



Amerigroup

RealSolutions

in healthcareSM

LOUISIANA

PROVIDER MANUAL

1-800-454-3730

WWW.AMERIGROUPCORP.COM/PROVIDERS

September 2011 Amerigroup Corporation

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How to apply for participation

If you are interested in participating in the Amerigroup Louisiana network, please visit [www.amerigroupcorp.com/providers] or call a Provider Relations representative at [1-888-821-1108 and select the Louisiana option].

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 www.amerigroupcorp.com/providers for the most up-to-date information.

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Dear Provider,

Welcome to the Amerigroup Louisiana network. We're pleased you have joined us.

We combine national expertise with an experienced local staff to operate community-based health care plans and are here to help you provide quality health care to our members.

Along with hospitals, pharmacies and other providers, you play the most important role in managed care. Earning your respect and gaining your loyalty are essential to a successful collaboration in the delivery of health care.

We want to hear from you. We invite you to participate in one of our quality improvement committees. Or feel free to call Provider Services at 1-800-454-3730 with any suggestions, comments or questions.

Together, we can make a real difference in the lives of our members — your patients.

Sincerely,

C. Brian Shipp
President and CEO
Amerigroup Louisiana

1. INTRODUCTION

1.1. Who is Amerigroup?

Amerigroup Louisiana is a wholly owned subsidiary of Amerigroup Corporation. As a leader in managed health care services for the public sector, our plans help low-income families, children, pregnant women, people with disabilities and members of Medicare Advantage and Special Needs Plans get the health care they need.

We help coordinate physical and behavioral health care, and we offer education, access to care and disease management programs. As a result, we lower costs, improve quality and encourage better health status for our members.

We:

Improve access to preventive primary care services

Ensure selection of a primary care provider who will serve as provider, care manager and coordinator for all basic medical services

Improve health status outcomes for members

Educate members about their benefits, responsibilities and appropriate use of care

Utilize community-based enterprises and community outreach

Integrate physical and behavioral health care

Encourage:

Stable relationships between our providers and members

Appropriate use of specialists and emergency rooms

Member and provider satisfaction

In a world of escalating health care costs, we work to educate our members about the appropriate use of our managed care system and their involvement in all aspects of their health care.

1.2. Quick Reference Information

1.3. Amerigroup Website

Our provider website, www.amerigroupcorp.com/providers, offers a full complement of online tools, including improved functions like:

- Enhanced account management tools
- Detailed eligibility look-up tool with downloadable panel listing
- Comprehensive, downloadable member listings
- Easier authorization submission
- New provider data, termination and roster tools
- Access to drug coverage information

1.4. Amerigroup Louisiana Health Plan Office Addresses

These offices will open in 2012.

Amerigroup Louisiana - Serving GSA 1
[Health Plan Address]
[City, State ZIP]
[Phone]

Amerigroup Louisiana - Serving GSA 2
[Health Plan Address]
[City, State ZIP]
[Phone]

Amerigroup Louisiana - Serving GSA 3
[Health Plan Address]
[City, State ZIP]
[Phone]

1.5. Phone Numbers

Provider Services	1-800-454-3730 Monday through Friday, 7:00 a.m. to 7:00 p.m. Central time Voice portal — 24 hours a day, 7 days a week Interpreter services available
Member Services	1-800-600-4441 Monday through Friday, 7:00 a.m. to 7:00 p.m. Central time Saturday, 8:00 a.m. to 12:00 p.m. Central time
Amerigroup On Call Nurse Help Line	24 hours a day, 7 days a week
AT&T Relay Services	1-800-855-2880
Vision Services EyeQuest	[1-800-949-0574]
Nonemergent Transportation Logisticare	[1-xxx-xxx-xxxx]
Durable Medical Equipment, Home Health and Home Infusion Univita	[1-888-914-2201]
Electronic Data Interchange Hotline	1-800-590-5745
Member Eligibility	Online at www.amerigroupcorp.com/providers 1-800-454-3730
Precertification/ Notification	Online at www.amerigroupcorp.com/providers 1-800-964-3627 Fax 1-800-454-3730 Phone

Please provide:

- Member ID number
- Legible name of referring provider
- Legible name of person referred to provider
- Number of visits/services
- Date(s) of service
- Diagnosis
- CPT code
- Clinical information

Forms are available online.

Claims Information

File claims online through www.amerigroupcorp.com/providers.

Electronic Claims Payer ID:

- Emdeon (formerly WebMD) is 27514
- Capario (formerly MedAvant) is 28804
- Availity (formerly THIN) is 26375

Paper claims go to:

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

Timely filing is within 365 calendar days of the date of service.

Check claim status online or through our Interactive Voice Response (IVR) system at 1-800-454-3730.

Member Medical Appeal Information

Must be filed within 30 calendar days of the date of action

You may appeal on behalf of the member with written authorization.

Submit a member medical appeal to:

Central Appeals and Grievance Processing
Amerigroup Louisiana
P.O. Box 62429
Virginia Beach, VA 23466-2429

1.6. Provider Claims Payment

Questions or Issues

Amerigroup strives to continuously increase service quality to our providers. Our Provider Experience Program helps you with claims payment* and issue resolution.

Just Call 1-800-454-3730 and select the Claims prompt within our voice portal.

The Provider Experience Program connects you with a dedicated resource team 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

**Please note that if you choose to use the program, you may miss your opportunity to file a formal payment dispute, as the timely filing period will commence from the date of the Explanation of Payment (EOP).*

Payment Dispute

If after working through the Provider Experience Program you remain in disagreement over a zero or partial claim payment, or in lieu of this process, you may file a formal dispute with the Amerigroup Payment Dispute Unit. We must receive your dispute within 90 calendar days from the date of the EOP.

We will send a determination letter within 30 business days of receiving the dispute.

If you are dissatisfied, you may submit a request for a Level II review. We must receive your request within 30 calendar days of receipt of the Level I determination letter.

Submit a payment dispute to:
Payment Dispute Unit
Amerigroup Louisiana
P.O. Box 61599
Virginia Beach, VA 23466-1599

Member Grievances

Submit a member grievance to:
Central Appeals and Grievance Processing
Amerigroup Louisiana
P.O. Box 62509
Virginia Beach, VA 23466-2509

Case Managers

Available from 7:30 a.m. to 4:30 p.m. Central time
For urgent issues at all other times, call 1-800-454-3730.

Provider Services

1-800-454-3730

Louisiana Department
of Health and Hospitals,
Bureau of Health
Services Financing

1-888-342-6207

2. PROVIDER INFORMATION

2.1. Member Medical Home

As a Primary Care Provider (PCP), you serve as the entry point into the health care system for the member — you are the foundation of the collaborative concept known as a Patient-Centered Medical Home (PCMH). The PCMH is a model of care that strengthens the clinician-patient relationship by replacing episodic care with coordinated care.

Each patient has a relationship with a PCP who leads a team that takes collective responsibility for patient care, providing for all of the patient's health care needs and appropriately arranging care with other qualified professionals. A medical home is a collaborative relationship that provides high levels of care, access and communication, care coordination and integration, and care quality and safety, including provision of preventive services and treatment of acute and chronic illness. The medical home is intended to result in more personalized, coordinated, effective and efficient care.

Several organizations have introduced a set of standards and a process through which primary care practices may be recognized as PCMHs. The best reason for pursuing PCMH recognition is that fulfilling the requirements of a recognition process will help your organization make great strides toward transforming into a true medical home — a health center of the 21st century where care is coordinated, accessible and keeps patients at the center. Completing the recognition process will allow your organization to assess its strengths and achievements, recognize areas for improvement and ultimately develop more efficient, effective and patient-centered care processes.

Amerigroup acknowledges and supports practices that participate in and align with various accrediting organizations. The National Committee for Quality Assurance (NCQA) offers a Physician Practice Connections (PPC[®])-PCMH[™] program to recognize practices as PCMHs. There are six standards containing 27 individual elements. Six of these elements are designated as must pass. The four primary care specialty societies that developed the Joint Principles — American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, and the American Osteopathic Association — recommended these must-pass elements because they were seen as essential building blocks of a medical home. There are three levels of NCQA PCMH recognition; each level reflects the degree to which a practice meets the requirements of the elements and factors that comprise the standards. Practices seeking PPC[®]-PCMH[™] recognition complete a web-based data collection tool and provide documentation that validates responses.

We offer the following support to practices that achieve PCMH status:

- Suite of reports to assist with management of your patient population
- Opportunities for frequent interaction with our medical director
- Dedicated, local medical-practice consultants who support practice improvements and facilitate information sharing
- Alignment of care coordination activities, including case managers who work with your practice and may collaborate with you onsite
- Quality coaches who educate and support your practice to build systems for quality improvement
- Innovative models of reimbursement and incentives

2.2. Primary Care Providers

You are responsible for the complete care of your patient, including:

- Providing primary care

- Provide the level of care and range of services necessary to meet the medical needs of members, including those with special needs and chronic conditions
- Coordinating and monitoring referrals to specialist care
- Coordinating and monitoring referrals to specialized behavioral health in accordance with state requirements
- Referring patients to subspecialists and subspecialty groups and hospitals for consultation and diagnostics according to evidence-based criteria for such referrals as it is available
- Authorizing hospital services
- Maintaining the continuity of care
- Assuring all medically necessary services are made available in a timely manner
- Providing services ethically and legally and in a culturally competent manner
- Monitoring and following up on care provided by other medical service providers for diagnosis and treatment
- Maintaining a medical record of all services rendered by you and other referral providers
- Communicating with members about treatment options available to them, including medication treatment options regardless of benefit coverage limitations
- Providing a minimum of 32 office hours per week of appointment availability as a PCP
- Arranging for coverage of services to assigned members 24 hours a day, 7 days a week in person or by an on-call physician
- Offering evening and Saturday appointments for members (strongly encouraged for all PCPs)
- Answering emergent and urgent telephone calls from members immediately or return calls within 30 minutes from when calls are received
- Continuing care in progress during and after termination of your contract for up to 30 days until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations

2.3. Responsibilities of the PCP

You also have the responsibility to:

Communicate with Members

- Make provisions to communicate in the language or fashion primarily used by the member; contact our customer care center for help with oral translation services if needed
- Freely communicate with members about their treatment regardless of benefit coverage limitations
- Provide complete information concerning their diagnoses, evaluations, treatments and prognoses and give members the opportunity to participate in decisions involving their health care
- Advise members about their health status, medical care and treatment options regardless of whether benefits for such care are provided under the program
- Advise members on treatments which may be self-administered
- Contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings

Maintain Medical Records

- Treat all members with respect and dignity
- Provide members with appropriate privacy
- Treat members' disclosures and records confidentially, giving members the opportunity to approve or refuse their release

- Maintain the confidentiality of family planning information and records for each individual member, including those of minor patients
- Comply with all applicable federal and state laws regarding the confidentiality of patient records
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research shall be clearly contrasted with entries regarding the provision of nonresearch-related care
- Share records subject to applicable confidentiality and HIPAA requirements
- Obtain/store medical records from any specialty referrals in members' medical records
- Manage the medical and health care needs of members to assure all medically necessary services are made available in a timely manner

Cooperate and Communicate with Amerigroup

- Participate in:
 - Internal and external quality assurance
 - Utilization review
 - Continuing education
 - Other similar programs
 - Complaint and grievance procedures when notified of a member grievance
- Inform Amerigroup if a member objects to provision of any counseling, treatments or referral services for religious reasons
- Identify members who would benefit from our case management/disease management programs
- Comply with our Quality Improvement Program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner

Cooperate and Communicate with Other Providers

- Monitor and follow up on care provided by other medical service providers for diagnosis and treatment, including services available under Medicaid fee-for-service
- Provide the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through Medicaid
- Provide case management services to include but not be limited to screening and assessing, developing a plan of care to address risks, medical/behavioral health needs and other responsibilities as defined in the Coordinated Care Network-Prepaid (CCN-P) program
- Coordinate the services Amerigroup furnishes to the member with the services the member receives from any other CCN-P program during member transition
- Share with other health care providers serving the member the results of your identification and assessment of any member with special health care needs (as defined by the state) so those activities are not duplicated

Cooperate and Communicate with Other Agencies

- Maintain communication with the appropriate agencies such as:
 - Local police
 - Social services agencies
 - Poison control centers
 - Women, Infants and Children (WIC) program
- Develop and maintain an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens
- Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act

As a PCP, you may practice in a:

- Solo or group setting
- Clinic (e.g., a Federally Qualified Health Center [FQHC] or Rural Health Center [RHC])
- Outpatient clinic

2.4. Who Can Be a PCP?

Physicians with the following specialties can apply for enrollment with Amerigroup as a PCP:

- Advance nurse practitioner
- Family practitioner
- General practitioner
- General pediatrician
- General internist
- Nurse practitioner certified as a specialist in family practice or pediatrics
- OB/GYN
- FQHCs and RHCs

2.5. PCP Onsite Availability

You are required to abide by the following standards to ensure access to care for our members:

- Offer 24-hour-a-day, 7-day-a-week telephone access for members. A 24-hour telephone service may be used. The service may be answered by a designee such as an:
 - On-call physician
 - Nurse practitioner with physician backup
 - Answering service or a pager system; however, this must be a confidential line for member information and/or questions. An answering machine is not acceptable. If an answering service or pager system is used, the call must be returned within 30 minutes.
- Be available to provide medically necessary services. You or another physician must offer this service.
- Follow the referral/precertification guidelines. This is a requirement for covering physicians.

Additionally, we encourage you to offer after-hours office care in the evenings and on Saturdays.

It is not acceptable to automatically direct the member to the emergency room when the PCP is not available.

2.6. PCP Access and Availability

The ability for Amerigroup to provide quality access to care depends upon your accessibility.* You are required to adhere to the following access standards:

Type of Care	Standard
Emergency	Immediately
Urgent Care	Within 24 hours
Nonurgent Sick Care*	Within 72 hours
Routine or Preventive Care*	Within six weeks
Prenatal Care*^ – Initial Visit	For 1st Trimester: 14 days For 2nd Trimester: 7 days For 3rd Trimester: 3 days High Risk: Within 3 days or sooner if needed

*In-office wait time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room.

^For women who are past their first trimesters of pregnancy on the first day they are determined to be eligible for Louisiana Medicaid, first prenatal appointments shall be scheduled as outlined in this chart.

Each patient should be notified immediately if the provider is delayed for any period of time. If the appointment wait-time is anticipated to be more than 90 minutes, the patient should be offered a new appointment. Walk-in patients with nonurgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

As part of our commitment to providing the best quality provider networks for our members, we conduct annual telephonic surveys to verify provider appointment availability and after-hours access. Providers will be asked to participate in this survey each year.

Providers may not use discriminatory practices such as:

- Showing preference to other insured or private-pay patients
- Maintaining separate waiting rooms
- Maintaining appointment days
- Denying or not providing to a member any covered service or availability of a facility
- Providing to a member any covered service that is different or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large

We will routinely monitor providers' adherence to access-to-care standards and appointment wait times. You are expected to meet federal and state accessibility standards and those standards defined in the Americans with Disabilities Act of 1990. Health care services provided through Amerigroup must be accessible to all members.

For urgent care and additional after-hours care information, see Urgent Care/After-hours Care section.

2.7. Members Eligibility Listing

You should verify each member receiving treatment in your office actually appears on your membership listing. Accessing your panel membership listing via our provider website online tool is the most accurate way to determine member eligibility. You will have secure access to an electronic listing of your panel of assigned members,, once registered and logged into our provider website.

To request a hard copy of your panel listing be mailed to you, call Provider Services.

2.8. Specialty Care Providers

A specialty care provider is a network physician responsible for providing specialized care for members, usually upon appropriate referral from members' PCPs.

