occupational, and speech therapy	N/A	N/A	Amerigroup*	Medicare/ Medicare HMO	Medicare/ Medicare HMO	Amerigroup*
Adult foster care/personal home care	N/A	N/A	Amerigroup*	N/A	N/A	Amerigroup*
Assisted living	N/A	N/A	Amerigroup*	N/A	N/A	Amerigroup*
Transition assistance services (for members leaving a nursing facility) — $2,500 maximum	N/A	N/A	Amerigroup*	N/A	N/A	Amerigroup*
Respite (with or without self-directed models)	N/A	N/A	Amerigroup*	N/A	N/A	Amerigroup*
Dietitian/nutritional assistance (for assisted living residents)	N/A	N/A	Amerigroup*	N/A	N/A	Amerigroup*
Cognitive rehabilitation therapy	N/A	N/A	Amerigroup*	N/A	N/A	Amerigroup*
Support consultation/ management	N/A	Amerigroup*	Amerigroup*	N/A	Amerigroup*	Amerigroup*
Employment assistance	N/A	N/A	Amerigroup*	N/A	N/A	Amerigroup*

Service types	Nondual (Medicaid only) + OCC	Nondual (Medicaid only) + CFC	Nondual (Medicaid only) + SPW	Dual-eligibles (Medicaid and Medicare) + OCC	Dual-eligibles (Medicaid and Medicare) + CFC	Dual-eligibles (Medicaid and Medicare) + SPW
Supported employment	N/A	N/A	Amerigroup*	N/A	N/A	Amerigroup*

* Members should contact a service coordinator or call Member Services to find out if they qualify for services.

6.6.4 STAR+PLUS long-term services and supports benefit descriptions

The following descriptions refer to the STAR+PLUS benefits grid above. Please see the grid for additional information on benefit availability.

Primary home care/personal assistance services (PAS) are available to all STAR+PLUS members based on medical and functional necessity and are provided to members living in their own home and community settings. Services include but are not limited to:

- Assisting with the activities of daily living such as feeding, preparing meals, transferring, and toileting.
- Assisting with personal maintenance such as grooming, bathing, dressing, and routine care of hair and skin.
- Assisting with general household activities and chores necessary to maintain the home in a clean, sanitary, and safe environment such as changing bed linens, housecleaning, laundering, shopping, storing purchased items, and washing dishes.
- Providing protective supervision.
- Providing extension of therapy services.
- Providing ambulation and exercise.
- Assisting with medications that are normally self-administered.
- Performing nursing tasks delegated by registered nurses.
- Escorting the member on trips to obtain medical diagnoses, treatment, or both.

Day Activity and Health Services (DAHS) — All STAR+PLUS members may receive medically and functionally necessary DAHS. DAHS includes nursing and personal care services, physical rehabilitative services, nutrition services, transportation services, and other supportive services. These services are provided at facilities licensed or certified by HHSC.

Acquisition, maintenance, and enhancement of skills training is available to CFC and SPW members to enable the member to accomplish activities of daily living, instrumental activities of daily living and other health-related tasks.

Adult Foster Care (AFC) is a benefit for HCBS STAR+PLUS Waiver (SPW) members that provides a 24-hour living arrangement in an HHSC-contracted foster home for persons who, because of physical, mental, or emotional limitations, are unable to continue independent functioning in their own homes. Services may include meal preparation, housekeeping, personal care, nursing tasks, supervision, companion services, daily living assistance and provision of, or arrangement for, transportation.

The SPW AFC member must reside in an SPW AFC home. Providers of AFC must live in the household and share a common living area with the member. Detached living quarters do not constitute a common living area. The individual enrolled to provide AFC must be the primary caregiver. Providers may serve up to three adult members in a HHSC-enrolled AFC home without licensure as a personal care home. Up to four residents may be served in a foster home, though there are limitations as to the number of members at each level who may reside in one home.

SPW members are required to pay for their own room and board costs and contribute to the cost of their care, if able, through a copay to the AFC provider.

Adaptive aids and medical supplies are covered benefits for SPW members when needs for the member to have optimal function, independence and well-being are identified and approved by the managed care organization in the individual service plan. Adaptive aids and medical supplies are specialized medical equipment and supplies including devices, controls or appliances specified in the plan of care that enable individuals to increase their abilities to perform activities of daily living or perceive, control, or communicate with the environment in which they live. Adaptive aids and medical supplies are reimbursed with the goal of providing individuals a safe alternative to nursing facility placement. Items not of direct remedial benefit (providing a remedy to cure or restore health) or medical benefit to the individual are excluded from reimbursement.

Adaptive aids and medical supplies are limited to the most cost-effective items that can:

- Meet the member's needs.
- Directly aid the member to avoid premature nursing facility placement.
- Provide nursing facility residents an opportunity to return to the community.

The HCBS STAR+PLUS Waiver is not intended to provide every member with any and all adaptive aids or medical supplies the member may receive as a nursing facility resident. Details of items covered under this category can be found in the STAR+PLUS handbook at **https://hhs.texas.gov/laws-regulations/handbooks/sph/section-6000-specific-starplus-hcbs-program-services**.

Dental services for HCBS STAR+PLUS Waiver members are services provided by a dentist to preserve teeth and meet the medical needs of the member. Allowable services include:

- Emergency dental treatment necessary to control bleeding, relieve pain, and eliminate acute infection.
- Preventive procedures required to prevent the imminent loss of teeth.
- The treatment of injuries to teeth or supporting structures.
- Dentures and the cost of preparation and fitting.
- Routine procedures necessary to maintain good oral health.

Dental services for SPW members are limited to $5,000 per waiver plan year. This limit may be exceeded upon approval by Amerigroup up to an additional $5,000 per waiver plan year when medically necessary treatment requires the services of an oral surgeon. Amerigroup may also approve other dental services above the $5,000 waiver plan year limit on a case-by-case basis due to medical necessity, functional necessity, or the potential for improved health of the member. Amerigroup must review and approve any treatment in excess of the waiver plan year limit prior to services being rendered.

Cognitive rehabilitation therapy is available to SPW members to assist a member in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry in order to enable the member to compensate for the lost cognitive functions. Cognitive rehabilitation therapy may be provided when an appropriate professional assesses the member and determines it is medically necessary. Cognitive rehabilitation therapy is provided in accordance with the plan of care developed by the assessor and includes reinforcing, strengthening, or re-establishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems.

Employment assistance means assistance provided to an SPW member to help the member locate paid employment in the community. Employment assistance includes:

- Identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions.
- Locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements.
- Contacting a prospective employer on behalf of a member and negotiating the member's employment.

Employment assistance is not available to members receiving services through a program funded by the *Rehabilitation Act of 1973* or the *Individuals with Disabilities Education Act*.

Supported employment means assistance provided to an SPW member in order to sustain paid employment to a member who, because of a disability, requires intensive, ongoing support to be self-employed, work from home or perform in a work setting at which members without disabilities are employed. Supported employment includes employment adaptations, supervision and training related to a member's diagnosis.

Supported employment is not available to members receiving services through a program funded by the *Rehabilitation Act of 1973* or the *Individuals with Disabilities Education Act*.

Financial management services (FMS) are assistance provided to members who elect to participate in the Consumer Directed Services (CDS) option to manage funds associated with services elected for self-direction. The assistance is provided by the CDS agency. This includes initial orientation and ongoing training related to the responsibilities of being an employer and adhering to legal requirements for employers. A monthly administrative fee is authorized on the individual service plan and paid to the CDS agency for FMS.

Support consultation services are available to SPW members participating in the CDS option. It is an optional service. A member's service planning team may recommend the service when the employer (the individual or legally authorized representative [LAR]) or the designated representative (DR) would benefit from additional support with employer responsibilities. Support consultation services must not duplicate or replace services to be delivered through a case manager, a service coordinator, the Financial Management Services Agency (FMSA) or other sources. A support advisor provides skills-specific training, assistance and supports to the employer or the employer's DR to meet responsibilities of the CDS option.

Examples of services a support advisor may provide include training related to recruiting and screening applicants for employment and verifying employment eligibility, assistance with developing job descriptions, coaching on problem solving and coordinating employee management activities, training on developing and implementing service backup and corrective action plans, and coaching on handling other employer responsibilities.

Support management benefits are available to Community First Choice members. Voluntary training may be received on how to select, manage, and dismiss attendants.

6.7 STAR Kids covered services

6.7.1 Nondual-eligible members

We will cover STAR Kids acute care and long-term services and supports benefits for members who are not eligible for Medicare (Medicaid-only members). The ***Covered Services and Extra Benefits*** chapter has information on acute care benefits.

6.7.2 Dual-eligible members

Acute care for dual-eligible members is covered by Medicare or a Medicare HMO. STAR Kids members who are covered by both Medicaid and Medicare will receive most prescription drug services through Medicare. Dual-eligible members receive coverage for STAR Kids long-term services and supports benefits.

6.7.3 STAR Kids long-term services and supports and waiver program benefits

STAR Kids long-term services and supports covered services are based on how the individual qualifies for membership. The member types are:

- Receives Supplemental Security Income (SSI) but is not enrolled in a state waiver program
- Enrolled in the Medically Dependent Children Program (MDCP)
- Enrolled in the Youth Empowerment Services (YES) waiver
- Enrolled in an IDD waiver program:
    - Community Living Assistance and Support Services (CLASS)
    - Deaf-Blind with Multiple Disabilities (DBMD)
    - Home- and Community-Based Services (HCS)
    - Texas Home Living (TxHmL)

6.7.4 STAR Kids long-term services and supports coverage table

The chart on the next page provides an overview of STAR Kids long-term services and supports benefits by type and category of coverage. For the YES and IDD member types, the waiver program provides some of the long-term services and supports benefits.

Claims for long-term services and supports benefits covered by the YES waiver program should be submitted to the Department of State Health Services (DSHS). Claims for long-term services and supports

benefits covered by the IDD waiver programs (CLASS, DBMD, HCS and TxHmL) should be submitted to HHSC.

For members who reside in a nursing facility or an intermediate care facility for individuals with intellectual disabilities (ICF/IID), we will pay for any Amerigroup covered services that are received outside the facility. We will also provide service coordination for the member. Claims for the services covered by Amerigroup should be submitted to us as described in the ***Billing and Claims Administration*** chapter.

<table>
<tr><th colspan="5">STAR Kids long-term services and supports
Members should contact a service coordinator or call Member Services to find out if they qualify for services.</th></tr>
<tr><th>Service types
Checkmarks (✓) represent benefits that are covered by Amerigroup.</th><th>SSI recipient not in a waiver program</th><th>MDCP</th><th>YES waiver</th><th>IDD (CLASS, DBMD, HCS or TxHmL) waiver</th></tr>
<tr><td>Personal care services (PCS)</td><td>√</td><td></td><td></td><td></td></tr>
<tr><td>Private duty nursing (PDN)</td><td>√</td><td>√</td><td>√</td><td>√</td></tr>
<tr><td>Day activity and health services (DAHS) (ages 18 and over)</td><td>√</td><td>√</td><td>√</td><td>√</td></tr>
<tr><td>Prescribed pediatric extended care (PPECC) services</td><td>√</td><td>√</td><td>√</td><td>√</td></tr>
<tr><td>Personal attendant services (CFC)</td><td>CFC only*</td><td>√</td><td>√</td><td rowspan="12">Waiver program determines and provides benefits</td></tr>
<tr><td>Habilitation services</td><td>CFC only*</td><td>√</td><td>√</td></tr>
<tr><td>Emergency response services (emergency call button)</td><td>CFC only*</td><td>√</td><td>√</td></tr>
<tr><td>Support management</td><td>CFC only*</td><td>√</td><td>√</td></tr>
<tr><td>Adaptive aids**</td><td rowspan="10">Not covered</td><td>√</td><td rowspan="10">Waiver program determines and provides benefits</td></tr>
<tr><td>Employment assistance</td><td>√</td></tr>
<tr><td>Financial management services***</td><td>√</td></tr>
<tr><td>Flexible family support services</td><td>√</td></tr>
<tr><td>Minor home modifications</td><td>√</td></tr>
<tr><td>Respite services</td><td>√</td></tr>
<tr><td>Supported employment</td><td>√</td></tr>
<tr><td>Transition assistance services</td><td>√</td></tr>
</table>

*The member must qualify for Community First Choice (CFC) benefits.
**Durable medical equipment including adaptive aids is a state plan benefit for all STAR Kids members.
*** Financial management services are a covered benefit for members who use the consumer-directed services option for personal care services or personal attendant services.

6.7.5 STAR Kids long-term services and supports benefit descriptions

The following descriptions refer to the STAR Kids benefits grid above. Please see the grid for additional information on benefit availability.

Adaptive aids are specialized medical equipment, including devices, controls, or appliances specified in the plan of care, that enable individuals to increase their abilities to perform activities of daily living or perceive, control, or communicate with the environment in which they live. Adaptive aids are reimbursed with the goal of providing individuals a safe alternative to nursing facility (NF) placement. Items not of direct remedial benefit (providing a remedy to cure or restore health) or medical benefit to the individual are excluded from reimbursement. The service limit on adaptive aids is $4,000 per individual service plan period.

Adaptive aids are limited to the most cost-effective items that can:

- Meet the member's needs.
- Directly aid the member in avoiding premature NF placement.
- Provide NF residents an opportunity to return to the community.

Community First Choice (CFC) services include the following:

- Emergency response services (emergency call button)
- Habilitation services (acquisition, maintenance, and enhancement of skills training) — provided to enable the member to accomplish activities of daily living, instrumental activities of daily living, and other health-related tasks
- Personal attendant services — assistance to members in performing the activities of daily living and instrumental activities of daily living necessary to maintain the home in a clean, sanitary, and safe environment; services are available to members based on medical and functional necessity and provided to members living in their own home and community settings; personal attendant services include but are not limited to:
    - Assisting with the activities of daily living (for example, feeding, preparing meals, transferring and toileting)
    - Assisting with personal maintenance (for example, grooming, bathing, dressing, and routine care of hair and skin)
    - Assisting with general household activities and chores necessary to maintain the home in a clean, sanitary, and safe environment (for example, changing bed linens, housecleaning, laundering, shopping, storing purchased items, and washing dishes)
    - Providing protective supervision
    - Providing extension of therapy services
    - Providing ambulation and exercise
    - Assisting with medications that are normally self-administered
    - Performing nursing tasks delegated by registered nurses
    - Escorting the member on trips to obtain medical diagnoses, treatment, or both
- **Support management** — voluntary training that may be received on how to select, manage, and dismiss attendants

Day activity and health services (DAHS) — All STAR Kids members age 18 and older may receive medically and functionally necessary DAHS. DAHS includes nursing and personal care services, physical rehabilitative services, nutrition services, transportation services, and other supportive services. These services are provided at facilities licensed or certified by HHSC.

Employment assistance is assistance provided to a member to help the member locate paid employment in the community. Employment assistance includes:

- Identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions.
- Locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements.
- Contacting a prospective employer on behalf of a member and negotiating the member's employment.

Financial management services (FMS) are assistance provided to members who elect to participate in the Consumer Directed Services (CDS) option to manage funds associated with services elected for self-direction. The assistance is provided by a financial management services agency (FMSA). This includes initial orientation and ongoing training related to the responsibilities of being an employer and adhering to legal requirements for employers. A monthly administrative fee is authorized on the individual service plan and paid to the FMSA.

- **Support consultation** services are also available only to members participating in the CDS option. This is an optional service. A member's service planning team may recommend the service when the employer (the individual or legally authorized representative [LAR]) or the designated representative (DR) would benefit from additional support with employer responsibilities. Support consultation services must not duplicate or replace services to be delivered through a case manager, a service coordinator, the FMSA or other sources. A support advisor provides skills-specific training, assistance and supports to the employer or the employer's designated representative (DR) to meet responsibilities of the CDS option.
- Examples of services a support advisor may provide include training related to recruiting and screening applicants for employment and verifying employment eligibility, assistance with developing job descriptions, coaching on problem solving and coordinating employee management activities, training on developing and implementing service backup and corrective action plans, and coaching on handling other employer responsibilities.

Flexible family support services are individualized, disability-related services that support a member to participate in:

- Childcare.
- Independent living.
- Post-secondary education.

Flexible family support services include personal care supports for basic activities of daily living (ADL) and instrumental ADL, skilled task, and delegated skilled task supports. Flexible family support services promote community inclusion in typical child and youth activities through the enhancement of natural supports and systems and through recognition that these supports may vary by child, provider, setting and daily routine.

Minor home modifications are those physical adaptations to a member's home necessary to prevent institutionalization or support de-institutionalization and that are necessary to ensure the member's health, welfare, and safety, or that enable the member to function with greater independence in the home. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the member's welfare. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the member, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit.

The minor home modification lifetime limit is $7,500. All services are provided in accordance with applicable state or local building codes and must adhere to *Americans with Disabilities Act (ADA)* requirements.

Personal care services are support services furnished to a member who has physical, cognitive, or behavioral limitations related to their disability or chronic health condition that limit their ability to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs) or health maintenance activities. Personal care services, also called personal assistance services, include:

- Assistance with feeding, dressing, moving, bathing, or other personal needs or maintenance.
- General supervision or oversight of the physical and mental well-being of a person who needs assistance to maintain a private and independent residence, or who needs assistance to manage their personal life, regardless of whether a guardian has been appointed for the person.

Prescribed pediatric extended care (PPECC) is daily medical care away from the member's residence for minors from birth to age 20 who have a medically complex condition. If prescribed by a physician, a member can attend a PPECC up to a maximum of 12 hours per day. Care can include medical, nursing, psychosocial, therapeutic, and developmental services. The types of services provided are based on the needs of the individual's medical condition and developmental status. Members must be determined eligible for PPECC services in compliance with medical necessity and other requirements in 1 TAC, Chapter 363, Subchapter B.

Private duty nursing is nursing services in the home of members who require more individual and continuous care than is available from a visiting nurse. Services are provided by a registered nurse (RN) or licensed vocational nurse (LVN) and include both direct skilled nursing care and caregiver education and training.

Respite care is a service that provides temporary relief from caregiving to the member's primary caregiver during the times when the primary caregiver would normally provide care. The primary caregiver may be the member's parent, guardian, family member, or spouse. The following are requirements for this benefit:

- Respite may only be provided during the time the primary caregiver would usually provide care to the member. Respite may not be provided during the time the primary caregiver is at work, attending school or in job training.
- Respite may not be delivered by the primary caregiver; the member's spouse; or the member's parent, representative, guardian, or managing conservator, if the individual is under 18.
- Respite may be delivered by attendants or nurses employed through the CDS option.

- Respite care is not limited to the member's home.

Supported employment is assistance provided in order to sustain paid employment for a member who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which members without disabilities are employed. Supported employment includes employment adaptations, supervision, and training related to a member's assessed need.

Transition assistance services (TAS) pays for nonrecurring, set-up expenses for individuals transitioning from nursing facilities to a home in the community. A nursing facility resident discharged from the facility into the MDCP waiver program is eligible to receive up to $2,500 in TAS. This benefit is available on a one-time only basis. Allowable expenses are those necessary to enable the individual to establish a basic household and may include:

- Payment of security deposits required to lease an apartment or home.
- Setup fees or deposits to establish utility services for the home, including telephone, electricity, gas, and water.
- Purchase of essential furnishings for the apartment or home, including table, chairs, window blinds, eating utensils, food preparation items, and bath linens.
- Payment of moving expenses required to move into or occupy the home or apartment.
- Payment for services to ensure the health and safety of the individual in the apartment or home, such as pest eradication, allergen control, or a one-time cleaning before occupancy.

Waiver individuals who are temporarily residing in a nursing facility may also be eligible for TAS. This benefit may be used if the waiver member's living conditions are inadequate. Inadequate living conditions may include situations in which the individual has lost a residence because of moving into the nursing facility or conditions in the previous residence are so inadequate that the individual cannot return.

6.8 Settings for provision of LTSS benefits

Community-based long-term services and supports means services provided to members in their home or other community-based settings necessary to provide assistance with activities of daily living, allowing the member to remain in the most integrated setting possible.

Community-based LTSS must be provided in settings that allow the member an opportunity to:

- Seek employment and work in competitive integrated settings.
- Engage in community life.
- Control personal resources.
- Receive services in the community to the same degree of access as individuals not receiving Medicaid LTSS.

The setting for services must ensure the individual's rights of privacy, dignity and respect, and freedom from coercion and restraint. The setting should optimize but not regiment individual initiative, autonomy, and independence in making life choices including but not limited to daily activities, physical environment, and the choice of with whom to interact. The setting must facilitate individual choice regarding services and supports and who provides them.

Members should be advised about and assisted with accessing the most appropriate and least restrictive home- and community-based services as alternatives to institutional care. The member must be given an opportunity to make an informed choice among the options for care settings including non-disability specific settings and an option for a private unit in a residential setting. The setting options must be:

- Identified and documented in the member's service plan.
- Based on the member's individual needs, preferences and, for residential settings, resources available for room and board.

In a provider-owned or controlled setting, the following additional rights must be given to individuals:

- The same responsibilities and protections from eviction that tenants have under state and local law
- Privacy in their sleeping or living unit, including locking doors, choice of roommates, and freedom to furnish and decorate sleeping and living areas
- Freedom and support to control schedules and activities including access to food at any time and having visitors at any time

Settings for community-based LTSS do not include:

- A nursing facility.
- An institution for mental diseases.
- An intermediate care facility for individuals with intellectual disabilities.
- A hospital.
- Any other location that has the quality of an institutional setting.

6.9 Service coordination

6.9.1 Service coordinator roles and responsibilities

Service coordination is specialized care management services that are performed by a licensed, certified and/or experienced person called a service coordinator. This includes but is not limited to the following activities:

- Identifying a member's needs through an assessment
- Documenting how to meet the member's needs in a care plan
- Engaging the member, the member's representative, and caregivers in the design of the member's individual service plan (ISP)
- Arranging for delivery of the needed services and monitoring provision and timeliness
- Establishing a relationship with the member and being an advocate for the member in coordinating care
- Helping with coordination between different types of services
- Making sure the member has a primary care provider

The purpose of a service coordinator is to maximize a member's health, well-being, and independence. Service coordination should consider and address the member's situation as a whole, including their medical, behavioral, social, and educational needs. The service coordinator must work with the member's primary care provider to coordinate all covered services, noncapitated services, and noncovered services

available through other sources. This requirement applies even if the member is dual-eligible and the primary care provider is not in our network. In order to integrate the member's care while remaining informed of the member's needs and condition, the service coordinator must actively involve the member's primary and specialty care providers, including behavioral health service providers, and providers of noncapitated services and noncovered services.

6.9.2 STAR+PLUS service coordination services

We provide a single, identified person as a service coordinator to all STAR+PLUS members who qualify as Level 1 or Level 2 under HHSC guidelines or when we determine one is required based on our assessment of the member's health and support needs. We will also provide a service coordinator to any member who requests service coordination services. Level 1 members include HCBS STAR+PLUS Waiver recipients, individuals with severe and persistent mental illness (SPMI), and other members with complex medical needs. Level 2 members include those members receiving LTSS for personal assistance services or day activity and health services (PAS and DAHS), members with non-SPMI behavioral health issues, Medicaid Breast Cancer and Cervical Program members, and Medicare and Medicaid dual-eligibles that do not qualify as Level 1.

Level 3 members are those who don't qualify as Level 1 or Level 2. Level 3 members are not required to have a single identified person as a service coordinator unless the member requests service coordination services. All members within a nursing facility will be assigned the same service coordinator.

We will help ensure each STAR+PLUS member has access to a PCP or physician who is responsible for overall clinical direction. The PCP/physician, in conjunction with the service coordinator, serves as a central point of integration and coordination of covered services.

Service coordinators work with members and providers to coordinate all STAR+PLUS covered services and any other applicable services. Our service coordinators collaborate with the member's PCP/physician, regardless of network status. To speak with a service coordinator, call toll free at the number below for the service area, Monday to Friday from 8 a.m. to 5 p.m. local time.

- Bexar: **800-589-5274, ext. 106-103-5201**
- El Paso: **877-405-9871, ext. 106-103-5197**
- Harris and Jefferson: **800-325-0011, ext. 106-103-5198**
- Lubbock: **877-405-9872, ext. 106-103-5200**
- Tarrant/West RSA: **800-839-6275, ext. 106-103-5199**
- Travis: **800-315-5385, ext. 106-103-5202**

6.9.3 STAR Kids screening and assessment process

STAR Kids screening and assessment instrument (SAI) means the electronic assessment and screening tool that we are required to administer to STAR Kids members to help determine personal preferences, service needs and necessity of additional assessments.

STAR Kids screening and assessment process means all screenings, assessments, and other information-gathering methods that we use to inform our decisions about services needed for members.

We conduct an initial telephonic member screening for all new members. The telephonic screening is used to help prioritize which members require the most immediate attention. We also review claims data to prioritize members who may need the most immediate assistance. We may take up to 15 business days for the initial telephonic member screening unless notified by the member, the member's representative, or member's primary care provider by phone or in writing of a more urgent need.

6.9.4 STAR Kids Individual Service Plan (ISP) description

We will create and regularly update a comprehensive person-centered ISP for each STAR Kids member unless the member or member's representative declines the STAR Kids screening and assessment process. The purpose of the ISP is to articulate assessment findings, short- and long-term goals, service needs, and member preferences. The ISP must be used to communicate and help align expectations between the member, the member's representative, Amerigroup, and key service providers. The ISP must also be used by us to measure member outcomes over time. The ISP must be informed by findings from the STAR Kids screening and assessment process, in addition to input from the member, the member's family, caregivers, providers, and any other individual with knowledge and understanding of the member's strengths and service needs who is identified by the member, the member's representative, or Amerigroup.

Each member's ISP must be updated:

- At least annually.
- Following a significant change in health condition that impacts service needs.
- Upon request from the member or the member's representative.
- At the recommendation of the member's primary care provider.
- Following a change in life circumstance.
- Following the STAR Kids screening and assessment process or reassessment process.

We will provide a printed or electronic copy of the ISP to each member or member's representative following any significant update and no less than annually. We will provide a copy of the ISP to the member's providers and other individuals specified by the member or member's representative.

6.9.5 STAR Kids service coordination services

We provide a single identified person as a service coordinator to all STAR Kids members who:

- Qualify as level 1 or level 2 under HHSC guidelines (see guidelines below).
- Are enrolled in an IDD waiver program (CLASS, DBMD, HCS or TxHmL).
- Reside in a nursing facility or community-based ICF/IID.
- Request a personal service coordinator.

Level 1 members include:

- MDCP STAR Kids members.
- Members with complex needs or a history of developmental or behavioral health issues (multiple outpatient visits, hospitalization, or institutionalization within the past year).
- Members with a serious emotional disturbance (SED) or severe and persistent mental illness (SPMI).

- Members at risk for institutionalization.

All Level 1 members must receive a minimum of four face-to-face service coordination contacts annually and monthly phone calls unless otherwise requested by the member or member's representative.

Level 2 members include:

- Members who do not meet the requirements for level 1 classification but receive personal care services (PCS), Community First Choice (CFC) or nursing services (including PDN and PPECC).
- Members we believe would benefit from a higher level of service coordination based on results from the STAR Kids SAI and our additional findings.
- Members with a history of substance use (multiple outpatient visits, hospitalization, or institutionalization within the past year).
- Members without SED or SPMI but who have another behavioral health condition that significantly impairs function.

All level 2 members will receive a minimum of two face-to-face and six telephonic service coordination contacts annually unless otherwise requested by the member or member's representative.

Level 3 members are those members who do not qualify as level 1 or level 2. Level 3 members are not required to have a single identified person as a service coordinator unless the member requests service coordination services, the member is enrolled in an IDD waiver program (CLASS, DBMD, HCS or TxHmL), or resides in a nursing facility or community-based ICF/IID. All level 3 members must receive a minimum of one face-to-face visit annually and three telephonic service coordination outreach contacts yearly.

Audio-visual communication may be utilized instead of face-to-face contacts as allowed by HHSC policies with member consent if no assessment is being conducted.

Our service coordinators are available from 8 a.m. to 5 p.m. Central time by calling **866-696-0710** or Provider Services at **800-454-3730**. For urgent issues, assistance is available after normal business hours, during weekends, and on holidays through Provider Services.

6.9.6 Discharge planning

We will promptly assess the needs of a member discharged from a hospital, nursing facility, ICF/IID, inpatient psychiatric facility, or other care or treatment facility. Both physical and behavioral health needs, including substance use disorder treatment, will be assessed. A service coordinator will work with the member's PCP, the attending physician, the hospital, inpatient psychiatric facility, nursing facility or ICF/IID discharge planner, the member, and the member's family to assess and plan for the member's discharge including appropriate service authorizations.

Upon receipt of notice of a member's discharge from an inpatient psychiatric facility, a service coordinator will contact the member within one business day. When long-term services and supports are needed, we will ensure the member's discharge plan includes arrangements for receiving appropriate community-based care. The service coordinator will provide information to the member, the member's family, and the member's PCP regarding all service options available to meet the member's needs in the

community. For members being discharged from a nursing facility or ICF/IID to the community, we will provide timely access to service coordination and arrange for medically or functionally necessary personal care services (PCS) or nursing services.

6.9.7 Continuity of care transition plan for new STAR Kids and STAR+PLUS members

We will provide a transition plan for a member newly enrolled with Amerigroup in the STAR Kids or STAR+PLUS program who is already receiving long-term services and supports including nursing facility or ICF/IID services. Either HHSC or the previous MCO will give us information such as detailed care plans and names of current providers. We will ensure current providers are paid for medically necessary and functionally necessary covered services that are delivered in accordance with the member's existing care plan beginning with the member's date of enrollment with Amerigroup until the transition plan is developed and implemented.

The transition planning process will include the following:

- Review of existing care plans and ISPs prepared by a state agency or another MCO, covered services received, and the Individual Plan of Care for members enrolled in MDCP
- Preparation of a transition plan that ensures continuous care under the member's existing care plan during the transfer into the Amerigroup network while we conduct an appropriate assessment and development of a new plan, or updated ISP, if needed
- If durable medical equipment or supplies had been ordered prior to enrollment but have not been received by the date of enrollment, coordination and follow-through to ensure the member receives the necessary supportive equipment and supplies without undue delay
- Payment to the existing provider of service under any existing authorization, care plan or service plan for up to six months until we have completed an assessment and issued a new authorization and service plan/ISP

A transition plan will include:

- The member's history.
- A summary of current medical, behavioral health, and social needs and concerns.
- Immediate, short-term and long-term needs and goals.
- A list of services required and their frequency.
- A description of who will provide the services.

The transition plan may include information about services outside the scope of covered services such as how to access affordable, integrated housing. We will ensure the member or the member's representative is involved in the assessment process and fully informed about options, is included in the development of the transition plan, and is in agreement with the plan when completed.

For STAR+PLUS, we will review any existing care plan for a new member and develop a transition plan within 30 days of receiving notice of the member's enrollment. The transition plan will remain in place until we contact the member or the member's representative, and we coordinate modifications to the member's current care plan. We will ensure existing services continue and there is no break in services.

For members enrolling in the STAR+PLUS program on the start date of a new service area, we will review the existing care plan and develop the transition plan within 120 days of enrollment and honor existing long-term services and supports authorizations for up to six months or until we have evaluated and assessed the member and issued new authorizations.

For STAR Kids, we will review any existing care plan or ISP for a new member and begin to develop a transition plan within 10 business days of receiving notice of the member's enrollment or receiving the plan of care if not received at the time of enrollment. The transition plan will remain in place until we develop a new or updated ISP with input from the member and/or member's representative. We will ensure that existing services continue and that there is no break in services.

For members enrolling in the STAR Kids program on the start date of a new service area, we will honor existing long-term services and supports authorizations for up to six months or until we have completed the STAR Kids screening and assessment process and issued new service authorizations.

For members enrolling in the STAR Kids or STAR+PLUS program in an existing service area, we will honor existing long-term services and supports authorizations for up to 90 days or until we have evaluated and assessed the member and issued new service authorizations.

6.9.8 STAR Kids adult transition planning

Amerigroup will help to ensure that teens and young adult STAR Kids members receive early and comprehensive transition planning to help prepare them for service and benefit changes that will occur following their 21st birthday. Each MCO is responsible for conducting ongoing transition planning starting when the member turns 15 years old. The MCO must provide transition planning services as a team approach through the named service coordinator if applicable and with a transition specialist within Member Services. A transition specialist must be an employee of the MCO and wholly dedicated to counseling and educating members and others in their support network about considerations and resources for transitioning out of STAR Kids. Transition specialists must be trained on the STAR+PLUS system and maintain current information on local and state resources to assist the member in the transition process. Transition planning must include the following activities:

- Development of a continuity of care plan for transitioning Medicaid services and benefits from STAR Kids to the Medicaid managed care model under STAR+PLUS without a break in service
- Prior to the member turning age 10, the MCO must inform the member and the member's legally authorized representative (LAR) regarding LTSS programs offered through HHSC and, if applicable, provide assistance in completing the information needed to apply (HHSC LTSS programs include CLASS, DBMD, TxHmL and HCS)
- Once the member turns 15 years old, the MCO must regularly update the ISP with transition goals
- Coordination with the Department of Assistive and Rehabilitative Services (DARS) to help identify future employment and employment training opportunities
- If desired by the member or the member's LAR, coordination with the member's school and Individual Education Plan (IEP) to ensure consistency of goals
- Health and wellness education to assist the member with self-management

- Identification of other resources to assist the member, the member's LAR, and others in the member's support system to anticipate barriers and opportunities that will impact the member's transition to adulthood
- Assistance applying for community services and other supports under the STAR+PLUS program after the member's 21st birthday
- Assistance identifying adult health care providers

6.10 Authorizations

Prior authorization forms are available at **https://provider.amerigroup.com/TX**.

All long-term services and supports require authorization before services are rendered. Requests may be submitted via fax or by telephone for review and approval. We will send a fax or electronic confirmation of the service approval or denial.

STAR Kids — LTSS/PAS fax: **844-756-4604**
STAR+PLUS — LTSS/PAS fax numbers by service area:

- Austin: **877-744-2334**
- El Paso: **888-822-5790**
- Houston/Beaumont: **888-220-6828**
- Lubbock: **888-822-5761**
- San Antonio: **877-820-9014**
- Tarrant/West: **888-562-5160**

Telephone (if urgent): **800-454-3730**

6.11 Claims

6.11.1 Timely filing

Providers must ensure clean claims are submitted and received by Amerigroup within **95 calendar days of the date of service and/or date of discharge**. In the case of other insurance, submit a clean claim within 95 days of receiving a response from the third-party payer. Clean claims for members whose eligibility has not been added to the state's system must be received within 95 days from the date the eligibility is added. We must receive clean claims from out-of-network providers rendering services outside of Texas within one year of the date of service and/or date of discharge. Refer to the ***Billing and Claims Administration*** chapter of this manual for the definition of a clean claim.

Claims can be submitted electronically or by paper at the provider's preferred frequency (daily, weekly, etc.) but cannot exceed the filing limit deadline. When billing a span of dates on a single outpatient claim, the filing timeline is calculated from the first or earliest service date on the claim. Acute care and outpatient claims should be submitted in accordance with the requirements in the ***Billing and Claims Administration*** chapter of this manual.

6.11.2 Uniform Billing Code guidelines

Providers must follow the uniform coding guidelines for long-term services and supports as defined by the Texas Health and Human Services Commission (HHSC). Refer to our website at **https://provider.amerigroup.com/TX** for the current guidelines. Use only the uniform billing defined code, modifier, type, and place of service combinations. The STAR Kids LTSS Billing Matrix is located at **https://hhs.texas.gov/services/health/medicaid-chip/programs/star-kids**. The STAR+PLUS LTSS Codes and Modifiers grid is located at **https://hhs.texas.gov/laws-regulations/handbooks/sph/appendices/appendix-xvi-long-term-services-supports-codes-modifiers**.

6.11.3 Claim submission methods

Long-term services and supports providers have three options for submitting claims, including claims for services for MDCP and other waiver program members that are covered by Amerigroup under the STAR Kids program: Availity Essentials at **Availity.com**, electronic data interchange (EDI) or paper.

Availity Essentials
We furnish providers a free online claim submission tool at **Availity.com**. This tool submits claims directly to us without the use of a clearinghouse. Submission via the website requires provider registration.

Electronic Data Interchange
Information on Electronic Data Interchange (EDI) is located in Chapter 12 ***Billing and Claims Administration*** of this manual.

Paper claims
For more effective claims processing, paper claim forms:

- Must be submitted on original claim forms (*CMS-1500* or *CMS-1450/UB-04*) with dropout red ink and printed or typed (not handwritten) in a large, dark font.
- Cannot be submitted with alterations to key billing information; we do not accept claims with information that is marked through, handwritten, or whited out.

