Medicaid | Medicare-Medicaid Plan I Medicare

Amerigroup

Behavioral health: New provider orientation

Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.
Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees. Coverage provided by Amerigroup Inc.

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Today's discussion

Our mission, goals and who we are:

- Amerigroup products
- Member enrollment and marketing guidelines
- Credentialing
- Availity* applications
- Claims and claims submission
- Appeals and grievances
- Case management, disease management, and quality management
- Cultural competency
- Behavioral Health (BH) covered services
- Consumer record standards and documentation requirements
- Reference tools and key resources

Our mission

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

BH program goals

The goals of the behavioral health program are to:

- Ensure and expand service accessibility to eligible members.
- Promote the integration of the management and delivery of physical and behavioral health services.
- Achieve quality initiatives, including those related to Healthcare Effectiveness Data and Information Set (HEDIS®) and the National Committee for Quality Assurance (NCQA).
- Work with members, providers, and community supports to provide recovery tools and create an environment that supports members' progress toward their recovery goals.
- Ensure use of the most appropriate and least restrictive medical and behavioral healthcare in the right place and at the right time.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Who we are

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

Collaborative and integrated care

- Collaboration leads to well-informed treatment decisions. Providers work together to develop compatible courses of treatment, increasing the chances for positive health outcomes, and avoiding adverse interaction.

- Quality care depends on timely communication between the member's PCP or medical home and the BH specialists and or ancillary providers from whom they receive care.

Medicaid programs

Amerigroup offers the following Medicaid managed care programs:

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

Medicaid programs (cont.)

- STAR Kids:
  - STAR Kids is designed specifically for children and young adults with special needs. Most individuals 20 years old and younger who get 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.
- CHIP:
  - CHIP provides health coverage for children whose families earn too much to qualify for Medicaid but not enough to afford private health coverage. Members must be 18 or younger, Texas residents, and U.S. citizens or legal permanent residents.

Amerigroup Amerivantage (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 and extra benefits covering other healthcare services beyond what traditional Fee-For-Service (FFS) Medicare may offer.
- The SNPs that are part of the Amerigroup Amerivantage (Medicare Advantage) program 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.
- Traditional plans that are part of the Amerigroup Amerivantage program are for Medicare beneficiaries who are entitled to Medicare Part A and are enrolled in Medicare Part B.

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan)

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

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

Amerigroup STAR+PLUS MMP Service Coordination Team (SCT)

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

Member Medicaid enrollment

MAXIMUS:

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

Enrollment:

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

Member Medicaid enrollment (cont.)

Effective dates:

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

Plan changes:

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

Contact:

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

Member ID cards

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

Sample ID cards can be found in the Amerigroup provider manuals. These manuals are accessible through this link.

https://provider.amerigroup.com/texas-provider/resources/manuals-and-guides

Marketing activities

Sanctioned marketing activities:

- Attendance at MAXIMUS-sponsored member enrollment events
- Approved MCO-sponsored health fairs and community events
- Radio, television, and print advertisements

In Texas, the following activities are prohibited:

- Conducting direct-contact marketing, except through the HHSC-sponsored enrollment events
- Making any written or oral statement containing material that misrepresents facts or laws relating to Amerigroup or the STAR, STAR+PLUS, STAR Kids, and CHIP programs
- Promoting one MCO over another if contracted with more than one MCO

Please consult the Amerigroup provider manual at provider.amerigroup.com/TX for more details on HHSC marketing guidelines.

BH and substance use disorder (SUD)

Covered Medicaid services:

- Inpatient mental health services (may be provided in a free-standing psychiatric hospital in lieu of an acute care inpatient setting)
- Outpatient mental health services
- Applied behavior analysis
- Psychiatry services
- Psychotherapy for children and adults
- Outpatient SUD treatment services, including:
  - Assessment
  - Detoxification services
  - Counseling treatment
  - Medication-assisted therapy
- Residential SUD treatment services, including:
  - Detoxification services
  - Room and board
- Mental health rehabilitative services
- Mental health targeted case management
- Case management for children and pregnant women
- Collaborative care

Laboratory services

- Notification or precertification is not required if lab work is performed in a physician's office, participating hospital outpatient department (if applicable), or by one of our preferred lab vendors.
- We have national contracts with the following labs:
  - Clinical Pathology Laboratory (CPL)
  - LabCorp
  - Quest Diagnostics

Pharmacy program

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

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

Value-added benefits

- We cover extra healthcare benefits for our members. These extra benefits are also called value-added services, and they vary by product and member age.
- 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 and listed in our provider manual. If you have questions or need help finding the information, call Provider Services at **800-454-3730**.

Note: Value-added benefits in the member manuals are applicable only to the Medicaid and CHIP programs.

Targeted case management and mental health rehabilitation

Mental health rehabilitative services and mental health targeted case management must be available to eligible STAR, STAR Kids, STAR+PLUS, and Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) members who require these services based on one of the following standardized assessments:

- Adult Needs and Strengths Assessment (ANSA)
- Child and Adolescent Needs and Strengths (CANS)

Targeted case management and mental health rehabilitation (cont.)

Severe and persistent mental illness (SPMI) indicates a diagnosis of bipolar disorder, major clinical depression, schizophrenia, or other 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) refers to psychiatric disorders in children and adolescents that cause severe disturbances in their behavior, thoughts, and feelings.

Targeted case management and mental health rehabilitation (cont.)

Mental health rehabilitation includes trainings and services that help the member maintain independence in the home and community, such as:

- **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, 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

Targeted case management and mental health rehabilitation (cont.)

- **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, prevent admission to a more restrictive setting or reduce, the amount of time spent in the more restrictive setting

Targeted case management and mental health rehabilitation (cont.)