Members and providers can access a searchable online directory by logging into our website with their secure IDs and passwords. Providers receive this ID and password upon completion of credentialing and contracting with us, and can view the online directory by:

- Logging in to our provider website
- Selecting Referral Info from the RealTools menu
- Selecting either Searchable Directory or Downloadable Directories from the Referral Info drop-down menu

2.9. Role and Responsibility of Specialty Care Providers

As a specialist, you will treat members who are:

- Referred by network PCPs
- Self-referred

You are responsible for:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program
- Accepting all members referred to you
- Rendering covered services only to the extent and duration indicated on the referral
- Submitting required claims information including source of referral and referral number
- Arranging for coverage with network providers while off duty or on vacation
- Verifying member eligibility and precertification of services at each visit
- Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis
- Notifying the member's PCP when scheduling a hospital admission or scheduling any procedure requiring the PCP's approval
- Coordinating care with other providers for:
 - Physical and behavioral health comorbidities
 - Co-occurring behavioral health disorders
- Adhering to the same responsibilities as the PCP

2.10. Specialty Care Providers Access and Availability

You must adhere to the following access guidelines:

Type of Care	Access Standard
Medically Necessary Care	Same day (within 24 hours of referral)
Urgent Care	Within 24 hours of referral
Routine	Within one month of referral

Type of Care	Access Standard
Lab Referrals or X-rays – urgent care	Within 48 hours or as clinically indicated
Lab Referrals or X-rays – regular appointments	Not to exceed three weeks

2.11. Member Enrollment

Medicaid recipients who meet the state’s eligibility requirements for participation in managed care are eligible to join Amerigroup. Members are enrolled without regard to their health status. Our members:

- Are enrolled for a period of 12 months contingent upon continued Medicaid eligibility
- Can choose their PCPs and will be auto-assigned to PCPs if they do not select PCPs
- Are encouraged to make appointments with their PCPs within 90 calendar days of their effective dates of enrollment

Eligible newborns born to members are automatically enrolled with Amerigroup on the date of birth if the mother of the newborn was enrolled with Amerigroup before the birth and has not made an alternative CCN or PCP selection. We are responsible for all covered medically necessary services to the qualified newborn.

2.12. PCP Automatic Assignment Process for Members

During enrollment, a member can choose his or her Primary Care Physician (PCP). When a member does not choose a PCP at the time of enrollment or is automatically assigned to Amerigroup, he or she is auto-assigned to a PCP within one business day from the date Amerigroup processes the daily eligibility file from the state.

PCP auto-assignments are based on proximity to members’ home addresses, as well as ages, genders and primary spoken languages. If a member loses coverage for a period of time and is reinstated with Amerigroup, he or she will be assigned to the most recent provider that was previously assigned to him or her.

Members receive an Amerigroup-issued identification card that displays the PCP name and phone number, in addition to other important plan contact information.

Members may elect to change their PCPs at any time by calling Amerigroup Member Services. The requested changes will become effective no later than the following day, and a new ID card will be issued.

2.13. Member Identification Cards

Amerigroup member identification card sample:

 <p>Amerigroup Louisiana, 3850 N. Causeway Blvd., Metairie, LA 70002 www.myamerigroup.com/LA</p> <p>Member Name: MBRNAME Medicaid or LaCHIP Number: MBRALTKEY Primary Care Provider (PCP): PCPNAME PCP Telephone #: PCPPHONE PCP After Hours #: CLINICPHONE PCP Address: PCP_ADDRESS_LINE1 PCP_ADDRESS_LINE2 Vision Care: 1-800-787-3157</p> <p>Member Services and Behavioral Health: 1-800-600-4441 Amerigroup On Call/Nurse HelpLine: 1-866-864-2544</p>	<p>Effective Date: MDYEFF Date of Birth: MDYDOB Subscriber #: MEMBERID</p> <p>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. If you have an emergency, call 911 or go to the nearest emergency room. Always call your Amerigroup PCP for nonemergency care. If you have questions, call Member Services at 1-800-600-4441. If you are deaf or hard of hearing, call 1-800-855-2880.</p> <p>MIEMBROS: Lleve consigo siempre esta tarjeta de identificación. Muéstrela antes de recibir atención médica. Usted no necesita mostrar esta tarjeta antes de recibir atención de emergencia. Si tiene una emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Llame siempre a su PCP de Amerigroup para la atención que no es de emergencia. Si tiene alguna pregunta, llame a Servitros para Miembros al 1-800-600-4441. Llame al 1-800-855-2884 si es una persona sorda o tiene problemas de la audición.</p> <p>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.</p> <p>PROVIDERS: Certain services must be preauthorized. Care that is not preauthorized may not be covered. For preauthorization/billing information, call 1-800-454-3730.</p> <p>SUBMIT MEDICAL CLAIMS TO: AMERIGROUP • P.O. BOX 61010 • VIRGINIA BEACH, VA 23466-1010 USE OF THIS CARD BY ANY PERSON OTHER THAN THE MEMBER IS FRAUD. Louisiana Medicaid Fraud and Abuse Hotline: 1-800-422-2917</p> <p>LA01 01/12</p>
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This ID card is separate from the DHH ID card issued to the member by the state.

2.14. Member Missed Appointments

At times, members may cancel or not attend necessary appointments and fail to reschedule, which can be detrimental to their health. You should attempt to contact any member who has not shown up for or canceled an appointment without rescheduling. Contact the member by telephone to:

- Educate him or her about the importance of keeping appointments
- Encourage him or her to reschedule the appointment

For members who frequently cancel or fail to show up for appointments, please call Provider Services at 1-800-454-3730 to address the situation. Our goal is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCPs.

2.15. Noncompliant Members

Contact Provider Services if you have an issue with a member regarding:

- Behavior
- Treatment cooperation
- Completion of treatment
- Continuously missed or rescheduled appointments

We will contact the member to provide the education and counseling to address the situation and will report to you the outcome of any counseling efforts.

2.16. Members with Special Needs

Adults with special needs include those members with complex/chronic medical conditions requiring specialized health care services, including persons with physical, behavioral and/or developmental disabilities. Children with special health care needs are those members who have or are at an increased risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required generally by children.

Amerigroup has developed methods for:

- Well-child care
- Health promotion and disease prevention
- Specialty care for those who require such care
- Diagnostic and intervention strategies
- Therapies
- Ongoing ancillary services
- Long-term management of ongoing medical complications
- Care management systems for assuring children with serious, chronic and rare disorders receive appropriate diagnostic workups on a timely basis

We have policies and procedures to allow for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member.

Amerigroup, with the assistance of network providers, will identify members who are at risk of or have special needs. The identification will include the application of screening procedures for new members. These will include a review of hospital and pharmacy utilization. We will develop care plans with the member and his or her representatives that address the member's service requirements with respect to specialist physician care, durable medical equipment, home health services, transportation, etc. The care management system is designed to ensure that all required services are furnished on a timely basis and that communication occurs between network and non-network providers if applicable.

We work to ensure a new member with complex/chronic conditions receives immediate transition planning. The transition plan will include the following:

- Review of existing care plans
- Preparation of a transition plan that ensures continual care during the transfer to the plan

If a new member upon enrollment or a member upon diagnosis requires very complex, highly specialized health care services over a prolonged period of time, the member may receive care from a participating specialist or a participating specialty care center with expertise in treating the life-threatening disease or specialized condition.

Training sessions/materials and after-hours protocols for provider's staff will address members with special needs. Protocols must recognize that a nonurgent condition for an otherwise healthy member may indicate an urgent care need for a member with special needs.

Case/care managers, providers and Member Services staff are able to serve members with behavior problems associated with developmental disabilities, including the extent to which these problems affect the member's level of compliance.

2.17. Covering Physicians

During your absence or unavailability, you need to arrange for coverage for your members assigned to your panel. You will be responsible for making arrangements with:

- One or more network providers to provide care for your members or
- Another similarly licensed and qualified participating provider who has appropriate medical staff privileges at the same network hospital or medical group to provide care to the members in question

In addition, the covering provider will agree to the terms and conditions of the network provider agreement, including any applicable limitations on compensation, billing and participation.

You will be solely responsible for:

- A non-network provider's adherence to our network provider agreement
- Any fees or monies due and owed to any non-network provider providing substitute coverage to a member on the provider's behalf

2.18. Provider Support

We support our providers by providing telephonic access to Provider Services at our national contact centers, in addition to local Provider Relations representatives (PR reps).

- Provider Services supports provider inquiries about member benefits and eligibility and authorizations and claims issues via our Provider Experience Program.
- PR reps are assigned to all participating providers; they facilitate provider orientation and education programs that address Amerigroup policies and programs. PR reps visit provider offices to share information on at least an annual basis.

Amerigroup also provides communications to providers through newsletters, alerts and updates. These communications are posted to our Provider website and may also be sent to providers via email, fax or regular mail.

As part of our commitment to providing the best quality provider networks for our members, we conduct annual telephonic surveys to verify provider appointment availability and after-hours access. Providers will be asked to participate in this survey each year.

To collect your feedback on how well Amerigroup meets your needs, we conduct an annual provider satisfaction survey. You will receive this survey via mail or email. If you are selected to participate, we appreciate you taking the time complete the survey and provide input to improve our service to you.

2.19. Reporting Changes in Address and/or Practice Status

To maintain the quality of our provider data, we ask that changes to your practice contact information or the information of participating providers within a practice be submitted as soon as you are aware of the change.

If you have status or address changes, report them through www.amerigroupcorp.com/providers or to:

Provider Relations Department
Amerigroup Louisiana Main Office
[Health Plan Address]
[City, State ZIP]
Phone

2.20. Second Opinions

A member, parent and/or legally appointed representative or the member's PCP may request a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery 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 (see Provider Referral Directory) or a non-network provider if there is not a network provider with the expertise required for the condition. Authorization is required for a second opinion if the provider is not a network provider. Once approved, you will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. You 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 our 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 you and the member of the results of the second opinion and the consulting provider's conclusion and recommendation(s) regarding further action.

2.21. Medically Necessary Services

Medically necessary services are those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be:

- Deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction
- No more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational or cosmetic are specifically excluded from Medicaid coverage and will be deemed not medically necessary. The Medicaid director, in consultation with the Medicaid medical director, may consider authorizing services at his or her discretion on a case-by-case basis.

We only cover items and services which are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part.

2.22. Provider Bill of Rights

Each network provider who contracts with Amerigroup to furnish services to members has the right to:

- While acting within the lawful scope of practice, advise or advocate on behalf of a member who is his or her patient regarding:
 - o The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered
 - o Any information the member needs in order to decide among all relevant treatment options
 - o The risks, benefits and consequences of treatment or nontreatment
 - o The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and express preferences about future treatment decisions
- Receive information on the grievance, appeal and state fair hearing procedures
- Have access to Amerigroup policies and procedures covering the authorization of services
- Be notified of any decision by Amerigroup to deny a service authorization request or authorize a service in an amount, duration or scope that is less than requested
- Challenge on the member's behalf, at the request of the Medicaid/CHIP member, the denial of coverage or payment for medical assistance
- Be free from discrimination where Amerigroup selection policies and procedures govern particular providers that serve high-risk populations or specialize in conditions that require costly treatment
- Be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification

2.23. Provider Surveys

Amerigroup will conduct an annual survey to assess provider satisfaction with provider enrollment, communications, education, complaints resolution, claims processing, claims reimbursement and utilization management processes, including medical reviews and support toward patient-centered medical home implementation.

Our provider satisfaction survey tool and methodology will be submitted to the DHH for approval prior to administration. A results report summarizing the survey methods, findings and analysis of opportunities for improvement will be provided to the DHH for review within 120 days after the end of the plan year.

2.24. Prohibited Marketing Activities

Amerigroup and its subcontractors, including health care providers, are prohibited from engaging in the following, which are considered to be member marketing activities:

- Marketing directly to Medicaid potential enrollees or Amerigroup prospective enrollees, including persons currently enrolled in Medicaid or other Coordinated Care Networks (CCNs) (includes direct mail advertising, spam, door-to-door visits, telephonic or other cold call marketing techniques)
- Asserting that Amerigroup or any other CCN is endorsed by the Centers for Medicare & Medicaid Services, the federal or state government or similar entity
- Distributing plans and materials or making any statement (written or verbal) that the DHH determines to be inaccurate, false, confusing, misleading or intended to defraud members or the DHH; this includes statements which mislead or falsely describe covered services, membership, availability of providers, qualifications and skills of providers or assertions the recipient of the communication must enroll in a specific health plan in order to obtain or not lose benefits

- Portraying CCN competitors or potential competitors in a negative manner
- Attaching a Medicaid application and/or an enrollment form to marketing materials
- Assisting with enrollment or improperly influencing CCN selection
- Inducing or accepting a member's enrollment or disenrollment
- Using the seal of the state of Louisiana or the DHH name, logo or other identifying marks on any materials produced or issued without the prior written consent of DHH
- Distributing marketing information (written or verbal) that implies joining CCNs or a particular CCN is the only means of preserving Medicaid coverage, that CCNs or a particular CCN is the only provider of Medicaid services and the potential enrollee must enroll in the CCN or CCNs to obtain benefits or not lose benefits
- Comparing Amerigroup to another organization and/or CCN by name
- Sponsoring or attending any marketing or community health activities or events without notifying DHH at least 30 days in advance
- Engaging in any marketing activities, including unsolicited personal contact with a potential enrollee at an employer-sponsored enrollment event where employee participation is mandated by the employer
- Offering gifts or material (either provided by Amerigroup or a third-party source) with financial value or financial gain as incentive to or conditional upon enrollment; promotional items having no substantial resale value (e.g., \$15.00 or less) are not considered things of financial value; cash gifts of any amount, including contributions made on behalf of people attending a marketing event, gift certificates or gift cards are not permitted to be given to enrollees or the general public
- Making reference to any health-related rewards offered by the plan (e.g., monetary rewards for participation in smoking cessation) in pre-enrollment marketing materials
- Marketing or distributing marketing materials, including member handbooks, and soliciting members in any other manner – inside, at the entrance or within 100 feet of check-cashing establishments, public assistance offices, Department of Children and Family Services eligibility offices for the Supplemental Nutrition Assistance Program (SNAP), Family Independence Temporary Assistance Program, Medicaid Eligibility Offices and/or certified Medicaid Application Centers; Medicaid Eligibility Office staff or approved DHH agents shall be the only authorized personnel to distribute such materials
- Conducting marketing or distributing marketing materials in hospital emergency rooms, including the emergency room waiting areas, patient rooms or treatment areas
- Copyrighting or releasing any report, graph, chart, picture or other document produced in whole or in part relating to services provided under the state contract on behalf of the CCN without the prior written consent of DHH
- Purchasing or otherwise acquiring or using mailing lists of Medicaid eligibles from third-party vendors, including providers and state offices
- Using raffle tickets or event attendance or sign-in sheets to develop mailing lists of prospective enrollees
- Charging members for goods or services distributed at events
- Charging members a fee for accessing the CCN website
- Influencing enrollment in conjunction with the sale or offer of any private insurance
- Using a personal or provider-owned communication device (e.g., telephone, cell phone, fax machine or computer) to assist a person enrolling in a CCN
- Using terms that would influence, mislead or cause potential members to contact the CCN rather than the DHH-designated enrollment broker for enrollment
- Referencing the commercial component of the CCN in any of its Medicaid CCN enrollee marketing materials, if applicable

- Using terms in marketing materials such as choose, pick, join, etc. unless the marketing materials include the enrollment broker's contact information