Altered claims are rejected and returned to the provider with an explanation of the reason for the return.
Submit long-term services and supports (LTSS) paper claims to us at:

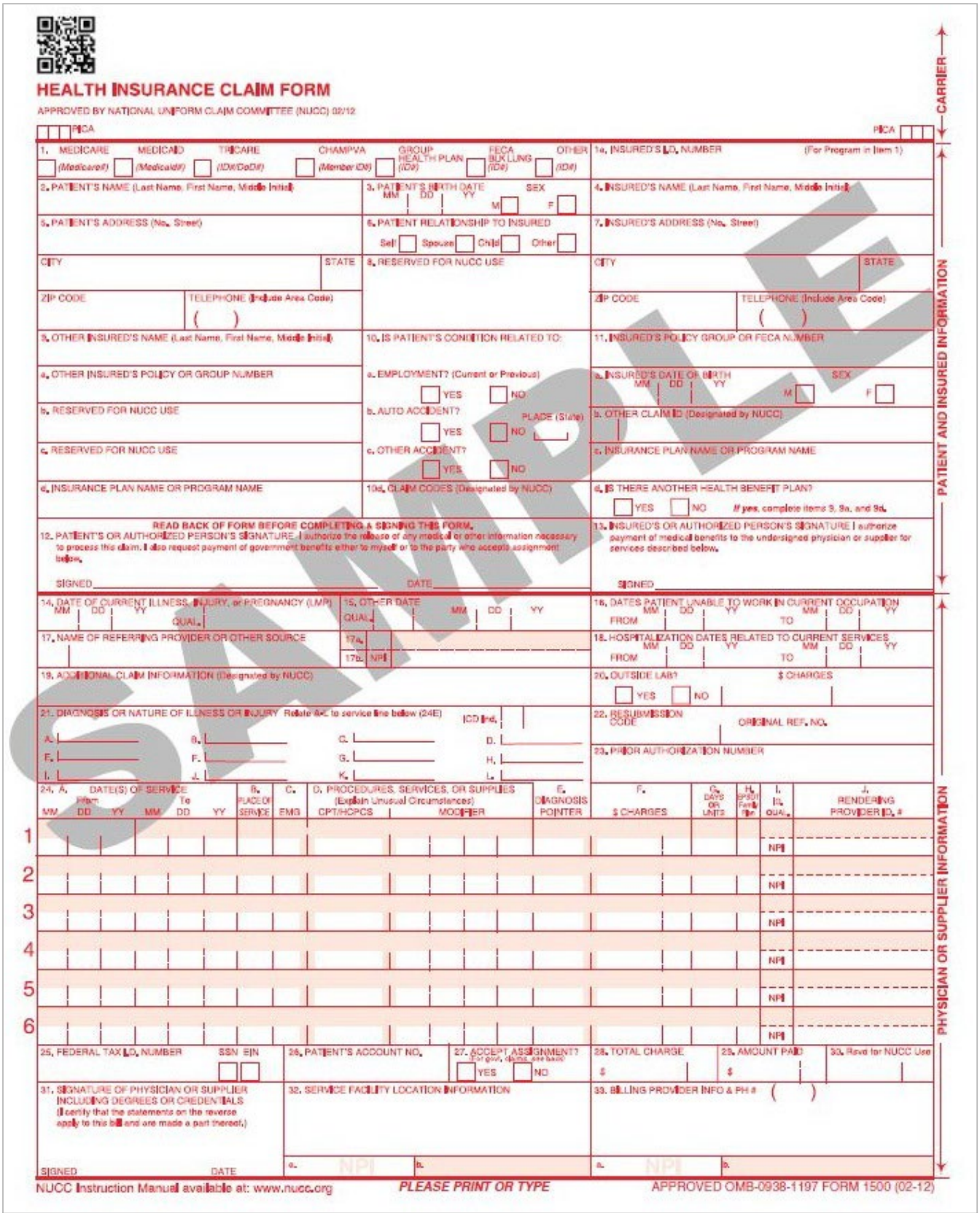
LTSS Claims
Amerigroup
P.O. Box 61010
Virginia Beach, VA 23466-1010

6.11.3.1 *CMS-1500* claim form

Noninstitutional providers and suppliers must use the *CMS-1500* form. You may bill either individual dates of service or bill using a span of dates. Example: Claim may be submitted for dates of service from January 1, 2023, to January 15, 2023, on one claim. Box 24 should indicate service dates **from** January 1, 2023, **to** January 15, 2023.

A sample of the *CMS-1500* claim form is on the following page.

This form and instructions are available from the Centers for Medicare & Medicaid Services (CMS) website at **cms.gov**. See sample below.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

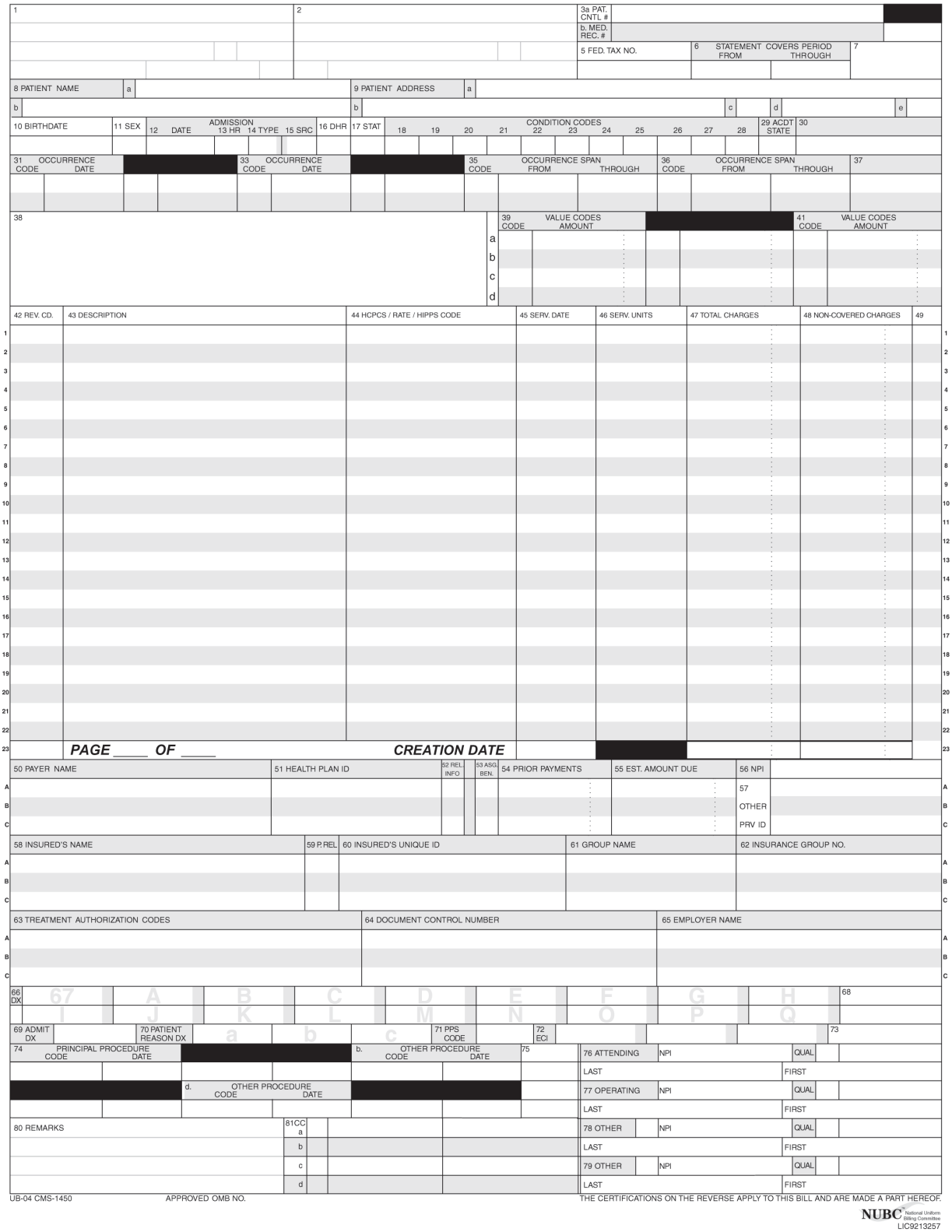
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

6.11.3.2 *CMS-1450* claim form

Institutional and other selected providers must use the *CMS-1450 (UB-04)* form. This form and instructions are available on the CMS website at **cms.gov**. See sample below.



6.11.3.3 Claim adjudication and reimbursement

Our members must not be balance billed for covered services. Additional information can be found in the ***Billing and Claims Administration*** chapter of this manual.

Clean claims for Medicaid members are adjudicated within 30 days from the date we receive them. Clean claims not adjudicated within 30 days of receipt by us are subject to interest payments.

Adjudication edits are based on the member's eligibility, benefit plan, authorization status, *HIPAA* coding compliance and our claim processing guidelines. Claim coding is subject to review using code-editing software.

Claim reimbursement is based on the provider's contract. We are responsible for paying an enhanced fee to long-term services and supports providers who are part of the Texas Health and Human Services Commission (HHSC) Attendant Care Enhancement Program. When contracted with us for this program, the fees will be built into the provider's fee schedule. We are not required to match the HHSC program. Details of this program are provided starting in the ***Attendant Care Enhancement Payment (ACEP) Program*** section of this manual below.

6.11.4 Cost reporting to HHSC

Long-term services and supports providers must submit periodic cost reports and supplemental reports to HHSC in accordance with 1 T.A.C. Chapter 355, including Subchapter A (Cost Determination Process) and 1 T.A.C. §355.403 (Vendor Hold). If a long-term services and supports provider fails to comply with these requirements, HHSC will notify Amerigroup to hold payments to the provider until HHSC instructs us to release the payments.

6.12 Attendant Care Enhancement Payment (ACEP) Program

Attendant Care Enhancement Payment (ACEP) Program is a legislatively mandated program providing additional compensation to long-term care direct care providers. We administer the enhanced payments for direct care providers rendering services to our members.

6.12.1 Attendant Care Enhancement Payment (ACEP) Program enrollment

Providers, including nursing facility providers, are eligible to enroll in the ACEP program for the following services for STAR+PLUS members: assisted living/residential care (ALRC), day activity and health services (DAHS) and personal attendant services (PAS). For STAR Kids, only DAHS for members 18 and older is included in the program.

We allow contracted providers in the Texas Health and Human Services Commission (HHSC) Attendant Care Enhancement Program to enroll in our ACEP program. The agreement between these providers and us includes language defining the requirements for enhancement payments.

Any provider joining our ACEP program or requesting a change in participation level will be required to demonstrate enrollment in good standing in the HHSC ACEP program. Acceptable documentation includes either a copy of the ACEP participation letter to the provider indicating the level of participation or the

provider's long-term services and supports (LTSS) contract number that can be verified with the HHSC ACEP participation list. A newly contracted provider's enrollment into our program will be effective concurrently with the effective date of their *Provider Participation Agreement*/contract.

A provider with an existing participation agreement/contract with us may request an amendment for participation in our ACEP program during our annual open enrollment period. In some cases, LTSS providers in certain counties are no longer afforded the opportunity to hold HHSC program contracts because HHSC does not administer a particular program in those counties or HHSC has exceeded available funding to support new enrollment or provider movement within their program levels. In these instances, we will allow new or contracted providers to enroll in our ACEP program. This exception is granted under the following conditions:

- The provider is licensed by HHSC.
- The provider has not been sanctioned, disciplined, restricted, prohibited from contracting and/or disenrolled from the HHSC program contracts in the previous three state fiscal periods.

Participants in our ACEP program must demonstrate timely response to Amerigroup audits and reviews.

The ACEP program enrollment form and attestation is required to be completed by the participating provider by September 30th of each year. If the enrollment form and attestation is not completed each year, the provider will be disenrolled.

6.12.2 Attendant Care Enhancement Payment (ACEP) Program payment levels

We will increase our fee schedule rates for those codes included within the ACEP program for contracted providers who enroll. Services eligible for the additional payment under the program are PAS, DAHS and ALRC. Enhancement payments are available in 35 levels, which mirror the HHSC ACEP participation levels. The amount of the fee schedule increase will be determined based on a financial analysis of the historic costs of the enhancement program to the extent these are available. The enhancement payment amount will be added to the provider's negotiated rate schedule for eligible services. The enhancement payment is made as part of the claim payment. The payment and *Explanation of Payment (EOP)* issued to the provider will **not** indicate the provider was paid at the enhanced rate.

We reserve the right to adjust and amend the ACEP program fee schedule at any time with appropriate notice to program participants. The ACEP program under Amerigroup administers 35 levels of payment:

Level	Payment	Level	Payment	Level	Payment
Level 1	Hourly Base rate + $0.05	Level 13	Hourly Base rate + $0.65	Level 25	Hourly Base rate + $1.25
Level 2	Hourly Base rate + $0.10	Level 14	Hourly Base rate + $0.70	Level 26	Hourly Base rate + $1.30
Level 3	Hourly Base rate + $0.15	Level 15	Hourly Base rate + $0.75	Level 27	Hourly Base rate + $1.35
Level 4	Hourly Base rate + $0.20	Level 16	Hourly Base rate + $0.80	Level 28	Hourly Base rate + $1.40
Level 5	Hourly Base rate + $0.25	Level 17	Hourly Base rate + $0.85	Level 29	Hourly Base rate + $1.45
Level 6	Hourly Base rate + $0.30	Level 18	Hourly Base rate + $0.90	Level 30	Hourly Base rate + $1.50
Level 7	Hourly Base rate + $0.35	Level 19	Hourly Base rate + $0.95	Level 31	Hourly Base rate + $1.55
Level 8	Hourly Base rate + $0.40	Level 20	Hourly Base rate + $1.00	Level 32	Hourly Base rate + $1.60
Level 9	Hourly Base rate + $0.45	Level 21	Hourly Base rate + $1.05	Level 33	Hourly Base rate + $1.65
Level 10	Hourly Base rate + $0.50	Level 22	Hourly Base rate + $1.10	Level 34	Hourly Base rate + $1.70
Level 11	Hourly Base rate + $0.55	Level 23	Hourly Base rate + $1.15	Level 35	Hourly Base rate + $1.75
Level 12	Hourly Base rate + $0.60	Level 24	Hourly Base rate + $1.20		

Level amounts are subject to change based on the funds available for our ACEP program. Providers will be notified of rate changes through provider updates. The enhanced payment for ACEP does not apply to the Consumer Directed Services (CDS) option.

6.12.3 Attendant Care Enhancement Payment (ACEP) Program monitoring and assurance

We require each contracted provider participating in the ACEP program to attest to the funds paid by us for the ACEP program for each State Fiscal Year are used to compensate direct care works as intended by the T.A.C., Title 1, Part 15, Chapter 355, Subchapter A, §355.112. Amerigroup tracks the submission of annual attestations. Based on the review of the attestations submitted by each provider, Amerigroup will conduct detailed audits when necessary.

Should the provider have failed to distribute the funds appropriately, Amerigroup will take corrective action against the provider(s) to ensure that the funds are distributed correctly within 45 days of the notice of corrective action to the provider. Should the provider fail to comply with the corrective action, we will take action, including but not limited to:

- Retracting the funds.
- Reporting inappropriate use of funds by the provider to HHSC.
- Suspending or terminating the provider's participation in the ACEP program under Amerigroup.
- Terminating the Amerigroup *Provider Participation Agreement*.

The enrollment form and attestation are required to be completed by the participating provider by September 30th of each year. If the enrollment form and attestation is not completed each year, the provider will be disenrolled from Amerigroup's Attendant Care Enhancement Payment Program.

6.13 Provider complaints

A complaint is a written expression of dissatisfaction regarding any aspect of health care services provided by Amerigroup, network providers or staff, other than an appeal or claim payment dispute. For a description of the provider complaint process, see the ***Complaints, Appeals, and Provider Disputes*** chapter of this manual.

6.14 Provider claim payment disputes

If you disagree with the outcome of a claim, you may utilize the Amerigroup provider claim payment dispute process. The simplest way to define a claim payment dispute is when you disagree with the outcome of a finalized claim. The Amerigroup provider payment dispute process is explained in the ***Complaints, Appeals, and Provider Disputes*** chapter of this manual.

Changes or errors in CPT codes are not considered payment disputes. Corrected claims should be resubmitted with a notation of **corrected claim** to:

LTSS Claims
Amerigroup
P.O. Box 8668
Virginia Beach, VA 23466-8668

6.15 Long-term services and supports Quality Review Compliance Program

Amerigroup has a quality review program in place to review quality and appropriateness of care for long-term services and supports (LTSS) services rendered by monitoring for potential organizational quality issues. Providers are required to meet our LTSS quality review requirements and to maintain compliance with all federal and state laws, accreditation and licensing requirements, and health plan provider contract provisions. We will systematically identify, investigate, and resolve compliance and quality of care issues through the Quality Review Compliance Program.

A quality compliance review will generally follow these steps:

Step one: Notification and documentation request
LTSS providers are assessed through random selection and/or are assessed through a risk analysis developed to help recognize providers that did not meet the standards of the quality review or that exhibit other risk factors. Audit notifications and documentation request letters are sent to selected providers. This will also include a LTSS reaudit letter for providers that are subject to reaudit. The review may be conducted remotely (via desktop) or onsite. The notification letter contains the request for initial documents needed to complete the review and indicates if the review will be conducted via desktop or onsite. Included in the request is a list of employees from which samples will be selected for review. Another round of documents will be requested from the employee list once it has been received.

The auditor will contact the provider to schedule an onsite date (if applicable) and to discuss any questions the provider has. All documentation is to be submitted via secure email or fax to your auditor by the requested deadline (typically two weeks from audit notification). Each document should be labeled by request number and sample numbers/names. Any templates provided should be utilized. A subsequent round of documents may be requested by your auditor if needed.

Step two: **Review**
During this phase of the process, the auditor will be reviewing the documents submitted. If the audit is to take place onsite, the auditor will visit the facility on the previously agreed upon date and time. Please be prepared to provide a tour. Onsite audits are typically completed in 1 to 2 business days. Desktop audits will be conducted at the auditor's convenience.

Questions often arise during this phase. If onsite, the auditor will be available for any questions/clarifications during the audit review process. Any additional documentation needed should be supplied while the auditor is onsite.

For desktop audits, the auditor will contact the provider via email and/or set up a mutually agreeable time for a conference call or online meeting to review documentation and questions. A deadline for any additional documentation requests will be discussed at that time. Providers will be allowed a maximum of five business days to submit any missing documentation during this time for desktop audits.

Step three: Results and corrective action
Once the audit is complete, a formal exit conference will be conducted with the provider to discuss the results of the audit. If onsite, the auditor will complete this formal exit conference face to face with the provider or person in charge of the audit process. For desktop audits, the auditor will contact the provider via email and/or set up a mutually agreeable time for a conference call or online meeting to review documentation and questions. If any documents are still missing at the conclusion of the audit, the auditor can allow the provider to provide any missing documentation by close of business on the next business day after the conclusion of the audit.

The provider will be sent a results letter at the conclusion of the audit. The letter will detail the scores, observations and any corrective action requested (if applicable). If corrective action is requested, additional details will be provided.

Upon completion of the final report, the following are the guidelines for the corrective action plan (CAP) process:

- If the agency scores less than 90% in any area, Amerigroup will require a corrective action plan on the category found to be deficient.
- The agency must complete the correction of the deficiencies within the time frames outlined in the following chart for deficiencies cited during the audit.

Number of deficiencies	Follow-up requirements
Less than 2 categories found to be deficient.	The agency must complete and return the CAP within 5 business days.
More than 2 categories found to be deficient but no more than 5.	The agency must complete and return the CAP within 10 business days.
More than 5 categories found to be deficient.	The agency must complete and return the CAP with 15 business days.

- Once the auditor receives the corrective action plan, the auditor will review the plan to determine if the agency is compliant. The chart below outlines the auditor's next steps with the corrective action plan.

If…	Then…
The agency is in compliance	Auditor: • Will change CAP status to CAP Closed. • Will prepare and send CAP Closure Letter.
The agency is still deficient	Auditor: • Will contact the agency to revise CAP and provide an additional 5 business days to correct CAP. • During this time, auditor will notify agency that they will be reaudited next year due to level of involvement and responsiveness.

Upon conclusion of the final report, the following are the protocols for deficiencies in accordance with federal and state laws, accreditation and licensing requirements, and health plan provider contract provisions:

a. If the agency scores less than 90 percent in any area or total score falls under the current benchmark baseline, Amerigroup may conduct a targeted follow-up review in the future on the category found to be deficient.
b. The LTSS Quality Audit Team will review any state notice of potential threat to health and safety for Assisted Living Facilities that are within network and if a member is present at the facility.
c. The LTSS Quality Audit Team will also review complaints received for STAR+PLUS and STAR Kids for home health agencies providing personal assistance services.
d. If the provider did not meet their set deadline for audit documents due, did not meet the deadline for corrective action plan items due, or provided an incomplete corrective action plan, the provider could be recommended for reaudit in the next review period.
e. If at the follow-up review the agency scores less than 90 percent in any area, Amerigroup may impose sanctions. If the agency scores less than the initial review, Amerigroup may terminate the provider's contract. Amerigroup will return for a follow-up review within an appropriate amount of time of the corrective action plan implementation date.
f. If at the second follow-up review the agency scores less than 90 percent in any area, Amerigroup may take the proper actions to terminate the provider's contract.
g. If the quality review of claims shows overpayment, Amerigroup will request recoupment for the amount of overpayment.
h. If the follow-up review of claims shows an overpayment, Amerigroup may impose a payment hold of 100 percent of paid charges for 30 days while the provider corrects the deficiency or until the deficiency is remedied. If the provider scores less than the initial review, Amerigroup may terminate the provider's contract. Amerigroup will return for a follow-up review within an appropriate amount of time of the corrective action plan implementation date.

7 Behavioral Health Program

7.1 Overview

Behavioral health services are covered services for the treatment of mental, emotional, or chemical dependency disorders.

We provide coverage of medically necessary behavioral health services as indicated below:

1. Texas Health Steps behavioral health services for Medicaid members birth through age 20 necessary to correct or ameliorate a mental illness or condition: A determination of whether a service is necessary to correct or ameliorate a mental illness or condition may include consideration of other relevant factors, such as the criteria described in parts 2b-g below.
2. For Medicaid members over age 20 and CHIP members, behavioral health-related health care services that:
    a. Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain or prevent deterioration of functioning resulting from such a disorder
    b. Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care
    c. Are furnished in the most appropriate and least restrictive setting in which services can be safely provided.
    d. Are the most appropriate level or supply of service that can safely be provided
    e. Could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered
    f. Are not experimental or investigative
    g. Are not primarily for the convenience of the member or provider

We do not cover behavioral health services that are experimental or investigative. Covered services are not intended primarily for the convenience of the member or the provider. For more information about behavioral health services, providers should call **800-454-3730** and members should call **800-600-4441 (TTY 711)**/STAR Kids members: **844-756-4600 (TTY 711)**.

7.2 Covered behavioral health services

Medicaid behavioral health services covered under managed care are not subject to the quantitative treatment limitations that apply under traditional, Fee-For-Service (FFS) Medicaid coverage. The services may be subject to the HMO's nonquantitative treatment limitations, provided such limitations comply with the requirements of the *Mental Health Parity and Addiction Equity Act of 2008.* Covered behavioral health services include the following:

- Inpatient mental health services
- Outpatient mental health services
- Psychiatry services
- Counseling services for adults (age 21 and older)
- Outpatient substance use disorder treatment services, including:
    - Assessment

    - Detoxification services
    - Counseling treatment
    - Medication-assisted therapy
- Residential substance use disorder treatment services, including:
    - Detoxification services
    - Room and board
- Mental health rehabilitative services
- Mental health targeted case management

CHIP-covered* behavioral health services include the following:

- Inpatient mental health
- Outpatient mental health
- Inpatient substance use
- Outpatient substance use

* These services are not covered for CHIP Perinates (unborn children).

7.2.1 Mental health rehabilitative services and mental health targeted case management

Mental health rehabilitative services and mental health targeted case management must be available to eligible STAR, STAR Kids, and STAR+PLUS members who require these services based on the appropriate standardized assessment — either the Adult Needs and Strengths Assessment (ANSA) or the Child and Adolescent Needs and Strengths (CANS).

Severe and persistent mental illness (SPMI) means a diagnosis of bipolar disorder, major clinical depression, schizophrenia, or another behavioral health disorder as defined by the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)* accompanied by:

- Impaired functioning or limitations of daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping, or employment) due to the disorder.
- Impaired emotional or behavioral functioning that interferes substantially with the member's capacity to remain in the community without supportive treatment or services.

Severe emotional disturbance (SED) means psychiatric disorders in children and adolescents that cause severe disturbances in behavior, thinking and feeling.

Mental health rehabilitative (MHR) services are those age-appropriate services determined by HHSC and federally approved protocol as medically necessary to 1) reduce a member's disability resulting from severe mental illness for adults or serious emotional, behavioral, or mental disorders for children and 2) to restore the member to their best possible functioning level in the community. Services that provide assistance in maintaining functioning may be considered rehabilitative when necessary to help a member achieve a rehabilitation goal as defined in the member's rehabilitation plan.

MHR services include training and services that help the member maintain independence in the home and community such as the following:

- **Medication training and support:** curriculum-based training and guidance that serves as an initial orientation for the member in understanding the nature of their mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and the increased tenure in the community
- **Psychosocial rehabilitative services:** social, educational, vocational, behavioral, or cognitive interventions to improve the member's potential for social relationships, occupational or educational achievement, and living skills development
- **Skills training and development:** skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers, and teachers
- **Crisis intervention:** intensive community-based one-to-one service provided to members who require services in order to control acute symptoms that place the member at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting
- **Day program for acute needs:** short-term, intensive, site-based treatment in a group modality to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting or reduce the amount of time spent in the more restrictive setting

Mental Health Targeted Case Management (TCM) means services designed to assist members with gaining access to needed medical, social, educational, and other services and supports. TCM services include:

- Case management for members who have SED (children 3 to 17 years of age), which includes routine and intensive case management services.
- Case management for members who have SPMI (adults 18 years of age or older).

MHR and TCM services, including any limitations to these services, are described in the most current *TMPPM*, including the *Behavioral Health, Rehabilitation, and Case Management Services Handbook*. Amerigroup will authorize these services using the Department of State Health Services (DSHS) *Resiliency and Recovery Utilization Management Guidelines (RRUMG)*, but we're not responsible for providing any services listed in the *RRUMG* that are not covered services.

Texas *Resilience and Recovery Utilization Management Guidelines* for Adult Mental Health Services can be found at **https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/um-guidelines/trr-utilization-management-guidelines-adult.pdf**.

Texas *Resilience and Recovery Utilization Management Guidelines* for Child and Adolescent Services can be found at **https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/um-guidelines/trr-utilization-management-guidelines-child.pdf**.

Providers of MHR and TCM services must use, and be trained and certified to administer, the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths (CANS) tools to assess a member's need for services and recommend a level of care. Providers must use these tools to recommend a level of care to Amerigroup by using the current DSHS Clinical Management for Behavioral Health Services (CMBHS) web-based system. Providers must also complete the *Mental Health Rehabilitative and Mental Health Targeted Case Management Services Request Form* and submit the completed form to us. A provider entity must attest to Amerigroup that the organization has the ability to provide, either directly or through subcontract, the full array of *RRUMG* services to members. HHSC has established qualifications and supervisory protocols for providers of MHR and TCM services. This criteria is located in Chapter 15.1 of the *HHSC Uniform Managed Care Manual*.

Claims for MHR and TCM services do not require a denial from Medicare or other third-party insurance as a condition of payment.

7.2.2 Attention deficit hyperactivity disorder (ADHD)

Treatment of children diagnosed with ADHD, including follow-up care for children who are prescribed ADHD medication, is covered as outpatient mental health services. Reimbursement for these services will be determined according to the *Participating Provider Agreement*. Covered benefits are as outlined in the *TMPPM*.

7.3 Primary and specialty services

Members have access to the following primary and specialty services:

- Behavioral health clinicians available 24 hours a day, 7 days a week to assist with identifying the most appropriate and nearest behavioral health service
- Routine or regular laboratory and ancillary medical tests or procedures to monitor behavioral health conditions of members; these services are furnished by the ordering provider at a lab located at or near the provider's office
- Behavioral health case managers to coordinate with the hospital discharge planner and member to ensure appropriate outpatient services are available
- Support and assistance for network behavioral health care providers in contacting members within 24 hours to reschedule missed appointments

7.4 Behavioral health provider responsibilities

We maintain a behavioral health provider network that includes psychiatrists, psychologists and other behavioral health providers experienced in serving children, adolescents, and adults. The network provides accessibility to qualified providers for all eligible individuals in the service area. Our members can self-refer to a participating behavioral health provider.

PCPs providing behavioral health services must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. Screening and assessment tools to assist with the detection, treatment and referral of behavioral health care services are found on our website at **https://provider.amerigroup.com/TX** .

We will review prescribing patterns for psychotropic medications. For treatment of adults, we will base our parameters on a peer-reviewed, industry standard such as the *HHSC Psychiatric Drug Formulary* at **hhs.texas.gov/providers/health-care-facilities-regulation/psychiatric-drug-formulary**. For treatment of children, all providers must utilize the *Psychotropic Medication Utilization Parameters for Foster Children* found at **dfps.state.tx.us/Child_Protection/Medical_Services/documents/reports/2016-03_Psychotropic_Medication_Utilization_Parameters_for_Foster_Children.pdf**.

Providers who furnish routine outpatient behavioral health services must schedule initial appointments within the earlier of 10 business days or 14 calendar days of a request. Routine care after the initial visit must be scheduled within three weeks of a request. Providers who furnish inpatient psychiatric services must schedule outpatient follow-up and/or continuing treatment prior to a patient's discharge. The outpatient treatment must occur within seven days from the date of discharge. Behavioral health providers must contact members who have missed appointments within 24 hours to reschedule appointments.

PCPs should:

- Educate members with behavioral health conditions about the nature of the condition and its treatment.
- Educate members about the relationship between physical and behavioral health conditions.
- Contact a behavioral health clinician when behavioral health needs go beyond their scope of practice.

PCPs can offer behavioral health services when:

- Clinically appropriate and within the scope of their practice.
- The member's current condition is not so severe, confounding, or complex as to warrant a referral to a behavioral health provider.
- The member is willing to be treated by the PCP.
- The services rendered are within the scope of the benefit plan (for members who have Medicare, most behavioral health services are covered under the member's Medicare plan).

Behavioral health providers must:

- Refer members with known or suspected physical health problems or disorders to the PCP for examination and treatment.
- Utilize the most current *DSM* multi-axial classification when assessing members; HHSC may require the use of other assessment instruments or outcome measures in addition to the *DSM*; network providers must document all *DSM* and assessment/outcome information in the member's medical record.
- Send initial and quarterly summary reports of a member's behavioral health status to the PCP with the member's consent.
- Be licensed for physical health care services if they are provided.

7.5 Care continuity and coordination guidelines

PCPs and behavioral health care providers are responsible for actively coordinating and communicating continuity of care. Appropriate and timely sharing of information is essential when the member is

receiving psychotropic medications or has a new or ongoing medical condition. The exchange of information facilitates behavioral and medical health care strategies.

Our care continuity and coordination guidelines for PCPs and behavioral health providers include:

- Coordinating medical and behavioral health services with the local mental health authority (LMHA) and state psychiatric facilities regarding admission and discharge planning for members with SEDs and SMIs, if applicable.
- Completing and sending the member's consent for information release to the collaborating provider.
- Using the release as necessary for the administration and provision of care.
- Noting contacts and collaboration in the member's chart.
- Responding to requests for collaboration within one week or immediately if an emergency is indicated.
- Sending a copy of a completed *Coordination of Care/Treatment Summary* form to us and the member's PCP when the member has seen a behavioral health provider (the form can be found on our website at **https://provider.amerigroup.com/TX**).
- Sending initial and quarterly (or more frequently, if clinically indicated) summary reports of a member's behavioral health status from the behavioral health provider to the member's PCP.
- Contacting the PCP when a behavioral health provider changes the behavioral health treatment plan.
- Contacting the behavioral health provider when the PCP determines the member's medical condition could reasonably be expected to affect the member's mental health treatment planning or outcome and documenting the information on the *Coordination of Care and Treatment Summary* form.

7.6 Health Home

A Health Home is a provider practice that manages all of the health care a person needs — physical, mental, and social. The range of Health Home services and supports is more than is normally offered by a primary care provider. This type of person-based approach to care can be of great benefit to persons with one or more serious and ongoing mental or health conditions. The provider practice can be a primary care practice or, in some cases, a specialty care practice. A Health Home uses a team-based approach to improve access, coordination between providers and quality of care.

We will provide access to a Health Home for any member who asks for this service and for any member who would benefit from this type of care. Some of the main kinds of Health Home services are:

- Comprehensive case management
- Care coordination
- Patient self-management education and health promotion
- Transitional care from inpatient or emergency room
- Patient and family-centered care with patient and family support
- Referral to community and social support services
- Use of health information to link services

7.7 Substance use and dependency treatment

Substance use disorder includes substance abuse and dependence as defined by the current *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.

7.7.1 Substance use disorder service coordination

We will provide specialized service coordination to members with a substance use disorder. We will work with providers, facilities, and members to coordinate care for members with a substance use disorder and to ensure members have access to the full continuum of covered services (including, without limitation, assessment, detoxification, residential treatment, outpatient services and medication therapy) as medically necessary and appropriate. Amerigroup will also coordinate services with DSHS, DFPS and their designees for members requiring noncapitated services. Noncapitated services include, without limitation, services that are not available for coverage under the managed care contract, state plan, or waiver programs that are available under the Federal Substance Abuse and Prevention and Treatment block grant when provided by a DSHS-funded provider or covered by the DFPS under direct contract with a treatment provider. We will work with DSHS, DFPS and providers to ensure payment for covered services is available to out-of-network providers who also provide related noncapitated services when the covered services are not available through network providers.

7.8 Emergency behavioral health services

An emergency behavioral health condition means any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson possessing an average knowledge of health and medicine requires immediate intervention/medical attention. And in an emergency and without immediate intervention/medical attention, the member would present an immediate danger to himself, herself or others or would be rendered incapable of controlling, knowing, or understanding the consequences of their actions.

Emergency behavioral health conditions include **emergency detentions** as defined under Chapter 573, Subchapter A of the *Texas Health and Safety Code* and under Chapter 462, Subchapter C of the *Texas Health and Safety Code*.

In the event of a behavioral health emergency, the safety of the member and others is paramount. The member should be instructed to seek immediate attention at an emergency room or other behavioral health crisis service. An emergency dispatch service or 911 should be contacted if the member is a danger to self or others and is unable to go to an emergency care facility.

A behavioral health emergency occurs when the member is any of the following:

- Suicidal
- Homicidal
- Violent toward others
- Suffering a precipitous decline in functional impairment and is unable to take care of activities of daily living
- Alcohol- or drug-dependent with signs of severe withdrawal

We do not require a prior authorization or notification of emergency services, including emergency room and ambulance services.

7.9 Urgent behavioral services

An urgent behavioral health situation is defined as a condition that requires attention and assessment within 24 hours. In an urgent situation, the member is not an immediate danger to himself or herself or others and is able to cooperate with treatment.

Care for non-life-threatening emergencies should be within six hours.

7.10 Prior authorizations and referrals for behavioral health

Members may self-refer to any Amerigroup network behavioral health services provider. No prior authorization or referral is required from the PCP.

Providers may request a prior authorization or refer members for services by:

- Visiting Availity Essentials at **Availity.com**.
- Faxing information to our dedicated behavioral health fax lines at **844-430-6805** for inpatient services or **844-442-8010** for outpatient services.
- Calling Provider Services at **800-454-3730**.

Our staff is available 24 hours a day, 7 days a week, 365 days a year for routine, crisis or emergency calls and authorization requests. We are responsible for authorized inpatient hospital services, including free-standing psychiatric facilities.

7.11 Court-ordered services

We provide benefits for Medicaid- and CHIP-covered services ordered by a court pursuant to the statutory citations listed in the sections below. Amerigroup will:

- Not deny, reduce, or controvert a court order for Medicaid or CHIP inpatient mental health covered services for members through age 20 or ages 65 and older including services ordered as a condition of probation.
- Not deny, reduce, or controvert a court order for Medicaid inpatient mental health covered services for members of any age if the court-ordered services are delivered in an acute care hospital.
- Not limit substance use disorder treatment or outpatient mental health services for members of any age that are provided pursuant to a court order or required as a condition of probation.
- Not apply Amerigroup utilization management criteria through prior authorizations, concurrent reviews, or retrospective reviews for services required to be covered under a court order or as a condition of probation as detailed in the sections below.
- Accept court order documents from providers at the time of an authorization request.

Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. A member who has been ordered to receive treatment pursuant to a court order can only appeal the court order through the court system.

7.11.1 Court-ordered psychiatric services

We provide benefits for Medicaid- and CHIP-covered inpatient psychiatric services to members birth through age 20 and ages 65 and older who have been ordered to receive the services either:

- By a court of competent jurisdiction including services ordered pursuant to the *Texas Health and Safety Code* Chapter 573, Subchapters B and C; *Texas Health and Safety Code* Chapter 574, Subchapters A through G; *Texas Family Code* Chapter 55, Subchapter D
- As a condition of probation

These requirements do not apply to members who are considered incarcerated as defined by UMCM Chapter 16.1, Section 16.1.15.2.

7.11.2 Court-ordered substance use disorder treatment services

We provide benefits for Medicaid- and CHIP-covered substance use disorder treatment services, including residential treatment, required as either a:

- Court order consistent with Chapter 462, Subchapter D, of the *Texas Health and Safety Code*
- Condition of probation

These requirements do not apply to members who are considered incarcerated as defined by UMCM Chapter 16.1, Section 16.1.15.2.

7.12 Behavioral health value-added services: Healthy Rewards

Members who are not eligible for Medicare can earn Healthy Rewards dollars redeemable for gift cards for these healthy activities:

- $20 each year for a STAR+PLUS member through age 64 with schizophrenia or bipolar disorder on antipsychotic medicine who has a diabetes screening; members already diagnosed with diabetes are excluded
- $20 for STAR, CHIP, and STAR Kids members newly diagnosed with attention deficit hyperactivity disorder (ADHD) who have a follow-up visit with their prescribing provider within 30 days after starting their medication treatment, for members ages 6 to 12
- $20 for STAR, CHIP, STAR Kids, and STAR+PLUS members having 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

Members can call **888-990-8681** to learn more or log in to their account at **myamerigroup.com/TX** to access the Healthy Rewards site from the Benefits page. Value-added services are subject to change on September 1 of each year. Complete details of the extra benefits and how a member can access are in our member handbooks at **myamerigroup.com/TX**. If you have questions or need help finding the information, call Provider Services at **800-454-3730**.