- **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 to17 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 *Texas Medicaid Provider Procedures Manual (TMPPM)*, including the *Behavioral Health, Rehabilitation, and Case Management Services Handbook.*
- Please consult the *TMPPM* for definitions and documentation requirements: https://www.tmhp.com/resources/provider-manuals/tmppm

Telemedicine and telehealth services

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

A **distant site** is the location of the provider rendering the service. Distant site telemedicine benefits include services that are performed by the following providers, who must be enrolled as a Texas Medicaid provider.

Provider types –

- Physician
- CNS
- NP
- PA
- CNM
- Federally Qualified Health Center (FQHC)
- CDTFs
- OT/PT/ST
- LBA
- LBA
- LCSW
- LMFTs
- Others…

Telemedicine and telehealth services (cont.)

A **patient site** is the place where the client is physically located. A client's home may be the patient site for telemedicine medical services. Patient-site providers who are enrolled in Texas Medicaid may only be reimbursed for the facility fee using procedure code Q3014. Procedure code Q3014 is payable to NP, CNS, PA, physicians, rural health clinics, and outpatient hospital providers. Charges for other services that are performed at the patient site may be submitted separately. Procedure code Q3014 is not a benefit if the patient site is the client's home.

Please consult the *TMPPM Telecommunication Services Handbook* for additional information on telemedicine and telehealth services.

Psychological, neurobehavioral, and neuropsychological testing

- Psychological, neurobehavioral and neuropsychological testing involves the use of formal tests and other assessment tools to measure and assess a client's emotional and cognitive functioning in order to arrive at a diagnosis and guide treatment.
- These services require preauthorization.
- Pre-authorizations can be requested through the Interactive Care Reviewer in Availity at https://www.availity.com or by faxing in the authorization request form to **844-442-8010 for Medicaid and 844-430-1703 for Medicare**.
- Preauthorization forms can be found on the provider site at www.provider.amerigroup.com/TX.

Applied behavior analysis (ABA)

According to the *TMPPM*, behavior analysis is the scientific study of the principles of learning and behavior, specifically about how behavior affects, and is affected by, past and current environmental events in conjunction with biological variables. ABA refers to the application of current, evidence-based specialized principles of the applied behavior analysis discipline by a provider, such as a licensed and certified behavior analyst (LBA), trained in this intervention. The intent of ABA therapy is to effect meaningful changes, which are durable and generalizable, in socially significant behaviors in everyday settings. ABA focuses on treating behavior difficulties and shaping behavior patterns through environmental adaptations and consistent reinforcement and consequences across settings and situations.

ABA services are covered for Medicaid members 0 to 20 years of age who are diagnosed with Autism.

Applied behavior analysis (ABA) (cont.)

- ABA provider requirements:
  - Licensed behavior analysts (LBAs) must be enrolled with Medicaid. LBAs serve as direct supervisors of licensed assistant behavior analysts (LaBA) and behavior technicians (BT).
- LaBAs are licensed and must work within the scope of their training and competence. They assist the LBA in various responsibilities as delegated by the LBA. LaBAs may not enroll with Medicaid.
- Behavior technicians are high school graduate paraprofessionals who provide services under the supervision of an LBA or a LBA and LaBA. Behavior technicians must be certified as a registered behavior technician (RBT), board certified autism technician (BCAT), or applied behavior analysis technician (ABAT). Behavior Technicians may not enroll in Medicaid.

Applied behavior analysis (ABA) (cont.)

Billing guidelines

Direct treatment for the child or youth is limited to a total of eight hours per day, inclusive of procedure codes 97153, 97154, 97155, and 97158. The following modifiers are required.

Modifier	Description
HO	Licensed behavior analyst
HN	Licensed assistant behavior analyst
HM	Behavior technician
95	Telehealth

The following procedure codes will be authorized for a 30-day authorization period for ABA evaluation or re-evaluation.

Procedure code	Description	Limitations	Modifier options	Telehealth
97151	ABA Initial Evaluation	6 hours (24 units)	HO only	Yes
97151	ABA Re-evaluation	6 hours (24 units)	HO only	Yes

The following procedure codes may be reimbursed for ABA treatment.

Procedure code	Description	Modifier options	Telehealth
97153	ABA individual treatment	No modifier required	No
97155	ABA individual treatment	HO, HN	Yes
97154	ABA group treatment	No modifier required	No
97158	ABA group treatment	HO, HN	Yes
97156	Parent/caregiver, family education and training services.	HO, HN	Yes
99366	Interdisciplinary Team Meeting	No modifier required	Yes

Applied behavior analysis (ABA) (cont.)

- Reimbursement for procedure code 99366 is limited to autism diagnosis code F84 and is contingent upon prior authorization of ABA evaluation, re-evaluation, or treatment services.
- Reimbursement for covered ABA procedure codes is for the direct service time. Pre-work and post-work for the session are not reimbursed separately. Separate reimbursement for treatment planning, note documentation, report writing, or updating of charts and data sheet is prohibited (other than what is allowable under procedure code 97151).
- LaBAs and BTs may not deliver services via telehealth.

Procedure codes are paid in 15-minute increments, and they are based on the actual amount of billable time associated with the service. 1 unit = 15 minutes. Partial units should be rounded up or down to the nearest quarter hour.

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

Web: https://www.availity.com

You can also fax or call in your authorization request:
- Amerigroup fax: **844-442-8010**
- Phone: **800-454-3730**

Screening, brief intervention, and referral to treatment (SBIRT)

SBIRT is a comprehensive, integrated public health approach to the delivery of early intervention and screening for individuals with risky alcohol and drug use.