2.25. Coordinated Care Network Health Care Benefits

Covered Service
<p>Ambulatory Surgical Services Covered services include medically necessary diagnostic, preventive, therapeutic, rehabilitative or palliative items or services furnished to an outpatient.</p>
<p>Audiology Services Covered services include diagnostic, preventive or corrective services for individuals with speech, hearing and language disorders provided by or under the direction of an audiologist.</p>
<p>Behavioral Health Services Covered services include:</p> <ul style="list-style-type: none"> • Screening • Prevention • Early intervention and referral services given in the PCP's or practitioner's office • Inpatient hospital services based on medical need, such as acute medical detox
<p>Chiropractic Services Covered services include medically needed spinal manipulations for Medicaid members under age 21 referred to a chiropractor as part of an EPSDT checkup.</p>
<p>Clinic Services (Other than Hospitals) Covered services include diagnostic, preventive, therapeutic, rehabilitative or palliative items or services furnished to an outpatient by or under the direction of a physician in a facility that is not part of a hospital (e.g., mental health clinics, prenatal health care clinics, family planning clinics, end-stage renal disease facilities and radiation therapy centers)</p>
<p>Clinical Lab Services, Diagnostic Testing and Radiology Services</p> <ul style="list-style-type: none"> • Inpatient and outpatient lab services

Covered Service
<p>(see coverage limits for hospital outpatient facilities)</p> <ul style="list-style-type: none"> • Diagnostic testing and radiology services • Portable (mobile) services for members who cannot leave their home without special transport are included
<p>Communicable Disease Services Services include exams, treatment and health education to help control and prevent communicable diseases such as Tuberculosis (TB), Sexually Transmitted Infection (STI) and HIV/AIDS.</p>
<p>Durable Medical Equipment (DME) Services include medically needed medical supplies, appliances and assistive devices for members, including hearing aids and disposable incontinence supplies.</p>
<p>Early Periodic Screening, Diagnosis and Treatment (EPSDT)/Well-child Visits The EPSDT service is a complete and preventive child health program for Medicaid members under age 21.</p> <p>It covers a health and development history, complete physical exam, proper immunizations, screenings and diagnostic services (including lead blood level assessment). It also includes vision, hearing and dental screening to decide health care needs and other measures to identify, correct or improve physical or mental defects or chronic conditions.</p>
<p>Emergency Dental Services Covered services include laboratory or radiological services that may be required to treat an emergency or provide surgical services related to an emergency.</p>
<p>Emergency Medical Services Includes emergency care in and out of network and poststabilization care.</p>
<p>End-stage Renal Disease Services</p>
<p>Eye Care and Vision Services Includes vision services from a licensed ophthalmologist or optometrist.</p>

Covered Service
Family Planning Services
<p>Federally Qualified Health Centers Amerigroup covers access to behavioral health and covered services offered through a Federally Qualified Health Center (FQHC) if the member lives in the service area of the FQHC and either:</p> <ul style="list-style-type: none"> • Chooses the FQHC as his or her PCP • Needs emergency care • Requests to get these services from the FQHC by calling Member Services
<p>Home Health Services Amerigroup covers skilled nursing, therapeutic care, supplies and health aide services provided in a member's residence. Extended home health services are available to members ages newborn to 20 years.</p>
Immunizations
<p>Inpatient Hospital Services (Stays expected to last over 24 hours)</p> <p>Hospital care needed for the treatment of an illness or injury which can only be provided safely and adequately in a hospital setting.</p>
Medical Transportation Services
Organ Transplant and Related Services
<p>Outpatient Nonpsychiatric Hospital Services (Stays not expected to last over 24 hours)</p> <p>Services that can be properly given on an outpatient or ambulatory basis, such as lab, radiology, therapies, ambulatory surgery or observations.</p>
<p>Physician Services Services performed in a physician's office, such as medical assessments, treatments and surgical services.</p>
Podiatry Services
Poststabilization Care Services

Covered Service
Private Duty Nursing
Rehabilitation Therapy Services Occupational, physical, speech and respiratory therapies.
School-based Health Clinic Services Care and case management and referrals to Medicaid services offered within school setting to Medicaid-eligible children under age 21.
Sterilization Sterilization means a medical procedure, treatment or operation that causes the person to no longer be able to reproduce.
Transplant-related Services Services for members diagnosed with certain medical conditions needing heart, kidney, liver, bone marrow, small bowel or pancreas transplants.
Women’s Health Services – Abortions See form at the back of this manual
Women’s Health Services – Hysterectomies See form at the back of this manual
Women’s Health Services – OB/GYN Services
Women’s Health Services – Prenatal Services
Women’s Health Services - Postpartum Care

Note: We do not cover experimental procedures or medications.]

2.26. Amerigroup Value Added Services

Amerigroup covers extra benefits, including but not limited to the following, which eligible members cannot get from fee-for-service Medicaid. These extra benefits are called value-added services.

COVERED SERVICE	COVERAGE LIMITS
Amerigroup On Call	<p>Amerigroup On Call is a telephonic, 24-hour triage service your Amerigroup patients can call to speak with a Registered Nurse who can help them:</p> <ul style="list-style-type: none"> • Find doctors when your office is closed, whether after hours or weekends • Schedule appointments with you or other network doctors • Get to urgent care centers or walk-in clinics • Speak directly with a doctor or a member of the doctor’s

COVERED SERVICE	COVERAGE LIMITS
	<p>staff to talk about their health care needs</p> <p>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.</p> <p>Members can reach Amerigroup On Call at 1-866-864-2544 (Spanish 1-866-864-2545). TTY services are available for the hearing impaired, and language translation services are also available.</p>
<p>Bedding (hypoallergenic) For members diagnosed with asthma; bedding includes:</p> <ul style="list-style-type: none"> • Pillows • Pillow cases • Mattresses • Mattress covers • Sheets 	<p>One-time \$100 benefit per member per lifetime. Prior approval is required.</p>
<p>Cellular Phone Service SafeLink cell phone minutes for qualifying members</p>	<p>100 minutes per member per lifetime. The member must opt into receipt of no-cost health-oriented text message receipt from health plan. Pregnant members are encouraged to sign up for and opt into receive no-cost pregnancy education text messages during pregnancy from the Healthy Mothers Healthy Babies Text4baby program.</p>
<p>Disease Management Programs</p>	<p>Disease Management programs to help members manage:</p> <ul style="list-style-type: none"> • Asthma • Bipolar disorder • Chronic obstructive pulmonary disease • Congestive heart failure • Coronary artery disease • Diabetes • HIV/AIDS • Hypertension • Major depressive disorder • Obesity • Schizophrenia • Transplants
<p>Respite Services For caregivers of members who receive personal assistance services</p>	<p>Eight hours of respite per month per member. Prior approval is required.</p>
<p>Smoking Cessation Services Free online program that includes nicotine replacement therapies, coaching and support</p>	<p>Administered by National Jewish Health.</p> <p>All pregnant members are screened for smoking and offered information about accessing the state-sponsored Smoking</p>

COVERED SERVICE	COVERAGE LIMITS
	Cessation Quitline.
<p>Weight Management Support</p> <p>Weight Watchers program is available only for eligible health plan members</p> <p>Healthy Families Program for families with overweight or obese children ages 6 to 11 who have a history of comorbid conditions</p>	<p>Weight Watchers services include:</p> <ul style="list-style-type: none"> • Waiver of enrollment fees • Vouchers for free attendance at first four classes <p>Healthy Families services include:</p> <ul style="list-style-type: none"> • Six-month program support • Ten-week course of family-centric, twice weekly sessions
<p>Women’s Health Services – Prenatal Services</p>	<p>Prenatal Care Services</p> <ul style="list-style-type: none"> • 17 Alpha-Hydroxyprogesterone Caproate (17-P) coverage for members at significant risk of premature delivery (precertification is not required for administration of compounded 17P) • Providers receive faxed alerts identifying members who are potential candidate for 17P • Mail-order delivery of compounded 17P for administration to pregnant members in their providers’ offices • Healthy Mothers Healthy Babies/Amerigroup partnership to copromote the Text4baby program: Text4baby is a free service that pregnant woman may sign up for; women receive text messages throughout their pregnancies reminding them about health promotion activities and preparation for delivery • <i>Taking Care of Baby and Me</i>® program offers an array of services to the pregnant woman and her newborn to provide the best opportunity to have a healthy baby and be a successful mom; every identified member receives a prenatal packet that includes educational materials and two incentive-redemption cards (\$20 each) to encourage members to obtain and continue prenatal care; during the postpartum period, members receive similar postpartum packets with educational materials and incentive cards to encourage postpartum visits • Promotion of the Centering Health Institutes’s Centering Pregnancy (CP) program – an evidence-based free program that provides group care as the model of care; CP gives pregnant members the opportunity to meet with other pregnant women and a designated health care provider to learn care skills and discuss relevant pregnancy and infant care topics throughout their pregnancies

2.27. Services Covered Under the Louisiana State Plan or Fee-For-Service Medicaid

Some services are covered by the Louisiana State Plan or fee-for-service Medicaid instead of Amerigroup. These services are called carved-out services. Even though we do not cover these services, we expect you to:

- Provide all required referrals
- Assist in setting up these services

These services will be paid for by the DHH on a fee-for-service basis. Carved out benefits include:

- Services given through the DHH Early Steps program
- Dental services
- Hospice services
- Individualized education program services
- Intermediate care facility/developmentally disabled services
- Personal care services (EPSDT and long term-personal care services)
- Pharmacy services (e.g., prescription drugs)
- Nursing facility services
- Outpatient pharmacy services (provided by state fee-for-service program)
- School-based individualized education plan services given by a school district and billed through the intermediate school district or school-based services funded with certified public expenditures
- All home and community-based waiver services
- Specialized behavioral health services
- Targeted case management services

For details on how and where to access these services, call the Louisiana DHH at 1-888-342-6207.

Copays may apply for certain services covered under the Louisiana State Plan. Copays do not apply for services received by Native American Indian members at Native American Indian Health Clinics or for services covered by the CCN program.

2.28. Well-Child Visits Reminder Program

Based on our claims data, we send PCPs a list of members who have not received well-child services according to our schedule. We also mail information to these members, encouraging them to contact their PCPs to set up appointments for needed services.

Please note:

1. We list the specific service each member needs in the report.
2. You must render the services on or after the due date in accordance with federal EPSDT and State Department of Health guidelines.
3. We base our list on claims data we receive before the date on the list. Please check to see if you have provided the services after the report run date.
4. Please submit a completed claim form for those dates of services to the Amerigroup Claims department at:

Amerigroup Louisiana
P.O. Box 61010
Virginia Beach, VA 234666-1010

2.29. Immunizations

You must enroll in the Vaccines for Children (VFC) Program, which is administered by the State Health Division. Contact the State Health Division to enroll. The Immunization Program will review and approve

your enrollment request. You will need to cooperate with the State Health Division for orientation and monitoring purposes.

Once enrolled, you may request state-supplied vaccines for members through the age of 18 in accordance with the current American Committee on Immunization Practices schedule. You must report all immunizations of children up to age two to the State Health Division's Immunization Registry. If you do not have the capability to meet these requirements, we can help you.

We do not cover any immunizations, biological products or other products that are available free of charge from the State Health Division.

Our members can self-refer to any qualified provider in or out of our network.

We reimburse Local Health Departments for the administration of vaccines regardless of whether or not they are under contract with us.

We only cover the administration fee for members under 21.

2.30. Blood Lead Screening

You must screen for the presence of lead toxicity during a well-child visit for children between 6 months and 6 years old. Please perform a blood test at 12 months and 24 months to determine lead exposure and toxicity. You should also give blood screening lead tests to children over the age of 24 months up to 72 months if you have no past record of a test. You can find blood lead risk forms online at www.amerigroupcorp.com/providers.

2.31. Pharmacy Services

The Louisiana Medicaid Pharmacy Benefits Management Section within the Bureau is responsible for the development, implementation and administration of the Medicaid pharmacy program.

Pharmacy providers may verify prescriber numbers by calling the Point of Sale (POS) Pharmacy Help Desk at 1-800-648-0790 or 225-216-6381. Additional information is available at <http://www.lamedicaid.com/provweb1/Pharmacy/pharmacyindex.htm>

2.32. Amerigroup Member Rights and Responsibilities

Our members have rights and responsibilities. Our Member Services representatives serve as their advocates. Below are the rights and responsibilities of members.

Members have the right to:

Privacy

- Be treated with respect and with due consideration for their dignity and privacy
- Expect that we will treat their records (including medical and personal information) and communications confidentially
- Request and receive a copy of their medical records at no cost to the member and request that the records be amended or corrected
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation as specified in federal regulations

Take part in decisions regarding their health care

- Engage in candid discussions of appropriate or medically necessary treatment options for their conditions regardless of cost or benefit coverage
- Receive the appropriate services that are not denied or reduced solely because of medical condition
- Refuse health care (to the extent of the law) and understand the consequences
- Decide ahead of time the care they want if they become sick, injured or seriously ill by making a living will
- Be able to make decisions about their children's health care if members are under age 18 and married, pregnant or have children

Grievances, Appeals and Fair Hearings

- Pursue resolution of grievances and appeals about the health plan or care provided
- Freely exercise filing a grievance or an appeal without adversely affecting the way they are treated
- Continue to receive benefits pending the outcome of an appeal or a fair hearing under certain circumstances

Amerigroup Information

- Receive the necessary information to be an Amerigroup member in a manner and format they can understand easily
- Receive a current member handbook and a provider directory
- Receive assistance from Amerigroup in understanding the requirements and benefits of the plan
- Receive notice of any significant changes in the benefit package at least 30 days before the intended effective date of the change
- Make recommendations about our rights and responsibilities policies
- Know how we pay our providers

Medical Care

- Choose their PCPs from our network of providers
- Choose any Amerigroup network specialist after getting a referral from their PCPs, if appropriate
- Be referred to health care providers for ongoing treatment of chronic disabilities
- Have access to their PCPs or backups 24 hours a day, 365 days a year for urgent or emergency care
- Get care right away from any hospital when their symptoms meet the definition of an emergency medical condition
- Get poststabilization services following an emergency medical condition in certain circumstances
- Be free from discrimination and receive covered services without regard to race, color, creed, gender, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated

Members have the responsibility to:

Respect their health care providers

- Treat their doctors, their doctors' staff and Amerigroup employees with respect and dignity
- Not be disruptive in the doctor's office
- Make and keep appointments and be on time
- Call if they need to cancel an appointment or change the appointment time or call if they will be late
- Respect the rights and property of all providers

Cooperate with the people providing health care

- Tell their providers about their symptoms and problems and ask questions
- Supply information providers need in order to provide care
- Understand the specific health problems and participate in developing mutually agreed upon treatment goals as much as they are able
- Discuss problems they may have with following their providers' directions
- Follow plans and instructions for the care they have agreed to with their practitioners
- Consider the outcome of refusing treatment recommended by a provider
- Discuss grievances, concerns and opinions in an appropriate and courteous way
- Help their providers obtain medical records from their previous providers and help their providers complete new medical records as necessary
- Secure referrals from their PCPs when specifically required before going to another health care provider unless they have a medical emergency
- Know the correct way to take medications
- Go to the emergency room when they have an emergency
- Notify their PCPs as soon as possible after they receive emergency services
- Tell their doctor who they want to receive their health information

Follow Amerigroup policies outlined in the member handbook

- Provide us with proper identification during enrollment
- Carry their Amerigroup and Medicaid ID cards at all times and report any lost or stolen cards
- Contact us if information on their ID cards is wrong or if there are changes to their name, address or marital status
- Call us and change their PCP before seeing the new PCP
- Tell us about any doctors they are currently seeing
- Notify us if a member or family member who is enrolled in Amerigroup has died
- Report suspected fraud and abuse

2.33. Member Grievance

Our members have the right to say they are dissatisfied with Amerigroup or a provider's operations. A member or member's representative (including a provider on behalf of a member) may file a grievance within 30 days of receipt of an initial determination notice from Amerigroup. If a provider files the grievance, he or she must have the member's written permission.

We will respond to a member's grievance and attempt to resolve it to the member's satisfaction in a timely manner. We investigate each grievance and all of its clinical aspects. We inform the member, investigate the grievance and resolve it within 90 calendar days from the date we received the grievance.

Urgent or emergent grievances are resolved within 24 hours of receipt.

A member can file a grievance orally by calling Member Services at 1-800-600-4441. He or she can also file a grievance by mail. Any supporting documents must be included. Grievances should be sent to:

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

An acknowledgement letter is mailed within five days of receiving a written grievance.