8 Member rights and responsibilities

8.1 Member right to designate an obstetrician/gynecologist

Our members are informed of their right to select an obstetrician/gynecologist (OB/GYN) without a referral from their PCP. Our members may access the health services of an OB/GYN for their annual well-woman exam, prenatal care, female medical conditions, and specialist referrals within the network.

The following language or similar information appears in our member handbooks. For members also covered by Medicare, an OB/GYN is selected from Medicare plan providers.

Do I have the right to choose an OB/GYN?
You have the right to pick an OB/GYN without a referral from your primary care provider. An OB/GYN can give you:

- One well-woman checkup each year.
- Care related to pregnancy.
- Care for any female medical condition.
- Referral to a specialist doctor within the network.

8.2 Medicaid member rights and responsibilities

8.2.1 STAR, STAR Kids, and STAR+PLUS member rights

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
    a. Be treated fairly and with respect.
    b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
    a. Be told how to choose and change your health plan and your primary care provider.
    b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
    c. Change your primary care provider.
    d. Change your health plan without penalty.
    e. Be told how to change your health plan or your primary care provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
    a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
    b. Be told why care or services were denied and not given.

4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
    a. Work as part of a team with your provider in deciding what health care is best for you.
    b. Say yes or no to the care recommended by your provider.
5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, external medical reviews and state fair hearings. That includes the right to:
    a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
    b. MDCP/DBMD escalation help line for members receiving Waiver services via the Medically Dependent Children Program or Deaf/Blind Multi-Disability Program.
    c. Get a timely answer to your complaint.
    d. Use the plan's appeal process and be told how to use it.
    e. Ask for an external medical review and state fair hearing from the state Medicaid program and get information about how that process works.
    f. Ask for a state fair hearing without an external medical review from the state Medicaid program and get information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
    a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
    b. Get medical care in a timely manner.
    c. Be able to get in and out of a health care provider's office; this includes barrier-free access for people with disabilities or other conditions that limit mobility, in accordance with the *Americans with Disabilities Act*.
    d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan; interpreters include people who can speak in your native language, help someone with a disability or help you understand the information.
    e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else's convenience or is meant to force you to do something you do not want to do or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment; your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copays or any other amounts for covered services.

8.2.2 STAR, STAR Kids, and STAR+PLUS member responsibilities

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
    a. Learn and understand your rights under the Medicaid program.
    b. Ask questions if you do not understand your rights.
    c. Learn what choices of health plans are available in your area.

2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
    a. Learn and follow your health plan's rules and Medicaid rules.
    b. Choose your health plan and primary care provider quickly.
    c. Make any changes in your health plan and primary care provider in ways established by Medicaid and by the health plan.
    d. Keep your scheduled appointments.
    e. Cancel appointments in advance when you cannot keep them.
    f. Always contact your primary care provider first for your nonemergency medical needs.
    g. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
    a. Tell your primary care provider about your health.
    b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
    c. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices and take action to maintain your health. That includes the responsibility to:
    a. Work as a team with your provider in deciding what health care is best for you.
    b. Understand how the things you do can affect your health.
    c. Do the best you can to stay healthy.
    d. Treat providers and staff with respect.
    e. Talk to your provider about all of your medications.

Additional member responsibilities while using NEMT services:

1. When requesting NEMT services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT services to travel to and from your medical appointments.
7. If you have arranged for an NEMT service but something changes and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

8.3 CHIP member rights and responsibilities

8.3.1 CHIP member rights

1. You have the right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.

2. Your health plan must tell you if they use a limited provider network. This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. Limited provider network means you cannot see all the doctors who are in your health plan. If your health plan uses limited networks, you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same limited network.
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered and/or medically necessary. You have the right to know about the people in the health plan who decide those things.
5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.
9. If your child has special medical problems and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.
10. Your daughter has the right to see a participating OB/GYN without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a copay, depending on your income. Copays do not apply to CHIP Perinate members.
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.
14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated fairly by your health plan, doctors, hospitals, and other providers.
16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
18. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

19. You have a right to know that you are only responsible for paying allowable copays for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

8.3.2 CHIP member responsibilities

You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. You must become involved in the doctor's decisions about your child's treatments.
3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
5. You must learn about what your health plan does and does not cover. Read your member handbook to understand how the rules work.
6. If you make the appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. If your child has CHIP, you are responsible for paying your doctor and other providers the copays you owe them. If your child is getting CHIP Perinatal services, you will not have any copays for that child.
8. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members, or health plans.
9. Talk to your child's provider about all of your child's medications.

8.4 CHIP Perinate member rights and responsibilities

8.4.1 CHIP Perinate member rights:

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals, and other providers.
2. You have a right to know how the CHIP Perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.
3. You have a right to know how the health plan decides whether a CHIP Perinatal service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
4. You have a right to know the names of the hospitals and other CHIP Perinatal providers in the health plan and their addresses.
5. You have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.
6. You have a right to emergency CHIP Perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.

7. You have the right and responsibility to take part in all the choices about your unborn child's health care.
8. You have the right to speak for your unborn child in all treatment choices.
9. You have the right to be treated fairly by the health plan, doctors, hospitals, and other providers.
10. You have the right to talk to your perinatal provider in private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
11. You have the right to a fair and quick process for solving problems with the health plan and the health plan's doctors, hospitals and others who provide CHIP Perinatal services for your unborn child. If the health plan says it will not pay for a covered CHIP Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
12. You have a right to know that doctors, hospitals, and other CHIP Perinatal providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

8.4.2 CHIP Perinate member responsibilities

You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the doctor's decisions about your unborn child's care.
3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.
4. You must learn about what your health plan does and does not cover. Read your CHIP Perinate member handbook to understand how the rules work.
5. You must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
6. You must report misuse of CHIP Perinatal services by health care providers, other members, or health plans.
7. Talk to your provider about all of your medications.

9 Complaints, appeals, and provider disputes

We offer five distinct complaint and appeal processes:

- Member complaints
- Member appeals
- Provider complaints
- Provider payment disputes
- Provider medical appeals

9.1 Member complaints and appeals

Medicaid and CHIP 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.

9.1.1 Member complaints and appeals definitions

Adverse benefit determination:

1) Denial or limited authorization of a member or provider requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2) Reduction, suspension, or termination of a previously authorized service;
3) Denial, in whole or in part, of payment for a service;
4) Failure to provide services in a timely manner, as defined and determined by the State;
5) Failure of an MCO to act within the timeframes provided in the State contract and 42 CFR §438.408(b);
6) For a resident of a rural area with only one MCO, the denial of a Medicaid member's request to exercise their right, under 42 CFR §438.52(b) (2) (ii), to obtain services outside the network; or
7) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Appeal: the formal process by which a member or their authorized representative requests a review by the health plan or utilization review agent of the health plan's adverse benefit determination as defined above

Appellant: any member, provider or other person or agency acting on behalf of the member who files an appeal

Complainant: any member (family member or caregiver of a member), provider, or other person or agency designated to act on behalf of the member (including the state's Medicaid Managed Care Division or the State's Ombudsman Program) who files a complaint

Complaint: an expression of dissatisfaction (orally or in writing) to the health plan by a complainant about any matter related to the health plan other than an adverse benefit determination as defined in this section. Possible subjects for complaints include the following:

- Quality of care or services provided
- Aspects of patient interpersonal relationships, such as rudeness of a provider or employee
- Failure of a provider or employee(s) to respect a member's rights

Complaint includes the member's right to dispute an extension of time proposed by the health plan to make an authorization decision. A complainant's oral or written dissatisfaction with an adverse benefit determination is considered a request for an appeal.

Designated (authorized) representative: Any person or entity acting on behalf of the member and with the member's written consent. Exception: CHIP does not require written consent**.**

9.1.2 Member complaint resolution

The following language or similar information appears in our member handbooks:

What should I do if I have a complaint? Who do I call?
We want to help. If you have a complaint, please call us toll free at **800-600-4441**/STAR Kids: **844-756-4600 (TTY 711)** to tell us about your problem. An Amerigroup Member Services representative or a member advocate can help you file a complaint. Just call **800-600-4441**/STAR Kids: **844-756-4600**. Most of the time, we can help you right away or at the most within a few days. Amerigroup cannot take any action against you as a result of you filing a complaint.

Can someone from Amerigroup help me file a complaint?
Yes, a member advocate or Member Services representative can help you file a complaint with us or with the appropriate state program. Please call Member Services at **800-600-4441**/STAR Kids: **844-756-4600 (TTY 711)**.

How long will it take to process my complaint?
Amerigroup will answer your complaint within 30 days from the date we get it.

If your complaint is about an ongoing emergency or hospital stay, it will be resolved as quickly as needed for the urgency of your case and no later than one business day from when we receive your complaint.

What are the requirements and time frames for filing a complaint?
You can tell us about your complaint by calling us or writing us. We will send you a letter within five business days of getting your complaint. This means that we have your complaint and have started to look at it. We will include a complaint form with our letter if your complaint was made by telephone. You must fill out this form and mail it back to us. If you need help filling out the complaint form, please call Member Services.

Do I have the right to meet with a complaint appeal panel?
Yes, if you're not happy with the answer to your complaint, you can ask us to look at it again. You must ask for a complaint appeal panel in writing. Write to us at:

Member Advocates
Amerigroup
2505 N. Highway 360, Suite 300
Grand Prairie, TX 75050

When we get your request, we'll send you a letter within five business days. This means we have your request and started to work on it. You can also call us at **800-600-4441**/STAR Kids: **844-756-4600 (TTY 711)** to ask for a complaint appeal panel request form. You must complete the form and return it to us.

We'll have a meeting with Amerigroup staff, providers in the health plan, and other Amerigroup members to look at your complaint. We'll try to find a day and time for the meeting so you can be there. You can bring someone to the meeting if you want to. You don't have to come to the meeting. We'll send you a letter at least five business days before the complaint appeal panel meeting. The letter will have the date, time, and place of the meeting. We'll send you all of the information the panel will look at during the meeting.

We'll send you a letter within 30 days of getting your written request. The letter will tell you the complaint appeal panel's final decision. This letter will also give you the information the panel used to make its decision.

For Medicaid members:
How do I file a complaint with the Health and Human Services Commission once I have gone through the Amerigroup complaint process?
If you are a Medicaid member, once you have gone through the Amerigroup complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll free to **866-566-8989**. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
Ombudsman Managed Care Assistance Team
PO Box 13247
Austin, TX 78711-3247

If you can get on the internet, you can send your complaint at: **hhs.texas.gov/managed-care-help**.

If you file a complaint, Amerigroup will not hold it against you. We will still be here to help you get quality health care.

For CHIP members:
If I am not satisfied with the outcome, who else can I contact?

If you are not satisfied with the answer to your complaint, you can also complain to the Texas Department of Insurance by calling toll free to **800-252-3439**. If you would like to make your request in writing, send it to:

Consumer Protection, MC: CO-CP
Texas Department of Insurance
P.O. Box 12030
Austin, Texas 78711-2030

If you can get on the internet, you can submit your complaint at **tdi.texas.gov**.

9.1.2.1 MDCP/DBMD escalation help line

What is the MDCP/DBMD escalation help line?

The MDCP/DBMD escalation help line assists people with Medicaid who get benefits through the Medically Dependent Children Program (MDCP) or the Deaf-Blind with Multiple Disabilities (DBMD) program.

The escalation help line can help solve issues related to the STAR Kids managed care program. Help can include, answering questions about external medical reviews and state fair hearings and continuing services during the appeal process.

When should members call the escalation help line?

Call when you have tried to get help but have not been able to get the help you need. If you don't know who to call, you can call **844-999-9543** and they will work to connect you with the right people.

Is the escalation help line the same as the HHS Office of the Ombudsman?

No. The MDCP/DBMD escalation help line is part of the Medicaid program. The Ombudsman offers an independent review of concerns and can be reached at **866-566-8989** or go on the internet (hhs.texas.gov/managed-care-help). The MDCP/DBMD escalation help line is dedicated to individuals and families that receive benefits from the MDCP or DBMD program.

Who can call the help line?

You, your authorized representatives, or your legal representative can call.

Can members call any time?

The escalation help line is available Monday through Friday from 8 a.m. to 8 p.m. After these hours, please leave a message and one of our trained on-call staff will call you back.

9.1.3 Member medical appeal process and procedures

Amerigroup has established and maintains a system for resolving dissatisfaction with actions regarding the denial or limitation of coverage of health care services filed by a member or a provider acting on behalf of a member. This process is called a member appeal.

Note: Medical appeals do not apply to nonmedical issues. Nonmedical concerns are classified as complaints.

What can I do if the MCO denies or limits my member's request for a covered service?
The appeal process is described in the following sections.

9.1.3.1. Medicaid appeal process

The following language or similar information describing the appeals process appears in our member handbooks:

What can I do if my doctor asks for a service or medicine for me that's covered but Amerigroup denies it or limits it?
There may be times when Amerigroup says we will not pay for all or part of the care that has been recommended. You have the right to ask for an appeal. An appeal is when you or your designated representative asks Amerigroup to look again at the care your doctor asked for and we said we will not pay for. A designated representative can be a family member, your provider, an attorney, a friend, or any person you choose.

If you ask someone (a designated representative) to file an appeal for you, you must also send a letter to Amerigroup to let us know you have chosen a person to represent you. Amerigroup must have this written letter to be able to consider this person as your representative. We do this for your privacy and security.

You can appeal our decision orally or in writing:

- You can call Member Services at **800-600-4441**/STAR Kids **844-756-4600 (TTY 711)**.
- You can send us a letter or the request form included with our decision letter to:

Amerigroup Appeals
P.O. Box 62429
Virginia Beach, VA 23466-2429

How will I find out if services are denied?
If we deny services, we will send you a letter at the same time the denial is made.

What are the time frames for the appeals process?
You or a designated representative can file an appeal. You must do this within 60 days of the date of the first letter from Amerigroup saying we will not pay for or cover all or part of the recommended care.

When we get your letter or call, we will send you a letter within five business days. This letter will let you know we got your appeal. We will also let you know if we need any other information to process your appeal. Amerigroup will contact your doctor if we need medical information about the service.

A doctor who has not seen the case before will look at your appeal. They will decide how we should handle the appeal.

We will send you a letter with the answer to your appeal. We will do this within 30 calendar days from when we get your appeal unless we need more information from you or the person you asked to file the appeal for you. If we need more information, we may extend the appeals process for 14 days if the delay

is in your best interest. If we extend the appeals process, we will let you know in writing the reason for the delay. You may also ask us to extend the process if you know more information that we should consider.

How can I continue receiving services that were already approved?
You have 60 days to file an appeal from the date of our decision letter. To continue receiving services that have already been approved by Amerigroup but may be part of the reason for your appeal, you must file a request for continuation of benefits on or before the later of:

- Ten days after we send the notice to you to let you know we will not pay for or cover all or part of the care.
- The date the notice says the service will end.

If the decision on your appeal upholds our first decision, you may be asked to pay for the services you received during the appeals process.

If the decision on your appeal reverses our first decision, Amerigroup will pay for the services you received while your appeal was pending.

Can someone from Amerigroup help me file an appeal?
Yes, a member advocate or Member Services representative can help you file an appeal with Amerigroup or with the appropriate state program. Please call Member Services toll free at **800-600-4441**/STAR Kids: **844-756-4600 (TTY 711)**.

Can members request an external medical review and state fair hearing?
Yes, you can ask for an external medical review and state fair hearing after the Amerigroup internal appeal process is complete. Your request must be made within 120 days of the date of our appeal decision letter. An external medical review cannot be requested without a state fair hearing, but you can withdraw your request for the hearing after you get the external medical review decision.

Can members request a state fair hearing only?
Yes, you can ask for a state fair hearing without an external medical review after the Amerigroup internal appeal process is complete. Your request must be made within 120 days of the date of our appeal decision letter.

9.1.3.2. CHIP adverse benefit determination appeal process

The following language or similar information appears in our member handbooks:

What can I do if my child's doctor asks for a service or medicine for my child that's covered but Amerigroup denies or limits it?
There may be times when Amerigroup says we will not pay for all or part of the care your doctor recommends. You have the right to ask for an appeal. An appeal is when you or a person acting on your behalf asks us to look again at the care your child's doctor requested and we denied. You must file an appeal within 60 days from the date on our first denial letter (letter stating we won't pay for a service).

You can appeal our decision two ways:

- Call Member Services at **800-600-4441 (TTY 711)**
- Send us a letter and any information you want us to look at to:

Amerigroup Appeals
P.O. Box 62429
Virginia Beach, VA 23466-2429

You can have someone else help you with the appeal process. This person can be a family member, friend, your doctor, attorney, or any other person you choose.

How will I find out if services are denied?
If we deny services, we will send you a letter at the time the denial is made.

What are the time frames for the appeal process?
You, or a person acting on your behalf, must file an appeal within 60 days of the date on the first letter from Amerigroup saying we will not pay for all or part of the recommended care.

When we get your letter or call asking for an appeal, we will send you a letter within five business days. This letter will let you know we got your appeal. We will also let you know if we need anything else to process your appeal. Amerigroup will contact your child's doctor if we need medical information about the service.

A licensed physician who has not seen your case before will look at your appeal and make a decision. We will send you a letter with the appeal decision within 30 calendar days of receiving your appeal request.

What is a specialty review?
A specialty review is a review where a provider who specializes in the type of care your child's provider asked for will look at your child's case. Your child's provider can ask for this either:

- As part of your appeal after our first letter saying we won't pay for all or part of the requested care. Your child's provider must ask for this within 10 business days from the date we receive your appeal request.
- If your appeal is denied and a specialty review was not requested with the appeal. Your child's provider can ask for a specialty review within 10 business days of the date of the appeal denial letter.

When we get the specialty review request, we will send you a letter within five business days. This letter will let you know we got the specialty review request. We will send you a decision letter within 15 business days of when we got the request. This letter is our final decision. If you do not agree with our decision, you may ask for an independent external review.

When do I have the right to ask for an appeal?
You must request an appeal within 60 days from the date on our first letter saying we will not pay for all or part of the service. If you, the person acting on your behalf, or the provider are not happy with the answer to your appeal, the provider can send us a letter to ask for a specialty review if it was not requested as part of your appeal. This letter must be sent within 10 business days from the date on our letter with the answer to your appeal.

If you file an appeal, Amerigroup will not hold it against you. We will still be here to help you get quality health care.

Does my request have to be in writing?
No, you can request an appeal by calling Member Services at **800-600-4441 (TTY 711)**.

Can someone from Amerigroup help me file an appeal?
You can call Member Services at **800-600-4441 (TTY 711)** if you need help filing an appeal.

9.1.3.3 Emergency/expedited medical appeals

An emergency/expedited medical appeal will be performed when appropriate. A member can request an emergency/expedited medical appeal in cases where time expended in the standard resolution could jeopardize the member's life; health; or ability to attain, maintain or regain maximum function. An emergency/expedited medical appeal concerns a decision or action by Amerigroup that relates to:

- Health care services including but not limited to procedures or treatments for a member with an ongoing course of treatment ordered by a health care provider, the denial of which, in the provider's opinion, could significantly increase the risk to a member's health or life.
- A treatment referral, services, procedure, or other health care service that if denied could significantly increase risk to a member's health or life.

The following language or similar information appears in our member handbooks:

What is an emergency/expedited appeal?
An emergency/expedited appeal is when the health plan has to make a decision quickly based on the condition of your health and taking the time for a standard appeal could jeopardize your life or health.

How do I ask for an emergency/expedited appeal? Does my request have to be in writing?
You or the person you ask to file an appeal for you can request an emergency/expedited appeal. You can request an emergency/expedited appeal orally or in writing.

- You can call Member Services at **800-600-4441**/STAR Kids: **844-756-4600 (TTY 711)**
- You can send us a letter or the request form included with our decision letter to:

Amerigroup Appeals
P.O. Box 62429
Virginia Beach, VA 23466-2429

What are the time frames for an emergency/expedited appeal?
For Medicaid members:
After we get your letter or call and agree your request for an appeal should be expedited, we will send you a letter with the answer to your appeal. We will do this within 72 hours from receipt of your appeal request.

If your appeal relates to an ongoing emergency or hospital stay, we will call you with an answer within one business day or 72 hours, whichever is shorter. We will also send you a letter with the answer to your appeal within 72 hours.

For CHIP members:
After we get your letter or call and agree your appeal request should be expedited, we will communicate our decision by the shorter of one business day from when we get all information needed to make a decision or within 72 hours from our receipt of the appeal request. We will let you know by phone or electronically, and written notice will also be sent within 72 hours from our receipt of the appeal request.

What happens if Amerigroup denies the request for an emergency/expedited appeal?
If we do not agree that your request for an appeal should be expedited, we will call you right away. We will send you a letter within two calendar days to let you know how the decision was made and that your appeal will be reviewed through the standard review process.

Who can help me file an emergency/expedited appeal?
A member advocate or Member Services representative can help you file an emergency/expedited appeal. Please call Member Services toll free at **800-600-4441**/STAR Kids: **844-756-4600 (TTY 711)**.

9.1.3.4 CHIP external independent review

CHIP members must complete the first level of the Amerigroup appeal process resulting in an adverse decision prior to filing a request for a review by an external Independent Review Organization (IRO).

External Independent Review Organization process — The following language or similar information appears in our member handbooks:

What is an Independent Review Organization?
An Independent Review Organization (IRO) is an organization separate from Amerigroup that can look at your appeal. If we deny requested care after an appeal or specialty review and the decision involved medical judgement, you, the person helping you, or your child's provider can ask for an external review by an IRO.

Can I ask for an external review by an IRO before I exhaust the Amerigroup internal appeal process?
You can ask for an expedited external review:

- If you ask for an expedited appeal after our initial denial and waiting up to 72 hours would seriously jeopardize your child's life, health, or ability to regain maximum function, you can request an expedited external review at the same time.
- When waiting up to 45 calendar days for a standard external review would seriously jeopardize your child's life, health, or ability to regain maximum function.
- If the appeal decision is about an admission, availability of care, continued stay, or health-care service for which emergency services were received but the member has not been discharged from the facility.

How do I ask for a review by an Independent Review Organization?
You, a person acting on your behalf, an attorney, or your provider can ask for an external review within four months of getting the appeal decision. MAXIMUS Federal Services, Inc. is the independent review organization that will conduct the external review. You can use forms from MAXIMUS to ask for an external review or send a written request, including any additional information for review.

You can get the MAXIMUS forms by doing one of the following:

- Call Member Services at **800-600-4441 (TTY 711)**.
- Call MAXIMUS at **888-866-6205**.
- Visit **externalappeal.cms.gov**.

Fill out one or both of the MAXIMUS forms based on who will ask for an external review. Complete:

- The *HHS-Administered Federal External Review Request Form* to request an external review yourself.
- Both the *HHS-Administered Federal External Review Request Form* and the *Appointment of Representative Form* if you want your child's provider or another person to ask for the external review for you:
    - Both you and your authorized representative need to complete this form.
    - If you are asking for an expedited review, the provider can make the request without this form.

Or, send a written request with:

- Name
- Address
- Phone
- Email address
- Whether the request is urgent
- Signature of member, parent or legal guardian, or authorized representative
- A short description of the reason you disagree with our decision

Send your forms or written request to us at:

Amerigroup Appeals
P.O. Box 62429
Virginia Beach, VA 23466-2429

You can also send your request directly to MAXIMUS by one of the ways below:

- Online: **Externalappeal.cms.gov** under the *Request a Review Online* heading
- Mail:

  MAXIMUS Federal Services
  3750 Monroe Ave., Suite 705
  Pittsford, NY 14534

- Fax: **888-866-6190**

If you send additional information to MAXIMUS for the review, it will be shared with Amerigroup so we can reconsider the denial. If you have questions during the external review process, contact MAXIMUS at **888-866-6205** or go to **externalappeal.cms.gov**.

How to request an expedited external review:

- Online: You can select "expedited" when submitting the review request
- Email: FERP@maximus.com
- Call: Federal External Review Process at **888-866-6205**

What are the time frames for this process?
MAXIMUS will send you a letter with its decision within 45 days after their examiner received your request. For an expedited external review, a decision will be made as quickly as necessary for your child's medical condition, but no longer than 72 hours after the examiner received the request for expedited review. Notice of the decision for an expedited review can be given to you verbally but will be followed by a written notice within 48 hours.

9.1.3.5 Medicaid state fair hearing and external medical review information

Can a member ask for a state fair hearing?
If a member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the member has the right to ask for a state fair hearing. The member may name someone to represent them by contacting the health plan in writing and giving the name of the person the member wants to represent him or her. A provider may be the member's representative if the provider is named as the member's authorized representative. The member or the member's representative must ask for the state fair hearing within 120 days of the date on the health plan's letter that tells of the decision being challenged. If the member does not ask for the state fair hearing within 120 days, the member may lose his or her right to a state fair hearing. To ask for a state fair hearing, the member or the member's representative should send a letter to the health plan at:

Amerigroup State Fair Hearing/EMR Coordinator
P.O. Box 62429
Virginia Beach, VA 23466-2429

Or call Member Services at **800-600-4441**/STAR Kids: **844-756-4600 (TTY 711)**.

If the member asks for a state fair hearing within 10 days from the time the health plan mails the appeal decision letter, the member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final hearing decision is made. If the member does not request a state fair hearing within 10 days from the time the health plan mails the appeal decision letter, the service the health plan denied will be stopped.

If the member asks for a state fair hearing, the member will get a packet of information letting the member know the date, time, and location of the hearing. Most state fair hearings are held by telephone. At that time, the member or the member's representative can tell why the member needs the service the health plan denied.

HHSC will give the member a final decision within 90 days from the date the member asked for the hearing.

Can a member ask for an external medical review?
If a member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the member has the right to ask for an external medical review. An external medical review is an optional, extra step the member can take to get the case reviewed for free before the state fair hearing. The member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the member wants to represent him or her. A provider may be the member's representative. The member or the member's representative must ask for the external medical review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the member does not ask for the external medical review within 120 days, the member may lose his or her right to an external medical review. To ask for an external medical review, the member or the member's representative should either:

- Fill out the *State Fair Hearing and External Medical Review Request Form* provided as an attachment to the member notice of MCO internal appeal decision letter and mail or fax it to Amerigroup by using the address or fax number at the top of the form;
- Call Amerigroup at **800-600-4441**/STAR Kids: **844-756-4600 (TTY 711)**.

If the member asks for an external medical review within 10 days from the time the health plan mails the appeal decision letter, the member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final state fair hearing decision is made. If the member does not request an external medical review within 10 days from the time the health plan mails the appeal decision letter, the service the health plan denied will be stopped.

The member, the member's authorized representative, or the member's LAR may withdraw the member's request for an external medical review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the member's external medical review request. The member, the member's authorized representative, or the member's LAR must submit the request to withdraw the external medical review using one of the following methods: 1) in writing, via United States mail, email, or fax; or 2) orally, by phone or in person. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an external medical review during member appeal processes related to adverse benefit determinations based on functional necessity or medical necessity. An external medical review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the external medical review decision is received, the member has the right to withdraw the state fair hearing request. The member may withdraw a state fair hearing request orally or in writing by contacting the hearings officer listed on *Form 4803, Notice of Hearing*.

If the member continues with a state fair hearing and the state fair hearing decision is different from the Independent Review Organization decision, the state fair hearing decision is final. The state fair hearing decision can only uphold or increase member benefits from the Independent Review Organization decision.

Can a member ask for an emergency external medical review?
If a member believes that waiting for a standard external medical review will seriously jeopardize the member's life or health, or the member's ability to attain, maintain, or regain maximum function, the member or member's representative may ask for an emergency external medical review and emergency state fair hearing by writing or calling Amerigroup. To qualify for an emergency external medical review and emergency state fair hearing, the member must first complete the Amerigroup internal appeals process.

9.1.3.6 Medicaid continuation of benefits

Medicaid members may request a continuation of their benefits during the medical appeal process by contacting Amerigroup Member Services at **800-600-4441**/STAR Kids: **844-756-4600 (TTY 711)**. To ensure continuation of currently authorized services, the member (or person acting on behalf of the member) must file an appeal with continuation of benefits request by the later of:

- Ten days following the date Amerigroup sent the notice of adverse benefit determination.
- The intended effective date of the adverse benefit determination as stated in the letter.

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

- The member or the member's representative files the appeal timely (within 60 days of the date of the initial notice of adverse benefit determination).
- The appeal involves the termination, suspension, or reduction of previously authorized services.
- The services were ordered by an authorized provider.
- The period covered by the original authorization has not expired.
- The member or the member's representative timely requests an extension of benefits as defined in the previous paragraph.

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

- The member withdraws the appeal or request for state fair hearing.
- 10 days pass after Amerigroup mails the appeal determination letter unless the member has, within the 10 days, requested a state fair hearing with continuation of benefits either with or without an external medical review.
- A state fair hearing officer issues a hearing decision adverse to the member.

The member may be responsible for the continued benefits if the final determination of the appeal or state fair hearing is not in their favor. If the final determination of the appeal or state fair hearing is in the member's favor, Amerigroup will authorize coverage of and arrange for disputed services as expeditiously as the member's health condition requires but no later than 72 hours from the date that notice is received of the determination reversal. If the final determination is in the member's favor and the member received the disputed services, Amerigroup will pay for those services.

9.2 Provider complaints, payment disputes and medical appeals

9.2.1 Provider complaint resolution

Amerigroup maintains a system for tracking and resolving provider complaints pertaining to administrative issues and non-payment-related matters within 30 calendar days of receipt. Amerigroup accepts provider complaints orally through Provider Services at **800-454-3730** or through local health plan Provider Relations representatives. Written provider complaints should be submitted to:

Amerigroup
P.O. Box 61789
Virginia Beach, VA 23466-1789

Written complaints may also be sent to the attention of the Provider Relations department of the local health plan or faxed to **844-664-7179**. Complaints may be sent by email to TXProviderRelations@amerigroup.com or via the provider website at **https://provider.amerigroup.com/TX**. When submitting complaint information, we recommend providers retain all documentation including fax cover pages, email correspondence and logs of telephone communications at least until the complaint is resolved.

Amerigroup will contact the complainant by telephone, email or in writing within 30 calendar days of receipt of the complaint with the resolution.

Amerigroup will not cease coverage of care pending a complaint investigation. If a provider is not satisfied with the resolution of the complaint by Amerigroup, the provider may complain to the state. A complaint to the state should contain a written explanation of the provider's position on the issue and be accompanied by all materials related to the complaint including medical records and the written response from Amerigroup. Medicaid (STAR, STAR Kids, and STAR+PLUS) complaints may be sent to:

Texas Health and Human Services Commission
MCCO Research and Resolution
P.O. Box 149030, MC: 0210
Austin, TX 78714-9030
ATTN: Resolution Services

Note: CHIP provider complaints are submitted to the Texas Department of Insurance (TDI) rather than HHSC. The address is:

Texas Department of Insurance
P.O. Box 12030
Austin, TX 78711-2030

9.2.2 Provider claim payment disputes

Provider claim payment dispute process
If you disagree with the outcome of a claim, you may utilize the Amerigroup provider payment dispute process. The simplest way to define a claim payment dispute is when a claim is finalized, but you disagree with the outcome.

Please be aware there are four common, claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, we've defined them briefly here:

- Claim inquiry: a question about a claim, but not a request to change a claim payment
- Claims correspondence: when Amerigroup requests further information to finalize a claim; typically, includes medical records, itemized bills, or information about other insurance a member may have
- Member medical necessity appeals: a pre-service appeal for a denied service
- Provider medical appeals: a post-service medical appeal for a denied service

For more information on each of these, please refer to the appropriate section in this chapter of the provider manual.

The Amerigroup provider claim payment dispute process consists of two internal options. You will **not** be penalized for filing a claim payment dispute, and no action is required by the member.

1. **Claim payment reconsideration:** This is a convenient option in the Amerigroup provider claim payment dispute process. The reconsideration is an initial request for an investigation into the outcome of the claim. Most issues are resolved with a claim payment reconsideration.
2. **Claim payment appeal:** This is an additional option in the Amerigroup provider claim payment dispute process. If you disagree with the outcome of a reconsideration or you choose not to ask for a reconsideration, you may request a claim payment appeal. Please note: If you did not ask for a claim payment reconsideration first, this will be the only internal appeal option available for your dispute.

For a claim payment appeal decision in which the denial is upheld, the provider should review the *Participating Provider Agreement* for any other available methods of dispute resolution. The provider may also file a complaint with HHSC or TDI as applicable.

A claim payment dispute may be submitted for multiple reason(s), including:

- Contractual payment.
- Disagreements over reduced or zero-paid claims.
- Other health insurance denial.
- Claim code editing.
- Duplicate claim.
- Retro-eligibility.
- Experimental/investigational procedure.
- Claim data.
- Timely filing.*

* We will consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

Claim payment reconsideration
The first available option in the Amerigroup claim payment dispute process is called the reconsideration. It is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally or online through Availity Essentials at **Availity.com** within 120 calendar days from the date on the *Explanation of Payment (EOP)* (see below for further details on how to submit). Reconsiderations filed more than 120 calendar days from the *EOP* will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect.

Amerigroup will resolve the claim payment reconsideration within 30 calendar days of receipt. We will send you a decision in a determination letter, which will include:

- A statement of the provider's reconsideration request.
- A statement of what action Amerigroup intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes, or provider manual references.
- An explanation of the provider’s right to request a claim payment appeal within 30 calendar days of the date of the reconsideration determination letter or 120 calendar days from the original *EOP* if later.
- How to submit a claim payment appeal.

If the decision results in a claim adjustment, any payment and the *EOP* will be sent separately.

Claim payment appeal
If you are dissatisfied with the outcome of a reconsideration determination or if you wish to bypass the reconsideration process altogether, you may submit a claim payment appeal.

We accept claim payment appeals online through Availity Essentials at **Availity.com** or in writing within the later of either:

- 30 calendar days from the date on the reconsideration determination letter
- 120 calendar days from the date of the original *EOP*

Claim payment appeals received later than these time frames will be considered untimely and upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the original denial or reconsideration determination was in error.

Amerigroup will resolve the claim payment appeal within 30 calendar days of receipt. We will send you a decision in a determination letter, which will include:

- A statement of the provider's claim payment appeal request.
- A statement of what action Amerigroup intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes, or provider manual references.

If the decision results in a claim adjustment, any payment and the *EOP* will be sent separately.

How to submit a claim payment dispute

We have several options to file a claim payment dispute:

- Online (for reconsiderations and claim payment appeals): Use the secure Availity Provider Payment Appeal Tool at **Availity.com**. Through Availity, you can upload supporting documentation and will receive immediate acknowledgement of your submission. Locate the claim you want to dispute on Availity using **Claim Status** from the *Claims & Payments* menu. If available, select **Dispute Claim** to initiate the dispute. Go to **Request** to navigate directly to the initiated dispute in the appeals dashboard to add the documentation and submit.
- Verbally (for reconsiderations only): Call Provider Services at **800-454-3730**.
- Written (for reconsiderations and claim payment appeals): Mail all required documentation (see below for more details), including the Provider Payment Dispute and Claim Correspondence Submission Form, to:

  Payment Dispute Unit
  Amerigroup
  P.O. Box 61599
  Virginia Beach, VA 23466-1599
- Fax (for reconsiderations and claim payment appeals) all required documentation to: **844-756-4607**.

9.2.3 Required documentation for claim payment disputes

Amerigroup requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

- Your name, address, phone number, email, and either your NPI or TIN
- The member’s name and their Amerigroup or Medicaid/CHIP ID number
- A listing of disputed claims, which should include the Amerigroup claim number and the date(s) of service(s)
- All supporting statements and documentation

When submitting a payment dispute, we recommend providers retain all documentation including fax cover pages, email correspondence and logs of telephone communications at least until the dispute is resolved.

Claim inquiries
A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but the outcome of the claim inquiry may result in the initiation of a claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Our Provider Relations program helps you with claim inquiries. Just call **800-454-3730** and select the *Claims* prompt within our voice portal. We connect you with a dedicated resource team, called the Provider Service Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact, issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

Claim correspondence
Claim correspondence is different from a payment dispute. Correspondence is when Amerigroup requires more information to finalize a claim. Typically, Amerigroup makes the request for this information through the *EOP*. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, Amerigroup will use it to reprocess the claim.

The following table provides examples of the most common correspondence issues along with guidance on the most efficient ways to resolve them.

Type of issue	**What do I need to do?**
EDI Rejected Claim(s)	Contact Availity Client Services with any questions at **800-Availity (282-4548)**
EOP Requests for Supporting Documentation (Sterilization/ Hysterectomy/Abortion Consent Forms, Itemized Bills, and Invoices)	Submit a *Provider Payment Dispute and Claim Correspondence Submission Form*, a copy of your *EOP*, and the supporting documentation to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
EOP Requests for Medical Records	Submit a *Provider Payment Dispute and Claim Correspondence Submission Form*, a copy of your *EOP*, and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Need to Submit a Corrected Claim due to Errors or Changes on Original Submission	Submit a *Provider Payment Dispute and Claim Correspondence Submission Form* and your corrected claim to:

Type of issue	What do I need to do?
	Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 120 calendar days of the *EOP*. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Amerigroup to adjust the other health insurance (OHI) payment information, the 95-day timely filing period starts with the date of the most recent OHI *EOB*.
Submission of *Coordination of Benefits (COB)*/Third-Party Liability (TPL) Information	Submit a *Provider Payment Dispute and Claim Correspondence Submission Form*, a copy of your *EOP*, and the *COB*/TPL information to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Emergency Room Payment Review	Submit a *Provider Payment Dispute and Claim Correspondence Submission Form*, a copy of your *EOP*, and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599

Member medical necessity appeals

A member medical necessity appeal refers to a situation in which an authorization for a service was denied prior to the service. Member medical necessity appeals/prior authorization appeals are different from claim payment disputes and should be submitted in accordance with the ***Member Medical Appeal Process and Procedures*** section of this chapter.