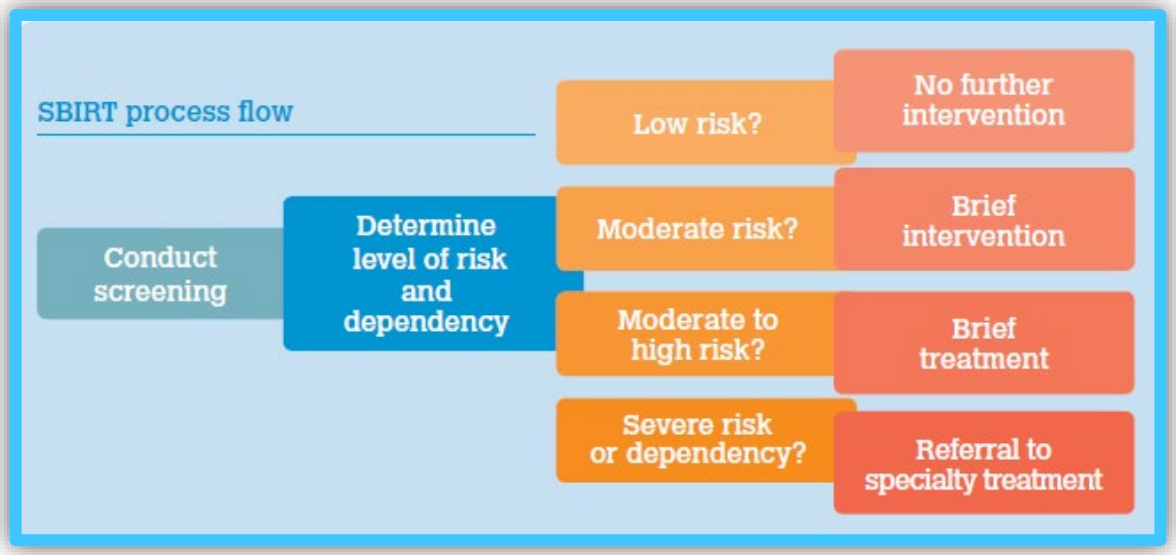
For these patients who are at a high risk of developing a substance use disorder or who are already dependent upon substances, SBIRT helps get them more intensive substance use treatment quickly.

The Substance Abuse and Mental Health Services Administration defines SBIRT as:

- Brief (typically 5-10 minutes for brief intervention and 5-12 minutes for brief treatment).
- Universal.
- Targeting one or more behaviors regarding risky alcohol and drug use.
- Delivered in a public health, nonsubstance abuse treatment setting.
- Comprehensive – comprised of screening and referral.
- Involving research, evaluation and collection of experiential evidence to assess the model's effectiveness.

Delivering SBIRT services

Primary care centers, hospital ERs, trauma centers, and community health settings have the best chance to intervene early with at-risk substance users and prevent more severe consequences. All PCPs (as defined by state law) as well as BH providers play a role in SBIRT.



Delivering SBIRT services (cont.)

SBIRT services can be provided by physicians, registered nurses, advanced practice nurses, physician assistants, psychologists, licensed clinical social workers, licensed professional counselors, certified nurse midwives, outpatient hospitals, federally qualified health centers (FQHCs), and rural health clinics (RHCs). Non-licensed providers may deliver SBIRT under the supervision of a licensed provider if such supervision is within the scope of practice for that licensed provider. The same SBIRT training requirements apply to nonlicensed providers. A person may have a maximum of two screening only sessions per rolling year, and up to four combined screening and brief intervention sessions per rolling year. Providers must refer the person to treatment if the screening results reveal severe risk of alcohol or substance use.

Delivering SBIRT services (cont.)

Screening

Screening persons for problems related to alcohol or substance use identifies the person's level of risk and determines the appropriate level of intervention indicated for the person. Providers must explain the screening results to the person, and if the results are positive, be prepared to subsequently deliver, or delegate to another provider, brief intervention services. Screening must be conducted using a standardized screening tool. Standardized tools that may be used include, but are not limited to, the following:

- Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- Drug Abuse Screening Test (DAST)
- Alcohol Use Disorders Identification Test (AUDIT)
- Cut-down, Annoyed, Guilty, Eye-opener (CAGE) questionnaire
- Car, Relax, Alone, Forget, Family or Friends, Trouble (CRAFFT) questionnaire
- Binge drinking questionnaire (Results obtained through blood alcohol content or through toxicology screening may also be used to screen for alcohol or substance use risk.)

Delivering SBIRT services (cont.)

Brief Intervention and Referral to Treatment:

- Brief intervention is performed following a positive screen or a finding of at least a mild to moderate risk for alcohol or substance use. During the session, brief intervention involves motivational interviewing techniques (such as the Brief Negotiated Interview) that is focused on raising the person's awareness of his or her alcohol or substance use and its consequences. The session is also focused on motivating the person toward behavioral change. Subsequent screening and brief intervention sessions within the allowable annual limitations may be indicated to assess for behavior change and further explore a person's readiness to make behavioral changes related to their alcohol or substance use.
- If the provider determines that the person is in need of more extensive treatment or has a severe risk for alcohol or substance use, the person must be referred to an appropriate substance use treatment provider.
- Referral to more extensive treatment is a proactive process that facilitates access to care for persons who require a more extensive level of service than SBIRT provides. Referral is an essential component of the SBIRT intervention because it ensures that all persons who are screened have access to the appropriate level of care.

Procedure codes and requirements:

- SBIRT is limited to persons who are 10 years of age and older.
- SBIRT is limited to up to two screening sessions per rolling year. A screening that results in a negative result does not require a brief intervention. In these instances, procedure code H0049 should be used. A provider may re-screen a person within the same rolling year to determine whether their substance use behavior has changed.
- Procedure code **99408** or **G2011** should be used when a brief intervention follows an SBIRT screening. Procedure code 99408 is limited to once per day. SBIRT is limited to four sessions per rolling year when it constitutes a screening followed by a brief intervention.

Delivering SBIRT services (cont.)

If a person requires more than four combined screening and brief intervention sessions per rolling year, the person must be referred for substance use disorder treatment. SBIRT is not reimbursable to providers (whether licensed or nonlicensed) who have not completed the required number of training hours in SBIRT methodology. Procedure codes 99408, G2011, and H0049 will be denied if billed for the same date of service as any of the following procedure codes:

Procedure Codes									
90791	90792	90832	90833*	90834	90836*	90837	90838*	90847	90853
90865	90870	96130	96131*	96132	96133*	96136	96137*		

*Add-on procedure codes must be billed with the appropriate primary code.