Member grievances do not involve:

- Medical management decisions
- Interpretation of medically necessary benefits
- Adverse determinations

These are called appeals and are addressed in the next section.

We will notify the member in writing of:

- The names(s), titles(s) and, in the case of a grievance with a clinical component, qualifying credentials of the person or persons completing the review of the grievance
- Our decision
- The reason for the decision
- Policies and procedures regarding the decision
- The right to further remedies allowed by the law
- How the grievance process may be continued with DHH if the member does not agree with the resolution after the member has exhausted all levels of our appeal process
- How the member may be advised or represented by a lay advocate, attorney or other representative as chosen by the member and agreed to by the representative

2.34. Medical Necessity Appeals

Our goal is to handle and resolve every appeal as quickly as the member's health condition requires. Our established time frames are:

- Standard resolution of appeal: 30 calendar days from the date of receipt of the appeal.
- Expedited resolution of appeal: 72 hours from receipt of the appeal. We make every reasonable effort to give the member or his or her representative oral notification and then follow it up with a written notification.

We will inform the member of the limited time he or she has to present evidence and allegations of fact or law with expedited resolution. And we also ensure that no punitive action will be taken against a provider who supports an expedited appeal.

We will send our members the results of the resolution in a written notice within 30 calendar days of receipt of the appeal. If an appeal is not wholly resolved in favor of the member, the notice will include:

- The right for our member to request a state fair hearing and how to do it
- The right to receive benefits while this hearing is pending and how to request it
- Notice that the member may have to pay the cost of these benefits if the state fair hearing officer upholds the Amerigroup action

2.35. Expedited Appeal

Our expedited appeal process is available upon the member's request or the provider indicates that a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum function.

The member or provider may file an expedited appeal either orally or in writing. No additional written follow-up on the part of the member or the provider is required for an oral request for an expedited appeal.

Amerigroup will resolve each expedited appeal and provide notice to the member as quickly as the member's health condition requires and within three business days after receipt of the expedited appeal request. There may be one extension of 14 calendar days to this timeline upon the member's request or if Amerigroup can show that there is a need for additional information and the delay is in the interest of the member. When the delay is for this reason and not as a result of a member request, Amerigroup will provide information describing the reason for the delay in writing to the member.

An acknowledgement letter is mailed within five days of receiving a written appeal.

If your request is deemed to be a nonexpedited issue, our standard 30-day timeline for appeals will apply.

2.36. Continuation of Benefits During Appeals or State Fair Hearings

We are required to continue a member's benefits while the appeals process or the state fair hearing is pending if all of the following are true:

- The appeal is submitted to us on or before the latter of the two: within 10 calendar days of our mailing the notice of action or the intended effective date of our proposed action
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment
- Services were ordered by an authorized provider
- The original period covered by the original authorization has not expired
- The member requests an extension of benefits

If the decision is against the member, we may recover the cost of the services the member received while the appeal was pending.

2.37. State Fair Hearing Process

The member or his or her representative shall submit a request for a state fair hearing to the Division of Administration – Administrative Law Judge Division (DOA) within 30 calendar days from the date of the notice of resolution regarding the member's standard appeal. The request will be submitted within 10 calendar days of the date of the notice of resolution if the member wishes to have continuation of benefits during the state fair hearing.

2.38. Prevent, Detect and Deter Fraud, Waste and Abuse

As the recipient of funds from federal and state-sponsored health care programs, we have a duty to help prevent, detect and deter fraud, waste and abuse. We have outlined our commitment to this in our Corporate Compliance Program.

As part of the requirements of the Federal Deficit Reduction Act, you are required to adopt our policies on this. You can find our policies and our Code of Business Conduct and Ethics at www.amerigroupcorp.com/providers.

We have several ways you and your staff can report fraud, waste and abuse:

- Make anonymous reports to www.amerigroup.silentwhistle.com
- Make anonymous reports by leaving a message at 757-518-3633
- Send an email to corpinvest@amerigroupcorp.com
- Call our national customer care line at 1-800-600-4441
- Reach out directly to our Chief Compliance Officer at 757-473-2711 or via email to ethics@amerigroupcorp.com

To meet all requirements, you must adopt our fraud, waste and abuse policies and distribute them to all employees and contractors who work with us. If you have any questions or need more information, please contact the Chief Compliance Officer.

You are the first line of defense against fraud, waste and abuse. Examples include:

Provider Fraud, Waste and Abuse

- Billing for services not rendered
- Billing for services that were not medically necessary
- Double billing
- Unbundling
- Upcoding

To help prevent fraud, waste and abuse, make sure your services are:

- Medically necessary
- Documented accurately
- Billed according to guidelines

Member Fraud, Waste and Abuse

- Benefit sharing
- Collusion
- Drug trafficking
- Forgery
- Illicit drug seeking
- Impersonation fraud
- Misinformation/misrepresentation
- Subrogation/third-party liability fraud
- Transportation fraud

To help prevent member fraud, waste and abuse:

- Educate members
- Be observant
- Spend time with members and review their prescription record
- Review their Amerigroup member ID card
- Make sure the cardholder is the person named on the card
- Encourage members to protect their cards, like credit cards, or cash

- Encourage them to report any lost or stolen card to us immediately

We also encourage our members to report any suspected fraud, waste and abuse by:

- Calling our national customer care line at 1-800-600-4441
- Emailing corpinvest@amerigroupcorp.com
- Contacting our Chief Compliance Officer at 757-473-2711
- Sending an anonymous report to www.amerigroup.silentwhistle.com

We will not retaliate against any individual who reports violations or suspected fraud, waste and abuse; and we will make every effort to maintain anonymity and confidentiality.

2.39. HIPAA

The Health Insurance Portability and Accountability Act (HIPAA):

- Improves the portability and continuity of health benefits
- Provides greater patient rights to access and privacy
- Ensures greater accountability in health care fraud
- Simplifies the administration of health insurance

We are committed to safeguarding patient/member information. As a contracted provider, you must have procedures in place to demonstrate compliance with HIPAA privacy regulations. You must also have safeguards in place to protect patient/member information, such as locked cabinets clearly marked and containing only protected health information, unique employee passwords for accessing computers and active screen savers.

We only request the minimum member information necessary to accomplish our purpose. Likewise, you should only request the minimum member information necessary for your purpose. However, regulations do allow the transfer or sharing of member information to:

- Conduct business and make decisions about care
- Make an authorization determination
- Resolve a payment appeal

Requests for such information fit the HIPAA definition of treatment, payment or health care operations.

You should maintain fax machines used for transmitting and receiving medically sensitive information in a restricted area. When faxing information to us, please:

- Verify the receiving fax number
- Notify us you are faxing information
- Verify that we received your fax

Do not use Internet email (unless encrypted) to transfer files containing member information to us. You should mail or fax this information. Mail medical records in a sealed envelope marked **confidential** and addressed to a specific individual or department in our company.

Our voicemail system is secure and password protected. You should only leave messages with the minimum amount of member information necessary.

When contacting us, please be prepared to verify your:

- Name
- Address
- NPI number

- TIN
- Amerigroup provider number

3. MEMBER MANAGEMENT SUPPORT

3.1. Welcome Call

We give new members a welcome call to:

- Educate them about our services
- Help them schedule initial checkups
- Identify any health issues (e.g., pregnancy or previously diagnosed diseases)

3.2. Amerigroup On Call

Amerigroup On Call 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 weekends
- Schedule appointments with you or other network doctors
- Get to urgent care centers or walk-in clinics
- Speak directly with a doctor or a member of the doctor's staff to talk about their health care needs

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 Amerigroup On Call at 1-866-864-2544 (Spanish 1-866-864-2545). TTY services are available for the hearing impaired, and language translation services are also available.

3.3. Case Management

We have a comprehensive program to meet our members' needs when they are pregnant or have conditions or diagnoses that require ongoing care and treatment. Once we have identified a member's need, our nurse will work with that member and the member's PCP to identify the:

- Level of case management needed
- Appropriate alternate settings to deliver care
- Health care services
- Equipment and/or supplies
- Community-based services
- Communication between the member and his or her PCP

For members who are hospitalized, our nurse will also work with the member, utilization review team, and PCP or hospital to develop a discharge plan of care and link the member to:

- Community resources
- Our outpatient programs
- Our Disease Management Centralized Case Unit (DMCCU)

Member Assessment

Our case manager conducts a comprehensive assessment to determine a member's needs, evaluating that person's:

- Medical condition
- Previous pregnancy history
- Current pregnancy status
- Functional status
- Goals
- Life environment
- Support systems
- Emotional status
- Ability for self-care
- Current treatment plan

Through communication with members or members' representatives and information from PCPs and specialists, our case manager will coordinate current medical and nonmedical needs.

Plan of Care

After the assessment, our case manager:

- Determines the level of case management services
- Guides, develops and implements an individualized plan of care
- Works with the member, the member's representative and his or her family and provider

Research has shown that our members comply with their treatment plans more when they can make their own health care decisions.

Case managers consider our members' needs for:

- Social services
- Educational services
- Therapeutic services
- Other nonmedical support services (personal care, WIC, transportation)

They also consider the strengths and needs of our members' family.

Our case manager nurses collaborate with case manager social workers and coordinate with member advocates or outreach associates to define ways to coordinate physical, behavioral health, pregnancy and social services. We then make sure we forward all written care plans to you by fax or mail.

3.4. Taking Care of Baby and Me Pregnancy Support Program

Taking Care of Baby and Me is a proactive case-management program for 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, lab reports, hospital census reports and provider and self-referrals. Once identified, we act quickly to assess the member's obstetrical risk and ensure she has the appropriate level of care and case-management services to mitigate those risks.

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, including transportation, WIC, home-visitor programs, breast-feeding support and counseling.

For parents' with infants admitted to the NICU, we offer the You and Your Baby in the NICU program. Parents receive counseling and support to be involved in the care of their babies, visit the NICU, interact

with hospital-care providers and prepare for discharge. Parents are provided with an education resource outlining successful strategies they may deploy to collaborate with the care team.

3.5. Disease Management Centralized Care Unit

Our Disease Management Centralized Care Unit (DMCCU) is based on a system of coordinated care management interventions and communications designed to assist physicians and other health care professionals in managing members with chronic conditions. DMCCU services include a holistic, member-centric care management approach that allows care managers to focus on multiple needs of members. Our disease management programs include:

- Asthma
- Bipolar Disorder
- Chronic Obstructive Disorder (COPD)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension
- Major Depressive Disorder
- Obesity
- Schizophrenia
- Transplant

Program Features

- Proactive identification process
- Evidence-based clinical practice guidelines from recognized sources
- Collaborative practice models that include the physician and support providers in treatment planning
- Continuous self-management education, including:
 - Primary prevention
 - Behavior modification
 - Compliance and surveillance
 - Home visits
 - Case management for high-risk members
- Ongoing process and outcomes measurement, evaluation and management
- Ongoing communication with providers regarding patient status

Disease management clinical practice guidelines are located at www.amerigroupcorp.com/providers. Simply access the Louisiana State page and log into the secure site by entering your **User Name and Password**. Please select the Clinical Practice Guidelines link on the top navigation menu. A copy of the guidelines can be printed from the website, or you can contact Provider Services at 1-800-454-3730 to receive a copy.

Who Is Eligible?

All members with the listed conditions are eligible. We identify them through:

- Continuous case finding welcome calls
- Claims mining
- Referrals

As a valued provider, we welcome your referrals of patients who can benefit from additional education and care management support. Our care 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 risk stratified based on the severity of their disease. They are provided with continuous education on self-management concepts, which include primary prevention, behavior modification and compliance/surveillance, as well as case/care management for high-risk members. Program evaluation, outcome measurement and process improvement are built into all the programs. Providers are given telephonic and/or written updates regarding patient status and progress.

Disease Management Centralized Care Unit 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 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 DMCCU (see our Provider Complaint and Grievance Procedure)

Hours of Operation

Our DMCCU Case Managers are licensed nurses and social workers. They are available:

- 7:30 a.m. to 4:30 p.m. CT
- Monday through Friday

Confidential voicemail is available 24 hours a day.

Contact

You can call a DMCCU team member at 1-888-830-4300. DMCCU program content is located at www.amerigroupcorp.com/providers. Printed copies are available upon request. Members can find out more by visiting www.myamerigroup.com/LA.

3.6. Provider Directories

Amerigroup makes provider directories available to members in online searchable and hard-copy formats. Since use of these directories is how members identify health care providers near them, it is important that your practice address/addresses, doctors' names and contact information are promptly updated when changes occur. You can update your practice information by:

- Visiting www.amerigroupcorp.com/providers
- Calling Provider Services
- Calling or emailing your local Provider Relations representative

3.7. Cultural Competency

With the increasing diversity of the American population, it is important for us to work effectively in cross-cultural situations. Your ability to communicate with your patients has a profound impact on the

effectiveness of the health care you provide. Your patients must be able to communicate symptoms clearly and understand your recommended treatments.

Our cultural competency program helps you and your patients to:

- Acknowledge the importance of culture and language
- Embrace cultural strengths with people and communities
- Assess cross-cultural relations
- Understand cultural and linguistic differences
- Strive to expand your cultural knowledge

Some important reminders include:

- The perception that illness, disease and their causes vary by culture
- Belief systems on health, healing and wellness are very diverse
- Culture influences help-seeking behaviors and attitudes toward providers
- Individual preferences affect traditional and nontraditional approaches to health care
- Patients must overcome their personal biases toward health care systems
- Providers from culturally and linguistically diverse groups are under-represented

Cultural barriers can affect your relationship with your patient, including:

- Our member's comfort level and his or her fear of what you might find in an examination
- Different levels of understanding among diverse consumers
- A fear of rejection of personal health beliefs
- A member's expectation of what you do and how you treat him or her

To help overcome these barriers, you need the following:

Cultural Awareness

- Recognize the cultural factors that shape personal and professional behavior, including:
 - Norms
 - Values
 - Communication patterns
 - World views
- Modify your own behavioral style to respond to others' needs while maintaining your objectivity and identity

Knowledge

- Culture plays a crucial role in the formation of health and illness beliefs
- Culture is generally behind a person's acceptance or rejection of medical advice
- Different cultures have different attitudes about seeking help
- Feelings about disclosure are culturally unique
- The acceptability and effectiveness of treatment modalities are different in various cultural and ethnic groups
- Verbal and nonverbal language, speech patterns and communication styles vary by culture and ethnic groups
- Resources like formally trained interpreters should be offered to and used by members with various cultural and ethnic differences

Skills

- Understand the basic similarities and differences between and among the cultures of the people we serve
- Recognize the values and strengths of different cultures

- Interpret diverse cultural and nonverbal behavior
- Develop perceptions and understanding of others' needs, values and preferred ways of having those needs met
- Identify and integrate the critical cultural elements to make culturally consistent inferences and demonstrate that consistency in actions
- Recognize the importance of time and the use of group process to develop and enhance cross-cultural knowledge and understanding
- Withhold judgment, action or speech in the absence of information about a person's culture
- Listen with respect
- Formulate culturally competent treatment plans
- Use culturally appropriate community resources
- Know when and how to use interpreters and understand the limitations of using interpreters
- Treat each person uniquely
- Recognize racial and ethnic differences and know when to respond to culturally based cues
- Seek out information
- Use agency resources
- Respond flexibly to a range of possible solutions
- Accept ethnic differences among people and understand how these differences affect treatments
- Work willingly with clients of various ethnic minority groups

3.8. Member Records

We require medical records to be current, detailed and organized for effective, confidential patient care and quarterly review. Your medical records must conform to good professional medical practice and must be permanently maintained at the primary care site.

Our member's previous provider must forward a copy of all medical records to you within 10 business days from receipt of your request at no charge. Members are entitled to one copy of their medical record per year, and the copy is provided at no cost to the member. Members or their representatives should have access to these records.