9.2.4 Provider medical appeals

This type of appeal is available to providers with respect to a denial of services that have already been provided to the member and determined to be not medically necessary or appropriate. These appeals do not include member medical necessity appeals as described in the ***Member Medical Appeal Process and Procedures*** section of this chapter.

Provider medical appeals should be submitted in writing to:

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

A provider must file a medical appeal within 120 calendar days of the earlier of the date of the denial letter or *EOP*. The appeal must include an explanation of what is being appealed and why. Appropriate supporting documentation must be attached to the appeal request.

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

The results of the review will be communicated in a written decision to the provider within 30 calendar days of our receipt of the appeal. If the appeal is approved, the provider will receive a denial overturn letter. An upheld denial of services decision receives an appeal determination letter. The determination letter includes the following:

- A statement of the provider's appeal
- The reviewer’s decision, along with a detailed explanation of the contractual and/or medical basis for such decision
- A description of the evidence or documentation that supports the decision
- A description of the method to obtain a second-level internal review

If a provider is dissatisfied with the appeal resolution, they may file a second-level appeal. This must be a written appeal submitted within 30 calendar days of the date of the first-level determination letter. The case is handled by reviewers not involved in the first-level review. The results of the review are communicated in a written decision to the provider within 30 calendar days of receipt of the appeal. If the appeal is approved, the provider will receive a denial overturn letter. An upheld denial of services decision receives an appeal determination letter. For a decision in which the denial was upheld, the provider should review the *Participating Provider Agreement* for any other available methods of dispute resolution. The provider may also file a complaint with HHSC or TDI as applicable.

9.3 Provider appeal process to HHSC (related to claim recoupment)

Upon notification of a claims payment recoupment, the first step is for the provider to recheck member eligibility to determine if a member eligibility change was made to Fee-for-Service or to a different managed care organization on the date of service.

1. **Member eligibility changed to Fee-for-Service on the date of service**

   Provider may appeal claim payment recoupment by submitting the following information to HHSC:

   - A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
   - **The *Explanation of Benefits (EOB)* showing the original payment.** Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.
   - **The *EOB* showing the recoupment and/or the plan's "demand" letter for recoupment.** If sending the demand letter, it must identify the client name, identification number, DOS and recoupment amount. The information should match the payment *EOB*.
   - **Completed clean claim.** All paper claims must include both the valid NPI and TPI number. In cases where issuance of a prior authorization (PA) is needed, the provider will be contacted with the authorization number, and the provider will need to submit a corrected claim that contains the valid authorization number.
   - **Note:** Label the request **"Expedited Review Request"** at the top of the letter to ensure the appeal request is reviewed prior to 18 months from the date of service.

   Mail Fee-for-Service related appeal requests to:

   Texas Health and Human Services Commission
   HHSC Claims Administrator Contract Management
   Mail Code-91X
   P.O. Box 204077
   Austin, TX 78720-4077

   Prepare a new paper claim for each claim that was recouped and insert the new claims as attachments to the administrative appeal letter. Include documentation such as the original claim and the statement showing that the claims payment was recouped.

   Submission of the new claims is not required before sending the administrative appeal letter. However, if a provider appeals prior to submitting the new claims, the provider must subsequently include the new claims with the administrative appeal.

   HHSC Claims Administrator Contract Management only reviews appeals that are received within 18 months from the date of service. In accordance with *1 TAC § 354.1003*, providers must adhere to all filing and appeal deadlines for an appeal to be reviewed by HHSC Claims Administrator Contract Management, and all claims must be finalized within 24 months from the date of service.

2. **Member eligibility changed from one managed care organization (MCO) to another on the date of service**

   Providers may appeal claims payment recoupments and denials of services by submitting the following information to the appropriate MCO to which the member eligibility was changed on the date of service:

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
- **The *Explanation of Benefits (EOB)* showing the original payment. The *EOB* showing the recoupment and/or the MCO's "demand" letter for recoupment** must identify the client name, identification number, DOS and recoupment amount. The information should match the payment *EOB*.
- **Documentation must identify** the client name, identification number, DOS, recoupment amount, and other claims information.
- **Note:** Label the request **"Expedited Review Request"** at the top of the letter to ensure the appeal request is reviewed prior to 18 months from the date of service.

Submit appeals online at: https://www.availity.com.

Mail Fee-for-Service related appeals to:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code-91X
P.O. Box 204077
Austin, TX 78720-4077

10 Provider rights and responsibilities

10.1 Providers' Bill of Rights

Each health care provider who contracts with HHSC or subcontracts with Amerigroup to furnish services to members will be assured of the following rights:

- To not be prohibited (when acting within the lawful scope of practice) from advising or advocating on behalf of a member who is their patient for the following:
    - The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered
    - Any information the member needs in order to decide among all relevant treatment options
    - The risks, benefits, and consequences of treatment or nontreatment
    - The member's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions
- To receive information on the complaint, appeal, external medical review, and state fair hearing procedures
- To have access to Amerigroup policies and procedures covering the authorization of services
- To be notified of any decision by Amerigroup to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested
- To challenge, on behalf of a Medicaid member, the denial of coverage of or payment for medical assistance
- To be assured Amerigroup provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment
- To be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of their license or certification under applicable state law solely on the basis of that license or certification

10.2 Network provider general responsibilities

Each health care provider contracted with Amerigroup has the following general responsibilities:

- Provide Amerigroup members with a professionally recognized level of care and efficacy consistent with community standards, compliant with Amerigroup clinical and nonclinical guidelines and within the practice of your professional license.
- Treat all Amerigroup members in a fair and nondiscriminatory manner and with respect and consideration.
- Abide by the terms of your Amerigroup *Participating Provider Agreement*.
- Comply with all Amerigroup policies and procedures, including those found in this provider manual and any future updates or supplements.
- Facilitate inpatient and ambulatory care services at in-network facilities.
- Arrange referrals for care and service within the Amerigroup network.
- Verify member eligibility and obtain prior authorization for services as required by Amerigroup.

- Notify Amerigroup immediately if unable to render authorized services to the full extent authorized.
- Ensure members understand the right to obtain medication from any network pharmacy.
- Maintain confidential medical records consistent with Amerigroup medical records guidelines, as outlined in the ***Member Record Standards*** section of this manual and applicable *HIPAA* regulations.
- Maintain a facility that promotes patient safety.
- Participate in the Amerigroup Quality Improvement Program initiatives.
- Participate in provider orientations and continuing education.
- Abide by the ethical principles of your profession.
- Notify Amerigroup if you are undergoing any type of legal or regulatory investigation or if you have agreed to a written order issued by the state licensing agency for your profession.
- Notify Amerigroup if a member has a change in eligibility status by contacting Provider Services.
- Maintain professional liability insurance in an amount that meets Amerigroup credentialing requirements and/or state-mandated requirements.
- Notify both Amerigroup and the HHSC administrative services contractor promptly if there is a change in your physical office or remittance address, tax identification number, group affiliation or any other type of demographic change.

10.2.1 Update enrollment and demographic information with TMHP

Texas Medicaid & Healthcare Partnership (TMHP) is the provider enrollment administrator for HHSC and serves as the authoritative source for HHSC providers' enrollment and demographic information. Once you update your enrollment and demographic information with TMHP at **tmhp.com**, your data will be reconciled with the demographic information on file with the managed care organizations (MCOs).

You can also contact TMHP directly at **800-925-9126** for assistance.

10.2.2 Reporting abuse, neglect, or exploitation (ANE) — Medicaid managed care

Report suspected abuse, neglect, and exploitation:
MCOs and providers must report any allegation or suspicion of ANE that occurs within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include MCO and provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and provider requirements continue to apply.

The provider must provide the MCO with a copy of the Abuse, Neglect and Exploitation report findings within one business day of receipt of the findings from the Department of Family and Protective Services (DFPS). In addition, the provider is responsible for reporting individual remediation on confirmed allegations to the MCO.

Report to the Health and Human Services Commission (HHSC) if the victim is an adult or child who resides in or receives services from:

- Nursing facilities.
- Assisted living facilities.

- Home and Community Support Services Agencies (HCSSAs) — Providers are required to report allegations of ANE to both DFPS and HHSC.
- Adult day care centers.
- Licensed adult foster care providers.

Contact HHSC at **800-458-9858**.

Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:
An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:

- Local Intellectual and Developmental Disability Authority (LIDDA), Local Mental Health Authority (LMHA), community center, or mental health facility operated by the Department of State Health Services
- A person who contracts with a Medicaid managed care organization to provide behavioral health services
- A managed care organization
- An officer, employee, agent, contractor, or subcontractor of a person or entity listed above
- An adult with a disability receiving services through the Consumer Directed Services option

Contact DFPS at **800-252-5400** or, in nonemergency situations, online at **txabusehotline.org**.

Report to local law enforcement
If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

Failure to report or false reporting:

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, HHSC or a law enforcement agency (See: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).
- It is a criminal offense to knowingly or intentionally report false information to DFPS, HHSC or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

10.3 Advance directives

We adhere to the *Patient Self-Determination Act* and maintain written policies and procedures regarding advance directives. Advance directives are documents signed by a competent person giving direction to health care providers about treatment choices in certain circumstances. There are two types of advance directives. A durable power of attorney for health care (durable power) allows the member to name a patient advocate to act on behalf of the member. A living will allows the member to state their wishes in

writing but does not name a patient advocate. We encourage members to request education about advance directives and ask for an advance directive form from their PCP at their first appointment.

Members age 18 and over and emancipated minors are able to make an advance directive. Their response is to be documented in the medical record. Amerigroup will not discriminate or retaliate based on whether a member has or has not executed an advance directive.

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

We will assist members with questions about advance directives. However, no associate of Amerigroup may serve as witness to an advance directive or as a member's designated agent or representative. Amerigroup notes the presence of advance directives in the medical records when conducting medical chart audits.

10.4 *Americans with Disabilities Act* requirements

All providers are expected to meet federal and state accessibility standards and those defined in the *Americans with Disabilities Act of 1990*. Health care services provided through us must be accessible to all members.

Our policies and procedures are designed to promote compliance with the *Americans with Disabilities Act of 1990* (*42 U.S.C. §12101 et seq*). Providers are required to take actions to remove an existing barrier and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes the following:

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

10.5 Appointments

Routine care
Health care for covered preventive and medically necessary health care services that are nonemergent or nonurgent is considered routine care.

Urgent care
A health condition (including an urgent behavioral health situation) that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that their condition requires medical treatment evaluation or treatment by the member's PCP or PCP designee within 24 hours to prevent serious deterioration of the member's condition or health.

Emergency care

Emergency care is defined as any medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical care could result in any of the following:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement
- Serious jeopardy to the health of a woman or her unborn child (in the case of a pregnant woman)

Appointment and access standards

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

Standard name	Amerigroup
Emergency services	Immediately upon member presentation at the service delivery site, including at non-network and out-of-network facilities
Urgent care	Within twenty-four (24) hours
Post-emergency room or hospital discharge (nonbehavioral health)	Within fourteen (14) days of discharge
Primary routine care	Within fourteen (14) days
Specialty routine care	Within three (3) weeks /21 days (per State contract)
Preventive health: adult 21 and older	Within ninety (90) days
Preventive health: child (new member — STAR, STAR Kids, and STAR+PLUS)	For new members birth through age twenty (20), overdue or upcoming Texas Health Steps checkups should be offered as soon as practicable and no later than ninety (90) days of enrollment.
Preventive health: child less than 6 months old	Within fourteen (14) days
Preventive health: child age 6 months-20 years	Within sixty (60) days
Prenatal care: initial visit	Within fourteen (14) days
Prenatal care: high-risk or third trimester — initial visit	Within five (5) days or immediately, if an emergency exists.
Prenatal care: after initial visit	Based on the provider's treatment plan

Behavioral health	
Behavioral health: non-life-threatening emergency	Within six (6) hours (NCQA)
Behavioral health: urgent care	Within twenty-four (24) hours
Post-hospital discharge (behavioral health)	Within seven days of discharge (for missed appointments, provider must contact member within 24 hours to reschedule appointment)
Behavioral health: routine care — initial visit	The earlier of ten (10) business days (NCQA) or fourteen (14) calendar days
Behavioral health: routine care — follow-up visits	Within three (3) weeks
After-hours access	
After-hours care	For PCPs: practitioners must be accessible 24/7 directly or through answering service • Answering service or recording assistance in English and Spanish • Member reaches on-call physician or medical staff within 30 minutes
Other Services	
Community Long-term Services and Supports - STAR+PLUS	Services must be initiated within seven (7) days from the start date on the Individual Service Plan (ISP) or the eligibility effective date for non-HCBS STAR+PLUS Waiver members*
Community Long-term Services and Supports – STAR Kids	Services must be initiated within seven (7) days from the authorization; for members receiving MDCP services, the services must be initiated by the start date of the ISP Tracker

* Unless the referring provider or member requests or the STAR+PLUS Handbook states otherwise.

Providers may not use discriminatory practices, such as preference to other insured or private-pay patients, including separate waiting rooms, hours of operation or appointment days. We routinely monitor providers' adherence to the access to care standards.

10.6 Continuity of care

The care of newly enrolled members may not be disrupted or interrupted. This is true for care that falls within the scope of benefits. We will work to provide continuity of care of newly enrolled members whose health or behavioral health conditions have been treated by specialty care providers or whose health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted.

We will honor existing service authorizations for new members in the same amount, duration, and scope until the shorter of:

- 90 calendar days.
- The end of the current authorization period.
- The time it takes for us to evaluate and assess the member and issue or deny a new authorization.

In the case of a newly enrolled member who is receiving a service that did not require authorization from the prior plan, we will authorize services in the same amount, duration, and scope until the shorter of:

- 90 calendar days.
- The time it takes for us to evaluate and assess the member and issue or deny a new authorization.

For members enrolling on the operational start date of an HHSC program or on the start date of a new service area, we will honor existing acute-care authorizations for the earlier of 90 days or the expiration of the current authorization. We will honor existing long-term services and supports authorizations for up to six months or until we have completed a new assessment for the member and issued new service authorizations.

Pregnant Amerigroup members past the 24th week of pregnancy are allowed to remain under the care of their current OB/GYNs through their postpartum checkup within six weeks of delivery. This applies even if the providers are out-of-network. If a member wants to change her OB/GYN to one who is in-network, she will be allowed to do so if the new provider agrees to accept her.

For new members who have been diagnosed with a terminal illness, we will approve out-of-network care by existing providers for up to nine months while enrolled with Amerigroup (12 months for STAR Kids members).

We pay a new member's existing out-of-network providers for medically necessary covered services until the member's records, clinical information and care can be transferred to a network provider or until the member is no longer enrolled with us, whichever is shorter.

Member moves out of service area
We provide or pay out-of-network providers for medically necessary covered services to members who move out of the service area. Members are covered through the end of the period for which they are enrolled in Amerigroup.

Pre-existing condition not imposed
We do not impose any pre-existing condition limitations or exclusions. We do not require evidence of insurability to provide coverage to any member.

10.7 Covering physicians

During a provider's absence or unavailability, they need to arrange for coverage for their members. The provider will either:

- Make arrangements with one or more network providers to provide care for their patients.
- Make arrangements with another similarly licensed and qualified provider with appropriate medical staff privileges at the same network hospital or medical group, as applicable, to provide care to the members in question.

The covering provider will agree to the terms and conditions of the network provider agreement, including any applicable limitations on compensation, billing, and participation. Providers will be solely responsible for a non-network provider's adherence to such provisions. Providers will be solely responsible for any fees or monies due and owed to any non-network provider providing substitute coverage to a member on the provider's behalf.

10.8 Credentialing and recredentialing

To be reimbursed for services rendered to Medicaid managed care members, providers must be enrolled in Texas Medicaid. Providers are not considered participating with us until they've enrolled in Texas Medicaid and have been credentialed with a duly executed contract with us.

We adhere to NCQA standards and state requirements for credentialing and recredentialing. In accordance with these standards, providers must submit all requested information necessary to complete the credentialing or recredentialing process. Each provider must cooperate with us as necessary to conduct credentialing and recredentialing pursuant to our policies and procedures.

To initiate the network enrollment process, contact Amerigroup at email TXCredentialing@amerigroup.com or visit the provider website at **https://provider.amerigroup.com/TX** for information on how to join our network. Amerigroup will utilize the Credentialing Verification Organization (CVO), Aperture, for all initial credentialing and recredentialing requests. We will notify Aperture of a provider's intent to become a credentialed provider. Aperture will collect all credentialing applications, forms, licenses, and other relevant information needed to validate a provider's credentials — this is called primary source verification (PSV).

Upon review of the PSV, Aperture will notify Amerigroup whether a file is complete or incomplete. If a file is deemed complete, we perform an internal review for accuracy and completeness. Once the internal process is complete, the file will be submitted to the Credentialing Committee for review. You will receive a final notification from Amerigroup upon completion of all credentialing-related actions.

The CVO process is for credentialing only — providers must still contract with Amerigroup. The initial credentialing process and our claims system will be able to recognize a newly contracted provider no later than 90 calendar days after Aperture's receipt of a complete application.

A provider has the right to inquire about the status of a network enrollment request by the following methods:

- To check the status of your credentialing application, call Aperture at **855-743-6161, option 3**
- Email: TXCredentialing@amerigroup.com

As an applicant for participation in our network, each provider has the right to review information obtained from other sources during the credentialing process except for peer review protected information or recommendations or if disclosure is prohibited or protected by law. We will notify the provider of any discrepancy between the information submitted with the application and information obtained from other sources if the discrepancy affects or is likely to adversely affect the credentialing decision.

Upon notification from us of a discrepancy, the provider has the right to explain information obtained from another party that may vary substantially from the information provided in the application and to submit corrections to the facts in dispute. The provider must submit a written explanation within 30 days to the Texas Credentialing email address above or appear before the credentialing committee if deemed necessary.

If a provider qualifies for expedited credentialing under Texas Insurance Code 1452, Subchapters C, D and E, regarding providers joining established medical groups or professional practices already contracted with us, our claims system will be able to process claims from the provider as if the provider was a network provider, no later than 30 days after receipt of a complete application, even if the credentialing process has not yet been completed.

Amerigroup will provide expedited credentialing for certain provider types and allow services to members on a provisional basis as required by Texas Government Code §533.0064 and our state contract with HHSC. Provider types included are dentists, dental specialists including dentists and physicians providing dental specialty care, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, and psychologists. To qualify for expedited credentialing, the provider must meet the following criteria:

- Be a member of a provider group already contracted with Amerigroup
- Be Medicaid-enrolled
- Agree to comply with the terms of the existing provider group contract
- Timely submit all documentation and other information required to begin the credentialing process

At least once every three years, we will review and approve the credentials of all participating licensed and unlicensed providers who participate in the Amerigroup network. The process will take into consideration provider performance data including member complaints and appeals, quality of care, and utilization management.

Providers are required to notify us of a change in address or practice status within 10 days of the effective date of the change. Practice status is defined as a change in office hours, panel status, etc. The inclusion of a new address on a recredentialing application is not an acceptable form of notification. The Provider Data Management (PDM) tool in Availity Essentials at **Availity.com** should be used to submit demographic change requests for all professional and facility providers. The HHSC administrative services contractor must also be notified of all demographic changes. A notice of termination must adhere to the advance notice timelines stated in the provider's agreement and be sent to:

Provider Configuration
Amerigroup
P.O. Box 62509
Virginia Beach, VA 23466-2509

10.8.1 Credentialing decision appeal process

In the event of a decision by the credentialing committee to limit or restrict the credentials or terminate the participation of a provider in the Amerigroup network as part of the recredentialing process, the provider will be notified in writing of a 30-calendar-day time frame in which the provider may appeal the decision. We have a two-level appeal process.

The request from the provider for an appeal must set forth in detail those matters the provider believes were improperly determined by the credentialing committee and/or medical director and the specific

reasons why the provider believes the decision to be improper. The provider may include any statement, documents, or other materials the provider would like the credentialing appeals committee (first-level appeals) or credentialing hearing committee (second-level appeals), or appointed hearing officer to consider prior to rendering a final decision. If the provider does not submit a written appeal within the 30-calendar-day time frame, the appeal right expires and the initial determination will stand.

If the credentialing appeals committee does not render a favorable decision to a provider in a first-level recredentialing appeal, the provider may request a second-level appeal. The provider must request the additional appeal in writing within 30 days of the date of the denial notification letter. When we receive the provider's request for a second-level appeal, an acknowledgment letter will be sent to the provider, which sets forth the next steps in the appeal process.

The second-level appeal is reviewed by the credentialing hearing committee, led by a hearing officer. The provider may participate by phone or appear in person and has the right to be represented by an attorney or other representative. The hearing will take place within 30 days of the date of the provider's letter requesting the second-level appeal. We will send a letter to the provider 14 days in advance of the hearing, which will state the date, time, and place of the hearing. The provider will receive an evidence packet that will be used for reference by the credentialing hearing committee. During the hearing, the provider may call, examine, and cross-examine any witnesses. The provider may also submit a written statement at the close of the hearing.

The credentialing hearing committee will consist of individuals who a) are participating licensed practitioners; b) are not in direct economic competition with the provider; c) are not in business with the provider; and d) have not previously made a recommendation or decision regarding the provider's participation in our network.

The outcome of the second-level appeal may be to reinstate the provider, establish a provisional reinstatement subject to certain conditions, or uphold the decision of the credentialing appeals committee. The provider will be notified in writing of the committee's decision within 15 days of the meeting. The findings of the credentialing hearing committee are final. If a determination to terminate is upheld, termination will be effective the first day of the month following 30 days from the date of the letter detailing the credentialing hearing committee's second-level appeal decision.

10.8.2 Practitioner office site quality

We establish standards and thresholds for office site criteria and medical/treatment record-keeping practices. This applies to all practitioners within the scope of credentialing.

To protect the health and safety of our members, we developed a process for evaluating a physician office site for one or more of the following reasons:

- Receipt of a member complaint concerning physical accessibility, physical appearance, adequacy of waiting or examining room space, or adequacy of medical/treatment records
- Receipt of a member complaint determined to be severe enough to potentially endanger or which endangers members' health and well-being
- When a pattern related to the quality of the site is identified

- At the time of initial credentialing or recredentialing as outlined by contractual requirement
- To complete the open investigation of any quality or quality of service issue

All physicians/practitioners are required to meet standards set forth by us and to comply with state and federal regulations.

If we identify a physician/practitioner office site receiving three or more complaints within a six-month period related to the following components (with the exception of physical accessibility for which the complaint threshold is one), a Practitioner Office Site Quality Assessment will be conducted that will include a review of the following:

- Physical accessibility
- Physical appearance
- Adequacy of waiting or examining room space
- Adequacy of medical/treatment record-keeping practices

We may choose to conduct an office site quality assessment if a complaint is determined to be severe enough to potentially endanger a member's health or well-being (in this case the threshold is one complaint).

The *Amerigroup Practitioner Office Site Evaluation* form is used to score the office site quality measurements. A minimum threshold of 80 percent or greater **in each** component is considered a passing audit score. The acceptable performance for on-site visits for each office location and medical record reviews for the applicant is a minimum passing score of 80 percent in each of the four designated components outlined above. Any exception to the minimum passing score is at the discretion of the health plan credentialing committee and must be based on compelling circumstances.

Practitioner Office Site Assessment Criteria		
		Scoring
Physical accessibility		
1	Is there accessibility for people with disabilities? If not, does staff have an alternative plan of action?	Must have first-floor ramp or elevator access. Bathroom and hallways must accommodate a wheelchair. If yes, 2 points; if no, 0 points
2	Is accessible parking clearly marked?	Off-street accessible parking is identified by a sign or a painted symbol on the pavement. Score as N/A if street-side parking only is available. If yes, 1 point; if no, 0 points
3	Are doorways and stairways that provide access free from obstructions at all times, and do they allow easy access by wheelchair or stretcher?	There should be no boxes, furniture, etc. blocking doorways or stairways. If yes, 2 points; if no, 0 points
4	Are exits clearly marked, and is there emergency lighting in instances of power failure?	Exits are marked with appropriate chevrons and emergency powered in case of power outage. There is a posted evacuation plan by either staff design or building management. If yes, 2 points; if no, 0 points
5	Are building and office suite clearly identifiable (clearly marked office sign)?	The sign identifying the office is clearly posted. If yes, 1 point; if no, 0 points
Physical appearance		

Practitioner Office Site Assessment Criteria		
		Scoring
1	Is the office clean, well-kept, and smoke-free?	Mark yes if there are no significant spills on furniture or floor, the trash is confined, and the office and waiting area appears neat. Does the office prevent hazards that might lead to slipping, falling, electrical shock, burns, poisoning and other trauma? If yes, 2 points; if no, 0 points
2	Is treatment area clean and well-kept? (No significant spills on floors, counters or furnishings, no trash on floor)	Mark yes if there are no significant spills on furniture or floor, the trash is confined, the treatment area appears neat. If yes, 2 points; if no, 0 points
3	Does office have smoke detector(s)?	Smoke detectors should be in place and tested twice yearly. How does the office log the twice-yearly check? Is the office a smoke-free facility? If yes, 2 points; if no, 0 points
4	Is there easy access to a clean, supplied bathroom?	• Soap, toilet paper and hand towels are available. • Hand washing instructions are posted. • Lavatory is clean; toilet is functioning. If yes, 1 point; if no, 0 points
5	Is the waiting room well-lit?	Is there adequate lighting and comfort level for reading? If yes, 1 point; if no, 0 points
6	Are fire extinguishers clearly present and fully charged with a current inspection (even if the office has a sprinkler system)?	Fire extinguisher tag is dated within the last year; there should be an adequate number of fire extinguishers for the square footage placed at opposite ends of office. If yes, 1 point; if no, 0 points
Adequacy of waiting/examining room space		
1	Is there adequate seating in the waiting area (based on the number of physicians/practitioners)?	1 provider = 6 seats, 2 providers = 8 seats, 3 providers = 11 seats, 4 providers = 14 seats, 5 providers = 17 seats If yes, 1 point; if no, 0 points
2	Does the staff provide extra seating when the waiting room is full?	Ask the staff where patients go when waiting area is full. If yes, 1 point; if no, 0 points
3	Is there a minimum of two exam rooms per scheduled provider? (two consultation rooms for BH providers)	Count exam/consultation rooms and compare against provider schedule. If yes, 1 point; if no, 0 points
4	Is there privacy in exam/consultation rooms?	There must be door or curtain closures; exam/consultation rooms cannot be seen from waiting room. If yes, 1 point; if no, 0 points
5	Are exam/consultation rooms reasonably soundproof to ensure patient privacy during interviews/examinations?	Conversations cannot be heard from waiting room or other exam/consultation rooms. If yes, 2 points; if no, 0 points
6	Is an otoscope, an ophthalmoscope, a blood pressure cuff, and a scale readily accessible?	Applies to all physicians/practitioners except BH providers If yes, 1 point; if no, 0 points
7	7a — For OB/GYNs only or any physician/practitioner providing OB care: 7b — Is a fetalscope (DeLee and/or Dopler) and a measuring tape for fundal height measurement readily accessible — Supplies for dipstick urine analysis (glucose, protein)?	Score 7a and 7b as N/A if provider does not provide OB services If yes, 1 point for each; if no, 0 points
Adequacy of medical records		
1	Are there individual patient records?	Each patient has an individual record. There should be no family charts. If yes, 2 points; if no, 0 points
2	Are records stored in a manner that ensures confidentiality? Who is the designated person in charge of clinical records? (provide name)	Records are maintained in locations not easily accessible to patients and office visitors. If yes, 2 points; if no, 0 points
3	Are all items secured in the chart?	All patient medical information must be secured within the chart. If yes, 2 points; if no, 0 points

Practitioner Office Site Assessment Criteria		
		Scoring
4	Are medical records readily available?	Medical records should be available within 15 minutes of request. Providers with more than one office location must have a mechanism to assure the medical record is available for reference if a patient is seen at an alternate site to the usual office. If yes, 2 points; if no, 0 points
5	Medical recordkeeping practices:	We are only determining there is a place within a blank chart to document the information in 5a thru 5f. Due to *HIPAA* regulations and other reasons related to the legal right to access, we **MUST NOT** ask to review an actual patient chart for providers in the initial credentialing process. We may only review charts of those Amerigroup members actually assigned or currently being seen by the providers/practitioners. There would be none for initial providers. When medical records are retired, what is the procedure for storage and final destruction?
5a	Is there a place to document allergies?	Allergies or the absence of allergies, along with the reactions, should be prominently displayed in or on the medical record. The absence of medicine sensitivities should also be noted. If yes, 2 points; if no, 0 points
5b	Is there a place to document a current medication list?	All medications, both prescription and over-the-counter/herbal medications, should be documented in the chart along with the dosages. A notation should also include No Medications to attest that the inquiry was made. If yes, 2 points; if no, 0 points
5c	Is there a place to document current chronic problems list?	A problem list would be generated as part of each visit's assessment. If yes, 2 points; if no, 0 points
5d	Is there an immunization record on pediatric charts? N/A for BH providers	The immunization record should be completed to the age the child has reached at the time of the last encounter. If shots were completed prior to the first encounter with the current physician/practitioner, the notation *Immunizations are up-to-date* is acceptable. If yes, 2 points; if no, 0 points
5e	Is there a growth chart on pediatric charts? N/A for BH providers	Height and weight are documented annually; head circumference is documented until age 2. If yes, 2 points; if no, 0 points
5f	Is there a place to document presence/absence and discussion of a patient self-determination/advance directive?	There is a place for documentation that an advance directive has been executed or that the physician/practitioner has inquired as to whether the patient has a written advance directive. If yes, 2 points; if no, 0 points Score as N/A if patient is < 21 years old.

Appointment availability		
	Please see specific appointment availability requirements	If yes, 1 point for each; if no, 0 points
Documentation evaluation		
1	Is there a no-show follow-up procedure/policy?	A written policy should be available. If not, the staff should verbally describe the follow-up process. Staff should be encouraged to adapt policy into a written format. If yes, 2 points; if no, 0 points
2	Is there a chaperone policy? May not apply to some specific BH situations — Ask for clarification and document same on form.	A written policy should be available. If a written policy is not in place, the staff should verbally describe the process and provide a statement on the office letterhead stating a chaperone will be in the exam room. Staff should be encouraged to adapt the policy into a written format. **The provider must have this element in place to pass the site evaluation and participate with Amerigroup.** If yes, 2 points; if no, 0 points
3	Is the Patient Bill of Rights posted? Are copies available upon request?	A notice should be posted in a prominent location, and copies should be available upon request. If yes, 1 point; if no, 0 points

4	Is a medical license/occupational license displayed? Are the hours of operation posted?	Licensures and hours of operation should be posted within the office. If yes, 1 point; if no, 0 points
5	Is there a notice of member complaint process?	A notice should be posted in a prominent location. If yes, 1 point; if no, 0 points
6	Is there a written policy for hand washing, gloved procedures and disposal of sharps? May not be applicable for BH providers in private practice setting.	A written policy for hand washing should be available (1 point). A written policy for sharp disposal should be available (1 point). Sharps should be disposed of immediately. Reusable containers must not be opened, emptied or cleaned manually. Policies may be located in the office OSHA manual. If yes, 2 points; if no, 0 points
7	Is there a written OSHA exposure control plan that includes universal precautions and blood-borne pathogen exposure procedures for staff?	A written policy should be in place detailing the process to protect staff from exposure to hazardous waste materials and the cleanup/disposal of same. Are MSDS sheets available? If yes, 2 points; if no, 0 points
8	Is a copy of the *Clinical Laboratory Improvement Amendments (CLIA)* Certificate or Certificate of Waiver if applicable posted? **If the PCP provides Texas Health Steps services, must have *CLIA*/waiver or lab services within the same building**.	If the provider offers laboratory services that require a *CLIA* or Certificate of Waiver, the current notice should be posted and a copy obtained and attached to the site visit form. If yes, 1 point; if no, 0 points
9	Is there a copy of the current radiology services certification or licensure if applicable posted?	If the provider offers radiology services, current licensure and/or certification must be posted and copy obtained and attached to the site visit form. Are pregnancy signs posted? If yes, 1 point; if no, 0 points
10	If the provider employs nurse practitioners, physicians' assistants, or other mid-level providers that will assess health care needs of members, do they have written policies describing the duties and supervision of such providers?	A written policy should be available describing the level/type of care provided by the mid-level practitioners within the physician's/practitioner's office and the level/type of supervision of same. If yes, 2 points; if no, 0 points

***HIPAA* requirements/regulations**		
1	Is there a written policy and procedure addressing permitted uses/disclosures and required disclosures of patient personal health information (PHI)/individually identifiable heath information (IIHI)?	There should a written policy and procedure addressing permitted uses and disclosures as well as required disclosures of patient PHI/IIHI, as required by *HIPAA* regulations. Providers should have appropriate forms available for members and patients. If yes, 2 points; if no, 0 points
2	Does the provider have authorization forms available to designate personal representative(s) to which PHI/IIHI may be released and/or disclosed?	Does the provider have an authorization form for disclosure of PHI/IIHI, as required by *HIPAA* regulations? Form should include an expiration date. Forms should also include description of how members/patients may revoke authorization in writing. If yes, 2 points; if no, 0 points
3	Are there physical safeguards in place to protect the privacy of patient PHI/IIHI?	There should be no papers with PHI in areas accessible to other patients. Examples: All patient information is securely placed in locked cabinet. No confidential information is left out in the open for other patients or staff members to see (for example, patient sign-in sheet). Is there a shredding machine and policy on storage and disposal of medical records? Computer has safeguards in place: security codes for access, safety. If yes, 2 points; if no, 0 points
4	Is there a designated compliance and privacy person?	**You must include the name of the individual in the space provided on the site evaluation form.** If yes, 2 points; if no, 0 points

Office evaluation		
1	Is there an approved process for biohazardous disposal?	There is a written policy for biohazardous waste disposal in a manner that protects employees from occupational exposure. Biohazardous waste includes liquid or semi-liquid blood or other potentially infectious materials. Bio-hazardous items include contaminated items that would release blood if compressed, items caked with blood, contaminated sharps, and pathological and microbiological waste. If yes, 2 points; if no, 0 points
2	Are pharmaceutical supplies and medication stored in a locked area that is not readily accessible to patients?	• Medications are in a locked area, including samples. • Prescription pads are kept in a secured location away from patient access; pads should not be found in exam rooms or left on countertops unsupervised by office staff. If yes, 2 points; if no, 0 points
3	Is there a plan/procedure for narcotic inventory, control and disposal?	There is a plan to randomly check that sample medications are current, and there is a procedure for disposing of expired medications — wasting of medications. If yes, 1 point; if no, 0 points
4	Are vaccines and other biologicals refrigerated as appropriate?	If refrigeration is required for medication, there is a separate space provided. There should be no other items — including food and biological specimens — on the same shelf as medication (preferably these are in a separate refrigerator). Look for Penny Test in freezer to document power outages. If yes, 1 point; if no, 0 points
5	Is emergency equipment available? If not, note how the staff accommodates emergency situations.	The minimum requirement is an oral airway and Ambu bag (for children and/or adults based on age range). If the office has an emergency kit or cart, check for routine inspections and expired supplies or medications. If yes, 1 point; if no, 0 points
6	Observe 2-3 office staff interactions: Are they professional and helpful? Are CPR-trained staff in the office at all times when patients are present?	If yes, 2 points; if no, 0 points

10.9 Culturally and linguistically appropriate services

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

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

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

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

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

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.

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

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

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

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

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

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

Cultural competency training and other resource materials are available at **https://provider.amerigroup.com/TX**.

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

10.10 Early Childhood Intervention (ECI)

We contract with qualified ECI providers to provide ECI covered services to eligible members from birth to 3 years of age. Members are permitted to self-refer to local ECI service providers without a referral from the member's PCP. Our providers are required to identify and provide referral information to the legally authorized representative (LAR) of any member birth to 3 years of age suspected of having a developmental disability or delay, or otherwise meeting eligibility criteria for ECI services in accordance with 40 TAC Chapter 108, within seven calendar days from the day the provider identifies the member. HHSC provides information and publications on its website at **https://hhs.texas.gov/services/disability/early-childhood-intervention-services,** which should be used as resources by providers to identify children in need of ECI services. The local ECI program will determine eligibility for ECI services using the criteria contained in 40 TAC Chapter 108.

The member's LAR must be informed that ECI participation is voluntary. Amerigroup must provide medically necessary services to a member if the member's LAR chooses not to participate in ECI.

The Individual Family Service Plan (IFSP) is an agreement developed by an interdisciplinary team that includes the member's LAR, the ECI service coordinator, ECI professionals directly involved in the eligibility determination and member assessment, ECI professionals who will be providing direct services to the child, and other family members, advocates, or other persons as requested by the LAR. If the member's LAR provides written consent, the member's PCP or Amerigroup staff may be included in IFSP meetings. The IFSP identifies the member's present level of development based on assessment, describes the services to be provided to the child to meet the needs of the child and the family, and identifies the person or persons responsible for each service required by the plan.

The IFSP is a contract between the ECI contractor and the member's LAR. The LAR signs the IFSP to consent to receive the services established by the IFSP. The IFSP contains information specific to the member as well as information related to family needs and concerns. If the member's LAR provides written consent, the ECI program may share a copy of IFSP sections relevant only to the member with Amerigroup and the PCP to enhance coordination of the plan of care. These sections of the IFSP may be included in the member's medical record or service plan.