Procedure codes 99408 and H0049 cannot both be billed on the same date. Physicians and other qualified healthcare professionals that bill an Evaluation and Management (E/M) code for a visit where SBIRT occurred must use modifier 25 to identify a significant, separately identifiable E/M service rendered by the same provider on the same date of service.

SBIRT training

Providers who perform SBIRT must be trained in the correct practice of this method and will be required to complete at least four hours of training. Proof of completion of SBIRT training must be maintained in an accessible manner at the provider's place of service.

Information regarding available trainings and standardized screening tools can be found through https://www.samhsa.gov/ .

Early Childhood Intervention

- Early Childhood Intervention (ECI) is a federally mandated program for infants and toddlers under the age of 3 who are at risk for developmental delays and/or disabilities.
- The federal ECI regulations are found at *34 C.F.R. § 303.1 et seq*.
- The state ECI rules are found within the Texas Administrative Code, Title 26, Part 1, Chapter 350.
- Amerigroup must ensure network providers are educated regarding the federal laws on child-find and referral procedures (for example, *20 U.S.C. § 1435(a)(5); 34 C.F.R. § 303.303)*.

Early Childhood Intervention (cont.)

- Amerigroup must require network providers to identify and refer any member under the age of 3 who is suspected of having a developmental delay or disability (or otherwise meets eligibility criteria for ECI services in accordance with *Texas Administrative Code*, Title 26, Part 1, Chapter 350) to the designated ECI program for screening and assessment within seven calendar days from the day the provider identifies the member.
- Amerigroup must use written educational materials developed or approved by HHSC for ECI services for these child-find activities. Materials are located at: https://hhs.texas.gov/services/disability/early-childhood-intervention-services .

Early Childhood Intervention (cont.)

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

Early childhood intervention (cont.)

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

Credentialing

- To initiate the network enrollment process, practitioners can enroll through our provider digital enrollment by going to Availity.com . Facility and ancillary providers should contact Amerigroup at TXCredentialing@amerigroup.com.
- Amerigroup will use the credentialing verification organization (CVO) **Aperture*** for all initial credentialing and re-credentialing 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.

Credentialing (cont.)

- Credentialing is for a three-year period.
- Re-credentialing efforts begin eight months prior to the end of the current credentialing period.
- First notice and second notice letters are faxed to providers.
- Third notice and final notice letters are mailed to providers.
- Providers who do not respond or submit complete recredentialing information will be terminated.
- Upon termination, providers must begin the contracting and credentialing process from the beginning to rejoin our network.
- Notify your Relationship Management representative with changes in licensure, demographics or participation status immediately.
- Providers located in the MRSA are credentialed by Texas True Choice Multiplan, contact https://www.multiplan.com/TexasTrueChoice .

Provider demographic updates

Update us immediately concerning changes in your:

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

Contact your Relationship Management representative for assistance with updating your demographics and remember to update your demographic information with TMHP.

Behavioral Health Areas of Expertise Profile (BHAEP)

- The *BHAEP* is designed to capture supplemental data to enhance our online and paper provider directory. This will help our members find the right BH provider for their unique needs.
- There is a *BHAEP* for individual practitioners and facilities.
- Group practices must complete the survey for all participating providers and newly credentialed providers.
- Facilities must complete the survey for all participating locations and newly credentialed locations.
- Your local Relationship Management representative can provide information on completing the survey.