Our medical records standards include:

1. Patient identification information – patient name or ID number must be shown on each page or electronic file
2. Personal/biographical data – age, sex, address, employer, home and work telephone numbers, and marital status
3. Date and corroboration – dated and identified by the author
4. Legibility – if someone other than the author judges it illegible, a second reviewer must evaluate it
5. Allergies – must note prominently:
 - Medication allergies
 - Adverse reactions
 - No Known Allergies (NKA)
6. Past medical history – for patients seen three or more times. Include serious accidents, operations, illnesses and prenatal care of mother and birth for children
7. Immunizations – a complete immunization record for pediatric members 20 and under with vaccines and dates of administration
8. Diagnostic information
9. Medical information – including medication and instruction to patient
10. Identification of current problems

- Serious illnesses
 - Medical and behavioral conditions
 - Health maintenance concerns
11. Instructions – including evidence the patient was provided basic teaching and instruction for physical or behavioral health condition
 12. Smoking/alcohol/substance abuse – notation required for patients age 12 and older and seen three or more times
 13. Consultations, referrals and specialist reports – consultation, lab and X-ray reports must have the ordering physician’s initials or other documentation signifying review; any consultation or abnormal lab and imaging study results must have an explicit notation
 14. Emergencies – all emergency care and hospital discharge summaries for all admissions must be noted
 15. Hospital discharge summaries – must be included for all admissions while enrolled and prior admissions when appropriate
 16. Advance directive – must document whether the patient has executed an advance directive such as a living will or durable power of attorney

3.9. Patient Visit Data

You must provide:

1. A history and physical exam with both subjective and objective data for presenting complaints
2. Behavioral health treatment – including at-risk factors:
 - Danger to self/others
 - Ability to care for self
 - Affect
 - Perpetual disorders
 - Cognitive functioning
 - Significant social health
3. Admission or initial assessment must include:
 - Current support systems
 - Lack of support systems
4. Behavioral health treatment – documented assessment at each visit for client status and symptoms, indicating:
 - Decreased
 - Increased
 - Unchanged
5. A plan of treatment including:
 - Activities
 - Therapies
 - Goals to be carried out
6. Diagnostic tests
7. Behavioral health treatment – evidence of family involvement in therapy sessions and/or treatment
8. Follow-up care encounter forms or notes indicating follow-up care, call or visit in weeks, months or PRN
9. Referrals and results of all other aspects of patient care and ancillary services

We systematically review medical records to ensure compliance, and we institute actions for improvement when our standards are not met.

We maintain a professional recordkeeping system for services to our members. We make all medical management information available to health professionals and state agencies and retain these records for seven years from the date of service.

3.10. Clinical Practice Guidelines

We work with you and providers like you to develop clinical policies and guidelines. Each year, we select at least four evidence-based clinical practice guidelines that are relevant to our members and measure at least two important aspects of each of those four guidelines. We also review and revise these guidelines at least every two years. You can find these Clinical Practice Guidelines on our website.

3.11. Advance Directives

We adhere to the Patient Self-Determination Act and recognize and support the following advance directives:

- Durable power of attorney
- Living will

A durable power of attorney lets a member name a patient advocate to act on his or her behalf. A living will lets a member state his or her wishes on medical treatment in writing.

We encourage members age 18 and over to ask you for an Advance Directive form and education at their first appointment. Please document their forms in your medical records.

We understand a facility or physician may conscientiously object to an advance directive. However, we also recognize the member's right to determine his or her own care.

Please note that an Amerigroup associate cannot act as a witness to an advance directive nor serve as a member's advocate or representative.

4. PRECERTIFICATION/PRIOR NOTIFICATION PROCESS

Referrals to in-network specialists are not required. However, some specialty services require precertification as specified below. Amerigroup encourages members to consult with their PCPs prior to accessing nonemergency specialty services. The two processes are defined below.

Precertification is defined as the **prospective** process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered, a member's severity of illness, medical history and previous treatment to determine the medical necessity and appropriateness of a given coverage request. Prospective means the coverage request occurred prior to the service being provided.

Prior notification is defined as, prior to rendering covered medical services to a member, the provider must notify Amerigroup by telephone, fax or the provider website of the intent to do so. There is no review against medical necessity criteria. However, member eligibility and provider status (network and non-network) are verified. In some instances (e.g., like emergency visits) providers should notify Amerigroup within 24 hours of the visit.

4.1. Precertification of all Inpatient Elective Admissions

We require precertification of all inpatient elective admissions. The referring PCP or specialist is responsible for precertification. The referring physician identifies the need to schedule a hospital admission; to do so you can :

- Submit through www.amerigroupcorp.com/providers
- Fax the request to 1-800-964-3627 **or**
- Call Provider Services

Submit requests for precertification with all supporting documentation immediately upon identifying the inpatient request or at least 72 hours prior to the scheduled admission. This will allow us to verify benefits and process the precertification request. For services that require precertification, 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. The hospital can confirm that a precertification is on file by:

- Visiting our provider website
- Calling Provider Services at 1-800-454-3730

If coverage of an admission has not been approved, the facility should call Provider Services. We will contact the referring physician directly to resolve the issue.

We are available 24 hours a day, 7 days a week to accept precertification requests. When a request is received from the physician online, via telephone or fax for medical services, a care specialist will verify eligibility and benefits. This information will be forwarded to the precertification nurse.

Our precertification nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of all procedures. When appropriate, our precertification nurse will assist the physician in identifying alternatives for health care delivery as supported by the medical director.

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with nationally recognized standards of care, we will issue an Amerigroup reference number to the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

If medical necessity criteria for the admission are not met on the initial review, the requesting provider will be able to discuss the case with the Amerigroup medical director prior to the determination.

If the precertification documentation is incomplete or inadequate, the precertification nurse will not approve coverage of the request but will notify the referring provider to submit the additional necessary documentation.

If the medical director denies coverage of the request, the appropriate denial letter (including the member's and Fair Hearing appeal rights) will be mailed to the requesting provider, member's PCP and member.

4.2. Emergent Admission Notification Requirements

We request network hospitals to notify us within 48 hours of emergent admission. Network hospitals can call our National Customer Care department 24 hours a day, 7 days a week at 1-800-454-3730 or fax at 1-800-964-3627.

Our Medical Management staff will verify eligibility and determine coverage. A concurrent review nurse will review and authorize the coverage of emergent admissions.

Documentation must be complete. We will notify the hospital to submit whatever additional documentation is necessary.

If our medical director denies coverage, the attending provider will have an opportunity to discuss the case with him or her. The attending emergency room physician or provider actually treating the member is responsible until, and to determine when, the member is stabilized. We will mail a denial letter to the hospital, the member’s PCP and the member and include the member’s appeal and fair hearing rights and process.

4.3. Nonemergent Outpatient and Ancillary Services – Precertification and Notification Requirements

We require precertification for coverage of certain nonemergent outpatient and ancillary services (see following chart). To ensure timeliness, you must include:

- Member name and ID
- Name, telephone number and fax number of the physician providing the service
- Name of the facility and telephone number where the service will be performed
- Name of servicing provider and telephone number
- Date of service
- Diagnosis with ICD-9 code
- Name of elective procedure with CPT-4 code
- Medical information to support the request
 - Signs and symptoms
 - Past and current treatment plans, along with the provider who provided the surgery
 - Response to treatment plans
 - Medications, along with frequency and dosage

For the most up-to-date precertification/notification requirements, visit www.amerigroupcorp.com/providers and click on Precertification Lookup.

The following table lists precertification/notification requirement guidelines as of the printing of this manual.

4.4. Precertification/Notification Coverage Guidelines

Behavioral Health/Substance Abuse Services	No precertification is required for basic behavioral health services provided in a PCP or medical office.
Cardiac Rehabilitation	Precertification is required for all services.
Chemotherapy	<p>Precertification is not required for procedures performed in the following outpatient settings:</p> <ul style="list-style-type: none"> • Office • Outpatient hospital • Ambulatory surgery center <p>Precertification is required for:</p> <ul style="list-style-type: none"> • Inpatient and outpatient chemotherapy <p>To check the coverage and precertification requirement status for oncology</p>

	drugs and adjunctivants agents, please refer to the Precertification Look-up tool on our provider website under Quick Tools.
Circumcision	No precertification is required.
Dermatology	No precertification is required for a network provider for: <ul style="list-style-type: none"> • E&M • Testing • Procedures Cosmetic services or services related to previous cosmetic procedures are not covered.
Diagnostic Testing	No precertification is required for: <ul style="list-style-type: none"> • Routine diagnostic testing Precertification is required for: <ul style="list-style-type: none"> • MRA • MRI • CAT scans • Nuclear cardiac • PET scans • Video EEG
Durable Medical Equipment (DME)	No precertification is required for: <ul style="list-style-type: none"> • Glucometers and nebulizers • Dialysis and ERSD equipment • Gradient pressure aid • Light therapy • Sphygmomanometers • Walkers • Orthotics for arch support • Heels, lifts, shoe inserts and wedges Precertification is required for: <ul style="list-style-type: none"> • All rental DME equipment • Certain prosthetics, orthotics and DME For code-specific precertification requirements, visit www.amerigroupcorp.com/providers . Click on Medical Supplies for guidelines on disposable medical supplies. Request precertification with a Certificate of Medical Necessity (CMN) — available on our website — or by submitting a physician order and Amerigroup Referral and Authorization Request form. You must send a complete CMN with each claim for: <ul style="list-style-type: none"> • Hospital beds • Support surfaces • Motorized wheelchairs • Manual wheelchairs • Continuous Positive Airway Pressure (CPAP) • Lymphedema pumps • Osteogenesis stimulators • Transcutaneous Electrical Nerve Stimulators (TENS) • Seat lift mechanism • Power Operated Vehicles (POV) • External infusion pump • Parenteral nutrition • Enteral nutrition and oxygen We must agree on HCPCS and/or other codes for billing, and we require you to use appropriate modifiers (NU for new equipment, RR for rental equipment).

	For DME services, please contact Univita at 1-888-914-2201.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Visit	Self-referral Use the EPSDT schedule, and document visits. Note: Vaccine serum is received under the Vaccine for Children (VFC) Program.
Educational Consultation	No precertification is required.
Emergency Room	No precertification is required. We must be notified within 24 hours or the next business day if a member is admitted into the hospital through the emergency room.
ENT Services (Otolaryngology)	No precertification is required for a network provider for: <ul style="list-style-type: none"> • E&M • Testing • Certain procedures Precertification is required for: <ul style="list-style-type: none"> • Tonsillectomy and/or adenoidectomy • Nasal/sinus surgery • Cochlear implant surgery and services
Family Planning/STI Care	Self-referral Members may self-refer to any in-network or out-of-network provider. Encourage patients to receive family planning services in network to ensure continuity of service.
Gastroenterology Services	No precertification is required for a network provider for: <ul style="list-style-type: none"> • E&M • Testing • Certain procedures Precertification is required for: <ul style="list-style-type: none"> • Bariatric surgery • Insertion, removal and/or replacement of adjustable gastric restrictive devices and subcutaneous port components • Upper endoscopy
Gynecology	No precertification is required for a network provider for: <ul style="list-style-type: none"> • E&M • Testing • Certain procedures Precertification is required for: <ul style="list-style-type: none"> • Elective surgery
Hearing Aids	Precertification is required for digital hearing aids.
Hearing Screening	Precertification is required for digital hearing aids. No precertification is required for: <ul style="list-style-type: none"> • Diagnostic and screening tests • Hearing aid evaluations • Counseling
Home Health Care	Precertification is required. Covered services include: <ul style="list-style-type: none"> • Skilled nursing • Home health aide • Physical, occupational and speech therapy services • Physician-ordered supplies Note: Drugs and DME require separate precertification. Call Univita at [1-888-914-2201] to schedule services.
Hospital Admission	Precertification is required for:

	<ul style="list-style-type: none"> • Elective admissions • Some same-day/ambulatory surgeries <p>We must be notified within 24 hours or the next business day if a member is admitted into the hospital through the emergency room. Preadmission testing must be performed by an Amerigroup preferred lab vendor or network facility outpatient department. Please see our provider directory for a complete listing. We do not cover:</p> <ul style="list-style-type: none"> • Rest cures • Personal comfort and convenience items • Services and supplies not directly related to patient care (telephone charges, take-home supplies, etc.)
Laboratory Services (Outpatient)	<p>Precertification is required for:</p> <ul style="list-style-type: none"> • Genetic testing • All laboratory services furnished by non-network providers (except hospital laboratory services in the event of an emergency medical condition) <p>If your office has limited or no lab facilities, please refer tests to one of our preferred lab providers. See our Provider Referral Directory for a complete listing.</p>
Medical Supplies	No precertification is required for disposable medical supplies.
Medical Injectables	<p>The following are examples of drugs that require precertification. Call the Amerigroup pharmacy department at 1-800-237-2767 for assistance.</p> <p>This is not a complete list, but it represents the most commonly prescribed injectables. For a complete list visit our provider website.</p> <ul style="list-style-type: none"> • Synagis • Erythropoiesis Stimulating Agents (ESA) such as Epogen, Procrit, Aranesp) • Makena • Colony Stimulating Factors (CSF) such as Neupogen, Neulasta • IVIG • Growth Hormones • Interferons • Biologic Response Modifiers such as Remicade • Hyaluronic Acid derivatives such as Synvisc, Orthovisc • Biologic Oncology agents such as Erbitux, Avastin, Rituxan, Camptosar, Eloxatin, Gemzar, Ixempra, Easigna, Taxol, Taxotere
Neurology	<p>No precertification is required for a network provider for:</p> <ul style="list-style-type: none"> • E&M • Testing • Certain other procedures <p>Precertification is required for:</p> <ul style="list-style-type: none"> • Neurosurgery • Spinal fusion • Artificial intervertebral disc surgery
Observation	No precertification is required for in-network observation. If your observation results in an admission, you must notify us within 24 hours or on the next business day.
Obstetrical Care	<p>No precertification is required for:</p> <ul style="list-style-type: none"> • Obstetrical services and diagnostic testing • Obstetrical visits • Certain diagnostic tests and lab services by a participating provider • Labor and delivery for newborns up to 12 weeks in age

	<p>You must notify us:</p> <ul style="list-style-type: none"> • At the first prenatal visit • Within 24 hours with newborn information (please include baby's weight, gestational age and disposition at birth) <p>OB case management programs are available.</p>
Ophthalmology	<p>No precertification is required for:</p> <ul style="list-style-type: none"> • E&M • Testing • Certain procedures <p>Precertification is required for:</p> <ul style="list-style-type: none"> • Repair of eyelid defects <p>We do not cover services that are considered cosmetic.</p>
Oral Maxillofacial	See Plastic/Cosmetic/Reconstructive Surgery.
Out-of-Area/Out-of-Network Care	Precertification is required except for emergency care, EPSDT screening, family planning and OB care.
Outpatient/Ambulatory Surgery	Precertification requirement is based on procedure performed; visit our provider website for further details.
Pain Management/Physiatry/Physical Medicine and Rehabilitation	<p>Precertification is required for:</p> <ul style="list-style-type: none"> • Non-E&M level testing and procedures
Plastic/Cosmetic/Reconstructive Surgery (including Oral Maxillofacial Services)	<p>No precertification is required for:</p> <ul style="list-style-type: none"> • E&M services • Oral maxillofacial E&M services <p>Precertification is required for:</p> <ul style="list-style-type: none"> • All other services • Trauma to the teeth • Oral maxillofacial medical and surgical conditions • TMJ <p>We do not cover:</p> <ul style="list-style-type: none"> • Services considered cosmetic in nature • Services related to previous cosmetic procedures <p>Reduction mammoplasty requires our medical director's review.</p>
Podiatry	No precertification is required for E&M.
Radiology	See Diagnostic Testing.
Rehabilitation Therapy (Short Term): OT, PT, RT and ST	<p>No precertification is required for:</p> <ul style="list-style-type: none"> • Evaluation • Initial visit <p>Precertification is required for:</p> <ul style="list-style-type: none"> • Treatments <p>Therapy to improve a child's ability to learn and participate in school should be evaluated for school-based therapy. Therapies for rehabilitative care are covered as medically necessary.</p>
Skilled Nursing Facility	Precertification is required.
Sterilization	<p>No precertification is required for:</p> <ul style="list-style-type: none"> • Sterilization • Tubal ligation • Vasectomy <p>We require a sterilization consent form for claims submissions. We do <u>not</u> cover reversal of sterilization.</p>
Transportation	No precertification is required.
Urgent Care Center	No precertification is required for a participating facility.
Well-woman Exam	No precertification is required. We cover one well-woman exam per year when performed by her PCP or an in-network GYN. It includes:

	<ul style="list-style-type: none"> • Examination • Routine lab work • STI screening • Mammograms for members 35 and older • Pap smears <p>Members can receive family planning services without precertification at any qualified provider. Encourage patients to receive family planning services in-network to ensure continuity of service.</p>
<p>Revenue (RV) Codes</p>	<p>Precertification is required for services billed by facilities with RV codes for:</p> <ul style="list-style-type: none"> • Inpatient • OB • Home health care • Hospice • CT, PET and Nuclear Cardology • Chemotherapeutic agents • Pain management • Rehabilitation (physical/occupational/respiratory therapy) • Rehabilitation Short Term (speech therapy) • Specialty pharmacy agents <ul style="list-style-type: none"> ○ Refer to the Quick Tools on our website for code-specific precertification requirement status <p>For a complete list of specific RV codes, visit www.amerigroupcorp.com/providers.</p>

We have clinical staff available 24 hours a day, 7 days a week to accept precertification requests. When a medical request is faxed, we:

- Verify our member’s eligibility and benefits
- Determine the appropriateness of the request
- Issue you a reference number

For urgent or stat requests, we give you a decision within one business day. If documentation is not complete, we will ask for additional necessary documentation.