The IFSP is the authorization for the program-provided services (in other words, services provided by the ECI contractor) included in the plan. Prior authorization 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 behavioral health

program-provided services contained in the IFSP must be provided to the member in the amount, duration, scope, and service setting established by the IFSP. Medical diagnostic procedures required by ECI, including diagnostic specific evaluations so ECI can meet the 45-day timeline established by federal rule, will be covered by Amerigroup.

ECI providers must submit claims for all program-provided, covered services outlined in the IFSP to Amerigroup. Amerigroup must pay claims for ECI covered services in the amount, duration, scope, and service setting established by the IFSP.

Amerigroup coordinates with local ECI programs that perform assessment, case management and non-health related services required by a member's IFSP when needs are identified (or as requested). ECI Targeted Case Management services and ECI Specialized Skills Training are not MCO capitated services, as described in the Texas Uniform Managed Care Contract (UMCC), Section 8.2.2.8, and the STAR Kids Managed Care Contract, Section 8.1.24.8. Amerigroup is not responsible for payment of these services; ECI providers are to bill Texas Medicaid & Healthcare Partnership (TMHP).

10.11 Eligibility verification

PCPs can obtain listings of members assigned to their panels through the Provider Online Reporting application that is accessed through Payer Spaces on Availity Essentials at **Availity.com**. If a member calls Amerigroup to change their PCP, the change will be effective the same business day. The PCP should verify that each Amerigroup member receiving treatment in their office is on the membership listing. For questions regarding a member's eligibility, providers may visit **Availity.com** (select Patient Registration > Eligibility & Benefits) or call the automated Provider Inquiry Line at **800-454-3730**.

10.12 Emergency services

We provide a 24-hour Nurse HelpLine with clinical staff to provide triage advice and referrals (if necessary) and to make treatment arrangements for the member. The service is available 24 hours a day, 7 days a week. The staff has access to qualified behavioral health professionals to assess behavioral health emergencies.

We encourage members to contact their PCP in situations where urgent, unscheduled care is necessary. If you are unable to see the member, you can refer them to one of our participating urgent care centers. If the member needs care during nonbusiness hours, they can be seen by a provider who participates in our after-hours care program. Prior authorization by Amerigroup is not required for a member to access a participating urgent care center or a provider participating in our after-hours care program.

We do **not** discourage members from using the 911 emergency system, and we do not deny access to emergency services. Emergency services are provided to members without requiring prior authorization. Any hospital or provider calling for an authorization for emergency services will be granted one immediately upon request. Emergency services coverage includes services that are needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical care could result in:

- Serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child).
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement.

An emergency behavioral health condition is defined as any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing average knowledge of medicine and health:

- Requires immediate intervention and/or medical attention without which the member would present an immediate danger to themselves or others.
- Renders the member incapable of controlling, knowing, or understanding the consequences of their actions.

Emergency response is coordinated with community services, including the following (if applicable):

- Police, fire, and EMS departments
- Juvenile probation
- The judicial system
- Child protective services
- Chemical dependency agencies
- Emergency services
- Local mental health authorities

When a member seeks emergency services at a hospital, we request immediate notification by network hospitals of emergent admissions. Our Medical Management staff will verify eligibility and determine benefit coverage. The determination as to whether the need for those services exists will be made for purposes of treatment. The determination is made by a physician licensed to practice medicine or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of, or in collaboration with, a physician licensed to practice medicine. The physician or other appropriate personnel will indicate the results of the emergency medical screening examination in the member's chart. We will compensate the provider for the screenings, evaluations and examinations that are reasonable and calculated to assist the provider in determining whether or not the patient's condition is an emergency medical condition.

If there is concern surrounding the transfer of a patient (in other words, whether the patient is stable enough for discharge or transfer or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) actually caring for the patient at the treating facility prevails and is binding on Amerigroup. If the emergency department is unable to stabilize and release the member, we will assist in coordination of the inpatient admission, regardless of whether the hospital is network or non-network. All transfers from non-network to network facilities are to be conducted only

after the member is medically stable and the facility is capable of rendering the required level of care. The transferring facility should make all attempts to transfer our members to a network facility. If the member is admitted, the Amerigroup concurrent review nurse will implement the concurrent review process to ensure coordination of care.

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

10.13 Fraud, waste, and abuse

First line of defense against fraud
We are committed to protecting the integrity of our health care program and the effectiveness of our operations by preventing, detecting, and investigating fraud, waste, and abuse. Combating fraud, waste, and abuse begins with knowledge and awareness.

- *Fraud* — Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it — or any other person. The attempt itself is fraud, regardless of whether or not it is successful.
- *Waste* — Includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions but, rather, occurs when resources are misused.
- *Abuse* — When health care providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

Importance of detecting, deterring, and preventing fraud, waste, and abuse
Health care fraud costs taxpayers increasingly more money every year. There are state and federal laws designed to crack down on these crimes and impose strict penalties. Fraud, waste, and abuse in the health care industry may be perpetuated by every party involved in the health care process. There are several stages to inhibiting fraudulent acts including detection, prevention, investigation, and reporting. In this section, we educate providers on how to help prevent member and provider fraud by identifying the different types.

Examples of provider fraud, waste, and abuse:

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering, or receiving kickbacks or bribes
- Unbundling — when multiple procedure codes are billed individually for a group of procedures that should be covered by a single comprehensive procedure code
- Upcoding — when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

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

Examples of member fraud, waste, and abuse:

- Forging, altering, or selling prescriptions
- Letting someone else use the member's ID (identification) card
- Relocating to out-of-service plan area and not letting us know
- Using someone else's ID card

To help prevent fraud, waste, and abuse, providers can assist by educating members. For example, spending time with patients and reviewing their records for prescription administration will help minimize drug fraud and abuse. One of the most important steps to help prevent member fraud is simply reviewing our member ID card; it's the first line of defense against fraud. We may not accept responsibility for the costs incurred by providers rendering services to a patient who is not a member, even if that patient presents an Amerigroup member ID card. Providers should take measures to ensure the cardholder is the person named on the card.

Additionally, encourage members to protect their Amerigroup member ID card as they would a credit card or cash. Members should carry their ID card at all times and report any lost or stolen cards to us as soon as possible. Members can also utilize a digital ID card available in their secure member website account or in the Sydney Health app instead of a physical card. Understanding the various opportunities for fraud and working with members to protect their health benefit ID card can help prevent fraudulent activities. If you or a patient suspect ID theft, call Provider Services at **800-454-3730**.

Learn more about health care fraud at **fighthealthcarefraud.com**.

10.13.1 Fraud reporting information

Reporting waste, abuse, or fraud by a provider or member

Medicaid Managed Care and CHIP

Do you want to report waste, abuse, or fraud?
Let us know if you think a doctor, dentist, pharmacist at the drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid or CHIP ID.
- Using someone else's Medicaid or CHIP ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse, or fraud, choose one of the following:

- Call the OIG Hotline at **800-436-6184**.

- Visit **https://oig.hhs.texas.gov/** and select the red **Report Fraud** box to complete the online form.
- Report directly to your health plan:

Compliance Officer
Amerigroup
2505 N. Highway 360, Suite 300
Grand Prairie, TX 75050
800-839-6275

Other reporting options include:

- Amerigroup Provider Services: **800-454-3730**
- Special Investigations Fraud Hotline: **866-847-8247** (reporting can be anonymous)
- Visiting our **fighthealthcarefraud.com** education site; at the top of the page, select **Report it** and complete the ***Report Waste, Fraud and Abuse*** form

To report waste, abuse, or fraud, gather as much information as possible.
When reporting about a provider (a doctor, dentist, counselor, etc.), include:

- Name, address, and phone number of provider.
- Name and address of the facility (hospital, nursing home, home health agency, etc.).
- Medicaid number of the provider and facility if you have it.
- Type of provider (doctor, dentist, therapist, pharmacist, etc.).
- Names and phone numbers of other witnesses who can help in the investigation.
- Dates of events.
- Summary of what happened.

When reporting about someone who receives benefits, include:

- The person's name.
- The person's date of birth, Social Security number, or case number if you have it.
- The city where the person lives.
- Specific details about the waste, abuse, or fraud.

10.13.2 Fraud investigation process

We investigate all reports of fraud, abuse, and waste for all services provided under the contract, including those services subcontracted to outside entities. If appropriate, allegations and the investigative findings are reported to all appropriate state, regulatory, and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste, or abuse, which may include, but is not limited to:

- *Written warning and/or education*: We send certified letters to the provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries or may advise of further action.
- *Medical record review*: We review medical records to substantiate allegations or validate claims submissions.
- *Special claims review*: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.

- *Recoveries*: We recover overpayments directly from the provider. Failure of the provider to return the overpayment may result in reduced payment of future claims and/or further legal action.

10.13.3 Acting on investigative findings

If you are working with the Special Investigations Unit (SIU), all checks and correspondence should be sent to:

Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Paper medical records and/or claims are a different address, which is supplied in correspondence from the SIU. If you have questions, contact your investigator. An opportunity to submit claims and/or supporting medical records electronically is an option if you register for Availity Essentials. Contact Availity Client Services at **800-Availity (282-4548)** for more information.

Acting on Investigative Findings

If, after investigation, the SIU determines a provider appears to have committed fraud, waste, or abuse, the provider:

- May be presented to the credentialing committee and/or peer review committee for disciplinary action, including provider termination
- Will be referred to other authorities as applicable and/or designated by the State
- The SIU will refer all suspected criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

Failure to comply with program policy or procedures, or any violation of the provider contract, may result in termination from our plan.

If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily disenrolled from our health plan, with state approval.

10.13.4 General obligation to prevent, detect and deter fraud, waste, and abuse

As recipients of funds from state and federally sponsored health care programs, we each have a duty to help prevent, detect, and deter fraud, waste, and abuse. Our commitment to detecting, mitigating, and preventing fraud, waste and abuse is outlined in our corporate compliance program. As part of the requirements of the federal *Deficit Reduction Act*, each Amerigroup provider is required to adopt our policies on detecting, preventing and mitigating fraud, waste, and abuse in all the federally and state-funded health care programs in which we participate. Electronic copies of this policy are available on our website, **https://provider.amerigroup.com/TX**.

Relevant legislation

To meet the *Deficit Reduction Act* requirements, providers must adopt our fraud, waste, and abuse policies. Additionally, providers must distribute the policies to any staff members or contractors who work with us. If you have questions or would like to have more details concerning our fraud, waste and abuse detection, prevention, and mitigation program, contact our chief compliance officer.

If a network provider receives annual Medicaid payments of at least $5 million (cumulative, from all sources), the network provider must:

- Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the network provider; the policies must provide detailed information about the *False Claims Act*, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims and whistleblower protections under such laws as described in Section 1902(a)(68)(A) of the *Social Security Act*.
- Include as part of such written policies detailed provisions regarding the network provider's policies and procedures for detecting and preventing fraud, waste, and abuse.
- Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A) of the *Social Security Act*, the rights of employees to be protected as whistleblowers, and the provider's policies and procedures for detecting and preventing fraud, waste, and abuse.

False Claims Act

We are committed to complying with all applicable federal and state laws, including the federal *False Claims Act (FCA)*. The *FCA* is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the *FCA*, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of $5,500 to $11,000 per false claim.

The *FCA* also contains Qui Tam or *whistleblower* provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government, or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the *FCA* and may be entitled to a percentage of the funds recovered by the government.

10.14 ImmTrac2

ImmTrac2 is the DSHS statewide immunization and tracking database system that:

- Consolidates immunization records from multiple providers into one easily accessible record.
- Enables immunization providers to review patient immunization histories (providing records have been forwarded to the system) and enter information on administered vaccines.
- Assists providers in dealing with complex vaccination schedule requirements and produces recall and reminder notices for vaccines that are due and overdue.

Providers are required to:

- Submit immunization information to ImmTrac2.
- Obtain written consent to release a child's individual immunization data to ImmTrac2.
- Verify the Texas birth certificate registration form includes a parental consent statement.

Providers should register with ImmTrac2 at **dshs.texas.gov/immunize/immtrac**.

10.15 Laboratory Services (Outpatient)

All outpatient laboratory tests should be performed at an Amerigroup-preferred network lab (LabCorp, Clinical Pathology Laboratories (CPL) or Quest Diagnostics) or a network facility outpatient lab. The exception to this requirement is when the service being performed is a *Clinical Laboratory Improvement Amendments (CLIA)*-approved office test or for Texas Health Steps. Visit the CMS website at **cms.gov** for a complete list of *CLIA*-approved tests.

CLIA requires all laboratories serving Medicaid clients to maintain a certificate of registration or a certificate of waiver. Those laboratories with a certificate of waiver may only provide the following nine tests:

1. Dipstick or tablet reagent urinalysis for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen
2. Fecal occult blood
3. Ovulation tests
4. Urine pregnancy tests
5. Erythrocyte sedimentation rate, nonautomated
6. Hemoglobin-copper sulfate, nonautomated
7. Blood glucose by glucose monitoring devices cleared by the FDA specifically for home use
8. Spun microhematocrit
9. Hemoglobin by single analyte instruments with self-contained or component features to perform specimen/reagent interaction, providing direct measurement and readout

If a laboratory test cannot be directed to or provided by a network provider, prior authorization is required for coverage.

Texas Health Steps requires providers to use Texas Department of State Health Services (DSHS) laboratory services for specimens obtained as part of a Texas Health Steps medical checkup, including Texas Health Steps newborn screens, blood lead testing, hemoglobin electrophoresis and total hemoglobin tests processed at the Austin Laboratory. Providers may submit specimens for glucose, cholesterol, HDL, lipid profile, HIV, and rapid plasma reagin (RPR) to the DSHS laboratory or to a laboratory of the provider's choice. Hematocrit may be performed at the provider's clinic if the provider needs an immediate result for anemia screening. The Texas Health Steps online provider training modules referencing specimen collection on the DSHS website and the *Texas Medicaid Provider Procedures Manual*, *Children Services Handbook*, should be referenced for the most current information and any updates.

10.16 Locum tenens

We allow reimbursement of locum tenens physicians in accordance with CMS guidelines, subject to benefit design, medical necessity, and authorization guidelines.

We will reimburse the member's regular physician or medical group for all services (including emergency visits) of a locum tenens physician during the absence of the regular physician. This applies in cases where the regular physician pays the locum tenens physician on a per diem or similar fee-for-time basis. Reimbursement to the regular physician or medical group is based on the applicable fee schedule or contracted rate. The locum tenens physician may not provide services to a member for more than a period of 60 continuous days.

A member's regular physician or medical group should bill the appropriate procedure code(s) identifying the service(s) provided by the locum tenens physician. A modifier Q6 must be appended to each procedure code.

If a locum tenens physician only performs postoperative services furnished during the period covered by the global fee, these services are not identified on the claim as substitution services. Additionally, these services do not require modifier Q6.

10.17 Member missed appointments

Amerigroup members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. We require providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling the appointment. The contact must be by telephone, allowing the provider to educate the member about the importance of keeping appointments. It's also a good time for the provider to encourage the member to reschedule the appointment.

Amerigroup members who frequently cancel or fail to show up for appointments without rescheduling may need additional education in appropriate methods of accessing care. In these cases, providers can call Provider Services at **800-454-3730** or the local health plan member advocate to address the situation. Our staff will contact the member and provide more extensive education and/or case management as appropriate. Our goal is for members to recognize the importance of maintaining preventive health visits and adhering to the PCP's recommended plan of care. Providers may not bill us or our members for missed appointments.

10.18 Member record standards

Our providers are required to maintain medical records that conform to good professional medical practice and appropriate health management. A permanent medical record is maintained at the primary care site for every member and is available to the PCP and other providers. Medical records must be kept in accordance with Amerigroup and state standards as outlined below.

The records 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.

Documentation of each visit must include the following:

1. Date of service
2. Complaint or purpose of visit

3. Diagnosis or medical impression
4. Objective finding
5. Assessment of patient's findings
6. Plan of treatment, diagnostic tests, therapies, and other prescribed regimens
7. Medications prescribed
8. Health education provided
9. Signature or initials and title of the provider rendering the service

Note: 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.

These standards will, at a minimum, meet the following medical record requirements:

1. **Patient identification information:** Each page or electronic file in the record must contain the patient's name or patient ID number.
2. **Personal/biographical data**: The record must include the patient's age, sex, address, employer, home and work telephone numbers, and marital status.
3. **Date and corroboration**: All entries must be dated and author-identified.
4. **Legibility**: Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
5. **Allergies**: Medication allergies and adverse reactions must be prominently noted on the record. Absence of allergies (no known allergies — NKA) must be noted in an easily recognizable location.
6. **Past medical history for patients seen 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.
7. **Physical examination:** A record of physical examination(s) appropriate to the presenting complaint or condition must be noted.
8. **Immunizations:** For pediatric records of members age 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.
9. **Diagnostic information:** Documentation of clinical findings and evaluation for each visit should be noted.
10. **Medication information:** This notation includes medication information and instruction(s) to the patient.
11. **Identification of current problems:** Significant illnesses, medical and behavioral health conditions, and health maintenance concerns must be identified in the medical record. A current problem list must be included in each patient record.
12. **Instructions:** The record must include evidence that the patient was provided with basic teaching/instructions regarding physical/behavioral health condition.

13. **Smoking/alcohol/substance use:** A notation concerning cigarettes and alcohol use and substance use must be stated if present for patients age 12 and older. Abbreviations and symbols may be appropriate.
14. **Preventive services/risk screening:** The record must include consultation and provision of appropriate preventive health services and appropriate risk screening activities.
15. **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.
16. **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.
17. **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.
18. **Advance directive:** Medical records of adult patients must document whether or not the individual has executed an advance directive. An advance directive is a written instruction, such as a living will or durable power of attorney, which directs health care decision-making for individuals who are incapacitated.
19. **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.
20. **Release of information:** Written procedures are required for the release of information and obtaining consent for treatment.
21. **Documentation:** Documentation is required setting forth the results of medical, preventive, and behavioral health screening and of all treatment provided and results of such treatment.
22. **Multidisciplinary teams:** Documentation of the team members involved in the multidisciplinary team of a patient needing specialty care is required.
23. **Integration of clinical care:** Documentation of the integration of clinical care in both the physical and behavioral health records is required. Such documentation must include the following:
    - Notation of screening for behavioral health conditions (including those that may be affecting physical health care and vice versa) and referral to behavioral health providers when problems are indicated
    - Notation of screening and referral by behavioral health providers to PCPs when appropriate
    - Notation of receipt of behavioral health 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 behavioral health provider to the PCP

- A written release of information that will permit specific information sharing between providers
- Documentation that behavioral health professionals are included in primary and specialty care service teams when a patient with disabilities, or chronic or complex physical or developmental conditions, has a co-occurring behavioral disorder

10.19 Member's right to designate an OB/GYN

Amerigroup allows the member to pick any Amerigroup OB/GYN, whether that doctor is in the same network as the member's primary care provider or not.

The information below is included in member handbooks:

ATTENTION FEMALE MEMBERS
Members have the right to pick an OB/GYN without a referral from their primary care provider. An OB/GYN can give the member:

- One well-woman checkup each year.
- Care related to pregnancy.
- Care for any female medical condition.
- A referral to a specialist doctor within the network.

For members who also have Medicare, an OB/GYN is selected from Medicare plan providers.

10.20 Noncompliant Amerigroup members

Call Provider Services at **800-454-3730** if you need help working with a member regarding any of the following:

- Behavior
- Treatment cooperation and/or completion
- Appointment compliance

A member advocate will contact the member to address the situation with education and counseling. The outcome of the counseling efforts will be reported back to you.

To remove a member from your panel after efforts with the member have been unsuccessful, you must:

- Not make a removal decision based on the member's health status or utilization of services that are medically necessary for treatment of the member's condition.
- Send a certified letter to the member or head of household stating the member must select a new PCP within 30 days of the notice.
- Send a copy of the letter to:
  Member Advocates
  Amerigroup
  2505 N. Highway 360, Suite 300
  Grand Prairie, TX 75050
- Continue to provide care to the member until the effective date of the assignment to a new PCP.

- Not take any retaliatory action against a noncompliant member.

In extreme situations where a member consistently refuses to cooperate with us and our providers, misuses or loans their member ID card to another person to obtain services, or refuses to comply with managed care restrictions, we may request that HHSC disenroll the member from Amerigroup. If the member disagrees with the disenrollment, they may utilize our member complaint process and the HHSC state fair hearing process.

10.21 Patient visit data

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

- A history and physical exam that includes appropriate subjective and objective information obtained for the presenting complaints.
- Behavioral health treatment that includes at-risk factors (danger to self/others, ability to care for self, affect/perceptual disorders, cognitive functioning, and significant social health) for behavioral health patients.
- An admission or initial assessment that must include current support systems or lack of support systems.
- An assessment for behavioral health patients (performed at each visit) of status/symptoms regarding the treatment process; assessment may indicate initial symptoms of the behavioral health condition as decreased, increased or unchanged during the treatment period.
- A plan of treatment that includes activities/therapies and goals to be carried out.
- Diagnostic tests.
- Therapies and other prescribed regimens for patients who receive behavioral health treatment, including evidence of:
    - Family involvement (as applicable).
    - Family inclusion in therapy sessions when appropriate.
- Follow-up care encounter forms or notes indicating when follow-up care, a call, or a visit (noted in weeks, months or PRN) should occur; notes should include the specific time to return with unresolved problems from any previous visits.
- Referrals and results including all other aspects of patient care, such as ancillary services.

We will systematically review medical records to ensure compliance with these standards. To be considered compliant with medical record performance standards, your medical record score must be 80 percent, including six clinical elements that must be met. We will institute actions for improvement when standards are not met.

We maintain an appropriate record-keeping system for services to members. This system will collect all pertinent information relating to the medical management of each member and make that information readily available to appropriate health professionals and appropriate state agencies. All records will be retained in compliance with applicable federal and state laws and contract requirements.

10.22 Primary care providers

Members that are eligible for both Medicare and Medicaid will receive primary care from their Medicare plan and will not select a Medicaid primary care provider.

10.22.1 Medical home

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

We promote the medical home concept to all of our members. The PCP is the member's and family's initial contact point when accessing health care. The PCP has an ongoing and collaborative contractual relationship with:

- The member and family.
- The health care providers within the medical home.
- The extended network of consultants and specialists with whom the medical home works.

The providers in the medical home are knowledgeable about the member's and family's special, health-related social and educational needs. The medical home providers are connected to community resources that will assist the family in meeting those needs. When a PCP refers a member for a consultation, specialty/hospital services, or health and health-related services through the medical home, the medical home provider maintains the primary relationship with the member and family. They keep abreast of the current status of the member and family through the PCP.

10.22.2 PCP provider types (network limitations)

Physicians with the following specialties can apply for enrollment with us as PCPs:

- Family practitioners
- General practitioners
- General pediatricians
- General internists
- Advanced practice registered nurses (APRNs) and physician assistants (PAs), when practicing under the supervision of a physician specializing in family practice, internal medicine, pediatrics, or obstetrics/gynecology who also qualifies as a PCP
- Nurse practitioners certified as specialists in family practice or pediatrics
- FQHCs, RHCs and similar clinics
- Obstetricians/gynecologists
- Specialist physicians who are willing to provide a medical home to selected members with special needs and conditions
- Indian Health Care Providers (IHCP) for Indian members

The provider must be enrolled in the Medicaid program at the service location where they wish to practice as a PCP before contracting with us for STAR, STAR Kids, and STAR+PLUS.

10.22.3 PCP responsibilities

The PCP is a network physician who has the responsibility for the complete care of their patients, whether providing it himself or herself or by referral to the appropriate provider of care within the network. FQHCs and RHCs may be included as PCPs. The PCP shall:

- Manage the medical and health care needs of members including monitoring and follow-up on care provided by other providers (both in- and out-of-network); providing coordination necessary for referrals to specialists (both in- and out-of-network); and maintaining a medical record of all services rendered, including those rendered by other providers.
- Make referrals for specialty care for members on a timely basis based on the urgency of the member's medical condition, but within no later than 30 calendar days from the date the need is identified or requested.
- Provide 24-hour-a-day, 7-day-a-week coverage in accordance with the ***After-Hours Coverage*** section of this manual; regular hours of operation should be clearly defined and communicated to members.
- Be available to provide medically necessary services.
- Ensure that covering physicians follow the referral/prior authorization guidelines.
- Provide services ethically and legally in a culturally competent manner; meet the unique needs of members with special health care needs.
- Participate in any system established by Amerigroup to facilitate the sharing of records, subject to applicable confidentiality and *HIPAA* requirements.
- Make provisions to communicate in the language or fashion primarily used by their patients.
- Participate and cooperate with Amerigroup in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by Amerigroup.
- Participate in and cooperate with the Amerigroup complaint procedures; we will notify the provider of any member complaint.
- Not balance-bill members; however, the PCP is entitled to collect applicable copays for non-preventive office visits for CHIP members; Medicaid members do not have an out-of-pocket expense for covered services.
- Continue care in progress during and after termination of their contract for up to 90 days until a continuity of care plan is in place to transition the member to another provider or, for pregnant members, through postpartum care in accordance with applicable state laws and regulations.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records.
- Develop and have an exposure control plan, in compliance with Occupational Safety and Health Administration standards, regarding blood-borne pathogens.
- Establish an appropriate mechanism to fulfill obligations under the *Americans with Disabilities Act*.
- Support, cooperate and comply with the Amerigroup Quality Improvement program initiatives and any related policies and procedures.
- Provide quality care in a cost-effective and reasonable manner.
- Inform Amerigroup if a member objects to provision of any counseling, treatments, or referral services for religious reasons.

- Treat all members with respect and dignity; provide members with appropriate privacy and treat member disclosures and records confidentially, giving the member the opportunity to approve or refuse their release.
- Provide members complete information concerning their diagnosis, evaluation, treatment, and prognosis; give members the opportunity to participate in decisions involving their health care, except when contraindicated for medical reasons.
- Advise members about their health status, medical care, or treatment options, regardless of whether benefits for such care are provided under the program.
- Advise members on treatments that may be self-administered.
- When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems, abnormal laboratory, or abnormal radiological findings.
- Have a policy and procedure to ensure proper identification, handling, transport, treatment, and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
- Agree to maintain communication with the appropriate agencies such as local police, social services agencies, and poison control centers to provide high-quality patient care.
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of clinical research shall be clearly contrasted with entries regarding the provision of nonresearch-related care.
- Report any suspicion or allegation of member abuse, neglect, or exploitation in accordance with Texas Human Resources Code §48.051, Texas Health and Safety Code §260A.002 and Texas Family Code §261.101.

We do ***not*** cover the use of any experimental procedures or experimental medications, except under certain circumstances.

10.22.4 After-hours coverage

We encourage PCPs to offer extended office hours to include nights and weekends.

To ensure continuous 24-hour coverage, PCPs must maintain one of the following arrangements after normal business hours:

- Have the office telephone answered after-hours by an answering service that can contact the PCP or another designated network medical practitioner; all calls answered by an answering service must be returned within 30 minutes. The answering service must have both English and Spanish language capability.
- Have the office telephone answered after normal business hours by a recording in both English and Spanish; the recorded message should direct the member to call another number to reach the PCP or another provider designated by the PCP; someone must be available to answer the designated provider's telephone; another recording is not acceptable.
- Have the office telephone transferred after office hours to another location where someone will answer the telephone; the person answering the calls must be able to contact the PCP or a designated Amerigroup network medical practitioner who can return the call within 30 minutes.

The following telephone answering procedures are **NOT** acceptable:

- Answering the office telephone only during office hours
- Answering the office telephone after hours by a recording that tells members to leave a message
- Answering the office telephone after hours by a recording that directs members to go to an emergency room for any services needed
- Returning after-hours calls outside of 30 minutes

10.22.5 New members

We encourage enrollees to select a PCP for preventive and primary medical care. PCPs also ensure authorization and coordination of all medically necessary specialty services. Medicaid members age 20 and younger are encouraged to obtain a well-child visit within 90 days of the date of enrollment. Other members are also encouraged to make an appointment with the PCP within 90 calendar days of their effective date of enrollment. Members who have both Medicaid and Medicare benefits will select a PCP from their Medicare plan.

10.22.6 PCP changes and transfers

We encourage members to remain with their PCPs to maintain continuity of care. However, members may request to change a PCP for any reason by contacting Member Services at **800-600-4441**/STAR Kids: **844-756-4600 (TTY 711)** or through their secure account on the member website at **myamerigroup.com/TX**. The member's name will be provided to the new PCP on the membership roster.

PCP change requests will be processed generally on the same day or by the next business day. Members will receive a new ID card within 10 days.

10.22.7 Specialist as a PCP

Under certain circumstances, a member may require the regular care of a specialist. We may approve that specialist to serve as a member's PCP. The criteria for a specialist to serve as a member's PCP include the member having a disability; special health care needs; or a chronic, life-threatening illness or condition of such complexity whereby:

- The need for multiple hospitalizations exists.
- The majority of care needs to be given by a specialist.
- The administrative requirements arranging for care exceed the capacity of the nonspecialist PCP; this would include members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis, etc.

A member who resides in a nursing facility may also designate a specialist as their PCP.

The specialist must:

- Agree to serve as the member's primary care provider.
- Meet the requirements for PCP participation (including contractual obligations and credentialing).
- Provide 24/7 access to care.
- Coordinate the member's health care, including preventive care.

When such a need is identified, the member or specialist must contact our Case Management department and complete a *Specialist as PCP Request* form. A case manager will review the request and submit it to our medical director. We will notify the member and the provider of our determination in writing within 30 days of receiving the request.

The designation cannot be retroactive. If the request is approved, we will not reduce the compensation owed to the original PCP before the date of the new designation of the specialist as PCP. If we deny the request, however, the member may appeal the decision through our member complaint process. Under that process, we must respond to the member's complaint in writing within 30 days. For further information, call Provider Services at **800-454-3730**.

Members that are eligible for both Medicare and Medicaid will receive primary care from their Medicare plan and will not select a Medicaid primary care provider.

10.22.8 Health Homes

A Health Home is a provider practice that manages all the health care a person needs — physical, mental, and social. The range of Health Home services and supports is more than is normally offered by a primary care provider. This type of person-based approach to care can be of great benefit to persons with one or more serious and ongoing mental or health conditions. The provider practice can be a primary care practice or, in some cases, a specialty care practice. A Health Home uses a team-based approach to improve access, coordination between providers and quality of care.

We will provide access to a Health Home for any member who asks for this service and for any member who would benefit from this type of care. Some of the main kinds of Health Home services are:

- Comprehensive case management
- Care coordination
- Patient self-management education and health promotion
- Transitional care from inpatient or emergency room
- Patient and family-centered care with patient and family support
- Referral to community and social support services
- Use of health information to link services

10.23 Provider disenrollment process

Providers may cease participating with us for either mandatory or voluntary reasons. Mandatory disenrollment occurs when a provider becomes unavailable due to immediate, unforeseen reasons. Examples of this include death or loss of license. Members are assigned to another PCP to ensure continued access to our covered services as appropriate. We will notify members of any termination of PCPs or other providers from whom they receive ongoing care.

We will provide notice to affected members when a provider disenrolls for voluntary reasons such as retirement. Providers must furnish written notice to us within the time frames specified in the *Participating Provider Agreement*. Members linked to a PCP who disenrolled for voluntary reasons will be

notified to select a new PCP. We are responsible for submitting notification of all provider disenrollments to the Texas Health and Human Services Commission (HHSC).

10.24 Provider marketing

Providers are prohibited from engaging in direct marketing to members to increase enrollment in a particular health plan. This, however, should not constrain network providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

Providers must comply with HHSC's marketing policies and procedures as set forth in Chapter 4.3 of the *HHSC Uniform Managed Care Manual*, available at **https://hhs.texas.gov/services/health/medicaid-chip/provider-information/managed-care-contracts-manuals**.

10.25 Provider quality incentive programs

We have provider quality incentive programs to reward PCPs and other provider types for the provision of quality, medically appropriate health care services to our members. The programs vary by the provider's panel size and use of predefined measures, such as HEDIS® and access measures. Providers must be in good standing and meet the eligibility criteria of the given program to participate. For additional information regarding the programs, call your Provider Relations representative.

10.26 Radiology

When both a physician and a radiologist read an X-ray, only the radiologist can submit a claim for reading the film. If the physician feels there's a problem with the reading diagnosis, they should contact the radiological facility to discuss the concern.

10.27 Referrals

Providers shall refer patients to participating providers and facilities when available. We will provide members with timely and adequate access to out-of-network services if those services are necessary and covered but not available within the network.

10.28 Self-referrals

We do not require members to seek a referral from their PCP prior to accessing services from other providers in the Amerigroup network. HHSC specifically requires the services in the table below to be available to members through self-referral.

Service	Authorization for services
Obstetric/gynecological services	• One well-woman checkup each year • Care related to pregnancy • Care for any female medical condition • Referral to specialist doctor within the network
Behavioral health (nonparticipating providers must seek prior approval from Amerigroup)	Members may self-refer to any Amerigroup network behavioral health services provider. No prior approval from the PCP is required. Providers may refer members for services by: • Calling Provider Services at **800-454-3730**. • Faxing referral information to our dedicated behavioral health faxes at **844-430-6805** for inpatient and **844-442-8010** for outpatient. Our staff is available to callers 24 hours a day, 7 days a week, 365 days a year for routine, crisis or emergency calls and authorization requests.
Texas Health Steps	Members may self-refer to any Texas Health Steps-certified provider.
Early childhood intervention (ECI) services	Members may self-refer to local, contracted ECI services providers. Within seven calendar days from the day the provider identifies the member, Amerigroup providers must provide referral information to the legally authorized representative of any member birth to 3 years of age who 1) is suspected of having a developmental disability or delay or 2) otherwise meets eligibility criteria for ECI services in accordance with 40 TAC Chapter 108.
Emergent care	No prior authorization or notification is required, regardless of network status with Amerigroup.
Family planning/sexually transmitted disease (STD)	For STAR, STAR Kids, and STAR+PLUS, no prior authorization or notification is required, regardless of network status with Amerigroup.
Sterilization	No prior authorization or notification is required for sterilization procedures, including tubal ligation and vasectomy, for Medicaid members age 21 and older. A *Sterilization Consent Form* is required for claims submission. Sterilization is not a covered benefit for CHIP members or Medicaid members age 20 and younger.
Tuberculosis, STDs, HIV/AIDS testing and counseling services	No prior authorization or notification is required for these services, regardless of network status with Amerigroup.

10.29 Reporting involvement in legal or administrative proceedings, changes in address, and practice status

Within 30 days of occurrence, a provider shall give written notice to us if they are named as a party in any civil, criminal, or administrative proceeding. Failure to provide such timely notice to us constitutes grounds for termination of the provider's contract with us.

Providers are required to notify us of a change in address or practice status within 10 days of the effective date of the change. Practice status is defined as a change in office hours, panel status, etc. The inclusion of a new address on a recredentialing application is not an acceptable form of notification. The Provider Data Management (PDM) tool in Availity Essentials at **Availity.com** should be used to submit demographic change requests for all professional and facility providers. The HHSC administrative services contractor must also be notified of all demographic changes. A notice of termination must adhere to the advance notice timelines stated in the provider's agreement and be sent to:

Provider Configuration
Amerigroup
P.O. Box 62509
Virginia Beach, VA 23466-2509

10.30 Second opinions

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

The second opinion must be obtained from a network provider or a non-network provider if there isn't a network provider with the expertise required for the condition. Once approved, the PCP will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The PCP will notify the member of the outcome of the second opinion.

We may also request a second opinion at our own discretion. This may occur under the following circumstances:

- Whenever there is a concern about care expressed by the member or the provider
- Whenever potential risks or outcomes of recommended or requested care are discovered by the plan during its regular course of business
- Before initiating a denial of coverage of service
- When denied coverage is appealed
- When an experimental or investigational service is requested

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

10.31 Specialty care providers

To participate in the Medicaid managed care model, the provider must have applied for enrollment in the Texas Medicaid program. The provider must be licensed by the state before signing a contract with us.

We contract with a network of provider specialty types to meet the medical specialty needs of members and provide all medically necessary covered services. The specialty care provider is a network physician who has the responsibility for providing specialized care for members, usually upon appropriate referral from a PCP, within the network. See the ***Specialty Care Providers' Roles and Responsibilities*** section of this manual for more information. In addition to sharing many of the same responsibilities as the PCP (see ***PCP Responsibilities***), the specialty care provider furnishes services that can include any of the following or others:

- Allergy and immunology services
- Burn services

- Community behavioral health (for example, mental health and substance use) services
- Cardiology services
- Clinical nurse specialists, psychologists, clinical social workers (behavioral health)
- Critical care medical services
- Dermatology services
- Endocrinology services
- Gastroenterology services
- General surgery
- Hematology/oncology services
- Neonatal services
- Nephrology services
- Neurology services
- Neurosurgery services
- Oncology services
- Ophthalmology services
- Orthopedic surgery services
- Otolaryngology services
- Pediatric services
- Perinatal services
- Psychiatry (adult) assessment services
- Psychiatry (child and adolescent) assessment services
- Trauma services
- Urology services

10.31.1 Specialty care providers' roles and responsibilities

Responsibilities of specialists contracted with Amerigroup include:

- Complying with all applicable statutory and regulatory requirements of the Medicaid and CHIP programs.
- Accepting all members referred to them.
- Submitting required claims information including source of referral to Amerigroup.
- Arranging for coverage with network providers while off duty or on vacation.
- Verifying member eligibility and prior authorization of services (if required) at each visit.
- Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis following a referral or routinely scheduled consultative visit.
- Notifying the member's PCP when scheduling a hospital admission.
- Coordinating care (as appropriate) with other providers involved in rendering care for members, especially in cases involving medical and behavioral health comorbidities or co-occurring mental health and substance use disorders.