Provider website

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

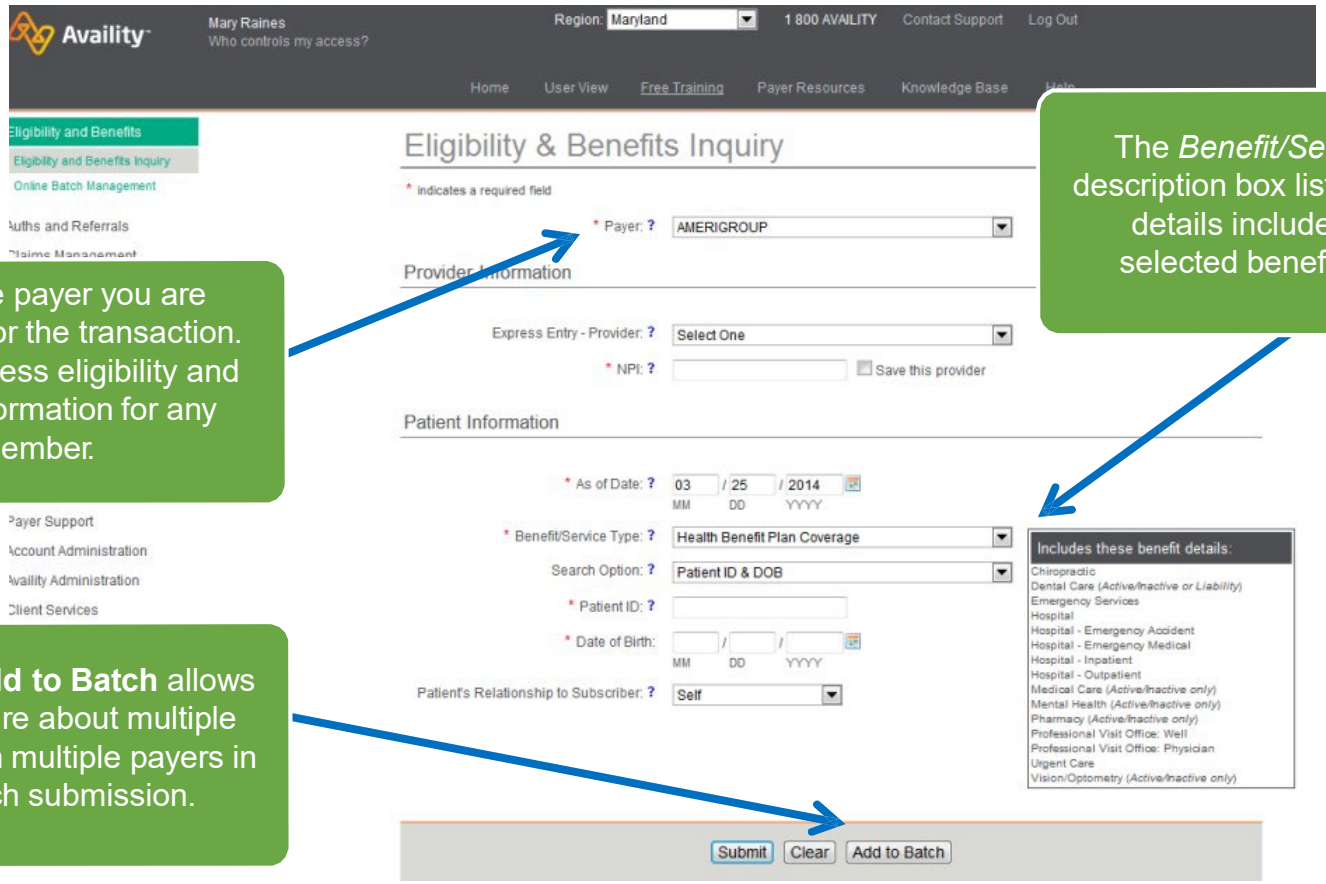
The Availity Essentials

- Use Availity Essentials to review patient eligibility and benefit information, and submit, track, and appeal claims.
- Submit authorization requests using the Interactive Care Reviewer (ICR) application.
- Patient 360 allows you to view secure member demographic and care management details.

Secure Availity registration

- Registration for the secured content on Availity is easy.
- Begin by navigating availity.com and selecting **Register**.
- There are multiple resources and trainings available to support navigation of the Availity and Amerigroup websites.

Eligibility and benefits



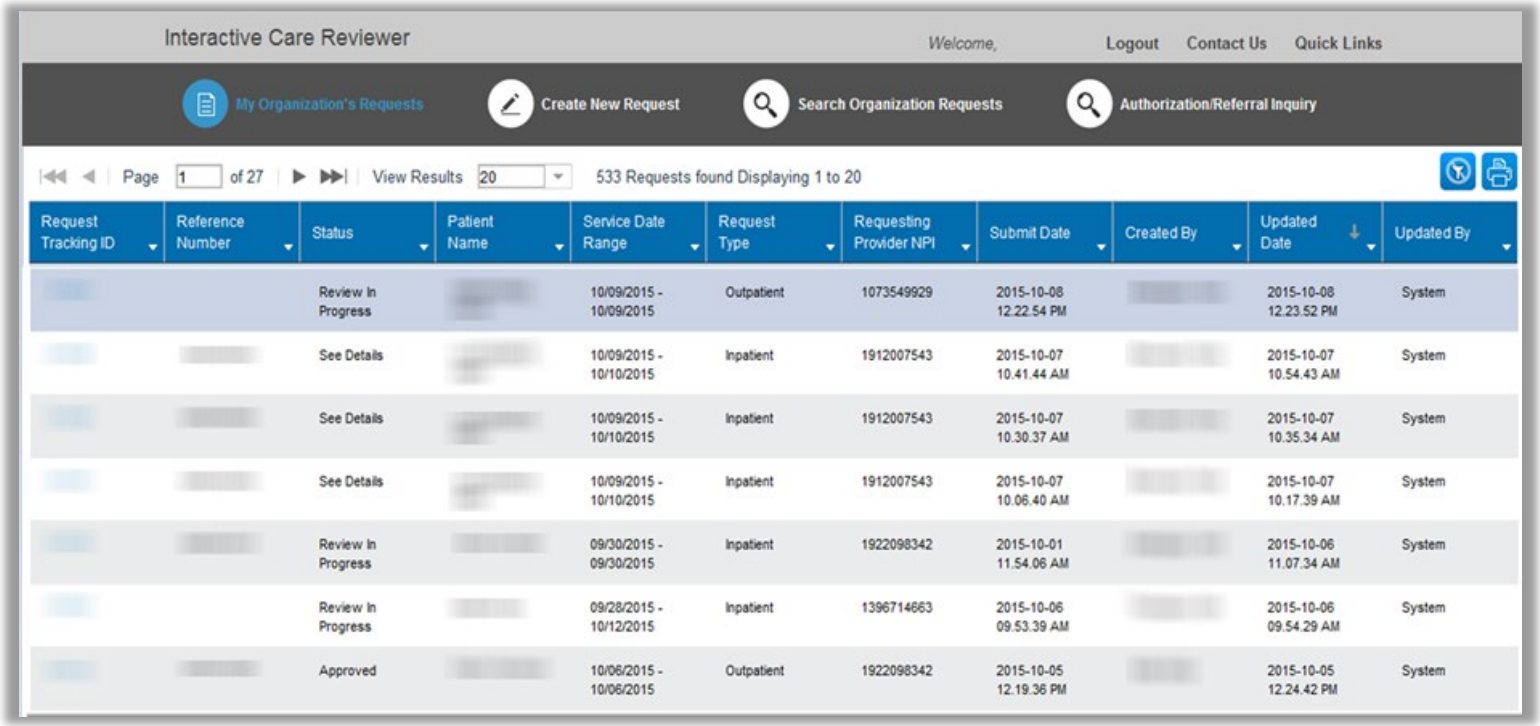
Select the payer you are submitting for the transaction. You can access eligibility and benefit information for any member.

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

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

Interactive Care Reviewer (ICR)

The ICR offers a streamlined process to request inpatient and outpatient preauthorization through the Availity Essentials.