If your request is denied by our medical director, you will have the opportunity to discuss your case with him or her before the final determination. We will mail a denial letter to the hospital, the member’s PCP and the member and include the member’s appeal and fair hearing rights and process.

4.5. Inpatient Reviews

Inpatient Admission Review

We review all inpatient hospital admissions and urgent and emergent admissions within one business day of notification. We determine the member’s medical status through:

- Onsite review
- Communication with the hospital’s Utilization Review department

We then document the appropriateness of stay and refer specific diagnoses to our Case Management staff for care coordination or case management.

Inpatient Concurrent Review

To determine the authorization of coverage, we conduct a concurrent review of the hospital medical record:

- At the hospital
- By telephone or fax

We conduct continued stay reviews daily and review discharge plans. Our Utilization Management (UM) clinician will also try and meet with the member and family to:

- Discuss any discharge planning needs
- Verify they know the member's PCP's name, address and telephone number

We authorize the covered length of stay one day at a time. Our medical director can make exceptions for severe illness and course of treatment or when it is predetermined by state law. Examples include:

- ICU
- CCU
- C-section or vaginal deliveries

We will communicate approved days and bed level coverage to the hospital for any continued stay.

4.6. Discharge Planning

Our UM clinician coordinates our members' discharge planning needs with

- The hospital utilizations review/case management staff
- The attending physician

The attending physician coordinates follow-up care with the member's PCP, and the PCP contacts the member to schedule it.

For ongoing care, we work with the provider to plan discharge to an appropriate setting such as:

- Hospice facility
- Convalescent facility
- Home health care program (e.g., home I.V. antibiotics)
- Skilled nursing facility

Precertifications include, but are not limited to:

- Home health
- DME
- Outpatient medical injectibles
- Follow-up visits to certain practitioners
- Outpatient procedures

4.7. Confidentiality of Information

The following ensure that patients' Protected Health Information (PHI) is kept confidential:

- Utilization management
- Case management
- DMCCU
- Discharge planning
- Quality management
- Claims payment
- Pharmacy

It is shared only with those individuals who need access to it to conduct utilization management.

4.8. Emergency Services

Emergency services require no precertification. We do not deny or discourage our members from using 911 or accessing emergency services. As a matter of course, we grant authorizations for these services immediately.

When a member seeks emergency services at a hospital, he or she is examined by a licensed physician to determine if a need exists for such services. The physician will note the results of the emergency medical screening examination on the member's chart.

If there is a concern about transferring the member, we defer to the judgment of the attending physician. If the emergency department cannot stabilize and release our member, we will help coordinate the inpatient admission.

Any transfer from a non-network hospital to a network hospital can only take place after the member is medically stable.

4.9. Urgent Care/After-hour Care

We require our members to contact their PCPs if they need urgent care. If you are unable to see the member, you can refer him or her to one of our participating urgent care centers or another provider who offers after-hour care. Precertification is not required.

We strongly encourage PCPs to provide evening and Saturday appointment access. To learn more about participating in the after-hour care program, please call your local Provider Relations representative.

5. QUALITY MANAGEMENT

5.1. Quality Management (QM) Program

We have a comprehensive quality management program to monitor the demographic and epidemiological needs of the population served. You have opportunities to make recommendations for areas of improvement.

We evaluate the needs of the health plan's specific population annually, including age/sex distribution and inpatient, emergent/urgent care and office visits by type, cost and volume. In this way we can define high-volume, high-risk and problem-prone conditions.

5.2. Quality of Care

We evaluate all physicians, advanced registered nurse practitioners and physician assistants for compliance with:

- Medical community standards
- External regulatory and accrediting agencies requirements
- Contractual compliance

We share these reviews to enable you to increase individual and collaborative rates for members.

Our quality program includes a review of quality of care issues for all care settings using:

- Member complaints
- Reported adverse events
- Other information

The results they submitted to our QM Department are incorporated into a profile.

5.3. Quality Management Committee

The Quality Management Committee's (QMC) responsibilities are to:

- Establish strategic direction and monitor and support implementation of the quality management program
- Establish processes and structure that ensure NCQA 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

5.4. Medical Review Criteria

We use review criteria based on nationally recognized standards of care as guidelines in medical decision making. We work with network providers to develop clinical guidelines of care for our membership. The Medical Advisory Committee (MAC) assists us in formalizing and monitoring guidelines.

If we use noncommercial criteria, the following standards apply to the development of the criteria. Criteria are:

- Developed with involvement from appropriate providers with current knowledge relevant to the content of treatment guidelines under development.
- Based on review of market practice and national standards/best practices.
- Evaluated at least annually by appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria of treatment guidelines under review and updated, as necessary. The criteria must reflect the names and qualifications of those involved in the development, the process used in the development and when and how often the criteria will be evaluated and updated.

5.5. Clinical Criteria

Amerigroup uses nationally recognized standards of care for clinical decision support for medical management coverage decisions. The criteria provide a system for screening proposed medical care based on member-specific, best medical care practices and rule-based systems to match appropriate services to member needs based upon clinical appropriateness. Criteria include:

- Acute care
- Home care
- Imaging studies and X-rays
- Rehabilitation
- Subacute care
- Surgery and procedures

Our utilization reviewers use these criteria as part of the precertification of any scheduled admission, concurrent review and discharge planning process to determine clinical appropriateness and medical necessity for coverage of continued hospitalization.

5.6. Medical Advisory Committee

Amerigroup has established a Medical Advisory Committee (MAC) to:

- Assess levels and quality of care provided to members
- Recommend, evaluates and monitors standards of care
- Identify opportunities to improve services and clinical performance by establishing, reviewing and updating clinical practice guidelines based on review of demographics and epidemiologic information to target high-volume, high-risk and problem-prone conditions
- Oversee the peer review process
- Conduct network maintenance through the credentialing/recredentialing process
- Advise the health plan administration in any aspect of the health plan policy or operation affecting network providers or members
- Approve and provide oversight of the peer review process, the QM Program and the Utilization Review Program
- Oversee and make recommendations regarding health promotion activities
- Use an ongoing peer review system to
 - Monitor practice patterns
 - Identify appropriateness of care
 - Improve risk prevention activities
- Approve clinical protocols/guidelines
- Review clinical study design and results
- Develop action plans/recommendations regarding clinical quality improvement studies
- Consider/act in response to provider sanctions
- Provide oversight of Credentialing Committee decisions to credential/recredential providers
- Approve credentialing/recredentialing policies and procedures
- Oversee member access to care
- Review and provide feedback regarding new technologies
- Approve recommendations from subordinate committees

5.7. Credentialing

Credentialing is an industry-standard, systemic approach to the collection and verification of an applicant's professional qualifications. This approach includes a review of relevant training, licensure, certification and/or registration to practice in a health care field, as well as academic background. The credentialing process evaluates the information gathered and verified and includes an assessment of whether the applicant meets certain criteria relating to professional competence and conduct. We use current NCQA Standards and Guidelines for the Accreditation of Managed Care Organizations, as well as state-specific

requirements for the credentialing and recredentialing of licensed independent providers and organizational providers with whom we contract. This process is completed before a practitioner or provider is accepted for participation in the Amerigroup network.

5.8. Credentialing Requirements

To become a participating Amerigroup provider, you must be enrolled in the Louisiana Medicaid program and must hold a current, unrestricted license issued by the state. You must also comply with the Amerigroup credentialing criteria and submit all additionally requested information. A complete Louisiana State Credentialing Application (practitioners) or an Amerigroup Ancillary/Facility Application and all required attachments must be submitted to initiate the process.

Amerigroup is one of over 600 participating health plans, hospitals and health care organizations that currently utilize the Council for Affordable Quality Healthcare (CAQH) Universal Provider Data Source (UPD) for gathering credentialing data for physicians and other health care professionals. Under this program, practitioners use a standard application (state-mandated applications are included in the UPD) and a common database to submit an electronic application.

5.9. Credentialing Procedures

We credential the following provider types:

- Doctors of medicine
- Doctors of osteopathic medicine
- Doctors of dental surgery
- Doctors of dental medicine
- Doctors of podiatric medicine
- Doctors of chiropractic medicine
- Physician assistants
- Optometrists
- Nurse practitioners
- Certified nurse midwives
- Physical/occupational therapists
- Speech/language therapists
- Hospitals and allied services (ancillary) providers
- Other applicable or appropriate mid-level providers

We use a Credentialing Committee comprised of licensed practitioners to review credentialing and recredentialing applicants, delegated groups and sanction activity related to existing network participants.. The Credentialing Committee is also responsible for the creation and regular review of all policies and procedures relevant to the credentialing program.

We revise our credentialing policy periodically and no less frequent than annually based on input from:

- Credentialing Committees
- Health plan medical director
- Chief Medical Officer
- State and federal requirements

By signing the application, providers must attest to the accuracy of their credentials. If there are discrepancies between the application and the information obtained during the external verification process, the Amerigroup Credentialing department will investigate them. Discrepancies may be grounds for our denial of network participation or the termination of an existing contractual relationship.

Practitioners and providers will be notified by telephone or in writing if any information obtained during the process varies substantially from what was submitted.

The following elements are reviewed in the course of credentialing. Most of these elements are also included at the time of recredentialing:

1. Board Certification. Acceptable sources of verification include, but are not limited to:
 - American Medical Association Provider Profile
 - American Osteopathic Association
 - American Board of Medical Specialties
 - American Board of Podiatric Surgery
 - American Board of Podiatric Orthopedics and primary Podiatric medicine
2. Education and Training. Education and training will be verified for all practitioners at the time of initial credentialing. Acceptable sources of verification include but are not limited to:
 - Board certification
 - State-licensing agency
 - Educational institution
3. Work History. A full work history, documenting at least the prior five years must be submitted at the time of practitioner credentialing. Any gaps in work history greater than six months must be explained in written format.
4. Hospital Affiliations and Privileges. Network Practitioners must have clinical privileges, as appropriate to their scope of practice, in good standing at an Amerigroup network hospital.
5. State Licensure or Certification. Initial credentialing applicants must have a current, legal state license or certification.. This information will be verified by referencing data provided to us by the state via:
 - Roster
 - Telephone
 - Written verification
 - Internet
6. Enforcement Administration (DEA) Number. Initial practitioner applicants must provide their current DEA numbers to Amerigroup for verification. State controlled substance certificates, when applicable, will also be queried for verification.
7. Evidence of Professional and General Liability Coverage. Amerigroup will verify practitioner and provider malpractice coverage at the time of initial credentialing. A copy of the malpractice facesheet will provide evidence of coverage. In addition, an attestation which includes the following information may be used:
 - Name of the carrier
 - Policy number
 - Coverage limits
 - Effective and expiration dates of such malpractice coverage

As a practitioner or a provider, you must maintain professional and general liability insurance in specified amounts in accordance with your Amerigroup contract.

8. Professional Liability Claims History. Initial credentialing applicants will be asked to provide a full professional liability claims history. This information will be assessed along with a query of the National Practitioner's Data Bank (NPDB).
9. CMS Sanctions. All initial credentialing practitioner and provider applicants must not have any sanctions by Medicare/Medicaid. This information is verified by accessing the NPDB or OIG.
10. Disclosures – Attestation and Release of Information. All initial credentialing applicants must respond to questions including within the application regarding the following: :
 - Reasons for being unable to perform the essential functions of the position with or without accommodation
 - History or current problems with chemical dependency, alcohol or substance abuse
 - History of license revocations, suspension, voluntary relinquishment, probationary status or other licensure conditions or limitations
 - History of conviction of any criminal offense other than minor traffic violations
 - History of loss or limitation of privileges or disciplinary activity, including denial, suspension, limitation, termination or nonrenewal of professional privileges
 - History of complaints or adverse action reports filed with a local, state or national professional society or licensing board
 - History of refusal or cancellation of professional liability insurance
 - History of suspension or revocation of a DEA or CDS certificate
 - History of any Medicare/Medicaid sanctions

Applicants must also provide a/an:

- Attestation of the correctness and completeness of the application
- Explanation in writing of any identified issues
- Disclosure of Ownership: The Centers for Medicare & Medicaid Services require Amerigroup to obtain certain information regarding the ownership and control of entities with which we contract for services for federal employees or federal health plans. This form is required for participation in the Amerigroup network. All individuals and entities included on the form must be clear of any sanctions by Medicare/Medicaid.

11. License History. The appropriate state-licensing board/agency is queried along with the National Practitioner Databank (NPDB) as part of the credentialing process.

5.10. Recredentialing

Recredentialing is required every three years by the state of Louisiana and NCQA. Amerigroup will perform recredentialing at least every 36 months if not earlier. Network practitioners and providers will receive requests for recredentialing applications and supporting documentation in advance of the 36-month anniversary of their original credentialing or last credentialing cycle. Information from quality improvement activities and member complaints will be assessed, along with assessments and verifications listed above.

5.11. Your Rights in the Credentialing and Recredentialing Process

You can request a status of your application through:

- Telephone

- Fax
- Mail

You have the right to:

- Review information submitted to support your credentialing application
- Explain information obtained that may vary substantially from what you provided
- Provide corrections to any erroneous information submitted by another party

You can do this by submission of a written explanation or by appearance before the Credentialing Committee.

The Amerigroup Medical Director has authority to approve clean files without input from the Credentialing Committee; all files not designated as clean will be sent to the Credentialing Committee for review and a decision regarding network participation.

We will inform you of the Credentialing Committee's decision in writing within 60 days. If your continued participation is denied, you can appeal this decision in writing within 30 days of the date of the denial letter.