The specialist shall:

- Manage the medical and health care needs of members to encompass:
    - Monitoring and following up on care provided by other providers.
    - Coordinating referrals to other specialists and providers (both in- and out-of-network).

    - Maintaining a medical record of all services rendered by the specialist and other providers.
- Maintain regular hours of operation that are clearly defined and communicated to members.
- Provide services ethically, legally and in a culturally competent manner that meets the unique needs of members with special health care requirements.
- Participate in Amerigroup systems that facilitate record sharing (subject to applicable confidentiality and *HIPAA* requirements).
- Participate in and cooperate with Amerigroup in any reasonable internal or external quality assurance, utilization review, continuing education, or other similar programs established by Amerigroup.
- Make reasonable efforts to communicate, coordinate and collaborate with other specialty care providers (including behavioral health providers) involved in delivering care and services to members.
- Participate in and cooperate with the Amerigroup complaint processes and procedures; we will notify the specialist of any member complaint brought against the specialist.
- Not balance-bill members; however, the specialist is entitled to collect applicable copays for office visits for CHIP members; Medicaid members do not have an out-of-pocket expense for covered services.
- Continue care in progress during and after termination of their contract for up to 90 days until a continuity of care plan is in place to transition the member to another provider or, for pregnant members, through postpartum care; this is to occur in accordance with applicable state laws and regulations.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records.
- Develop and have an exposure control plan regarding blood-borne pathogens in compliance with Occupational Safety and Health Administration standards.
- Make best efforts to fulfill the obligations under the *Americans with Disabilities Act* applicable to their practice location.
- Support, cooperate and comply with Amerigroup Quality Improvement Program initiatives and any related policies and procedures designed to provide quality care in a cost-effective and reasonable manner.
- Inform Amerigroup if a member objects for religious reasons to the provision of any counseling, treatment, or referral services.
- Treat all members with respect, dignity, and appropriate privacy; treating member disclosures and records confidentially and giving members the opportunity to approve or refuse their release as allowed under applicable laws and regulations.
- Provide members complete information concerning diagnosis, evaluation, treatment, and prognosis; give members the opportunity to participate in decisions involving health care, except when contraindicated for medical reasons.
- Advise members about their health status, medical care, or treatment options, regardless of whether benefits for such care are provided under the program.
- Advise members on treatments that may be self-administered.
- Contact members (when clinically indicated) as quickly as possible for follow-up regarding significant problems, abnormal laboratory, or abnormal radiological findings.

- Establish and maintain a policy and procedure to ensure proper identification, handling, transport, treatment, and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
- Agree to maintain communication with the appropriate agencies such as local police, social services agencies, and poison control centers to provide quality patient care.
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention that is part of a clinical research study is clearly distinguished from entries pertaining to nonresearch-related care.
- Within 30 days of occurrence, provide written notice to Amerigroup if the specialist is named as a party in any civil, criminal, or administrative proceeding; failure to provide timely notice to Amerigroup constitutes grounds for termination of the specialist's contract with Amerigroup.
- Report any suspicion or allegation of member abuse, neglect, or exploitation in accordance with *Texas Human Resources Code §48.051, Texas Health and Safety Code §260A.002,* and *Texas Family Code §261.101*.

Note: We do **not** cover the use of any experimental procedures or experimental medications except under certain preauthorized circumstances.

10.32 Texas Department of Family and Protective Services' coordination

Providers are required to cooperate and coordinate with the Texas Department of Family and Protective Services (DFPS) for the care of a member receiving services from or placed in the conservatorship of DFPS. Provider cooperation and coordination are demonstrated by:

- Providing medical records to DFPS.
- Testifying in hearings.
- Scheduling medical and behavioral health appointments within 14 days (unless requested earlier by DFPS).
- Recognizing abuse and neglect and appropriately referring those cases to DFPS.
- Providing all covered services defined in court orders or a DFPS service plan until the member has been disenrolled from Amerigroup.
    - Reasons for disenrollment include loss of Medicaid managed care eligibility or enrollment in STAR Health (HHSC's managed care program for children in foster care).

10.33 Texas Vaccines for Children program

The Texas Vaccines for Children (TVFC) program provides free vaccines for Medicaid and CHIP members from birth through 18 years of age. The free vaccines are provided according to the Recommended Childhood and Adolescent Immunization Schedule established by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP). Vaccines/toxoids must be obtained from TVFC for eligible members from birth through age 18. Providers must enroll in TVFC to obtain the vaccines.

10.34 How to help a member find dental care

The dental plan member ID card lists the name and phone number of a member's main dental home provider. The member can contact the dental plan to select a different main dental home provider at any time. If the member selects a different main dental home provider, the change is reflected immediately in the dental plan's system, and the member is mailed a new ID card within five business days.

If a member does not have a dental plan assigned or is missing a card from a dental plan, the member can call the Medicaid/CHIP Enrollment Broker's toll-free telephone number at **800-964-2777**.

10.35 Cancellation of product orders

If a network provider offers delivery services for covered products, such as durable medical equipment (DME), home health supplies, outpatient drugs, or biological products, the provider must reduce, cancel, or stop delivery at the member's or the member's authorized representative's written or oral request. The provider must maintain records documenting the request.

10.36 Reading/grade level consideration

Millions of Americans are functionally illiterate and many millions more are only marginally literate. Many of our members may have limited ability to understand and read instructions, but most people with literacy problems are ashamed and will try to hide their problem from providers. Low literacy may mean that your patient may not be able to comply with your medical advice and course of treatment because they do not understand your instructions. Materials provided to members should be written at a fourth to sixth grade reading level. Be sensitive to the fact that the member may not be able to read instructions for taking medicine or for treatment and may feel embarrassment about their limited literacy. If interpreter services are needed, call Provider Services at **800-454-3730**.

10.37 *Health Insurance Portability and Accountability Act*

The *Health Insurance Portability and Accountability Act (HIPAA)*, also known as the Kennedy-Kassebaum bill, was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud, and simplifies the administration of health insurance.

We strive to ensure that both Amerigroup and contracted participating providers conduct business in a manner that safeguards member information in accordance with the privacy regulations enacted pursuant to *HIPAA*. Contracted providers must implement procedures that demonstrate compliance with the *HIPAA* privacy regulations. This requirement is described in the following paragraphs.

We recognize our responsibility under the *HIPAA* privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, network providers should only request the minimum necessary member information required to accomplish their intended purpose when contacting us. However, please note that the privacy regulations allow the transfer or sharing of member information (such as a member's medical record), which we may request to conduct business and make decisions about care, make an authorization determination, or to resolve a

payment dispute. Such requests are considered part of the *HIPAA* definition of treatment, payment, or health care operations.

Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to us, verify the receiving fax number is correct, notify the appropriate staff at Amerigroup and verify the fax was appropriately received.

Internet email (unless encrypted) should not be used to transfer files containing member information to us (for example, Excel spreadsheets with claim information). Such information should be mailed or faxed.

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

Our voicemail system is secure and password protected. When leaving messages for our associates, providers should only leave the minimum amount of member information required to accomplish the intended purpose. When contacting us, be prepared to verify the provider's name, address, and tax identification number or Amerigroup provider number.

Medical records standards require that medical records must reflect all aspects of patient care, including ancillary services. The use of electronic medical records must conform to the requirements of *HIPAA* and other federal and state laws.

10.38 Misrouted protected health information (PHI)

Providers and facilities are required to review all member information received from Amerigroup to ensure no misrouted PHI is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email, or electronic remittance advice. Providers and facilities are required to immediately destroy misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please call our Provider Services team at **800-454-3730** for help.

11 Member management support

11.1 Appointment scheduling

Through our participating providers, we ensure members have access to primary care services for routine, urgent, and emergency services as well as specialty care services for chronic and complex care. Providers will respond to an Amerigroup member's needs and requests in a timely manner and must schedule our members for appointments using the guidelines outlined in the ***Appointments*** section of this manual.

11.2 Interpreter services

We can provide interpreter services in many different languages and dialects for members who do not speak English. We will set up and pay for an American Sign Language interpreter to assist members who are deaf or hard of hearing. These services are available at no cost to providers or members. Interpreter services should be requested at least 24 hours before the appointment. Services can be arranged by calling Provider Services at **800-454-3730**.

11.3 Case Management

Our Case Management program is part of a comprehensive health care management services program offering a continuum of services that include case management, care coordination and hospital discharge case management. These programs help reduce barriers by identifying the unmet needs of members and assisting them in meeting those needs. This may involve coordinating care, assisting members to access community resources, providing disease-specific education or any number of interventions designed to improve the quality of life and functionality of members. The programs are designed to make more efficient use of limited health care resources. Participation in case management is voluntary and member consent must be obtained prior to enrollment. All members have the option to opt in or out of case management at any time.

Scope of the Case Management program:

- Member identification and screening
- Initial and ongoing assessment
- Problem-based, comprehensive care planning that includes measurable goals and interventions tailored to the acuity level of the member, as determined by the initial assessment
- Coordination of care with PCPs and specialty providers
- Member education
- Effective member and provider communication
- Program monitoring and evaluation using quantitative and qualitative analysis of data
- Satisfaction and quality of life measurement

Objectives of the Case Management program:

- Maintain a cost-effective case management system to manage the needs of members with increased case management needs in one or more domains (physical, behavioral, or social).
- Empower members and their families by providing information and education that promote condition-specific self-care management to facilitate member behavior change.

- Utilize targeted, high-intensity interventions that include the option of in-person interactions with a specific identified group of members defined by the state as super-utilizers due to excessive utilization patterns.
- Identify barriers that may impede members from achieving optimal health.
- Implement agreed-upon interventions to increase the likelihood of improved health outcomes, improving quality of life.
- Reach out to effectively engage members and their families as partners in the case management process.
- Reduce unnecessary, duplicated and/or fragmented utilization of health care resources.
- Promote collaboration and coordination (at all levels of the health care delivery system) between physical health, behavioral health, the pharmacy program, and community-based social programs.
- Provide members with connection and coordination of community resources to address member needs including social drivers of health throughout the case management process but especially when benefits end, and the member still needs care.
- Foster improved coordination and communication among providers and with Amerigroup staff.
- Improve member and provider satisfaction and retention.
- Comply with applicable contractual and regulatory requirements related to case management.
- Identify opportunities to transition members to more appropriate federal/state programs (for example, STAR to STAR+PLUS).
- Serve as advocates for members.
- Assist members to match available benefits to their health care needs.
- Promote effective strategies to prevent or delay relapse or recurrence through interventions, such as member education and improved member self-management.
- Coordinate case management interventions with ongoing health promotion initiatives, such as dissemination of member education literature.
- Help members and their families mobilize internal and external resources and strengths to improve their health outcomes and manage the costs of care.
- Provide culturally competent case management services to members, families, and providers.
- Maintain the highest quality of ethical standards, including maintenance of confidentiality, in all dealings with members.
- Conduct quality management and improvement activities to ensure the highest possible level of service to members and their families.
- Monitor outcomes of interventions to assist in evaluating and improving programs.

Eligibility for case management

Any Amerigroup member is eligible for case management. Members are identified through continuous case-finding methods that include but are not limited to prior authorization, admission review, internal referrals, and/or provider or member requests.

For STAR+PLUS members who receive services through the ICF-IID program or an IDD Waiver, primary case management responsibilities will remain with the state for development of the service plan and the coordination of services:

- For individuals who live in ICF-IID facilities, the qualified intellectual disabilities professional (QIDP)
- For CLASS and DBMD Waiver members, a case manager

- For HCS and TxHmL Waiver members, a local authority service coordinator

We will also assign these members an Amerigroup personal service coordinator.

Comprehensive member assessment
A case manager will conduct a comprehensive assessment to further determine a member's needs. The assessment will include a range of questions identifying and evaluating the member's:

- Medical condition.
- Functional status.
- Social drivers of health.
- Goals.
- Life environment.
- Support systems.
- Emotional status.
- Capability for self-care.
- Current treatment plan.

Using the structured assessment tool, a case manager will conduct a telephone interview or face-to-face visit to collect and assess information from the member or their representative. To complete the assessment, the case manager will obtain information from the primary care provider and specialists, our continuous case-finding information, and other sources to coordinate and determine current medical needs and needed nonmedical services. This information is used to develop a comprehensive individualized plan of care.

Hours of operation
Our case managers are licensed nurses and social workers available Monday to Friday from 8 a.m. to 5 p.m. local time. Confidential voicemail is available 24 hours a day.

Contact information
To contact a case manager, call Provider Services at **800-454-3730** or your local health plan.

11.4 Members with Special Health Care Needs (MSHCN)

MSHCN means a Medicaid or CHIP member who both:

- Has a serious ongoing illness, a chronic or complex condition, or a disability that has lasted (or is anticipated to last) for a significant period of time.
- Requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel.

Examples are:

- Members diagnosed with respiratory illness (such as COPD, chronic asthma, or cystic fibrosis), diabetes, heart disease, kidney disease, HIV or AIDS.
- Child members receiving ongoing therapy services, which may include physical therapy, speech therapy or occupational therapy (such as for longer than six months).

- Members receiving Community First Choice, Personal Care Services, Private Duty Nursing, or Prescribed Pediatric Extended Care Center services.

MSHCN also include the following:

- Early Childhood Intervention program participants
- Pregnant women who have a high-risk pregnancy including:
    - Age 35 and older, or 15 and younger
    - Diagnosed with pre-eclampsia, high blood pressure or diabetes
    - Diagnosed with mental health or substance use disorders
    - With a previous preterm birth, as identified on the perinatal risk report
- Members who have a mental illness with a substance use disorder
- Members with behavioral health issues, including substance use disorders or serious emotional disturbance (SED) or serious and persistent mental illness (SPMI), that may affect physical health or treatment compliance
- Members with high-cost catastrophic cases or high service utilization such as a high volume of emergency room or hospital visits
- STAR Kids members
- STAR+PLUS members

We have an established system for identifying and contacting members who may have special health care needs. Members may also request to be assessed to determine if they meet the criteria for MSHCN.

For members identified as MSHCN, we provide service coordination, including the development of a service plan, to ensure the provision of covered services meet the special preventive, primary acute care and specialty health care needs appropriate for treatment of the member's condition and provide access to treatment by a multidisciplinary team when needed.

MSHCN members may have a specialist designated to serve as a PCP (see the ***Specialist as a PCP*** section of this manual).

To refer a patient who may qualify as having special health care needs, contact Provider Services at **800-454-3730**.

11.4.1 Service Coordination for STAR and CHIP

STAR and CHIP members who qualify as MSHCN will work with a service coordinator to help get covered care and services to treat a health condition. A qualified service coordinator will work with the member to develop a service plan with the goal of ensuring all the member's care and services work together. A service coordinator will work with the member and providers to help ensure the member receives all needed care and services.

A service coordinator will help the member get needed services by:

- Identifying member health care needs through an assessment.
- Creating a service plan to meet those needs.

- Discussing the service plan with the member, family, and the member's representative (if needed) to make sure the plan is understood and agreed upon.
- Helping the member get needed services.
- Working as a team with the member and providers.
- Making sure all health care and other services the member can get outside of Amerigroup are coordinated.

To contact a service coordinator, call Provider Services at **800-454-3730**. Service coordinators are available Monday through Friday from 8 a.m. to 5 p.m. local time.

11.4.2 Service Coordination for STAR+PLUS and STAR Kids

For information on service coordination for STAR+PLUS and STAR Kids members, refer to the ***Service Coordination*** section of the manual.

11.5 Communicable disease services

We cover communicable disease services to members. Communicable disease services help control and prevent diseases such as tuberculosis (TB), sexually transmitted diseases (STDs), and HIV/AIDS infection. Members can receive TB, STD, and HIV/AIDS services outside of our provider network through the Texas Department of Health and Environmental Control clinics without any restrictions. Providers should encourage members to receive TB, STD, and HIV/AIDS services through Amerigroup to ensure continuity and coordination of their total care.

Providers must report all known cases of TB, STD, and HIV/AIDS infection to the state public health agency within 24 hours. Providers must report all diseases **reportable by health care workers**, regardless of whether the case is also reportable by laboratories.

Control and prevention of communicable diseases
We will coordinate with public health entities in each service area regarding the provision of essential public health care services. We must meet the following requirements:

- Report to public health entities regarding communicable diseases and/or diseases that are preventable by immunization as defined by state law.
- Notify the local public health entity, as defined by state law, of communicable disease outbreaks involving members.
- Coordinate with local public health entities that have a child lead program, or with DSHS regional staff when the local public health entity does not have a child lead program, for follow-up of suspected or confirmed cases of childhood lead exposure.

11.6 Health Promotion

We strive to improve healthy behaviors, reduce illness, and improve the quality of life for our members through comprehensive programs. Educational materials are disseminated to our members, and health education classes are coordinated with community organizations and network providers.

We offer our members education and information regarding their health. Ongoing projects include:

- Annual member newsletter
- Health education publications developed to inform members of condition-specific information and health promotion issues
- Health Tips on Hold (educational telephone messages while the member is on hold)
- Relationship development with community-based organizations to enhance opportunities for members

11.7 Condition Care

Condition Care (CNDC) services are based on a system of coordinated care management interventions and communications. These resources are designed to assist physicians and other health care professionals in managing members with chronic conditions. CNDC services include a holistic, member-centric approach focusing on the needs of the member through telephonic and community-based resources. Motivational interviewing techniques are used in conjunction with member self-empowerment, and the ability to manage more than one condition to meet the changing healthcare needs of our member population. Our condition care programs include:

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder — adult
- Major depressive disorder — child and adolescent
- Schizophrenia
- Substance use disorder

In addition to our condition-specific condition care programs, our member-centric, holistic approach also allows us to assist members with smoking cessation and weight management education.

Program features:

- Proactive population identification processes
- Program content is based on evidence-based national practice guidelines
- Collaborative practice models to include physician and support-service providers in treatment planning for members
- Continuous patient self-management education
- Ongoing communication with providers regarding patient status
- Nine of our Condition Care programs are National Committee for Quality Assurance accredited and incorporate outreach, education, care coordination and follow-up to improve treatment compliance and enhance self-care.

Condition Care *Clinical Practice Guidelines* are located at **https://provider.amerigroup.com/TX** on the *Provider Manuals and Guides* page under *Resources*. A copy of the guidelines can be printed from the website, or you can call Provider Services at **800-454-3730** to receive a copy.

Who is eligible?
Members diagnosed with one or more of the above listed conditions are eligible for Condition Care services.

Our case managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and stratified based on the number of gaps in care/needs identified in the health risk assessment. They are provided with continuous education on self-management concepts related to healthy behaviors and compliance/monitoring as well as case/care management for high-risk members. Providers are given telephonic and/or written updates regarding patient status and progress.

Condition Care provider rights and responsibilities
You have the right to:

- Have information about Amerigroup, including:
  - Provided programs and services.
  - Our staff.
  - Our staff's qualifications.
  - Any contractual relationships.
- Decline to participate in or work with any of our programs and services for your patients.
- Be informed of how we coordinate our condition care-related interventions with your patients' treatment plans.
- Know how to contact the person who manages and communicates with your patients.
- Be supported by our organization when interacting with patients to make decisions about their health care.
- Receive courteous and respectful treatment from our staff.
- Communicate complaints about Condition Care as outlined in the Amerigroup provider complaint procedure.

Hours of operation
Our Condition Care case managers are registered nurses. They are available Monday to Friday from 8:30 a.m. to 5:30 p.m. local time. Confidential voicemail is available 24 hours a day. The 24-Hour Nurse HelpLine is available for our members 24 hours a day, 7 days a week.

Contact information
You can call a Condition Care team member at **888-830-4300**. Condition Care program content is located at **https://provider.amerigroup.com/TX**. Members can obtain information about our CNDC programs by visiting **myamerigroup.com/TX** or calling **888-830-4300**.

11.8 24-Hour Nurse HelpLine

The Amerigroup 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.

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.

Members can reach the 24-Hour Nurse HelpLine at **800-600-4441**/STAR Kids: **844-756-4600**. TTY services are available for members who are deaf or hard of hearing by calling **711**. Language translation services are also available.

11.9 Women, Infants, and Children program

The Women, Infants, and Children (WIC) program provides supplemental food and nutrition education to:

- Pregnant women.
- Women who are breastfeeding a baby under 1 year of age.
- Women who have had a baby in the past six months.
- Parents, step-parents and foster parents of infants and children ages 4 and younger.

These members are automatically eligible for WIC services if they:

- Are Medicaid-eligible.
- Have a family income up to 185 percent of the federal poverty level.

Providers must coordinate with the WIC Special Supplemental Nutrition program to provide medical information necessary for WIC program operations, such as height, weight, hematocrit, or hemoglobin. Please call **800-942-3678** for program details.

11.10 Taking Care of Baby and Me® program

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

Our members have access to pregnancy education, including a Pregnancy and Beyond Resource guide via the Amerigroup member website. When it comes to our pregnant members, we are committed to keeping both mom and baby healthy. That's why we encourage all of our moms-to-be to take part in this program, which offers:

- Individualized, one-on-one case management support for women at the highest risk to improve birth outcomes.
- Care coordination for moms who may need a little extra support.
- Educational materials and information on community resources.
- Incentives for certain checkups (prenatal and postpartum) through the Healthy Rewards program.

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

to necessary services. Members with multiple gestations, histories of preterm delivery (or a current preterm), or who are noncompliant in keeping appointments or following their prescribed plan of care will benefit most from case management.

Taking Care of Baby and Me provides case management to:

- Improve the member's level of knowledge about her pregnancy stage.
- Create systems that support the delivery of quality care.
- Measure and maintain or improve member outcomes related to the care delivered.
- Facilitate care with providers to promote collaboration, coordination, and continuity of care.

Amerigroup encourages notification of pregnancy after the first prenatal visit and notification of delivery following birth. You may choose to complete the notifications of pregnancy and delivery online in Availity Essentials or fax the forms to Amerigroup at **800-964-3627**.

In addition to submitting the Notification of Pregnancy form, we encourage providers to complete the Maternity form in Availity Essentials:

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

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

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

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

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

Our case managers are here to help you. If you have a member in your care that would benefit from case management, call us at **800-454-3730** and ask for an OB or a NICU case manager.

11.11 Texas Health Steps

Texas Health Steps is for children from birth through 20 years of age who have Medicaid. Texas Health Steps provides regular medical and dental checkups and case management services to babies, children, teens, and young adults. Texas Health Steps must be offered for all new members age 20 and younger who are due, soon due or overdue for checkups or case management services. These services must be performed no later than:

- 14 days from the date of enrollment for newborns.
- 90 days from the date of enrollment for all other eligible child members.

The Texas Health Steps annual medical checkup for an existing member 3 years of age (36 months) and older is due on the child's birthday. The annual medical checkup is considered timely if it occurs no later than 364 calendar days after the child's birthday. A checkup for an existing member from birth through 35 months of age is timely if received within 60 days beyond the periodic due date in the *Texas Medicaid Provider Procedures Manual*, based on the member's birth date.

Our members are encouraged to contact their physician within the first 90 days of enrollment to schedule a well-child visit. We encourage physician contact within 24 hours for newborns. Our members are eligible to receive these services from birth through age 20. The program provides the following:

- Comprehensive health and development history
- Physical and mental development assessment
- Comprehensive unclothed physical examination
- Age-appropriate immunizations
- Appropriate laboratory tests
- Health education

Documentation of completed Texas Health Steps components and elements
Each of the six components and their individual elements according to the recommendations established by the Texas Health Steps periodicity schedule for children, as described in the *Texas Medicaid Provider Procedures Manual*, must be completed and documented in the medical record.

Any component or element not completed must be noted in the medical record along with the reason it was not completed and the plan to complete the component or element. The medical record must

contain documentation on all screening tools used for TB, growth and development, autism, and mental health screenings. The results of these screenings and any necessary referrals must be documented in the medical record. THSteps checkups are subject to retrospective review and recoupment if the medical record does not include all required documentation.

THSteps checkups are made up of six primary components. Many of the primary components include individual elements. These are outlined on the Texas Health Steps Periodicity Schedule based on age and include:

1. **Comprehensive health and developmental history,** which includes nutrition screening, developmental and mental health screening, and TB screening:
    - A complete history includes family and personal medical history along with developmental surveillance and screening, and behavioral, social, and emotional screening. The Texas Health Steps Tuberculosis Questionnaire is required annually beginning at 12 months of age, with a skin test required if screening indicates a risk of possible exposure.
2. **Comprehensive unclothed physical examination,** which includes measurements: height or length, weight, fronto-occipital circumference, BMI, blood pressure, and vision and hearing screening:
    - A complete exam includes the recording of measurements and percentiles to document growth and development including fronto-occipital circumference (0-2 years) and blood pressure (3-20 years). Vision and hearing screenings are also required components of the physical exam. It is important to document any referrals based on findings from the vision and hearing screenings.
3. **Immunizations,** as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal and HPV:
    - Immunization status must be screened at each medical checkup and necessary vaccines such as pneumococcal, influenza and HPV must be administered at the time of the checkup and according to the current ACIP Recommended Childhood and Adolescent Immunization Schedule-United States unless medically contraindicated or because of parental reasons of conscience including religious beliefs.
    - The screening provider is responsible for administration of the immunization and is not to refer children to other immunizers, including local health departments, to receive immunizations.
    - Providers are to include parental consent on the Vaccine Information Statement, in compliance with the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac2).
    - Providers may enroll, as applicable, as Texas Vaccines for Children providers. For information, please visit **dshs.texas.gov/immunize/tvfc**.
4. **Laboratory tests**, as appropriate, which include newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia:
    - **Newborn screening**: Send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section in Austin. Providers must include detailed identifying information for all screened newborn members and the member's mother to allow DSHS to link the screens performed at the hospital with screens performed at the newborn follow-up Texas Health Steps medical checkup.
    - Anemia screening at 12 months
    - Dyslipidemia screening at 9 to 12 years of age and again 18 to 20 years of age

- HIV screening at 16 to 18 years of age
- Risk-based screenings include:
    - Dyslipidemia, diabetes, and sexually transmitted infections including HIV, syphilis, and gonorrhea/chlamydia.

5. **Health education** (including anticipatory guidance) is a federally mandated component of the medical checkup and is required in order to assist parents, caregivers, and clients in understanding what to expect in terms of growth and development. Health education and counseling includes healthy lifestyle practices as well as prevention of lead poisoning, accidents, and disease.
6. **Dental referral** every six months until the parent or caregiver reports a dental home is established:
    - Clients must be referred to establish a dental home beginning at 6 months of age or earlier if needed. Subsequent referrals must be made until the parent or caregiver confirms that a dental home has been established. The parent or caregiver may self-refer for dental care at any age.

Use of the THSteps *Child Health Record Forms* can assist with performing and documenting checkups completely, including laboratory screening and immunization components. Their use is optional and recommended. Each checkup form includes all checkup components, screenings that are required at the checkup and suggested, age-appropriate anticipatory guidance topics. They are available online in the resources section at **txhealthsteps.com**.

11.12 Welcome call

As part of our member management strategy, we make welcome calls to new members. Automated call scripts are designed to identify problems encountered by the member with enrollment and initiating services. Based on the answers given by the member during the call, a follow-up call will be performed if needed to resolve any issues. All welcome calls and screenings are performed as required by our contract with HHSC. New members who have been identified through health risk assessment as possibly needing additional services are called and educated regarding the health plan and available services.

11.13 Well-Child Visits Reminder Program

A list of Amerigroup members who, based on our claims data, may not have received well-child services according to schedule is sent to PCPs each month. Additionally, we mail information to these members encouraging them to contact their PCP's office to set up appointments for needed services. Please note the following:

- The specific service(s) needed for each member is listed in the report. Reports are based only on services received during the time the member is enrolled with us.
- Services must be rendered on or after the due date in accordance with federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Texas Department of State Health Services guidelines. In accordance with these guidelines, services received prior to the specified schedule date do not fulfill EPSDT requirements.
- This list of needed services is generated based on our claims data received prior to the date printed on the list. In some instances, the appropriate services may have been provided after the report run date.

- To ensure accuracy in tracking preventive services, please submit a claim through Availity Essentials or send a completed claim form for those dates of service to:

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

11.14 Telemedicine and Telehealth Services

Telemedicine and telehealth services are covered benefits of Texas Medicaid. The use of telemedicine and telehealth services is intended to promote and support Patient-Centered Medical Homes™ and care coordination. We encourage our network providers to offer telemedicine and telehealth capabilities to our members. Information will be included in our provider directories if providers have informed us these services are available. For more details concerning provision of these services, providers should review the *Telecommunications Services Handbook* in the *Texas Medicaid Providers Procedure Manual* (TMPPM) at www.tmhp.com.

Patient-Centered Medical Home™ (PCMH™) is a trademark of the National Committee for Quality Assurance.

"Telemedicine medical service" means a health care service, initiated by a physician who is licensed to practice medicine in Texas under Title 3, Subtitle B of the Occupations Code or provided by a health professional acting under physician delegation and supervision, that is provided for purposes of patient assessment by a health professional, diagnosis or consultation by a physician, or treatment, or for the transfer of medical data, and that requires the use of advanced telecommunications technology, other than telephone or facsimile technology, including:

- Compressed digital interactive video, audio, or data transmission
- Clinical data transmission using computer imaging by way of still-image capture and store-and-forward
- Other technology that facilitates access to health care services or medical specialty expertise

"Telehealth service" means a health service, other than a telemedicine medical service, delivered by a licensed or certified health professional acting within the scope of the health professional's license or certification who does not perform a telemedicine medical service and that requires the use of advanced telecommunications technology, other than telephone or facsimile technology, including:

- Compressed digital interactive video, audio, or data transmission
- Clinical data transmission using computer imaging by way of still-image capture and store-and-forward
- Other technology that facilitates access to health care services or medical specialty expertise

Amerigroup will reimburse telemedicine and telehealth services in accordance with the requirements of Texas Medicaid including:

- Telemedicine and telehealth covered services or procedures will be reimbursed at the same contracted rate as for the same in-person service or procedure.

- Amerigroup will not deny reimbursement for covered telemedicine and telehealth services and procedures delivered by contracted providers solely because an in-person service or procedure did not initially occur between the provider and the member.
- Amerigroup will not limit, deny, or reduce reimbursement for a covered service delivered by a contracted provider solely based on the provider's use of the telemedicine or telehealth platform.
- Federally qualified health centers may be reimbursed for the originating site facility fee, the distant site practitioner fee or both for covered telemedicine and telehealth services.
- Telemedicine and telehealth services must be billed using modifier 95.
- A patient site is the place where the member is physically located. Telemedicine and telehealth eligible originating patient sites are:
    - An established medical site
    - A state mental health facility
    - State supported living centers

A member's home may be the patient site for telemedicine and telehealth services.

- The following are not reimbursable telemedicine or telehealth services:
    - Audio-only communication unless specified as a covered benefit in the *Texas Medicaid Provider Procedures Manual* (TMPPM).
    - Text-only email message.
    - Facsimile transmission.

For questions about telemedicine and telehealth services including contracting questions, call Provider Services at **800-454-3730**.

Notification to Primary Care Provider and Attestation

Medicaid telemedicine and telehealth providers are required to notify the primary care provider of a Medicaid patient receiving telemedicine or telehealth services, provided the patient or their parent/legal guardian consents to the notice. This notice must include a summary of the telemedicine or telehealth service rendered, exam findings, a list of prescribed or administered medications and patient instructions.

Telemedicine and telehealth providers must attest to the MCO that they are providing notice of their telemedicine and telehealth encounters and outcomes to the primary care provider of a Medicaid patient, provided the patient or their parent/legal guardian consents. Telemedicine and telehealth providers must:

- Contact their Provider Relations representative to obtain an *Attestation Form* to complete and return to the representative.
- Obtain consent to the exchange of PHI from the patient or their parent/legal guardian.
- Keep a record of notifications to primary care providers in the patient's medical record.

Telemedicine School-Based Setting

Telemedicine medical services provided in a school-based setting by a physician, even if the physician is not the member's primary care provider, are covered benefits if all the following criteria are met:

- The physician is an authorized health care provider enrolled in Texas Medicaid.
- The member is a child who is receiving the service in a primary or secondary school-based setting.
- The parent or legal guardian of the member provides consent before the service is provided.

Telemedicine medical services provided in a school-based setting are also a benefit if the physician delegates provision of services to a nurse practitioner, clinical nurse specialist, or physician assistant, as long as the nurse practitioner, clinical nurse specialist, or physician assistant is working within the scope of their professional license and within the scope of their delegation agreement with the physician.

Prior authorization is not required for school-based telemedicine medical services.

Telemedicine and Telehealth Service Standards

Access — Amerigroup pays for telemedicine and telehealth care services delivered by care providers contracted with the health plan. The telemedicine and telehealth providers must confirm member eligibility every time members access virtual visits, similar to in-person visits.

Staffing Credentials — All professional staff are certified or licensed in their specialty or have a level of certification, licensure, education, and/or experience in accordance with state and federal laws.

Staff Orientation and Ongoing Training — The telemedicine and telehealth providers must comply with all applicable state, federal, and regulatory requirements relating to their obligations under contract with Amerigroup. Telemedicine and telehealth providers must participate in initial and ongoing training programs including policies and procedures.

Service Response Time — The telemedicine or telehealth provider will comply with the response time requirements outlined in their contract.

Informed Consent — A treating physician or health care professional who provides or facilitates the use of telemedicine medical services or telehealth services shall ensure that the informed consent of the patient, or another appropriate individual authorized to make health care treatment decisions for the patient, is obtained before telemedicine medical services or telehealth services are provided.

Compliance & Security — The telemedicine or telehealth platform should be HIPAA compliant and meets state, federal and 508 compliance requirements. The telemedicine and telehealth providers will conduct all member virtual visits via interactive audio and/or video telecommunications systems using a secure technology platform and will maintain member records in a secure medium, which meets state and federal law requirements for security and confidentiality of electronic patient information.

Certification — Amerigroup strongly encourages providers to obtain CHIQ, URAC or ATA accreditation.

Continuous Quality Improvement (CQI) — The telemedicine and telehealth providers must have a documented CQI program for identifying through data opportunities for real, time measured

improvement in areas of core competencies. There must be demonstrated ties between CQI findings and staff orientation, training, and policies and procedures.

Member Complaints — Telemedicine and telehealth providers are not delegated for complaint resolution but will log, by category and type, member complaints and should refer member complaints to Provider Services.

Regulatory Assessment Results — Amerigroup reserves the right to request access to any applicable regulatory audit results.

Utilization — The telemedicine or telehealth provider will comply with the reporting requirements outlined in their contract.

Electronic Billing/Encounter Coding — The telemedicine or telehealth provider will submit virtual visit encounters or claims with proper coding as part of its existing encounter submission process.

Eligibility Verification — The telemedicine or telehealth provider will use existing eligibility validation methods to confirm virtual visit benefits.

Case Communication — The telemedicine or telehealth provider will support patient records management for virtual visits using existing EMR systems and standard forms. Its EMR records should contain required medical information including referrals and authorizations.

Joint Operating Committee — The telemedicine or telehealth provider will participate in Joint Operations Meetings (JOM) or similar committees with the health plan to review data reports, quality issues, and address any administration issues at least quarterly if applicable.

Professional Environment — The telemedicine or telehealth provider will help ensure that, when conducting virtual visits with members, the rendering care provider is in a professional and private location. The telemedicine or telehealth provider (rendering care provider) will not conduct member virtual visits in vehicles or public areas.

Medical Director — The telemedicine or telehealth provider will employ or engage a licensed care provider as medical director. The medical director is responsible for clinical direction.

All laws regarding the privacy, security and confidentiality of health care information and a patient's rights to their medical information and personal information shall apply to telehealth interactions. This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. Participating providers and facilities shall be solely responsible for ensuring the security and privacy of their interactive audio/video platform. Such platform must at a minimum include technical, administrative, and physical safeguards to ensure that all information pertaining to covered members is protected in accordance with applicable law utilizing controls equivalent to those necessary for compliance with the Health Insurance Portability and Accountability Act ("HIPAA").

11.15 Telemonitoring Services

Telemonitoring services are covered benefits of Texas Medicaid. Home telemonitoring is a health service that requires scheduled remote monitoring of data related to a member's health and transmission of the data from the member's home to a licensed home health agency or hospital. The data transmission standards must comply with standards set by HIPAA.

Home telemonitoring is a benefit for members who have been diagnosed with either diabetes or hypertension or both. Home telemonitoring is also a benefit for members who are 20 years of age or younger, with one or more of the following conditions:

- End-stage solid organ disease
- Organ transplant recipient
- Requiring mechanical ventilation

For more details concerning provision of these services, providers should review the *Telecommunications Services Handbook* in the *Texas Medicaid Providers Procedure Manual* (TMPPM) at **tmhp.com**.

11.16 Patient360

The Patient360 application is an interactive dashboard available through *Payer Spaces* in Availity Essentials at **Availity.com** that gives instant access to detailed information about your Amerigroup patients. By clicking on each tab in the dashboard, you can drill down to specific items in a patient's medical record:

- Demographic information — member eligibility, other health insurance, assigned PCP and assigned case managers
- Care summaries — emergency department visit history, lab results, immunization history, and due or overdue preventive care screenings
- Claims details — status, assigned diagnoses and services rendered
- Authorization details — status, assigned diagnoses and assigned services
- Pharmacy information — prescription history, prescriber, pharmacy, and quantity
- Care management-related activities — assessment, care plans and care goals

To access Patient360, log in to **Availity.com**, select **Amerigroup** under *Payer Spaces*, and it will appear under the *Applications* tab on the bottom portion of the screen. Note: Your organization's Availity Administrator must assign you the P360 role for the application to be accessible.