Request Tracking ID	Reference Number	Status	Patient Name	Service Date Range	Request Type	Requesting Provider NPI	Submit Date	Created By	Updated Date	Updated By
		Review In Progress		10/09/2015 - 10/09/2015	Outpatient	1073549929	2015-10-08 12.22.54 PM		2015-10-08 12.23.52 PM	System
		See Details		10/09/2015 - 10/10/2015	Inpatient	1912007543	2015-10-07 10.41.44 AM		2015-10-07 10.54.43 AM	System
		See Details		10/09/2015 - 10/10/2015	Inpatient	1912007543	2015-10-07 10.30.37 AM		2015-10-07 10.35.34 AM	System
		See Details		10/09/2015 - 10/10/2015	Inpatient	1912007543	2015-10-07 10.06.40 AM		2015-10-07 10.17.39 AM	System
		Review In Progress		09/30/2015 - 09/30/2015	Inpatient	1922098342	2015-10-01 11.54.06 AM		2015-10-06 11.07.34 AM	System
		Review In Progress		09/28/2015 - 10/12/2015	Inpatient	1396714663	2015-10-06 09.53.39 AM		2015-10-06 09.54.29 AM	System
		Approved		10/06/2015 - 10/06/2015	Outpatient	1922098342	2015-10-05 12.19.36 PM		2015-10-05 12.24.42 PM	System

ICR and preauthorization

- Requests for initial and continuation authorization should be submitted via the ICR application in Availity, or by phone or fax (see below). ICR training is available on the Availity website.
  - Medicaid inpatient fax: **844-430-6805**
  - Medicaid outpatient fax: **844-442-8010**
  - Medicare inpatient fax: **844-430-1702**
  - Medicare outpatient fax: **844-430-1703**
  - Amerigroup STAR+PLUS MMP inpatient fax: **844-451-2825**
  - Amerigroup STAR+PLUS MMP outpatient fax: **844-430-6804**
  - Medicaid telephone (if urgent): **800-454-3730**
  - Medicare telephone (if urgent): **866-805-4589**
  - Amerigroup STAR+PLUS MMP telephone (if urgent): **855-878-1785**
- Medical necessity is based on Texas Department of Insurance and the American Society of Addiction Medicine regulations.
- Prior authorization forms are located on our website at https://provider.amerigroup.com/TX on the *Resources* tab under *Forms*.

Claims submission

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

Claims submission (cont.)

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

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

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

Rejected vs. denied claims

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

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

Billing members

- Our agreement with the state indicates that our members should not be burdened with any non-approved, out-of-pocket expenses for services covered under the Medicaid program:
  - This fundamental principle does not change when the member has other insurance.
  - Members should receive the best benefits available from both coverage plans.

When members should not be billed

Members should not be billed:

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

Billing members for noncovered services

Before billing members for services not covered, providers must:

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

Coordination of benefits

- Amerigroup is the payer of last resort.
- Coordination of benefits claims are paid up to the amount Amerigroup deems allowable, regardless of the primary carrier's allowable:

Example 1:

Amerigroup allowable	$4,000
Minus primary carrier payment	$2,000
Minus Amerigroup payment	$2,000
Final balance	$ 0

Coordination of benefits (cont.)

- Amerigroup will never pay more than our allowable.
- Patients cannot be billed when the Amerigroup allowable is less than the primary allowable. The balance must be adjusted.

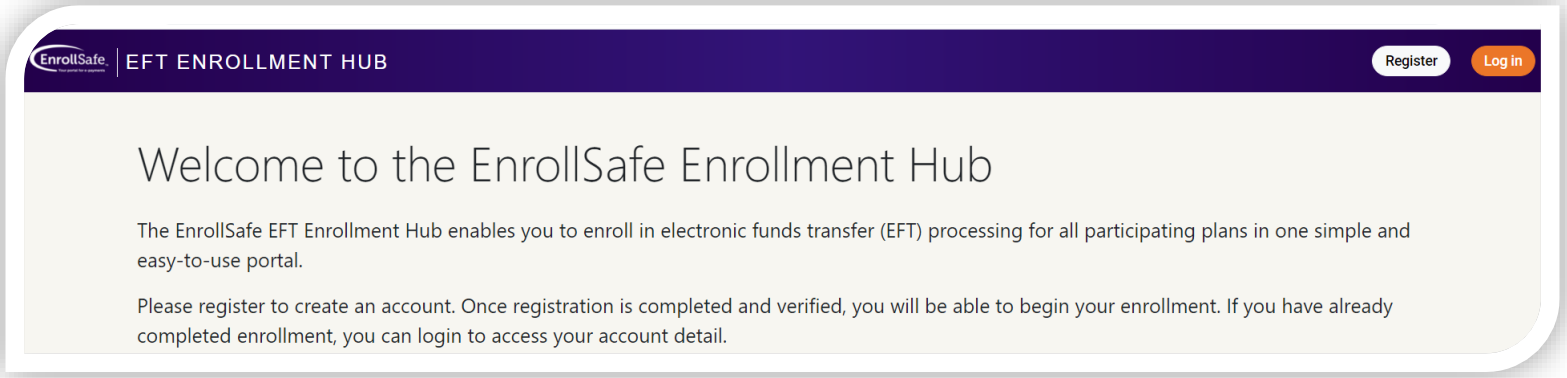
Example 2:

Amerigroup allowable	$3,000
Minus primary carrier payment	$4,000
Final balance	$ 0

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

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

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



Grievances and appeals

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

Appeals process

Payment disputes:

- There is a 120-day filing deadline from the date of *EOP.*
- Providers may use the payment dispute tool at https://www.availity.com . Supporting documentation can be uploaded using the attachment feature.
- Providers can also submit a *Provider Payment Dispute* form and relevant supporting documentation, including the original *EOP*, corrected claim, invoices, medical records, reference materials, etc.
  - **Fax: 844-756-4607**
  - **Verbally (for reconsiderations only):** Call Provider Services.
  - **Mail** to:

    Payment Dispute Unit

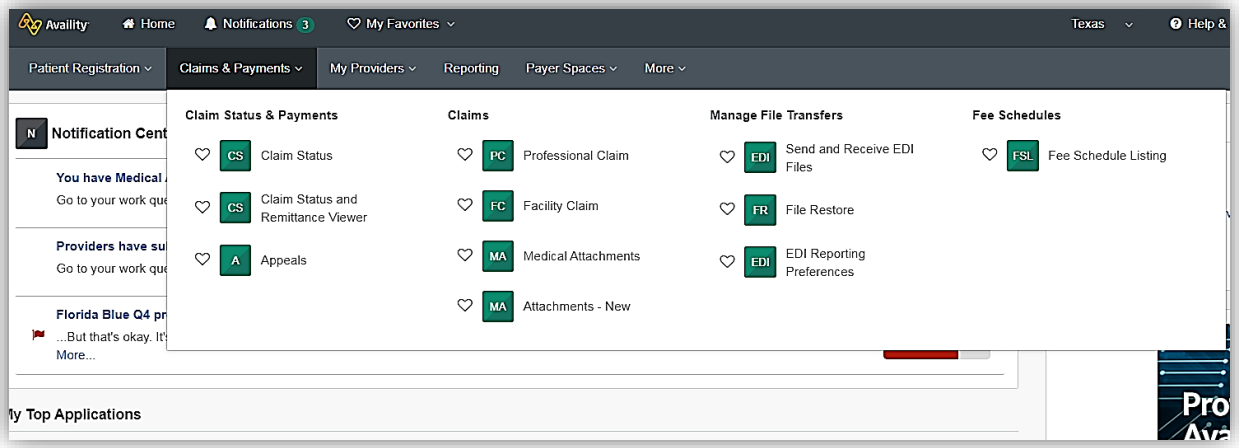
    Amerigroup

    P.O. Box 61599

    Virginia Beach, VA 23466-1599

Availity claims dispute tool

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



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

Provider medical appeals

This type of appeal is available to providers for a denial of services that have already been provided to the member and determined to be not medically necessary or appropriate.

- A provider medical appeal must be filed within 120 calendar days of the earlier date of the denial letter or the EOP. The appeal must be submitted in writing. Submit the Provider Payment Dispute to:

Amerigroup
Appeals Team

P.O. Box 61599

Virginia Beach, VA 23466-1599

Member medical appeals

- There is a 60-day filing limit from date of adverse benefit determination.
- Appeals may be submitted orally or in writing. A provider must have written authorization from the member to request a Medicaid member appeal. Written authorization is not necessary for a CHIP appeal.
- Member appeals can be requested by:
  Calling Member Services at **800-600-4441** (TTY 711) / STAR Kids **844-756-4600** (TTY 711).
- Send a letter or the request form included with our decision letter to:
  Amerigroup
  Appeals
  PO Box 62429
  Virginia Beach, VA 23466-2429

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.

Refer to the Provider Manual for complaint/appeal timelines.

Case management program

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

Disease management

- We offer programs for members living with:
  - Asthma.
  - Bipolar disorder.
  - Congestive heart failure.
  - Chronic obstructive pulmonary disease.
  - HIV/AIDS.
  - Hypertension.
  - Major depressive disorder.
  - Schizophrenia.
  - Substance use disorder and more.

Collaborative Care Model (CoCM)

According to Medicaid, the Collaborative Care Model (CoCM) is a systematic approach to the treatment of behavioral health conditions (mental health or substance use) in primary care settings. The model integrates the services of behavioral health care managers (BHCMs) and psychiatric consultants with primary care provider oversight to proactively manage behavioral health conditions as chronic diseases, rather than treating acute symptoms.

CoCM services are benefits of Texas Medicaid for people of all ages who have a mental health or substance use condition to include a pre-existing or suspected mental health or substance use condition, when provided by a primary care provider.

The primary care provider must attest they have an established CoCM program, prior to delivering CoCM services, using the *Attestation Form* for the Collaborative Care Model (CoCM) in Texas Medicaid that is available on the *Forms* web page of the TMHP website under the *Resources* menu. The primary care provider must complete an attestation form at the start of every new episode of care for each person receiving CoCM services to ensure adherence to the CoCM core principles and the specific functional requirements of the model, as described in the attestation form and the Texas Medicaid Provider Procedures Manual.

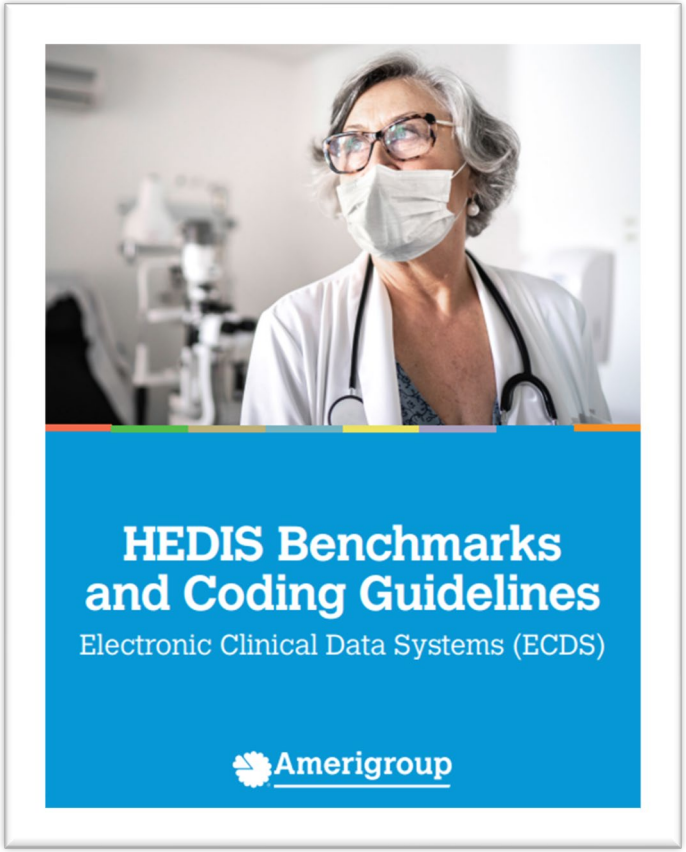
The attestation form must be maintained in the medical record of each person receiving CoCM services and made available to Texas Medicaid or its designee upon request.