5.12. Organizational Providers

Your signature on the application attests that you agree to the assessment requirements. The following providers require assessments:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Nursing homes
- Ambulatory surgical centers
- Behavioral health facilities

The following steps are included in the Amerigroup Organizational Provider Credentialing process:

- A review and primary source verification of a current copy of the state license
- A review of any restrictions to a license are investigated and could impact your participation in the network
- A review and primary source verification of any Medicare or Medicaid sanctions
- A review and verification of accreditation by one of the following:

Hospitals (e.g., acute, transitional or rehabilitation)

- Joint Commission on Accreditation of Healthcare Organizations (JCAHO),
- Health Care Facilities Accreditation Program, or
- American Osteopathic Association

Rehabilitation facilities

- The Commission on Accreditation of Rehabilitation Facilities

Home health agencies

- JCAHO, or
- Community Health Accreditation Program

Nursing homes

- JCAHO

Ambulatory surgical centers

- JCAHO, or
- Accreditation Association for Ambulatory Healthcare

If your facility, ancillary or hospital is not accredited, a copy of a recent state or CMS review may be submitted in lieu of performing an onsite review. If there is no current accreditation or a recent state or CMS review, Amerigroup will perform an onsite review.

Evidence of malpractice insurance, in amounts specified in the provider contract and in accordance with Amerigroup policy, must also be included at the time of contracting/credentialing.

Amerigroup will track a facility's/ancillary's reassessment date and reassess every 36 months or sooner as applicable. The requirements for recredentialing are the same for reassessment as they are for the initial assessment.

The organizational provider or ancillary will:

- Be notified either by telephone or in writing if any information obtained in support of the assessment or reassessment process varies substantially from the information submitted
- Have the right to review the information submitted in support of the assessment process and to correct any errors in the documentation

5.13. Delegated Credentialing

Provider groups with strong credentialing programs that meet Amerigroup Credentialing Standards may be evaluated for delegation. As part of this process, Amerigroup will conduct a predelegation assessment of a group's credentialing policy and program, as well as an on-site evaluation of credentialing files. A passing score is considered to be an overall average of 90 percent compliance. If deficiencies are identified, the group is expected to submit an acceptable corrective action plan within 30 days of receipt of the audit results. If there are serious deficiencies, we will deny the delegation or will restrict the level of delegation.

We may waive the need for the predelegation onsite audit if the group's credentialing program is NCQA-certified for all credentialing and recredentialing elements.

Amerigroup is responsible for ongoing oversight of any delegated credentialing arrangement and will schedule appropriate reviews. The reviews are held at least annually.

5.14. Peer Review

We continuously monitor the quality and appropriateness of care of our practitioner and provider network through peer review.

Peer review responsibilities are to:

- Participate in the established peer review system
- Review and make recommendations regarding individual provider peer review cases
- Work in accordance with the executive medical director

If an investigation of a member grievance results in concern regarding your compliance with community standards of care or service, all elements of peer review will be followed.

We apply dissatisfaction severity codes and levels of severity to quality issues. Peer review includes investigation of physician actions by the medical director. The medical director:

- Assigns a level of severity to the grievance
- Invites the cooperation of the physician
- Consults with and informs the MAC and Peer Review Committee
- Informs the physician of the Committee's decision, recommendations, follow-up actions and/or disciplinary actions to be taken

We report outcomes 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.

5.15. Provider Information Sharing

Amerigroup will provide PCPs with reports via our secure provider website. These reports will include but are not limited to:

- Monthly lists of members who have failed to obtain required EPSDT services for follow-up
- Semi-annual reports that identify assigned members who were visiting the emergency room for conditions that can generally be successfully managed in ambulatory settings
- Annual provider profiling reports that list all members for whom quality goals were not achieved

6. PROVIDER DISPUTE PROCEDURES

6.1. Provider Grievance Procedures

You can submit verbal or written grievances. Supporting documentation should accompany the grievance. Grievances are resolved fairly and are consistent with our policies and covered benefits. You will not be penalized for filing a grievance.

6.2. Verbal Grievance Process

Submit verbal grievances to:

- Provider Services at 1-800-454-3730
- The health plan at [XXX-XXX-XXXX]
- Your local Provider Relations representative

All provider calls will be answered immediately during normal business hours or will be returned within three business days of voicemail receipt. Inquiries will be resolved and/or results will be communicated to the provider within 30 business days of receipt, including referrals from DHH. If inquiries are not resolved within 30 days, Amerigroup will document the reasons why the issues go unresolved; however, the issue will be completely resolved within 90 days.

6.3. Written Grievance Process

Submit a grievance in writing by letter, fax or email to:

Amerigroup Louisiana

[Address]

[City, State ZIP]

[Fax #]

[Email address]

If the outcome of our review is adverse to you, we will provide a written notice of adverse action.

You can also appear in person at the following office to submit a complaint:

Amerigroup Louisiana Main Office

[Insert primary LA office address]

[City, State ZIP]

[Phone #]

6.4. Provider Payment Disputes

Amerigroup strives to continuously increase service quality to our providers. Our Provider Experience program helps you with claims* payment and issue resolution.

Just call 1-800-454-3730 and select the Claims prompt within our voice portal.

The Provider Experience program connects you with a dedicated resource team 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

**Please note that if you choose to use the program, you may miss your opportunity to file a formal payment dispute, as the timely filing period will commence from the date of the Explanation of Payment.*

A payment dispute is any dispute between the health care provider and Amerigroup for reason(s) including:

- Contractual payment issues
- Inappropriate or unapproved referrals initiated by providers
- Retrospective review
- Disagreements over reduced or zero-paid claims

You will not be penalized for filing a payment dispute. No action is required by the member.

6.5. Written Payment Dispute Process

You can submit written payment disputes within 90 calendar days of the date of the EOP. Complete the Provider Payment Dispute and Correspondence – Submission form located on our website and mail it to:

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

Written payment disputes should include supporting documentation such as an EOP or other written explanation with a copy of the claim.

Providers may also utilize the payment dispute tool on the web. When inquiring on the status of a claim, if a claim is considered disputable due to no or partial payment, a dispute button will display. Once this button is clicked, a web form will display for the provider to complete and submit. If all required fields are completed, the provider will receive immediate acknowledgement of his or her submission. When using the on-line tool, supporting documentation can be uploaded utilizing the attachment feature on the web dispute form and will attach to the form when submitted.

Changes and/or errors on claims, responses to itemized bill requests, and submission of coordination of benefits/third-party liability information are not considered payment disputes. These should be resubmitted with a notation of corrected claim or claim correspondence to:

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

A licensed/registered nurse will review payment disputes received with supporting clinical documentation when medical necessity review is required. We will apply established clinical criteria to the payment dispute. After review, we will either approve the payment dispute or forward it to the medical director for further review and resolution.

We will send a Level I determination letter to you within 30 business days from receipt of the dispute. The response includes the following information:

- Date of initial filing of concern
- Written description of the concern
- Decision
- Level II request instructions

If you are dissatisfied with the Level I payment dispute resolution, you may file a request for a Level II review. We must receive your request within 30 calendar days of the date of the Level I determination letter. We will issue a determination within 30 days of receipt of the Level II request.

Send the request to:

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

After all internal dispute levels have been exhausted, the provider has the option to request binding arbitration for claims that have denied or for underpaid claims or a group of claims bundled by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution.

If Amerigroup and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted shall be binding on all parties. The arbitrator shall conduct a hearing and issue a final ruling within 90 days of being selected unless Amerigroup and the provider mutually agree to extend this deadline.

If the arbitrator determines that Amerigroup must pay any disputed claim, or any portion thereof, that payment will be made, in accordance to the arbitrator's decision, within 30 calendar days of receipt of the reviewer's decision. Any fees due to the arbitrator will be paid by Amerigroup within 30 calendar days of receipt of the bill.

Amerigroup may, within 60 days, elect to file suit in any jurisdictional court to further review the decision and recover any awarded funds and reasonable attorney's fees.

7. CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

7.1. Claims Submission

You have the option of submitting claims electronically or by mail.

We encourage you to submit claims electronically, as you will be able to:

- Submit claims either through a clearinghouse or directly to Amerigroup
- Receive payments quickly
- Eliminate paper
- Save money

7.2. Clearinghouse Submission

You can submit electronic claims through Electronic Data Interchange (EDI). You must submit claims within 365 calendar days from the date of discharge for inpatient services or from the date of service for outpatient services. EPSDT screening claims must be filed within 60 days of the date of service. You can submit claims through:

- Emdeon (formerly WebMD) – Claim Payer ID 27514
- Capario (formerly MedAvant) – Claim Payer ID 28804
- Availity (formerly THIN) – Claim Payer ID 26375

An EDI claims submission guide is located at www.amerigroupcorp.com/providers.

7.3. Website Submission

Submit claims on our website by:

- Entering claims on a preformatted CMS-1500 and CMS-1450 claim template
- Uploading a HIPAA-compliant ANSI 837 5010 claim transaction

To start the electronic claims submission process or if you have questions, please contact our EDI Hotline at 1-800-590-5745.

7.4. Paper Claims Submission

You must submit a properly completed CMS-1450 or CMS-1500 (08-05) claim form:

- Within 365 calendar days from the date of discharge for inpatient services or from the date of service for outpatient services; EPSDT screening claims must be filed within 60 days of the date of service
- On the original red claim forms (not black and white or photocopied forms)
- Laser printed or typed (not handwritten)
- In a large, dark font

Submit paper claims to:

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

There are exceptions to the timely filing requirements. They include:

- Cases of coordination of benefits/subrogation. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date of the third-party's resolution of the claim.
- Cases where a member has retroactive eligibility. In situations of enrollment in Amerigroup with a retroactive eligibility date, the time frames for filing a claim will begin on the date that Amerigroup receives notification from the enrollment broker of the member's eligibility/enrollment.

Claim forms must include the following information (HIPAA compliant where applicable):

- Patient's ID number
- Patient's name
- Patient's date of birth
- ICD-9 diagnosis code/revenue codes
- Date of service
- Place of service
- Procedures, services or supplies rendered CPT-4 codes/HCPC codes/DRGs
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- Billing provider information
- NPI of billing and rendering provider when applicable
- COB/other insurance information
- Precertification number or copy of precertification
- Name of referring physician
- NPI/API
- NDC, unit of measure and quantity for medical injectibles
- Any other state-required data

We cannot accept claims with alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return.

CMS-1500 and CMS-1450 forms are available from the Centers for Medicare and Medicaid Services at www.cms.hhs.gov.

7.5. Encounter Data

If you are reimbursed by capitation, you must send encounter data to Amerigroup for each member encounter.

You must submit encounter data no later than 365 calendar days from the date of service through:

- EDI submission methods
 - CMS-1500 (08-05) claim form
 - Other arrangements that are approved by Amerigroup
- EPSDT screening claims must be filed within 60 days of the date of service.

Include the following:

- Member name (first and last name)
- Member date of birth
- Provider name according to contract
- Amerigroup provider number
- Coordination of benefit information
- Date of encounter
- Diagnosis code
- Types of services provided (utilizing current procedure codes and modifiers if applicable)
- Provider tax ID number
- NPI/API number

Our Utilization and Quality Improvement staff monitors compliance, coordinates it with the medical director and then reports to the QMC on a quarterly basis. Lack of compliance will result in:

- Training
- Follow-up audits
- Even termination

7.6. Claims Adjudication

We are dedicated to providing timely adjudication of claims. We process all claims according to generally accepted claims coding and payment guidelines defined by the CPT-4 and ICD-9 Manuals.

You must use HIPAA-compliant billing codes when billing Amerigroup electronically or on paper. When billing codes are updated, you are required to use appropriate replacement codes for submitted claims. We will reject claims submitted with noncompliant billing codes.

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.

Whether you submit claims through EDI or on paper, use our claims guide charts in Appendix A to ensure you submit clean and complete claims.

For your claims payment to be considered, you must adhere to the following time limits:

- Submit claims within 365 calendar days:
 - From the date of service
 - From the date of discharge for inpatient claims filed by a hospital
- Submit claims for EPSDT claims within 60 days from date of service
- In the case of other insurance, submit the claim within 365 calendar days of receiving a response from the third-party payer
- Claims for members whose eligibility has not been added to the state's eligibility system must be received within 365 calendar days from the date the eligibility is added and we are notified of the eligibility/enrollment

We will deny claims submitted after the filing deadline.

7.7. Clean Claims Payment

A clean claim is a request for payment for a service rendered by a provider that:

- Is submitted on time
- Is accurate
- Is submitted on a HIPAA-compliant standard claim form (CMS-1500 or CMS-1450 or successor forms)
- Requires no further information, adjustment or alteration to be processed and paid
- Is not from a provider who is under investigation for fraud or abuse
- Is not a claim under review for medical necessity

We will adjudicate clean claims to a paid or denied status within 15 business days of receipt. If we do not pay the claim within 30 calendar days, we will pay all applicable interest as required by law.

We produce and mail an EOP on a twice a week basis. It shows the status of each claim that has been adjudicated during the previous claim cycle.

If we do not receive all of the required information, we will deny the claim either in part or in whole within 15 business days of receipt of the claim. A request for the missing information will appear on your EOP.

Once we have received the requested information, we will process the claim within 15 business days.

We will return paper claims that are determined to be unclean along with a letter stating the reason for the rejection. We will return electronic claims that are determined to be unclean to the clearinghouse that submitted the claim.

7.8. Claims Status

You can check claims statuses by going to our website or by calling our Provider Inquiry Line at 1-800-454-3730. You can also use the claims status information for accepted and rejected claims that were submitted through a clearinghouse.

If we do not have the claim on file, resubmit your claim within the timely filing requirements. If filing electronically, check the confirmation reports for acceptance of the claim that you receive from your EDI or practice management vendor.

7.9. Coordination of Benefits and Third-Party Liability

We follow state-specific guidelines when Coordination of Benefits (COB) procedures are necessary. We use covered medical and hospital services whenever available or other public or private sources of payment for services rendered to our members.

When third-party resources and Third-Party Liability (TPL) resources are available to cover the costs of trauma-related claims and medical services provided to Medicaid members, we will reject the claim and redirect you to bill the appropriate insurance carrier (unless certain pay and chase circumstances apply — see below). Or, if we do not become aware of the resource until after payment for the service was rendered, we will pursue post-payment recovery of the expenditure. You must not seek recovery in excess of the Medicaid payable amount.

The pay and chase circumstances are:

- When the services are for preventive pediatric care, including EPSDT
- If the claim is for prenatal or postpartum care or if service is related to OB care
- For any service rendered to a child of an absent parent (i.e., primary coverage is through a noncustodial parent after a divorce)

Our subrogation vendor handles the filing of liens and settlement negotiations both internally and externally.

If you have any questions regarding paid, denied or pended claims, please call Provider Services at 1-800-454-3730.

7.10. Billing Members

Before rendering a service that is not covered by Amerigroup, inform our member that we do not cover the cost of the service; he or she will have to pay for the service.

If you choose to provide services that we do not cover:

- Understand that 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 specifying that the member will be held responsible for payment of services
- Understand that you 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

You cannot balance-bill for the amount above that which we pay for covered services.

In addition, you may not bill a member if any of the following occurs:

- Failure to submit a claim on time, including claims not received by Amerigroup
- Failure to submit a claim to Amerigroup for initial processing within the timely filing deadline for providers
- Failure to dispute a corrected claim within the clean-claim submission period
- Failure to appeal a claim within the 90-day payment dispute period
- Failure to appeal a utilization review determination within 30 days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made by provider in claims preparation, claims submission or the appeal/dispute process

7.11. Client Acknowledgment Statement

You may bill a member for a service that has been denied as not medically necessary or not a covered benefit **(only if both of the following conditions are true):**

- The member requests the specific service or item
- The provider obtains and keeps a written acknowledgement statement signed by the member and the provider stating:

“I understand that, in the opinion of (provider’s name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under Amerigroup as being reasonable and medically necessary for my care or are not a covered benefit. I understand that Amerigroup has established the medical necessity standards for the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined to be inconsistent with the Amerigroup medically necessary standards for my care or are not a covered benefit.”