11.17 Confidentiality of information

Utilization management, case management, condition care, discharge planning, quality management, and claims payment activities are designed to ensure that patient-specific information, particularly protected health information (PHI) obtained during review, is kept confidential in accordance with applicable laws, including *HIPAA*. Information is shared only with entities who have the authority to receive such information and only with those individuals who need access to such information in order to conduct utilization management and other activities and processes listed above.

12 Billing and claims administration

12.1 Claims submission

Providers have three options for submitting claims to us:

- Electronic Data Interchange (EDI)
- Availity Essentials
- Paper

These three methods can also be utilized for long-term services and supports (LTSS) claims for the Medically Dependent Children Program (MDCP) and other waiver program members who are covered by Amerigroup under the STAR Kids program.

Timely filing

Providers must adhere to the following guidelines and time limits for claims to be considered for payment:

- Submit clean claims within 95 calendar days from the date of discharge for inpatient services or within 95 calendar days from the date of service for outpatient services. For LTSS claims with a span of consecutive dates of service, the 95 calendar days begins on the first date in the span.
- In the case of other insurance or coordination of benefits/subrogation, submit clean claims within 95 calendar days of receiving a response from the third-party payer.
- In the case of retroactive member eligibility, submit clean claims within 95 calendar days from the date the member is added to the state's eligibility system but no later than 365 days from the date of service or the inpatient date of discharge.
- For a provider who has a new or changed enrollment in Texas Medicaid, clean claims must be submitted within 95 days of the effective date of the Texas Medicaid enrollment or change but no later than 365 days from the date of service.
- If a provider first submits a claim to the wrong health plan within the 95-day period and produces documentation of the filing, the provider may resubmit the claim to the correct health plan within 95 calendar days of the date of the denial from the wrong health plan.
- Corrected claims must be submitted within 120 days from the date of the *Explanation of Payment (EOP)*.

Note: Claims submitted after the filing timelines outlined above will be denied. We must receive claims from out-of-network providers rendering services outside of Texas within one year of the date of service and/or date of discharge.

Coding

Providers must use *HIPAA*-compliant codes when billing us for electronic, online and paper claim submissions. When billing codes are updated, the provider is required to use appropriate replacement codes. We will not accept claims submitted with noncompliant codes. We edit claims using SNIP Level One through Six edits.

All claims submitted are processed using generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by sources that include the National Correct Coding Initiative, the uniform billing editor, CPT-4 and ICD-10 manuals, and successor documents. In addition, we reserve the right to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure. Our clinical policies and bulletins are posted on our provider website at **https://provider.amerigroup.com/TX**.

International Classification of Diseases, 10th Revision (ICD-10) description
ICD-10 is the code set for medical diagnoses and inpatient hospital procedures in compliance with *HIPAA* requirements and in accordance with the rule issued by the U.S. Department of Health and Human Services (HHS).

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

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

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

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

Clean claim
A clean claim is one submitted for medical care or health care services rendered to a member with the data necessary for Amerigroup, or our subcontracted claims processor, to adjudicate and accurately report the claim. A clean claim must meet all requirements for accurate and complete data as defined in the appropriate 837-(claim type) encounter guides as follows:

- 837 Professional Combined Implementation Guide
- 837 Institutional Combined Implementation Guide
- 837 Professional Companion Guide
- 837 Institutional Companion Guide

Note: Additional clean claim definitions are provided in *21 TAC §21.2803*.

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

- Is submitted timely.
- Is accurate.
- Is submitted in a *HIPAA*-compliant format or using the standard claim form, including a *UB-04 CMS-1450* or *CMS-1500 (02-12)* or successor forms thereto, or the electronic equivalent of such claim form.

- Requires no further information, adjustment, or alteration by the provider or by a third party in order to be processed and paid by us.

CMS-1500 (02-12) and *CMS-1450 (UB-04)* forms must include the following information (*HIPAA*-compliant where applicable):

- Patient's ID number
- Patient's name
- Patient's date of birth
- ICD-10 diagnosis code/revenue codes
- Date of service
- Place of service
- CPT-4 codes/HCPCS procedure codes
- Modifiers
- Diagnosis pointers
- Itemized charges
- Days or units
- Provider's tax ID number
- Total charge
- Provider's name according to the contract
- NPI of billing provider
- Billing provider's taxonomy codes
- NPI of rendering provider
- Rendering provider taxonomy codes
- State Medicaid ID number (optional)
- COB/other insurance information
- Authorization number or copy of authorization
- Name of referring physician
- NPI of ordering/referring/supervising provider when applicable
- Any other state-required data
- National drug codes (NDCs)

As part of our compliance with Texas Medicaid/CHIP contract requirements, ordering/referring claim requirements are applied per Texas Government Code §531.024161 and *Texas Medicaid Provider Procedures Manual* Sections 6.4.2.3 and 6.4.2.4 for all services.

Clean claims are adjudicated within 30 calendar days of receipt (18 days for electronic pharmacy claims submission and 21 days for nonelectronic pharmacy claims). If we do not adjudicate the clean claim within the time frames specified above, we will pay all applicable interest as required by law.

We produce and distribute *Explanation of Payments (EOPs)* on a biweekly basis. The *EOP* delineates the status of each claim that has been adjudicated during the payment cycle.

Paper claims that are determined to be unclean will be returned to the billing provider along with a letter stating the reason for the rejection. Electronic claims that are determined to be unclean will be returned to the organization that submitted the claim.

Deficient claim
Also known as an unclean claim, a deficient claim is one submitted for medical care or health care services rendered to a member that does not contain the data necessary for Amerigroup or our subcontracted claims processor to adjudicate and accurately report the claim.

12.2 Methods of submission

12.2.1 Electronic Data Interchange submission

Amerigroup uses Availity as its exclusive partner for managing all electronic data interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient, and cost-effective way for providers to do business.

Use Availity for the following EDI transactions

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

Ways you can use the Availity EDI Gateway

Availity's EDI submission options:

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

EDI response reports
Claims submitted electronically will return response reports that may contain rejections. If using a clearinghouse or billing vendor, please work with them to ensure you are receiving all reports. It's important to review rejections as they will not continue through the process and require correction and resubmission. For questions on electronic response reports, contact your clearinghouse or billing vendor or Availity at **800-Availity (282-4548)**.

Availity's Payer ID
The Payer ID ensures your EDI submissions are routed correctly when received by Availity.

Payer ID: 26375

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

Electronic Remittance Advice (ERA)
The 835 eliminates the need for paper remittance reconciliation.
Use Availity Essentials to register and manage ERA account changes with these three easy steps:

- Log in to **Availity.com**
- Select **My Providers**
- Select **Enrollment Center** and select **Transaction Enrollment**

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

Electronic Funds Transfer (EFT)
Electronic claims payment through electronic funds transfer (EFT) is a secure and fast way to receive payment and reduce administrative processes. EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation. Use EnrollSafe (**https://enrollsafe.payeehub.org/**) to register and manage EFT account changes.

EDI submission for corrected claims
For corrected electronic claims, use the following frequency code:

- 7 – Replacement of Prior Claim

EDI segments required:

- Loop 2300 - CLM - Claim frequency code
- Loop 2300 - REF - Original claim number

Please work with your vendor on how to submit corrected claims.

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

Useful EDI documentation
Availity EDI Connection Service Startup Guide — This guide includes information to get you started with submitting Electronic Data Interchange (EDI) transactions to Availity, from registration to on-going support.

Availity EDI Companion Guide — This Availity EDI Guide supplements the HIPAA TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity.

Availity Registration Page — Availity Register page for users new to Availity.

X12 Code Sets — X12 code descriptions used on EDI transactions.

12.2.2 Online claims submission

Use the claim submission tool available at no cost for all providers at **Availity.com**. This tool submits claims directly to us without the use of a clearinghouse. Submission via this website requires provider registration.

12.2.3 Paper claims submission

We accept paper claim submissions on the following forms:

- *CMS-1450 (UB-04)* claim form for institutional or facility claim submissions
- *CMS-1500 (02-12)* claim form for professional claim submissions

The forms and instructions are available at the CMS website at **cms.gov**.

We use optical character recognition (OCR) technology as part of our front-end claims processing procedures. Claims must be submitted on original red claim forms (not black and white or photocopied forms) with laser printed or typed (not handwritten) information in a large, dark font. We cannot accept claims with alterations to billing information. Altered claims will be returned to the provider with an explanation of the reason for the return. We will not accept handwritten claims.

Submit paper claims to:

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

12.3 Itemized bills

An itemized bill is required under the following circumstances:

- Any claim that meets or exceeds the stop-loss provision in the provider agreement
- Any claim with charges that meet or exceed $5,000

We cannot accept itemized bills with alterations. Altered itemized bills will be returned to the provider with an explanation of the reason for the return.

Submit all itemized bills to:

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

12.4 Capitation

Providers contracted under capitated reimbursement methodologies receive payment on a per-member, per-month (PMPM) basis. Payment is issued at the beginning of the month for members assigned to the provider. The payment is adjusted for those members retroactively disenrolled by the state. Only services outlined in the contract are reimbursed above the capitation payment. Providers receiving capitation are required to submit encounter data for services covered under capitation.

12.5 Encounter data

Providers reimbursed by capitation must submit encounter data to us for each member encounter. Encounter data must be submitted in a manner similar to claim submissions, as outlined above.

12.6 Claims status

We offer two methods for accessing claim status 24 hours a day, 365 days a year:

- Provider website: **Availity.com**
  - You can check the status of a claim anytime by logging in to Availity Essentials at **Availity.com** and selecting **Claims & Payments**
  - When viewing the status of a claim on Availity Essentials, there may be options available to submit medical records or an itemized bill or dispute the claim.
- Phone: **800-454-3730**

12.7 Provider reimbursement

We can't pay providers or assign Medicaid members to providers for Medicaid services unless they are included on the state master file provided by the Texas Medicaid & Healthcare Partnership (TMHP). State master files are updated weekly.

Federal regulations require state Medicaid agencies to revalidate provider enrollment information every 3 to 5 years. If a provider's re-enrollment is not complete by the required date, the provider will not be able to receive payments for Medicaid services. Compliance with the re-enrollment process is solely the responsibility of the provider. Additional information is available through HHSC and the administrative services contractor.

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)
We offer electronic funds transfer (EFT) and electronic remittance advice (ERA) with online viewing capability. Providers can elect to receive our payments electronically through direct-deposit. In addition, providers can select from a variety of remittance information options including:

- ERA presented online.
- *HIPAA*-compliant data file for download directly to your practice management or patient accounting system.

Process to enroll or update electronic transactions		
Type of transaction	**How to enroll, update, change or cancel**	**Contact to resolve issues**
EFT only	Use EnrollSafe (**https://enrollsafe.payeehub.org/**) to register and manage EFT account changes.	**877-882-0384** support@payeehub.org
ERA only	Register for ERAs at **Availity.com**. Use Availity to register and manage ERA account changes with these three easy steps: 1. Log in to Availity at **Availity.com**. 2. Select **My Providers** 3. Select **Enrollment Center** and select **Transaction Enrollment** ***Note:*** *If you use a clearinghouse, billing service or vendor, please work with them on ERA registration.*	Availity **800-282-4548**

PCP reimbursement
We reimburse PCPs according to their contractual arrangement.

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

Specialty care provider services will be covered only when there is documentation of appropriate notification or prior authorization if required. We must be in receipt of the required claims and encounter information.

12.8 Reimbursement Policies

Reimbursement policies serve as a guide to assist you with accurate claim submissions and outline the basis for reimbursement if services are covered by the member's Amerigroup benefit plan. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines. You are required to use industry-standard, compliant codes on all claims submissions. Services should be billed with appropriate CPT codes, HCPCS

codes and/or revenue codes. The codes denote the service and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup may:

- Reject or deny the claim
- Recover and/or recoup claim payment

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by provider or state contract language or state, federal requirements or mandates. System logic or set-up may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup strives to minimize these variations.

Reimbursement hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursement. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity/clinical criteria, authorization requirements and/or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

Review schedules and updates to reimbursement policies

Reimbursement policies undergo reviews for updates to state contracts, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to an Amerigroup business decision. We reserve the right to review and revise our policies when necessary. When there is an update, we will publish the most current policies to our provider website.

Medical coding

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

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

Reimbursement by code definition

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

1. Evaluation and management
2. Anesthesia

3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Category II codes: supplemental tracking codes that can be used for performance measurement
8. Category III codes: temporary codes for emerging technology, services or procedures

12.9 Outlier reimbursement audit and review process

Requirements and policies
This section includes guidelines on reimbursement to providers and facilities for services on claims paid by diagnosis related group (DRG) with an outlier paid at percent of billed charge or where the entire claim is paid at percent of billed charge.

In addition to any header in this section, please refer to all other service specific sections which may have more stringent guidelines. There may be multiple sections that apply to any given reimbursable service.

Audits/records requests
At any time, a request may be made for on-site, electronic, or hard copy medical records, utilization review documentation, and/or itemized bills related to claims for the purposes of conducting audit or reviews.

Blood, and blood products
Administration of blood or blood products are not separately reimbursable on inpatient claims. Administration charges on outpatient claims are separately reimbursable when submitted without observation/treatment room charges.

Charges for blood storage and processing, thawing fee charges, irradiation, and other processing charges are also not separately reimbursable.

Emergency room supplies and services charges
The Emergency Room level reimbursement includes all monitoring, equipment, supplies, and time and staff charges. Reimbursement for the use of the Emergency Room includes the use of the room and personnel employed for the examination and treatment of patients. This reimbursement does not include the cost of physician services.

Facility personnel charges
Charges for inpatient services for facility personnel are not separately reimbursable, and the reimbursement for such is included in the room and board rate. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), professional therapy functions (including physical, occupational, and speech call back charges), nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Charges for outpatient services for facility personnel are also not separately reimbursable. The reimbursement is included in the payment for the procedure or observation charge.

Implants
Implants are objects or materials which are implanted such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert placed into a surgically or naturally formed cavity of the human body to continuously assist, restore, or replace the function of an organ system or structure of the human body throughout its useful life. Implants include, but are not limited to: stents, artificial joints, shunts, pins, plates, screws, anchors and radioactive seeds, in addition to non-soluble or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the member's body upon discharge from the inpatient stay or outpatient procedure.

Staples, sutures, clips, as well as temporary drains, tubes, similar temporary medical devices and supplies shall not be considered implants. Implants that are deemed contaminated and/or considered waste and/or were not implanted in the member will not be reimbursed.

IV sedation and local anesthesia
Charges for IV sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, is not separately reimbursable and is included as part of the Operating Room (OR) time/procedure reimbursement. Medications used for IV sedation and local anesthesia are separately reimbursable.

Lab charges
The reimbursement of charges for specimen collection are considered facility personnel charges and the reimbursement is included in the room and board or procedure/observation charges. Examples include venipuncture, urine/sputum specimen collection, draw fees, phlebotomy, heel sticks, and central line draws.

Processing fees, handling fees, and referral fees are considered included in the procedure/lab test performed and not separately reimbursable.

Labor care charges
Reimbursement will be made for appropriately billed room and board or labor charges. Payment will not be made on both charges when billed concurrently.

Nursing procedures
Fees associated with nursing procedures or services provided by facility nursing staff or unlicensed facility personnel (technicians) performed during an inpatient (IP) admission or outpatient (OP) visit will not be reimbursed separately. Examples include, but are not limited, to intravenous (IV) injections or IV fluid administration/monitoring, intramuscular (IM) injections, subcutaneous (SQ) injections, IV or PICC line insertion at bedside, nasogastric tube (NG) insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time, etc.) and inpatient blood transfusion administration/monitoring (with the exception of OP blood administration or OP chemotherapy administration which are submitted without observation/treatment room charges).

Operating room time and procedure charges
The operating room (OR) charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes. The operating room charge will reflect the cost of:
The use of the operating room
The services of qualified professional and technical personnel

Personal care items and services
Personal care items used for patient convenience are not separately reimbursable. Examples include but are not limited to: breast pumps, deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste, bedpans, chux, hot water bottles, icepacks, pillows, sitz baths, and urinals.

Pharmacy charges
Reimbursement will be made for the cost of drugs prescribed by the attending physician. Additional separate charges for the administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel will not be reimbursed separately. All other services are included in the drug reimbursement rate. Examples of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees, IV diluents such as saline and sterile water, IV Piggyback (IVPB), Heparin and saline flushes to administer IV drugs, and facility staff checking the pharmacy (Rx) cart.

Portable charges
Portable charges are included in the reimbursement for the procedure, test, or X-ray, and are not separately reimbursable.

Pre-operative care or holding room charges
Charges for pre-operative care or a holding room used prior to a procedure are included in the reimbursement for the procedure and are not separately reimbursed. In addition, nursing care provided in the pre-operative care areas will not be reimbursed separately.

Preparation (set-up) charges
Charges for set-up, equipment, or materials in preparation for procedures or tests are included in the reimbursement for that procedure or test will not be reimbursed separately.

Recovery room charges
Reimbursement for recovery room services (time or flat fee) includes the use of all and/or available services, equipment, monitoring, and nursing care that is necessary for the patient's welfare and safety during their confinement. This will include but is not limited to cardiac/vital signs monitoring, pulse oximeter, medication administration fees, nursing services, equipment, supplies (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

Recovery room services related to IV sedation and/or local anesthesia
Separate reimbursement will not be made for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post procedure room or a phase II recovery (step-down). Examples of procedures include arteriograms and cardiac catheterization.

Supplies and services
Items used for the patient which are needed as a direct result of a procedure or test are considered part of the room and board or procedure charges and are not separately reimbursable.

Any supplies, items, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately reimbursable in the inpatient and outpatient environments.

Special procedure room charge
Special procedure room charges are included in the reimbursement for the procedure. If the procedure takes place outside of the OR suite, then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Example: ICU, GI lab, etc.

Stand-by charges
Standby equipment and consumable items which are on standby, are not reimbursable. Standby charges for facility personnel are included in the reimbursement for the procedure and not separately reimbursable.

Stat charges
Stat charges are included in the reimbursement for the procedure, test, and/or X-ray. These charges are not separately reimbursable.

Supplies and equipment
Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, oxygen, and isolation carts and supplies are not separately reimbursable.

Telemetry
Telemetry charges in ER/ ICU/CCU/NICU or telemetry unit (step-down units) are included in the reimbursement for the place of service. Additional monitoring charges are not reimbursable.

Time calculation
- **Operating Room (OR)**: Time should be calculated on the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes.
- **Hospital/ Technical Anesthesia**: Reimbursement of technical anesthesia time will be based on the time the patient enters the operating room (OR) until the patient leaves the room, as documented on the OR nurse's notes. The time the anesthesiologist spends with the patient in pre-op and the recovery room will not be reimbursed as part of the hospital anesthesia time.
- **Recovery Room**: The reimbursement of recovery room charges will be based on the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit (PACU) record.

- **Post Recovery Room:** Reimbursement will be based on the time the patient leaves the recovery room until discharge.

Video or digital equipment used in operating room
Charges for video or digital equipment used in a surgery are included in the reimbursement for the procedure and are not separately reimbursable. Charges for batteries, covers, film, anti-fogger solution, tapes, etc., are not separately reimbursable.

Additional reimbursement guidelines for disallowed charges
The disallowed charges (charges not eligible for reimbursement) include, but are not limited to, the following, whether billed under the specified revenue code or any other revenue code. These guidelines may be superseded by your specific provider agreement. Please refer to your contractual fee schedule for payment determination.

The tables below illustrate examples of non-reimbursable items/services codes.

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0990 – 0999	Personal Care Items Courtesy/Hospitality Room Patient Convenience Items (0990) Cafeteria, Guest Tray (0991) Private Linen Service (0992) Telephone, Telegraph (0993) TV, Radio (0994) Non-patient Room Rentals (0995) Beauty Shop, Barber (0998) Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room (subject to Member's Benefit)
0221	Admission Charge
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment Used in Operating Room
0270, 0271, 0272	Supplies and Equipment Blood Pressure cuffs/Stethoscopes Thermometers, Temperature Probes, etc. Pacing Cables/Wires/Probes Pressure/Pump Transducers Transducer Kits/Packs SCD Sleeves/Compression Sleeves/Ted Hose Oximeter Sensors/Probes/Covers Electrodes, Electrode Cables/Wires Oral swabs/toothettes; Wipes (baby, cleansing, etc.) Bedpans/Urinals Bed Scales/Alarms Specialty Beds Foley/Straight Catheters, Urometers/Leg Bags/Tubing Specimen traps/containers/kits Tourniquets Syringes/Needles/Lancets/Butterflies Isolation carts/supplies Dressing Change Trays/Packs/Kits Dressings/Gauze/Sponges Kerlix/Tegaderm/OpSite/Telfa Skin cleansers/preps Cotton Balls; Band-Aids, Tape, Q-Tips Diapers/Chucks/Pads/Briefs Irrigation Solutions ID/Allergy bracelets Foley stat lock Gloves/Gowns/Drapes/Covers/Blankets Ice Packs/Heating Pads/Water Bottles Kits/Packs (Gowns, Towels and Drapes) Basins/basin sets Positioning Aides/Wedges/Pillows Suction Canisters/Tubing/Tips/Catheters/Liners

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.) Preps/prep trays Masks (including CPAP and Nasal Cannulas/Prongs) Bonnets/Hats/Hoods Smoke Evacuator Tubing Restraints/Posey Belts OR Equipment (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.) IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, fluid warmers, heparin and saline flushes, etc.)
0220 – 0222, 0229, 0250	Pharmacy Administrative Fee (including mixing meds) Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility) Patient transport fees
0223	Utilization Review Service Charges
263	IV Infusion for therapy, prophylaxis (96365, 96366) IV Infusion additional for therapy IV Infusion concurrent for therapy (96368) IV Injection (96374, 96379)
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) Medication prep Nonspecific descriptions Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges IV Solutions 250 cc or less, except for pediatric claims Miscellaneous Descriptions Non-FDA Approved Medications
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	Specimen collection Draw fees Venipuncture Phlebotomy Heel stick Blood storage and processing blood administration (Rev codes 0380, 0390 – 0392; 0399) Thawing/Pooling Fees
0270, 0272, 0300 – 0309	Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, glucose, etc.)
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	Supplies and Equipment Oxygen Instrument Trays and/or Surgical Packs

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	Drills/Saws (All power equipment used in O.R.) Drill Bits Blades IV pumps and PCA (Patient Controlled Analgesia) pumps Isolation supplies Daily Floor Supply Charges X-ray Aprons/Shields Blood Pressure Monitor Beds/Mattress Patient Lifts/Slings Restraints Transfer Belt Bair Hugger Machine/Blankets SCD Pumps Heal/Elbow Protector Burrs Cardiac Monitor EKG Electrodes Vent Circuit Suction Supplies for Vent Patient Electrocautery Grounding Pad Bovie Tips/Electrodes Anesthesia Supplies Case Carts C-Arm/Fluoroscopic Charge Wound Vacuum Pump Bovie/Electro Cautery Unit Wall Suction Retractors Single Instruments Oximeter Monitor CPM Machines Lasers Da Vinci Machine/Robot
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia Nursing care Monitoring

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	Intervention Pre- or Post-evaluation and education IV sedation and local anesthesia if provided by RN Intubation/Extubation CPR
410	Respiratory Functions: Oximetry reading by nurse or respiratory Respiratory assessment/vent management Medication Administration via Nebs, Metered dose (MDI), etc. Charges Postural Drainage Suctioning Procedure Respiratory care performed by RN
0940 – 0945	Education/Training

12.10 Overpayments

We are entitled to offset an amount equal to any overpayments made by us to a provider against any payments due and payable by us. Overpayments may be identified by our Cost Containment Unit (CCU), an Amerigroup vendor or the provider. When an overpayment is identified by the CCU or an Amerigroup vendor, the provider will receive written notification. The notification will include an *Overpayment Refund Notification Form*, specifying the reason for the return, to be completed by the provider and returned along with the refund check. The submission of the *Overpayment Refund Notification Form* allows us to process and reconcile the overpayment in a timely manner.

Providers must report identified overpayments and submit a refund to Amerigroup within 60 days from the time of identification. HHSC defines *identification* as when the provider has or should have, through reasonable diligence, determined that the provider has received an overpayment and quantified the overpayment amount. Overpayments should be reported, and refunds submitted using the *Overpayment Refund Notification Form* located on the provider website at **https://provider.amerigroup.com/TX** on the *Forms* page.

12.10.1 Provider preventable conditions

We are required to use the present on admission (POA) indicator information submitted on inpatient hospital claims and encounters to reduce or deny payment for provider preventable conditions. This includes any hospital-acquired conditions or health care acquired conditions identified in the *Texas Medicaid Provider Procedures Manual*. Reductions are required regardless of payment methodology and apply to all hospitals, including behavioral health hospitals.

Potentially preventable complications (PPCs) are harmful events or negative outcomes that develop after hospital admission and may result from processes of care and treatment rather than the natural progression of the underlying medical conditions. Potentially preventable re-admissions (PPRs) are return hospitalizations of a person within a period specified by HHSC that results from deficiencies in the care or treatment provided to the person during a previous hospital stay or from deficiencies in post-hospital discharge follow-up.

HHSC sends reports of PPR and PPC performance to Amerigroup including hospital lists, effective dates, and reduction data. We apply those reductions for each hospital on the report, including behavioral health hospitals. Amerigroup notifies each hospital on the list in writing of the applicable reduction amounts. As a payer of last resort, overpayments are subject to recovery and/or recoupment.

12.11 Claim audits

Except as specified in this section or by future changes in our contract with the state of Texas, we must complete all audits of a provider claim no later than two years after receipt of a clean claim, regardless of whether the provider participates in our network. This limitation does not apply in cases of provider fraud, waste, or abuse that we did not discover within the two-year period following receipt of the claim. In addition, the two-year limitation does not apply when an examination, audit, or inspection of a provider by an official or entity we're required, by our contract with the state of Texas, to allow access to records is concluded more than two years after we received the claim. Also, the two-year limitation does not apply when HHSC has recovered a capitation from us based on a member's ineligibility. If any exception to the two-year limitation applies, we may recoup related payments from providers.

If an additional payment is due to a provider as a result of an audit, we must make the payment no later than 30 days after the audit is completed. If the audit indicates we are due a refund from the provider, we must send the provider written notice of the basis and specific reasons for the recovery no later than 30 days after the audit is completed. If the provider disagrees with the refund request, we must give the provider an opportunity to appeal and may not attempt to recover the payment until the provider has exhausted all appeal rights.

12.12 *Coordination of Benefits*

Federal and state laws require Medicaid — including the STAR, STAR Kids, and STAR+PLUS programs — to be the payer of last resort. All other available third-party resources (including Medicare) must meet their legal obligation to pay claims before Medicaid funds are used to pay for the care of an individual eligible for Medicaid. Providers must submit claims to other health insurers for consideration prior to billing us. A copy of the other health insurer's *EOB/EOP* or rejection letter should be submitted with the claim to us. If

we are aware of other third-party resources at the time of claim submission, we will deny the claim and redirect the provider to bill the appropriate insurance carrier. If we become aware of the resource after payment for the service was rendered, we will pursue postpayment recovery.

In accordance with Section 1902(a)(25)(E) and (F) of the *Social Security Act*, we will first pay and then seek recovery from liable third parties for:

- Preventive pediatric care.
- Services provided due to a child support enforcement action.

CHIP member eligibility is based on the absence of any other health insurance, including Medicaid. A patient is not eligible for the CHIP program if they are covered by group health insurance or Medicaid.

We will process claim payments on potential subrogation cases for third-party resources other than health insurance. These cases will be referred to the HHSC administrator to pursue recovery. Any recoveries received on these subrogation cases will be remitted to the HHSC administrator.

12.13 Billing members

Our **members must not be balance billed** for the amount above that which is paid by us for covered services.

In addition, providers may **not** bill a member if any of the following occurs:

- Failure to timely submit a claim, including claims not received by us
- Failure to submit a claim to us for initial processing within the required filing deadline
- Failure to submit a corrected claim within the 120-day filing resubmission period
- Failure to appeal a claim within the 120-day payment dispute period
- Failure to submit a member appeal for a pre-service utilization review determination within 60 calendar days of the date of coverage denial
- Submission of an incomplete claim
- Errors made in claims preparation, claims submission or the appeal process

A member cannot be billed for failing to show for an appointment. Providers may not bill Medicaid members enrolled in Amerigroup for a third-party insurance copay. Medicaid members do not have any out-of-pocket expense for covered services.

Before rendering services, providers should always inform members they will be charged for the cost of services not covered by us. A provider who chooses to deliver services **not covered** by us must:

- Understand we only reimburse for services that are medically necessary, including hospital admissions and other services.
- Obtain the member's signature on the Client Acknowledgment Statement prior to the provision of the services, specifying the member will be held responsible for payment of services.
- Understand they may not bill for or take recourse against a member for denied or reduced claims for services that are within the amount, duration and scope of benefits of the Medicaid program.

12.14 Private Pay Agreement

Providers:

- Must advise members at the time the service is rendered that they are accepted as private-pay patients and, as such, are financially responsible for all services received.
- May bill for any service that is not a benefit of an Amerigroup program (like personal care items) without obtaining a signed Client Acknowledgment Statement.
- May bill a member as a private-pay patient if retroactive eligibility is not granted.
- Must have private-pay members agree in writing (see sample documentation shown below) to avoid being asked questions about how the member was accepted; **without written, signed documentation that the member has been properly notified of the private-pay status, the provider should not seek payment from an eligible program member.**

Sample Private Pay Agreement

"I understand [provider's name] is accepting me as a private-pay patient for the period of _____, and I am responsible for paying for any services I receive. The provider will not file a claim to Medicaid or Amerigroup for services provided to me."

_____ _____

Signed Date

12.15 Client Acknowledgment Statement

Providers may bill an Amerigroup member for a service denied as not medically necessary or not a covered benefit **only if** all of the following conditions are met:

- The member requests the specific service or item.
- The member was notified by the provider of the financial liability in advance of the service.
- The provider obtains and keeps a written acknowledgment statement signed by the member and the provider (as shown on the following page); the signed statement must be obtained prior to the provision of the service in question.

Client Acknowledgment Statement Form

I understand my doctor, _____ , or Amerigroup has said the services
Provider name

or items I have asked for on _____ are not covered under my Amerigroup plan.
Dates of service

Amerigroup will not pay for these services. Amerigroup has set up the administrative rules and medical necessity standards for the services or items I get. I may have to pay for them if Amerigroup decides they are not medically necessary or are not a covered benefit, and if I sign an agreement with my provider prior to the service being rendered, I understand I am liable for payment.

_____ Date: _____
Member name (print)

_____
Member signature

Participating providers may bill a member for a service that has been denied as not medically necessary or not a covered benefit **only if the following conditions are true**:

- The member requests the specific service or item.
- The member was notified by the provider of the financial liability in advance of the service.
- The provider obtains and keeps a written acknowledgment statement signed by the provider and by the member, above, **prior to the service being rendered**.

_____ Date: _____
Provider name (print)

_____
Provider signature

12.16 Cost sharing

12.16.1 Medicaid cost sharing

Medicaid members do not have copays.

12.16.2 CHIP cost sharing

To encourage responsible use of health care services, families are required to share in the CHIP program's cost by paying small copays.

Cost-sharing guidelines include:

- Information about copays and annual reporting caps is based on family income; the CHIP member ID card shows the member's copay amount.
- Members must report to Texas CHIP when they or their family reach the annual reporting cap; once the cap is met, the member will be issued a new ID card.
- Upon verbal notification from the member or presentation of an ID card showing the cost-sharing limit has been met, no copay is collected from the member for the balance of the year.

Cost-sharing guidelines require that providers:

- Only bill for valid, unpaid copays and noncovered services received by the member.
- Promptly refund member overpayments if an incorrect copay was collected for covered services.
- Not collect additional payment once the copay is made.
- Verify eligibility and copay amounts by calling Provider Services at **800-454-3730**.

Cost-sharing exemptions:

- Preventive health care services such as well-child exams, immunizations, and pregnancy-related services are included.
- Mental health or substance use disorder office visit or residential treatment service.
- Enrollment fees and copays do not apply to American Indians, Alaska Natives, CHIP Perinate, and CHIP Perinate newborn members.
- Copays may not be collected in excess of the cost of a covered service.

Refer to the ***Covered Services and Extra Benefits*** section of this manual for additional information on CHIP benefits, limitations, and exclusions. Copay information is shown in the table below.

CHIP Cost-Sharing Schedule

Enrollment fees (for 12-month enrollment period)	**Charge**
At or below 151% of FPL* or otherwise exempt from cost-sharing	$0
Above 151% up to and including 186% of FPL	$35
Above 186% up to and including 201% of FPL	$50
Copays (per visit):	
At or below 151% of FPL	**Charge**
Office visit (nonpreventive) **No copay is applied for mental health/substance use disorder (MH/SUD) office visits**	**$5**
Nonemergency ER	**$5**
Generic drug	**$0**
Brand drug	**$5**
Facility copay, inpatient (per admission) **No copay is applied for MH/SUD residential treatment services**	**$35**
Cost-sharing cap	**5% (of family's income)****
Above 151% up to and including 186% of FPL	**Charge**
Office visit (nonpreventive) **No copay is applied for MH/SUD office visits**	**$20**
Nonemergency ER	**$75**
Generic drug	**$10**
Brand drug **Copays for insulin cannot exceed $25 per prescription for a 30-day supply**	**$25 for insulin, $35 for all other drugs**
Facility copay, inpatient (per admission) **No copay is applied for MH/SUD residential treatment services**	**$75**
Cost-sharing cap	**5% (of family's income)****
Above 186% up to and including 201% of FPL	**Charge**
Office visit (nonpreventive) **No copay is applied for MH/SUD office visits**	**$25**
Nonemergency ER	**$75**
Generic drug	**$10**
Brand drug **Copays for insulin cannot exceed $25 per prescription for a 30-day supply**	**$25 for insulin, $35 for all other drugs**
Facility copay, inpatient (per admission) **No copay is applied for MH/SUD residential treatment services**	**$125**
Cost-sharing cap	**5% (of family's income)****

* The Federal Poverty Level (FPL) refers to income guidelines established annually by the federal government.

** Per 12-month term of coverage.

12.17 CHIP Perinate postpartum billing

Although the mother's eligibility expires after delivery, CHIP Perinate mothers are still eligible to receive two postpartum visits within 60 days of delivery. Providers should submit these claims to receive an incentive fee payment for correctly reporting these encounters. FQHCs and RHCs receive their encounter rate for these services. To ensure receipt of the reporting fee payment and/or the encounter rate, the codes listed below must be used to report postpartum care.

Providers will bill postpartum visits as follows:

- CPT code 59430 (postpartum care only); FQHCs must also bill with the all-inclusive encounter code and required modifiers
- DX code Z39.2 (postpartum care only)

12.18 Emergency services

Prior authorization is not required for coverage of emergency services. Any hospital or provider request for authorization of emergency services is granted immediately. Emergency services coverage includes services that are needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

12.19 Hospital emergency room claim processing

Hospital emergency room claims will be processed as emergent and reimbursed at the applicable contracted rate or valid out-of-network fee-for-service rate when a diagnosis from our designated auto-pay list is billed as the primary diagnosis on the claim. If the primary diagnosis is not on the auto-pay list, the provider must submit medical records with the claim. Upon receipt, the claim and records will be reviewed by a prudent layperson standard to determine if the presenting symptoms qualify the patient's condition as emergent. If the reviewer confirms the visit was emergent, according to the prudent layperson criteria, the claim will pay at the applicable contracted rate or valid out-of-network fee-for-service rate. If it is determined to be nonemergent, the claim will pay a triage fee.

In the event a claim from a hospital is submitted without a diagnosis from the auto-pay list as the primary diagnosis and no medical records are attached, the claim for the ER visit will automatically pay a triage fee.

A copy of the current ER diagnosis auto-pay list is available on our provider website at **https://provider.amerigroup.com/TX** on the *Claims Submissions and Disputes* page. The list of diagnoses is updated as needed.

12.20 Newborn diagnosis-related group claims

All newborn inpatient stays must have sufficient documentation provided to support an admission to an area beyond the newborn nursery, such as a neonatal intensive care unit, an inpatient stay beyond the normal newborn care period or for the higher level of care associated with a more complex newborn diagnosis-related group (DRG). Documentation to support the higher-level admission includes authorization or medical records. Failure to provide the appropriate documentation will result in the claim being processed based on the normal newborn rate.

For newborn claims submitted with only newborn care revenue codes (0170 and 0171) and with no authorization for services provided for a higher level of care to support a higher level of care DRG, the claims will automatically be paid at the normal newborn rate. A claim payment dispute can be submitted with the appropriate supporting clinical documentation in accordance with the ***Complaints, Appeals, and Provider Disputes*** section of this manual.

12.21 Special billing - newborns

When billing a newborn claim, use the newborn's Medicaid ID. If no ID has been assigned yet, call us at **800-454-3730** for assistance. Please do not submit a claim under the mother's global ID.

12.22 Provider payment disputes

Information on the payment dispute process is located in the ***Complaints, Appeals, and Provider Disputes*** section of this manual.

13 Quality Management

13.1 Overview

We maintain a comprehensive Quality Management program to objectively monitor and systematically evaluate the care and service provided to members. The scope and content of the program reflects the demographic and epidemiological needs of the population served. Members and providers have opportunities to make recommendations for areas of improvement. The Quality Management program goals and outcomes are available to both providers and members upon request. Studies are planned across the continuum of care and service with ongoing proactive evaluation and refinement of the program. If you would like more information about our Quality Management program goals, processes and outcomes, call Provider Services at **800-454-3730**.

The initial program development was based on a review of the needs of the population served. Systematic re-evaluation of the needs of the plan's specific population occurs on an annual basis. This includes not only age and gender distribution but also a review of utilization data — inpatient, emergent and urgent care, and office visits by type, cost, and volume. This information is used to define high-volume or problem-prone areas.