To access the *CoCM Attestation form*, please follow this link Collaborative Care Model (CoCM) Attestation Form (tmhp.com)

Quality Management team

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

The Quality Measures Desktop Reference for Medicaid Providers can be found on the Amerigroup provider site. Amerigroup Quality Measures Desktop Reference



Fraud, waste, and abuse

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

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

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

- The Special Investigations Fraud Hotline at **866-847-8247** (reporting can be anonymous)
- Provider Services at **800-454-3730**.

Cultural competency

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

Caring for diverse populations

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

Children of traveling farmworkers

- HHSC defines a traveling farm worker as “a migratory agriculture worker whose principal employment is in agriculture on a seasonal basis, who has been employed in the last 24 months and who establishes for the purpose of such employment a temporary abode.”
- Texas traveling farmworker children face higher proportions of dental, nutritional, and chronic health problems than other children.
- Amerigroup assists children of traveling farmworkers in receiving accelerated services while they are in the area.
- We ask primary care providers to assist Amerigroup in identifying a child of a traveling farmworker by asking the child or parent about the parent’s occupation during an office visit.
- Call Amerigroup if you identify a child of a traveling farmworker at **800-600-4441** .

Interpreter services

- 24 hours a day, 7 days a week
- Supports over 170 languages
- Medicaid and CHIP Provider Services phone number:
  - **800-454-3730**
- Medicare Provider Services phone number: **866-805-4589**
- Amerigroup STAR+PLUS MMP Provider Services phone number: **855-878-1785**

Access and availability standards

Amerigroup depends on you to be accessible to our members. You are required to adhere to the following accessibility standards:

Texas behavioral health provider standards	
Emergency	Immediately
Non-life-threatening emergency	Within 6 hours (NCQA)
Urgent care	Within 24 hours
Routine care initial visit	The earlier of 10 business days or 14 calendar days
Routine care follow-up visit	Within 3 weeks
Post-hospital discharge	Within 7 days of discharge (for missed appointments, provider must contact member within 24 hours to reschedule)

Member records and documentation requirements

- The records must reflect all aspects of patient care, including ancillary services. The use of electronic medical records must conform to *HIPAA* requirements and other federal and state laws. Documentation of each visit must include the following:
  - Date of service
  - Complaint or purpose of visit
  - Diagnosis or medical impression
  - Objective finding
  - Assessment of patient's findings
  - Plan of treatment, diagnostic tests, therapies, and other prescribed regimens
  - Medications prescribed
  - Health education provided
  - Signature or initials and title of the provider rendering the service (if more than one person documents in the medical record, there must be a record on file as to which signature is represented by which initials)

Medical record standards

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

Medical record standards (cont.)

- **Past medical history for patients seen three or more times:** Past medical history must be easily identified, including serious accidents, operations, and illnesses. For children, the history must include prenatal care of the mother and birth.
- **Physical examination:** A record of physical examination(s) appropriate to the presenting complaint or condition must be noted.
- **Immunizations:** For pediatric records of members 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.
- **Diagnostic information:** Documentation of clinical findings and evaluation for each visit should be noted.

Medical record standards (cont.)

- **Medication information**: This notation includes medication information and instruction(s) to the patient.
- **Identification of current problems:** Significant illnesses, medical and 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.
- **Instructions:** The record must include evidence that the patient was provided with basic teaching/instructions regarding physical/behavioral health condition.
- **Smoking/alcohol/substance abuse**: 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.
- **Preventive services/risk screening**: The record must include consultation and provision of appropriate preventive health services and appropriate risk screening activities.

Medical record standards (cont.)

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

Medical record standards (cont.)

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

Medical record standards (cont.)

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

Medical record standards (cont.)

Integration of clinical care: Documentation of the integration of clinical care in both the physical and 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 healthcare 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

Reference tools and key resources

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

Medicaid and CHIP Provider Services: • Available Monday to Friday, 8 a.m. to 5 p.m. CT Medicare Dedicated Services Unit for member eligibility, Nurse HelpLine and pharmacy services Amerigroup STAR+PLUS MMP Provider Services	**800-454-3730** **866-805-4589** **855-878-1785**
Behavioral health Medicaid and CHIP inpatient fax Medicare inpatient fax Amerigroup STAR+PLUS MMP inpatient fax	**844-430-6805** **844-430-1702** **844-451-2825**
Behavioral health outpatient Medicare fax Behavioral health outpatient Amerigroup STAR+PLUS MMP fax	**844-430-1703** **844-430-6804**
Behavioral health outpatient Medicaid and CHIP fax	**844-442-8010**
24-hour Nurse HelpLine — Clinical services available 24 hours a day, 7 days a week. TTY services are available for members who are deaf or hard of hearing by calling 711. Language translation services are also available. 24-hour Nurse HelpLine for STAR Kids members 24-hour Nurse HelpLine for Medicare members 24-hour Nurse Helpline for Amerigroup STAR+PLUS MMP members	**800-600-4441** **844-756-4600** **866-805-4589** **855-878-1784**
Medicaid and CHIP Member Services STAR Kids Member Services Medicare Member Services Amerigroup STAR+PLUS MMP Member Services	**800-600-4441** **844-756-4600** **866-805-4589** **855-878-1784**
Access2Care Nonemergency Transportation Services: STAR STAR+PLUS STAR Kids Amerigroup STAR+PLUS MMP Medicare Nonemergency Transportation Services	 **833-721-8184** **844-867-2837** **844-864-2443** **844-869-2767** **844-923-0733**

Amerigroup Provider Relationship Management

You can contact your Provider Relationship Management Consultant by using our online webform.

https://provider.amerigroup.com/texas-provider/contact-us/email

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

https://provider.amerigroup.com