HEDIS performance is evaluated annually and compared against national benchmarks. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) evaluates member satisfaction and experience annually. Performance is analyzed for barriers and best practices, and interventions are developed to improve performance.

We maintain a quality committee structure that includes a medical advisory committee (MAC), a credentialing committee (with participation from network physicians and practitioners) and a peer review committee. These committees are overseen by the quality management committee structure.

13.2 Quality management committee

The purpose of the quality management committee (QMC) is to maintain quality as a cornerstone of our culture. The committee serves as an instrument of change through demonstrable improvement in care and service.

The QMC's responsibilities are to:

- Establish strategic direction and monitor and support implementation of the Quality Management program.
- Establish processes and structure that ensure NCQA, HHSC and Texas Department of Insurance (TDI) compliance.
- Review planning, implementation, measurement, and outcomes of clinical/service quality improvement studies.
- Coordinate communication of quality management activities throughout the health plans.
- Review HEDIS data and action plans for improvement.
- Review and approve the annual *Quality Management Program Description*.
- Review and approve the annual work plans for each service delivery area.

- Provide oversight and review of delegated services.
- Provide oversight and review of subordinate committees.
- Receive and review reports of utilization review decisions and take action when appropriate.
- Analyze member and provider satisfaction survey responses.
- Monitor the plan's operational indicators through the plan's senior staff.

13.3 Medical advisory committee

The medical advisory committee (MAC) assesses levels and quality of care provided to members and recommends, evaluates, and monitors standards of care. It oversees the peer-review process that provides a systematic approach for monitoring the quality and appropriateness of care. The MAC conducts a systematic process for network maintenance through the credentialing and recredentialing processes. The MAC advises the health plan administration in any aspect of its policy or operation affecting network providers or members. The MAC approves and provides oversight of the peer-review process, the Quality Management program, and the Health Care Management Services program.

The MAC's responsibilities are to:

- Utilize an ongoing peer-review system to monitor practice patterns, identify appropriateness of care and improve risk-prevention activities.
- Review clinical study design and results.
- Develop action plans and recommendations regarding clinical quality improvement studies.
- Consider and act in response to provider sanctions.
- Provide oversight of credentialing committee decisions to credential and recredential providers for participation in the plan.
- Approve credentialing and recredentialing policies and procedures.
- Oversee member access to care.
- Review and provide feedback regarding new technologies.
- Approve recommendations from subordinate committees.

In addition to the Texas-based MAC, we maintain a super MAC comprised of actively practicing practitioners from each Amerigroup health plan. The super MAC identifies opportunities to improve services and clinical performance. The group establishes, reviews and/or updates national *Clinical Practice Guidelines*. The super MAC is chaired by an Amerigroup national medical director.

13.4 STAR Kids clinical and administrative advisory committees

The STAR Kids clinical and administrative advisory committees (CAACs) provide specialized review, expertise, and consultation on a variety of health issues related to the STAR Kids population. The purpose of these committees is to monitor, evaluate and improve performance and quality of health care services delivered to STAR Kids members.

The CAAC's responsibilities are to:

- Assist Amerigroup in developing, reviewing, and revising policies and procedures and *Clinical Practice Guidelines (CPGs)* based on the needs of STAR Kids members, clinical best practices and community standards.

- Assist Amerigroup in reviewing general clinical practice patterns and assessing provider compliance with clinical guidelines.
- Assist Amerigroup, HHSC and the state's External Quality Review Organization (EQRO) in developing quality improvement strategies and studies.
- Assist Amerigroup in development of improved administrative procedures.
- Provide Amerigroup with recommendations on how to improve care based on member feedback.
- Connect network providers and Amerigroup clinical experts for peer support and sharing of best practices.

13.5 Use of performance data

All providers must allow Amerigroup to use performance data in cooperation with our Quality Management program and activities.

13.6 Credentialing committee

The credentialing committee's purpose is to credential and recredential all participating physicians according to plan, state, and federal accreditation standards.

Committee responsibilities are to:

- Conduct reviews for all providers who apply for participation in the network.
- Review all participating providers for recredentialing purposes, including the review of any quality or utilization data/reports.
- Approve or deny providers submitted by a delegated credentialing entity.
- Review and update credentialing policies and procedures.
- Report physician corrective actions and sanctions imposed based upon recredentialing activity to the MAC.
- Approve or deny providers for participation in the network and report decisions to the MAC.
- Oversee delegated credentialing relationships.

13.7 Peer review

The peer review process provides a systematic approach for monitoring the quality and appropriateness of care.

Peer review responsibilities are to:

- Participate in the implementation of the established peer review system.
- Review and make recommendations regarding individual provider peer-review cases.
- Work in accordance with the executive medical director.

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

Dissatisfaction severity codes and levels of severity are applied to quality issues. The medical director assigns a level of severity to the complaint. Peer review includes investigation of physician actions by or at

the discretion of the medical director. The medical director takes action based on the quality issue and the level of severity, invites the cooperation of the physician, and consults and informs the MAC and peer review committee. The medical director informs the physician of the committee's decision, recommendations, follow-up actions and/or disciplinary actions to be taken. Outcomes are reported to the appropriate internal and external entities, which include the quality management committee. The peer review process is a major component of the MAC monthly agenda. The peer review policy is available upon request.

13.8 *Clinical Practice Guidelines*

Using nationally recognized, scientific, evidence-based standards of care, we work with providers to develop clinical policies and guidelines for the care of members. The super MAC oversees and directs us in formulating, adopting, and monitoring guidelines.

Clinical Practice Guidelines are located on our website at **https://provider.amerigroup.com/TX** on the *Provider Manuals and Guides* page under *Resources*. A copy of the guidelines can be printed from the website, or you may call Provider Services at **800-454-3730** to receive a printed copy.

We select at least four evidence-based *Clinical Practice Guidelines* that are relevant to the member population. We measure performance against at least two important aspects of each of the four *Clinical Practice Guidelines* annually. The guidelines must be reviewed and revised at least every two years or whenever the guidelines change.

13.9 Focus studies and Utilization Management reporting requirements

Quality Management is involved in conducting clinical and service utilization studies that may or may not require medical record review. We conduct gap analysis of the data and share opportunities for improvement with our network providers.

13.10 New technology

Our medical director and participating providers review and evaluate new medical advances in technology (or the new application of existing technology) in medical procedures, behavioral health procedures, pharmaceuticals, and devices to determine their appropriateness for covered benefits. Scientific literature and government approval are reviewed for determining if the treatment is safe and effective. The new medical advance or treatment (or new application of existing technology) must provide equal or better outcomes than the existing covered benefit treatment or therapy for it to be considered for coverage by Amerigroup.

14 Out-of-network providers

14.1 Claims submission

Nonparticipating providers located in Texas must submit clean claims to us within 95 days of service. Nonparticipating providers located outside of Texas must submit clean claims to us within 365 days of the date of service (refer to the definition of clean claim in the ***Billing and Claims Administration*** section of this manual). To submit claims for services provided to Medicaid (STAR, STAR Kids, and STAR+PLUS) members, providers must be enrolled with Texas Medicaid.

14.2 Prior Authorizations

Nonparticipating providers must obtain a prior authorization for any nonemergent services except as prohibited under federal or state law for in-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery or 96 hours following an uncomplicated delivery by Cesarean section. We require prior authorization of maternity inpatient stays for any portion in excess of these time frames.

Prior authorization requests must be submitted by contacting Provider Services at **800-454-3730** or by faxing the request to **800-964-3627**.

14.3 Reimbursement

Nonparticipating providers are reimbursed in accordance with a negotiated case rate or, in absence of a negotiated rate, as follows:

For Medicaid (STAR, STAR Kids, and STAR+PLUS), we reimburse:

- Out-of-network, in-area service providers at no less than the prevailing Medicaid FFS rate, less five percent.
- Out-of-network, out-of-area service providers at no less than 100 percent of the Medicaid FFS rate.

For CHIP, we allow for reimbursement at the usual and customary rate.

14.4 Indian Health Care Providers

Indian members may receive covered services from an out-of-network Indian Health Care Provider (IHCP) if the member is otherwise eligible to receive the services. We will pay for covered services provided to an Indian member by an out-of-network IHCP. For an IHCP that is enrolled in Medicaid as an FQHC, payment will be at a negotiated rate, or in the absence of a negotiated rate, payment will be made at no less than the amount that would be paid to a FQHC network provider that is not an IHCP.

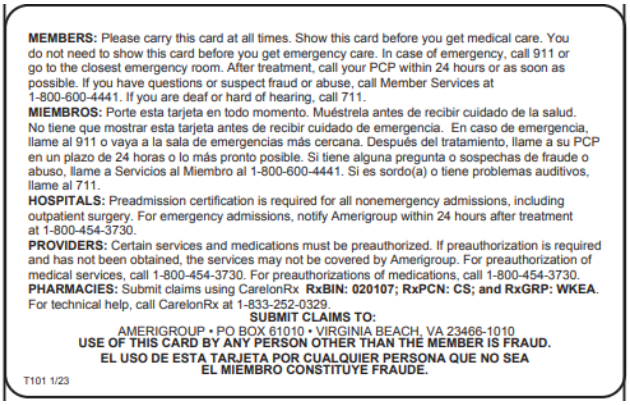
If an IHCP is not enrolled in Medicaid as an FQHC, regardless of whether the IHCP is a network provider, we will pay the IHCP either:

- The applicable encounter rate published annually in the Federal Register by the Indian Health Service.
- In the absence of a published encounter rate, the amount that would be payable under the State Plan in Medicaid FFS.

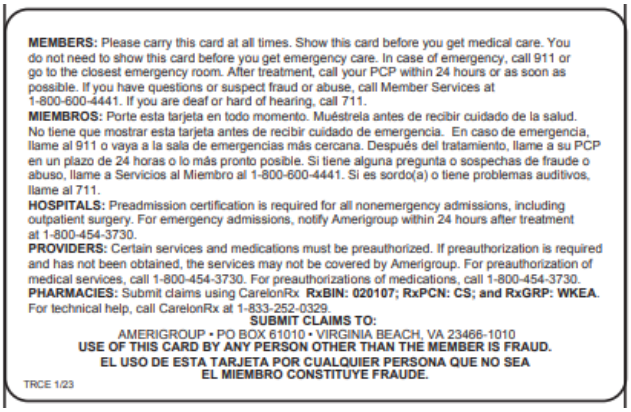
15 Appendix A – ID cards

Identification cards for our STAR Kids and STAR+PLUS members with Medicare do not list a PCP. The phrase **Long-Term Services and Supports Benefits Only** appears on the card. These members are required to obtain their acute care services through Medicare.

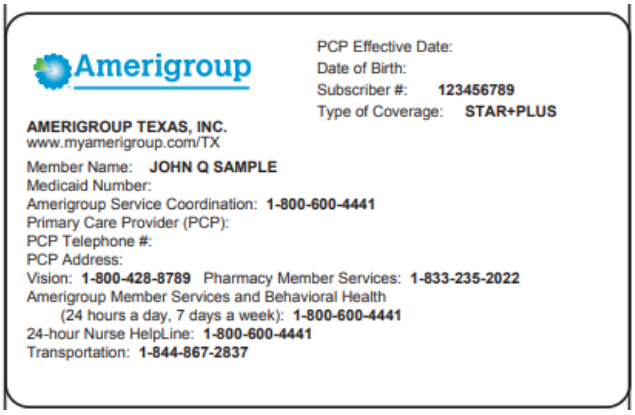
STAR (non-Rural Service Area)

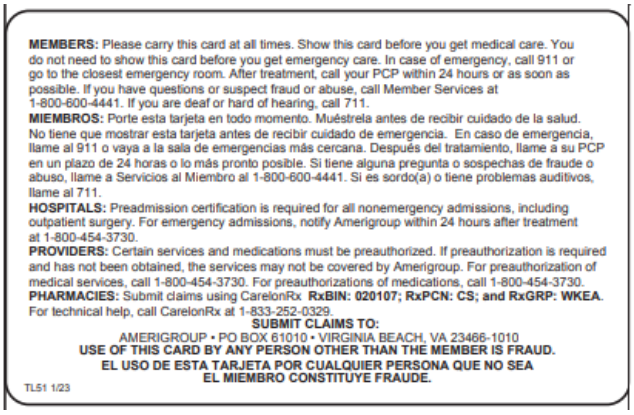


STAR (Rural Service Area)

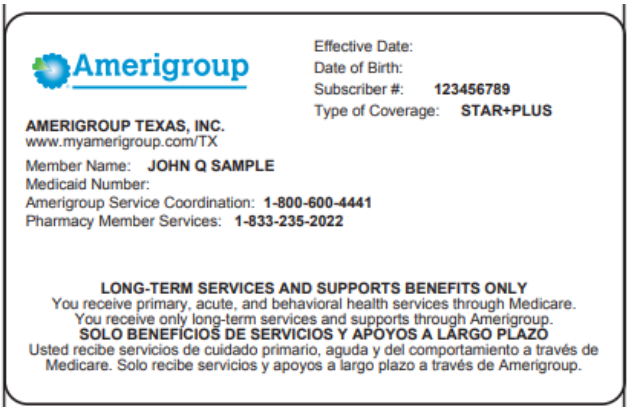


STAR+PLUS (non-duals, non-Rural Service Area)





STAR+PLUS (duals, non-Rural Service Area)



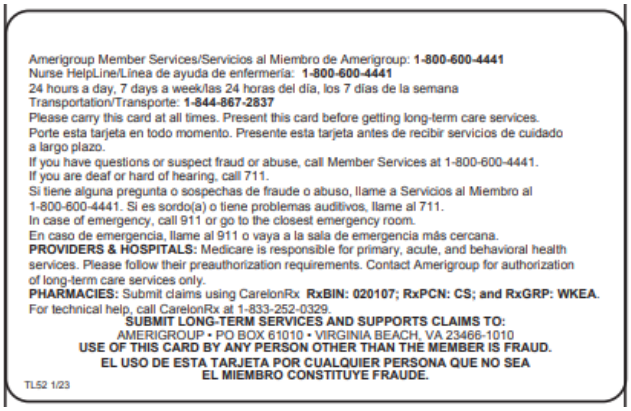
Amerigroup

Effective Date:
Date of Birth:
Subscriber #: **123456789**
Type of Coverage: **STAR+PLUS**

AMERIGROUP TEXAS, INC.
www.myamerigroup.com/TX

Member Name: **JOHN Q SAMPLE**
Medicaid Number:
Amerigroup Service Coordination: **1-800-600-4441**
Pharmacy Member Services: **1-833-235-2022**

LONG-TERM SERVICES AND SUPPORTS BENEFITS ONLY
You receive primary, acute, and behavioral health services through Medicare.
You receive only long-term services and supports through Amerigroup.
SOLO BENEFICIOS DE SERVICIOS Y APOYOS A LARGO PLAZO
Usted recibe servicios de cuidado primario, aguda y del comportamiento a través de Medicare. Solo recibe servicios y apoyos a largo plazo a través de Amerigroup.



Amerigroup Member Services/Servicios al Miembro de Amerigroup: **1-800-600-4441**
Nurse HelpLine/Línea de ayuda de enfermería: **1-800-600-4441**
24 hours a day, 7 days a week/las 24 horas del día, los 7 días de la semana
Transportation/Transporte: **1-844-867-2837**
Please carry this card at all times. Present this card before getting long-term care services.
Porte esta tarjeta en todo momento. Presente esta tarjeta antes de recibir servicios de cuidado a largo plazo.
If you have questions or suspect fraud or abuse, call Member Services at 1-800-600-4441.
If you are deaf or hard of hearing, call 711.
Si tiene alguna pregunta o sospechas de fraude o abuso, llame a Servicios al Miembro al 1-800-600-4441. Si es sordo(a) o tiene problemas auditivos, llame al 711.
In case of emergency, call 911 or go to the closest emergency room.
En caso de emergencia, llame al 911 o vaya a la sala de emergencia más cercana.
PROVIDERS & HOSPITALS: Medicare is responsible for primary, acute, and behavioral health services. Please follow their preauthorization requirements. Contact Amerigroup for authorization of long-term care services only.
PHARMACIES: Submit claims using CarelonRx **RxBIN: 020107; RxPCN: CS; and RxGRP: WKEA.**
For technical help, call CarelonRx at 1-833-252-0329.
SUBMIT LONG-TERM SERVICES AND SUPPORTS CLAIMS TO:
AMERIGROUP • PO BOX 61010 • VIRGINIA BEACH, VA 23466-1010
USE OF THIS CARD BY ANY PERSON OTHER THAN THE MEMBER IS FRAUD.
EL USO DE ESTA TARJETA POR CUALQUIER PERSONA QUE NO SEA EL MIEMBRO CONSTITUYE FRAUDE.
TL52 1/23

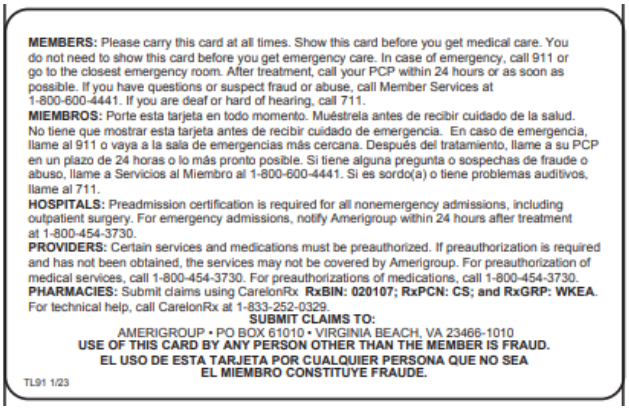
STAR+PLUS (non-duals, Rural Service Area)

Amerigroup

PCP Effective Date:
Date of Birth:
Subscriber #: **123456789**
Type of Coverage: **STAR+PLUS**

AMERIGROUP INSURANCE COMPANY
www.myamerigroup.com/TX

Member Name: **JOHN Q SAMPLE**
Medicaid Number:
Amerigroup Service Coordination: **1-800-600-4441**
Primary Care Provider (PCP):
PCP Telephone #:
PCP Address:
Vision: **1-800-428-8789** Pharmacy Member Services: **1-833-235-2022**
Amerigroup Member Services and Behavioral Health
(24 hours a day, 7 days a week): **1-800-600-4441**
24-hour Nurse HelpLine: **1-800-600-4441**
Transportation: **1-844-867-2837**



MEMBERS: Please carry this card at all times. Show this card before you get medical care. You do not need to show this card before you get emergency care. In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible. If you have questions or suspect fraud or abuse, call Member Services at 1-800-600-4441. If you are deaf or hard of hearing, call 711.
MIEMBROS: Porte esta tarjeta en todo momento. Muéstrela antes de recibir cuidado de la salud. No tiene que mostrar esta tarjeta antes de recibir cuidado de emergencia. En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después del tratamiento, llame a su PCP en un plazo de 24 horas o lo más pronto posible. Si tiene alguna pregunta o sospechas de fraude o abuso, llame a Servicios al Miembro al 1-800-600-4441. Si es sordo(a) o tiene problemas auditivos, llame al 711.
HOSPITALS: Preadmission certification is required for all nonemergency admissions, including outpatient surgery. For emergency admissions, notify Amerigroup within 24 hours after treatment at 1-800-454-3730.
PROVIDERS: Certain services and medications must be preauthorized. If preauthorization is required and has not been obtained, the services may not be covered by Amerigroup. For preauthorization of medical services, call 1-800-454-3730. For preauthorizations of medications, call 1-800-454-3730.
PHARMACIES: Submit claims using CarelonRx **RxBIN: 020107; RxPCN: CS; and RxGRP: WKEA.**
For technical help, call CarelonRx at 1-833-252-0329.
SUBMIT CLAIMS TO:
AMERIGROUP • PO BOX 61010 • VIRGINIA BEACH, VA 23466-1010
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EL USO DE ESTA TARJETA POR CUALQUIER PERSONA QUE NO SEA EL MIEMBRO CONSTITUYE FRAUDE.
TL91 1/23

STAR+PLUS (duals, Rural Service Area)

Amerigroup

Effective Date:
Date of Birth:
Subscriber #: **123456789**
Type of Coverage: **STAR+PLUS**

AMERIGROUP INSURANCE COMPANY
www.myamerigroup.com/TX

Member Name: **JOHN Q SAMPLE**
Medicaid Number:
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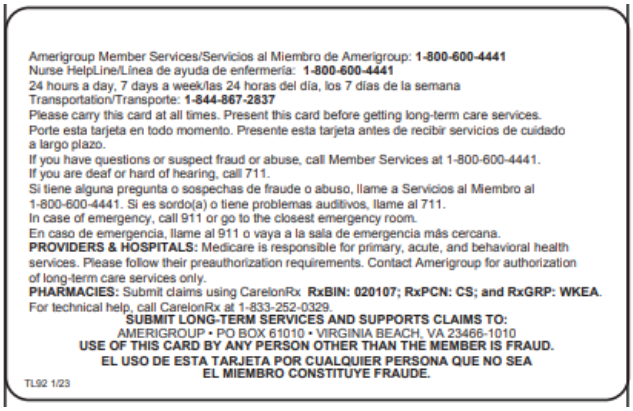

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24 hours a day, 7 days a week/las 24 horas del día, los 7 días de la semana
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Please carry this card at all times. Present this card before getting long-term care services.
Porte esta tarjeta en todo momento. Presente esta tarjeta antes de recibir servicios de cuidado a largo plazo.
If you have questions or suspect fraud or abuse, call Member Services at 1-800-600-4441.
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En caso de emergencia, llame al 911 o vaya a la sala de emergencia más cercana.
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For technical help, call CarelonRx at 1-833-252-0329.
SUBMIT LONG-TERM SERVICES AND SUPPORTS CLAIMS TO:
AMERIGROUP • PO BOX 61010 • VIRGINIA BEACH, VA 23466-1010
USE OF THIS CARD BY ANY PERSON OTHER THAN THE MEMBER IS FRAUD.
EL USO DE ESTA TARJETA POR CUALQUIER PERSONA QUE NO SEA EL MIEMBRO CONSTITUYE FRAUDE.
TL92 1/23

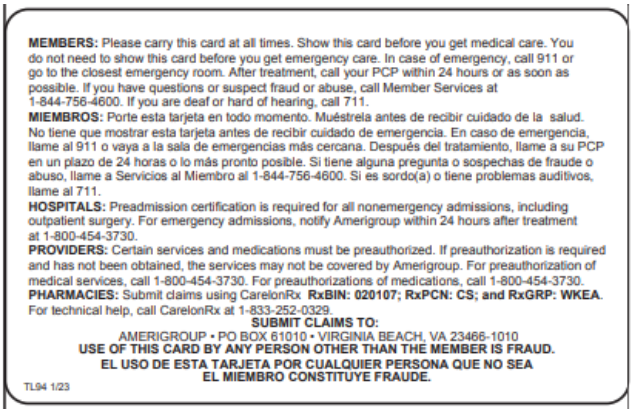
STAR Kids (non-duals, non-Rural Service Area)

Amerigroup

PCP Effective Date:
Date of Birth:
Subscriber #: **123456789**
Type of Coverage: **STAR Kids**

AMERIGROUP INSURANCE COMPANY
www.myamerigroup.com/TX

Member Name: **JOHN Q SAMPLE**
Medicaid Number:
Amerigroup Service Coordination: **1-866-696-0710**
Primary Care Provider (PCP):
PCP Telephone #:
PCP Address:
Vision: **1-800-428-8789** Pharmacy Member Services: **1-833-370-7463**
Amerigroup STAR Kids Only Member Services and Behavioral Health
(24 hours a day, 7 days a week): **1-844-756-4600**
24-hour Nurse HelpLine: **1-844-756-4600**
Transportation: **1-844-864-2443**



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HOSPITALS: Preadmission certification is required for all nonemergency admissions, including outpatient surgery. For emergency admissions, notify Amerigroup within 24 hours after treatment at 1-800-454-3730.
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PHARMACIES: Submit claims using CarelonRx **RxBIN: 020107; RxPCN: CS; and RxGRP: WKEA**. For technical help, call CarelonRx at 1-833-252-0329.

SUBMIT CLAIMS TO:
AMERIGROUP • PO BOX 61010 • VIRGINIA BEACH, VA 23466-1010
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TL94 1/23

STAR Kids (duals, non-Rural Service Area)

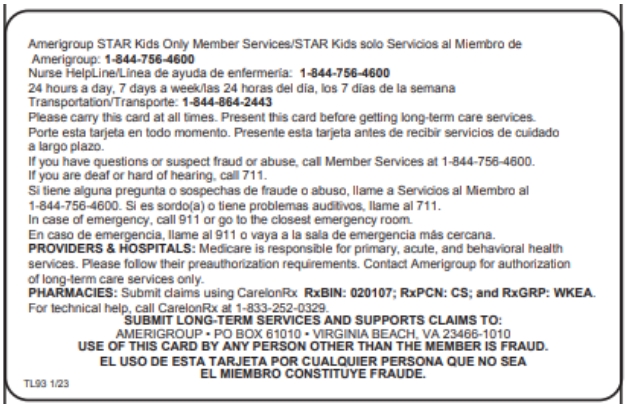
Amerigroup

Effective Date:
Date of Birth:
Subscriber #: **123456789**
Type of Coverage: **STAR Kids**

AMERIGROUP INSURANCE COMPANY
www.myamerigroup.com/TX

Member Name: **JOHN Q SAMPLE**
Medicaid Number:
Amerigroup Service Coordination: **1-866-696-0710**
Pharmacy Member Services: **1-833-370-7463**

LONG-TERM SERVICES AND SUPPORTS BENEFITS ONLY
You receive primary, acute, and behavioral health services through Medicare.
You receive only long-term services and supports through Amerigroup.
SOLO BENEFICIOS DE SERVICIOS Y APOYOS A LARGO PLAZO
Usted recibe servicios de cuidado primario, aguda y del comportamiento a través de Medicare. Solo recibe servicios y apoyos a largo plazo a través de Amerigroup.



Amerigroup STAR Kids Only Member Services/STAR Kids solo Servicios al Miembro de Amerigroup: **1-844-756-4600**
Nurse HelpLine/Línea de ayuda de enfermería: **1-844-756-4600**
24 hours a day, 7 days a week/las 24 horas del día, los 7 días de la semana
Transportation/Transporte: **1-844-864-2443**
Please carry this card at all times. Present this card before getting long-term care services.
Porte esta tarjeta en todo momento. Presente esta tarjeta antes de recibir servicios de cuidado a largo plazo.
If you have questions or suspect fraud or abuse, call Member Services at 1-844-756-4600.
If you are deaf or hard of hearing, call 711.
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TL93 1/23

STAR Kids (non-duals, Rural Service Area)

Amerigroup

PCP Effective Date:
Date of Birth:
Subscriber #: **123456789**
Type of Coverage: **STAR Kids**

AMERIGROUP INSURANCE COMPANY
www.myamerigroup.com/TX

Member Name: **JOHN Q SAMPLE**
Medicaid Number:
Amerigroup Service Coordination: **1-866-696-0710**
Primary Care Provider (PCP):
PCP Telephone #:
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(24 hours a day, 7 days a week): **1-844-756-4600**
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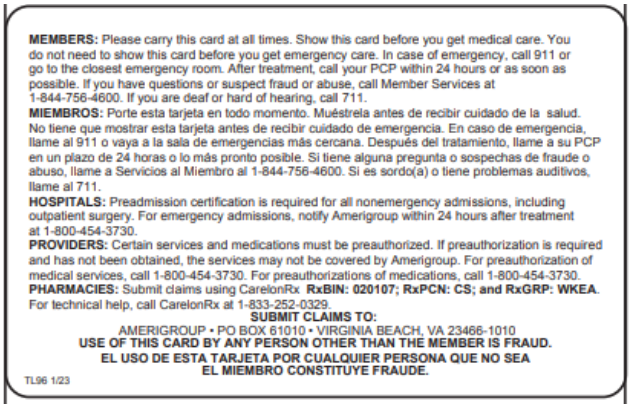
Transportation: **1-844-864-2443**

TRUE CHOICE



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

TL96 1/23

STAR Kids (duals, Rural Service Area)

Amerigroup

Effective Date:
Date of Birth:
Subscriber #: **123456789**
Type of Coverage: **STAR Kids**

AMERIGROUP INSURANCE COMPANY
www.myamerigroup.com/TX

Member Name: **JOHN Q SAMPLE**
Medicaid Number:
Amerigroup Service Coordination: **1-866-696-0710**
Pharmacy Member Services: **1-833-370-7463**

TRUE CHOICE

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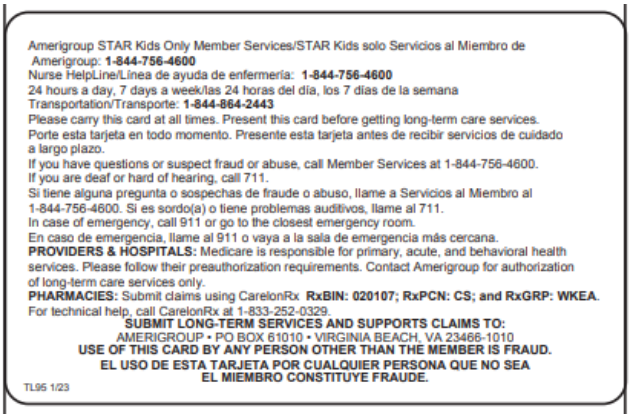
Usted recibe servicios de cuidado primario, aguda y del comportamiento a través de Medicare. Solo recibe servicios y apoyos a largo plazo a través de Amerigroup.



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EL USO DE ESTA TARJETA POR CUALQUIER PERSONA QUE NO SEA EL MIEMBRO CONSTITUYE FRAUDE.
TL95 1/23

CHIP

Amerigroup

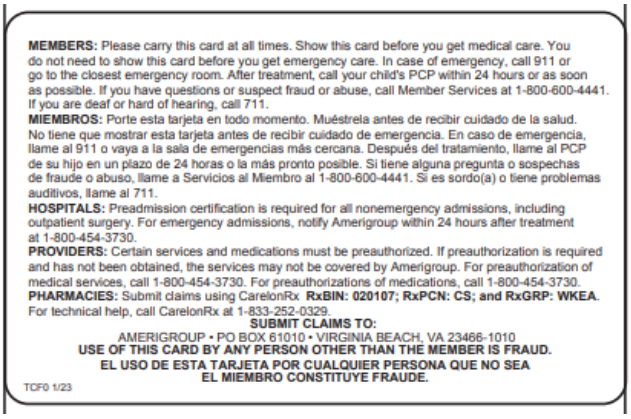
PCP Effective Date:
Date of Birth:
Subscriber #: **123456789**
Type of Coverage: **CHIP**

AMERIGROUP TEXAS, INC.
www.myamerigroup.com/TX

Member Name: **JOHN Q SAMPLE**
CHIP Number:
Primary Care Provider (PCP):
PCP Telephone #:
Copays: Office Visits: **$0** Emergency Room Visits: **$0**
Pharmacy: **$0 FOR GENERIC / $0 FOR BRAND NAME**
Vision: **1-800-428-8789** Pharmacy Member Services: **1-833-235-2022**

Amerigroup Member Services and Behavioral Health
(24 hours a day, 7 days a week): **1-800-600-4441**
24-hour Nurse HelpLine: **1-800-600-4441**

TDI



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PHARMACIES: Submit claims using CarelonRx **RxBIN: 020107; RxPCN: CS; and RxGRP: WKEA.**
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TCF0 1/23

CHIP Perinate

Amerigroup

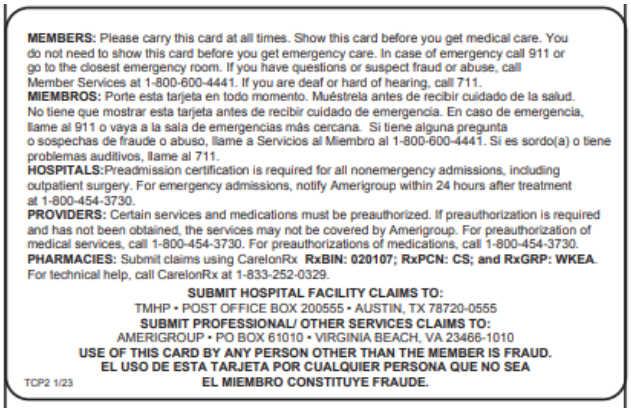
Effective Date:
Date of Birth:
Subscriber #: **123456789**
Type of Coverage: **CHIP**

AMERIGROUP TEXAS, INC.
www.myamerigroup.com/TX

Member Name: **JOHN Q SAMPLE**
CHIP Perinate Number:
Pharmacy Member Services: **1-833-235-2022**

Amerigroup Member Services and Behavioral Health
(24 hours a day, 7 days a week): **1-800-600-4441**
24-hour Nurse HelpLine: **1-800-600-4441**

TDI



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SUBMIT HOSPITAL FACILITY CLAIMS TO:
TMHP • POST OFFICE BOX 200555 • AUSTIN, TX 78720-0555
SUBMIT PROFESSIONAL/ OTHER SERVICES CLAIMS TO:
AMERIGROUP • PO BOX 61010 • VIRGINIA BEACH, VA 23466-1010
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EL USO DE ESTA TARJETA POR CUALQUIER PERSONA QUE NO SEA EL MIEMBRO CONSTITUYE FRAUDE.
TCP2 1/23

CHIP Perinate (newborn)


Amerigroup

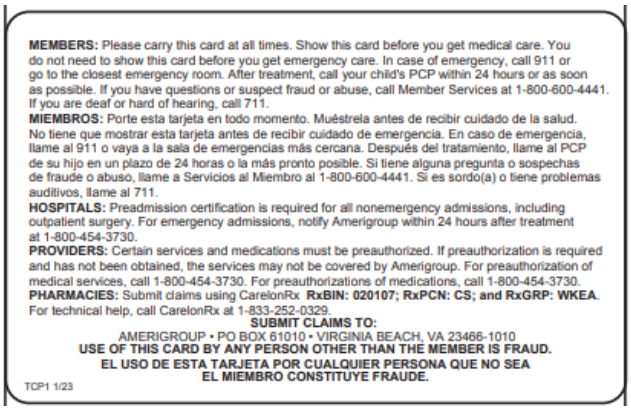
PCP Effective Date:
Date of Birth:
Subscriber #: **123456789**
Type of Coverage: **CHIP**

AMERIGROUP TEXAS, INC.
www.myamerigroup.com/TX

Member Name: **JOHN Q SAMPLE**
CHIP Perinate Newborn Number:
Primary Care Provider (PCP):
PCP Telephone #:
Vision: **1-800-428-8789** Pharmacy Member Services: **1-833-235-2022**
Copays do not apply.

Amerigroup Member Services and Behavioral Health
(24 hours a day, 7 days a week): **1-800-600-4441**
24-hour Nurse HelpLine: **1-800-600-4441**

TDI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SUBMIT CLAIMS TO:
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TCP1 1/23

16 Appendix B – HHSC required definitions for STAR Kids

1915(i) Home- and Community-Based Services — Adult Mental Health (HCBS-AMH)
Home- and Community-Based Services — Adult Mental Health (HCBS-AMH) is a statewide program that provides home- and community-based services to adults with serious mental illness. The HCBS-AMH program provides an array of services, appropriate to each member's needs, to enable them to live and experience successful tenure in their chosen community. Services are designed to support long-term recovery from mental illness.

Community Living Assistance and Support Services (CLASS) Waiver Program
The Community Living Assistance and Support Services (CLASS) program provides home- and community-based services to people with related conditions as a cost-effective alternative to an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). A related condition is a disability, other than an intellectual disability, that originated before age 22 that affects the ability to function in daily life.

Deaf Blind with Multiple Disabilities (DBMD) Waiver Program
The Deaf Blind with Multiple Disabilities (DBMD) program provides home- and community-based services to people who are deaf, blind and have another disability. This is a cost-effective alternative to an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). The DBMD program focuses on increasing opportunities for consumers to communicate and interact with their environment.

Dual-eligible
Medicaid recipients who are also eligible for Medicare

Home- and Community-Based Services (HCS) Waiver Program
The Home- and Community-Based Services (HCS) program provides individualized services and supports to people with intellectual disabilities who are living with their families, in their own homes or in other community settings, such as small group homes where no more than four people live. The local authority provides service coordination.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) means an intermediate care facility for individuals with intellectual disabilities or related conditions that provides residential care and services for those individuals based on their functional needs.

Long-Term Services and Supports (LTSS)
LTSS means assistance with daily health care and living needs for individuals with a long-lasting illness or disability.

Medically Dependent Children Program (MDCP) Waiver Program
The Medically Dependent Children Program (MDCP) provides services to support families caring for children who are medically dependent and encourages the transition of children in nursing homes back to the community.

Texas Home Living (TxHmL) Waiver Program
The Texas Home Living (TxHmL) program provides selected essential services and supports to people with an intellectual disability or a related condition who live in their own home or their family's home.

Youth Empowerment Services (YES) Waiver Program
The Youth Empowerment Services (YES) waiver provides comprehensive home- and community-based mental health services to youth between the ages of 3 and 18, up to a youth's 19th birthday, who have a serious emotional disturbance. The YES Waiver not only provides flexible supports and specialized services to children and youth at risk of institutionalization and/or out-of-home placement due to their serious emotional disturbance, but also strives to provide hope to families by offering services aimed at keeping children and youth in their homes and communities.

* Availity, LLC is an independent company providing administrative support 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. Superior Vision of Texas, offered by Versant Health, is an independent company providing vision and utilization management services on behalf of the health plan. Carelon Behavioral Health, Inc. is an independent company providing utilization management services on behalf of the health plan. DentaQuest is an independent company providing dental benefit management services on behalf of the health plan. CoverMyMeds is an independent company providing electronic prior authorization services on behalf of the health plan. Access2Care is an independent company providing nonemergency transportation services on behalf of the health plan.