Signature: _____

Date: _____

8. APPENDIX A – FORMS

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Claims Guide Charts

CMS1500		Required		
FIELD	FIELD NAME	Y=Yes, N=No	Description	Example
NUMBER		S=Situational	Format	
1	Type	N	Check appropriate box	X
1a	Insured ID	Y	Amerigroup Member ID	123456789
2	Patient Name	Y	Last Name, First Name, Middle Initial	Doe, John, E
3	Patient Date of Birth	Y	MM/DD/YY	07 04 99
3	Patient Sex	Y	Check M box for Male and F box for Female	X
4	Insured's Name	S	Last Name, First Name, Middle Initial	Doe, John, E
5	Patient's Address	Y	Number and Street	123 Somewhere St
5	Patient's City	Y	City	Anytown
5	Patient's State	Y	State abbreviated	VA
5	Patient's Zip Code	Y	US Postal ZIP Code	12345-0001
5	Patient Phone	N	Area Code plus phone number (10 digits)	757 123-4567
6	Patient Relationship to Insured	N	Check appropriate box	X
7	Insured Street	S	Number and Street	123 Somewhere St
7	Insured City	S	City	Anytown
7	Insured State	S	State abbreviated	VA
7	Insured Zip Code	S	US Postal ZIP Code	12345-0001
7	Insured Phone	N	Area Code plus phone number (10 digits)	757 123-4567
8	Patient Status	S	Check appropriate box	X
9	Other Insured Name	S	Last Name, First Name, Middle Initial	Doe, Mary, D
9a	Other Insured Policy or Group Number	S	Other Insured Member ID	555666777888
9b	Other Insured Date of Birth	S	MM/DD/YY	03 15 87
9b	Other Insured Sex	S	Check M box for Male and F box for Female	X
9c	Other Employer/School	S	Name of employer or school	Some Bank Name Inc.
9d	Other Insurance Name	S	Name of other insurance	For All Commercial Insurance
10a	Work Related Condition	S	Check appropriate box	X
10b	Auto Related Condition	S	Check appropriate box	X
10b	Accident Place State	S	State abbreviated	VA
10c	Other	S	Check appropriate box	X
10d	Local Use	N		
11	Insured Policy Group or FECA Number	S	Insured Group Number	FAC111222B
11a	Insured Date of Birth	S	MM/DD/YY	07 04 99

11a	Insured Sex	S	Check M box for Male and F box for Female	X
11b	Insured Employer/School	S	Enter Employer or School name	NONE
11c	Insured Plan Name	S	Insurance Plan Name	MEDICAID
11d	Other Benefit Indicator	S	Check appropriate box	X
12	Patient/Authorized Signature	N		
12	Patient/Authorized Date	N		
13	Insured/Authorized Signature	N		
14	Illness/Injury Date	S	MM/DD/YY	02 09 08
15	Similar Illness Date	S	MM/DD/YY	12 16 07
16	Disability Date - From	S	MM/DD/YY	02 05 08
16	Disability Date - To	S	MM/DD/YY	02 11 08
17	Referring Physician Name	S	Name of Physician who referred patient for services	Jane A Smith
17a	Referring Physician ID Qualifier	S	Use corresponding qualifier for Id number submitted in 17a- shaded. G2= AGP Number, 1D= Medicaid, ZZ= Taxonomy	ZZ
17a	Referring Physician ID	S	Appropriate and valid provider id. Medicaid, AGP, or Taxonomy	207QA0000X
17b	NPI	S	Valid 10 digit NPI number	9876543210
18	Hospitalization Date - From	S	MM/DD/YY	02 08 08
18	Hospitalization Date - To	S	MM/DD/YY	02 09 08
19	LOCAL USE	N		
20	Outside Lab	S	Check appropriate box	X
20	Lab Charges	S	Dollar amount from outside lab	60 00
21 1.	Diagnosis Code	Y	Valid primary diagnosis code	821.3
21 2.	Diagnosis Code	S	Valid secondary diagnosis code	
21 3.	Diagnosis Code	S	Valid tertiary diagnosis code	
21 4.	Diagnosis Code	S	Valid fourth diagnosis code	
22	Medicaid Resubmission Code	N		123
22	Medicaid Original Reference	N	Original Claim Number	ABC123456789
23	Prior Authorization Number	S	If authorization for services were obtained, enter Amerigroup authorization number.	1234AUTH5678
24	Shaded Area Data	S	Free form Text and / or NDC information	N400186115102 ML 1
24a	From Date	Y	MM/DD/YY	02 10 08
24a	To Date	Y	MM/DD/YY	02 10 08
24b	Place of Service	Y	2 Digit Place of Service Code	11
24c	EMG	N	Emergency Indicator "Y" or Blank = Assumed "N"	Y

24d	Procedure Code	Y	Valid CPT/HCPCS	99212
24d	Procedure Modifier 1	S	Valid 2 digit modifier	TN
24d	Procedure Modifier 2	S	Valid 2 digit modifier	TC
24d	Procedure Modifier 3	S	Valid 2 digit modifier	50
24d	Procedure Modifier 4	S	Valid 2 digit modifier	51
24e	Diagnosis Code Pointer	Y	Indicate which diagnosis code correlates to the line	1
24f	Charges	Y	Charges for line	\$150.00
24g	Days or Units	Y	Appropriate number for days or units	1
24h	EPSDT	Y	Y= if EPSDT service. N= if not an EPSDT service	N
24i-shaded	ID Qualifier	S	Use corresponding qualifier for Id number submitted in 24j- shaded. G2= AGP Number, 1D= Medicaid, ZZ= Taxonomy	ZZ
24j- shaded	Rendering Provider Id #	S	Appropriate and valid provider id. Medicaid, AGP, or Taxonomy	207XP3100X
24j- not shaded	Rendering Provider NPI	S	Valid 10 digit NPI number	1234567890
25	Federal Tax ID	Y	Valid 9 digit Tax ID or SSN	111223333
25	Federal Tax ID (SSN/EIN)	Y	Check SSN if social was used. Check EIN if Tax ID was used	X
26	Patient Account Number	S	Patient account number with provider	123ACCT456
27	Accept Assignment	S	Check appropriate box	X
28	Submitted Total Charge	Y	Total charges on claim	\$250.00
29	Patient Amount Paid	S	Amount patient paid	\$0.00
30	Balance Due	S	Amount still due on claim	\$250.00
31	Signature of Physician/ Physician Name	Y	Rendering Providers name	Jack T Specialist
31	Performing Provider Date	N	MMDDYY	2/10/2008
32	Service Facility Location Name	S	Name of facility were services were rendered	ABC Memorial Hospital
32	Service Facility Location Street	S	Number and Street	987 Somewhere St
32	Service Facility Location City	S	City	Anytown
32	Service Facility Location State	S	State abbreviated	VA
32	Service Facility Location Zip Code	S	US Postal Zip Code	12345-0001
32a	NPI	S	Valid 10 digit NPI number	9871234567
32b	Other ID	S	Appropriate and valid provider id. Medicaid, AGP, or Taxonomy	ZZ282NC2000X
33	Billing Provider Group Name	Y	Name of billing group or provider	JTS Orthopaedic Specialists
33	Billing Provider Street	Y	Number and Street	222 Somewhere St
33	Billing Provider City	Y	City	Anytown

33	Billing Provider First State	Y	State abbreviated	VA
33	Billing Provider First Zip Code	Y	US Postal Zip Code	12345-0001
33	Phone Number	N	Billing Provider Phone Number	(757) 555-4444
33a	NPI	Y	Valid 10 digit NPI number	9874561230
33b	Other ID	Y	Appropriate and valid provider id. Medicaid, AGP, or Taxonomy	ZZ207X00000X

UB04				
FIELD	FIELD NAME	Required	Description	Examples
No.		Y=Yes N=No S=Situational O=Optional	Format	
1	Billing Provider Name	Y	Facility Name <i>(Please ensure the name submitted matches the name used in the Amerigroup processing system)</i>	ABC Memorial Hospital
1	Billing Provider Street Address	Y	Number and Street	987 Somewhere St
1	Billing Provider Address - CITY	Y	City	Anytown
1	Billing Provider Address - STATE	Y	State abbreviation	VA
1	Billing Provider Address - ZIP	Y	US Postal ZIP Code	12345-0001
1	Billing Provider Telephone	O	Area Code plus phone number (10 digits)	757-555-4444
1	Billing Provider FAX	O	Area Code plus fax number (10 digits)	757-444-5555
1	Billing Country Code	N		
2	Provider Info/Pay To Name	S	Facility Name	123 Hospital System
2	Provider Info/Pay To Street	S	Number and Street	111 Somewhere St
2	Provider Info/Pay To City	S	City	Anytown
2	Provider Info/Pay To State	S	State abbreviation	NC
2	Provider Info/Pay To ZIP Code	S	US Postal ZIP Code	53211-0001
2	Provider Info/Pay To Phone Number	O	Area Code plus phone number (10 digits)	

3a	Patient Control Number	S	Provider's control number for patient	123CNTL456
3b	Medical Record Number	S	Provider's medical record number for patient	123REC456
4	Type of Bill	Y	Enter appropriate three digit code for type of bill	111
5	Federal Tax Number	Y	Valid 9 digit Tax ID or SSN	999887777
6	Statement Period From	Y	MMDDYY	021108
6	Statement Period To	Y	MMDDYY	021908
7	Local Use	N		
8a	Patient ID	Y	Member's Amerigroup number or state assigned Medicaid number	123456789
8b	Patient Name	Y	Last Name, First Name, Middle Initial	Doe, John E.
9a	Patient Street	Y	Number and Street	123 Somewhere St
9b	Patient City	Y	City	Anytown
9c	Patient State	Y	State abbreviation	VA
9d	Patient ZIP Code	Y	US Postal ZIP Code	12345
9e	ZIP Code + 4	S		0001
10	Birthdate	Y	MMDDYY	070499
11	Sex	Y	F=Female M=Male	M
12	Admission Date	S	MMDDYY	021108
13	Admission Hour	S	Enter admission hour	13
14	Admission Type	S	Enter valid admission type	01
15	Admission Source Code	S	Enter valid admission source code	07
16	Discharge Hour	S	Enter discharge hour	12
17	Status	S	Enter valid discharge status	01
18	Condition Code	S	Enter valid condition code	A9
19	Condition Code	S	Enter valid condition code	04
20	Condition Code	S	Enter valid condition code	M0
21	Condition Code	S	Enter valid condition code	
22	Condition Code	S	Enter valid condition code	
23	Condition Code	S	Enter valid condition code	
24	Condition Code	S	Enter valid condition code	
25	Condition Code	S	Enter valid condition code	
26	Condition Code	S	Enter valid condition code	
27	Condition Code	S	Enter valid condition code	
28	Condition Code	S	Enter valid condition code	
29	Accident State	S	State abbreviation	VA
30	Local Use	N		
31a & b	Occurrence Code / Date	S	Enter valid occurrence code and then date (MMDDYY)	a. 01 021108 b. 04 021108
32a & b	Occurrence Code / Date	S	Enter valid occurrence code and then date (MMDDYY)	a. 06 021108
33a & b	Occurrence Code / Date	S	Enter valid occurrence code and then date (MMDDYY)	
34a & b	Occurrence Code / Date	S	Enter valid occurrence code and then date (MMDDYY)	

35a & b	Occurrence Span Code/From/Through	S	Enter valid occurrence code and then date (MMDDYY)	a. 72 021108 021108
36a & b	Occurrence Span Code/From/Through	S	Enter valid occurrence code and then date (MMDDYY)	
37	Local Use	N		
38	Payer Name and Address	S	Enter the Claims submission address	AMERIGROUP Community Care PO Box 11111-1111 Virginia Beach, VA 23462
39a	Value Code / Amount	S	Enter valid value code and amount (<i>Note: all newborn claims should contain a value code of 54 -Newborn birth weight in Grams along with the birth weight of the baby</i>)	73 20 00
39b	Value Code / Amount	S	Enter valid value code and amount (<i>Note: all newborn claims should contain a value code of 54 -Newborn birth weight in Grams along with the birth weight of the baby</i>)	D3 45 00
39c	Value Code / Amount	S	Enter valid value code and amount (<i>Note: all newborn claims should contain a value code of 54 -Newborn birth weight in Grams along with the birth weight of the baby</i>)	54 30
39d	Value Code / Amount	S	Enter valid value code and amount (<i>Note: all newborn claims should contain a value code of 54 -Newborn birth weight in Grams along with the birth weight of the baby</i>)	
40a	Value Code / Amount	S	Enter valid value code and amount (<i>Note: all newborn claims should contain a value code of 54 -Newborn birth weight in Grams along with the birth weight of the baby</i>)	
40b	Value Code / Amount	S	Enter valid value code and amount (<i>Note: all newborn claims should contain a value code of 54 -Newborn birth weight in Grams along with the birth weight of the baby</i>)	
40c	Value Code / Amount	S	Enter valid value code and amount (<i>Note: all newborn claims should contain a value code of 54 -Newborn birth weight in Grams along with the birth weight of the baby</i>)	

40d	Value Code / Amount	S	Enter valid value code and amount (<i>Note: all newborn claims should contain a value code of 54 -Newborn birth weight in Grams along with the birth weight of the baby</i>)	
41a	Value Code / Amount	S	Enter valid value code and amount (<i>Note: all newborn claims should contain a value code of 54 -Newborn birth weight in Grams along with the birth weight of the baby</i>)	
41b	Value Code / Amount	S	Enter valid value code and amount (<i>Note: all newborn claims should contain a value code of 54 -Newborn birth weight in Grams along with the birth weight of the baby</i>)	
41c	Value Code / Amount	S	Enter valid value code and amount (<i>Note: all newborn claims should contain a value code of 54 -Newborn birth weight in Grams along with the birth weight of the baby</i>)	
41d	Value Code / Amount	S	Enter valid value code and amount (<i>Note: all newborn claims should contain a value code of 54 -Newborn birth weight in Grams along with the birth weight of the baby</i>)	
42	Revenue Code	Y	Enter valid revenue code	0450
43	Description	O		
44	HCPCS/Rates	S	Enter valid HCPC/Rate/HIPPS Code	99284
45	Service Date	S	MMDDYY	021108
46	Service Units	Y	Enter number of units	1
47	Total Charges	Y	Enter total chrages for line	500 00
48	Non-Covered Charges	N		
49	Local Use	N		
42-23	PAGE _ OF _	O	Enter Page Counts	1 OF 1
42-23	CREATION DATE	O	Enter Date claim was created	21208
42-23	TOTALS →	O	Enter Total chrages for the claim	
50a	Payor Name	Y	Enter the Primary payer name	Amerigroup
50b	Payor Name	S	Enter the Secondary payer name	For All Commercial Ins
50c	Payor Name	S	Enter the Tertiary payer name	
51a	Health Plan ID	N		
51b	Health Plan ID	N		
51c	Health Plan ID	N		

52a	Rel Info	Y	Indicate Release of Information statement on file	Y
52b	Rel Info	S		
52c	Rel Info	S		
53a	Assign Benefits	N		
53b	Assign Benefits	N		
53c	Assign Benefits	N		
54a	Prior Payments	S	Enter any prior payments	300 00
54b	Prior Payments	S	Enter any prior payments	
54c	Prior Payments	S	Enter any prior payments	
55a	Est. Amount Due	S	Enter estimate amount due from Patient	15 00
55b	Est. Amount Due	S		
55c	Est. Amount Due	S		
56	NPI	Y	Valid 10 digit NPI number	9871234567
57a	Other Provider ID	S	Appropriate and valid qualifier and provider id number. Taxonomy	ZZ282NC2000X
57b	Other Provider ID	S	Appropriate and valid qualifier and provider id number. Medicaid	1D 345678
57c	Other Provider ID	S	Appropriate and valid qualifier and provider id number. Amerigroup ID	
58a	Insured's Name	S	Last Name, First Name, Middle Initial	Doe, John, E.
58b	Insured's Name	S	Last Name, First Name, Middle Initial	
58c	Insured's Name	S	Last Name, First Name, Middle Initial	
59a	Patient Relationship	R	Enter a valid Patient relationship code	19
59b	Patient Relationship	R	Enter a valid Patient relationship code	18
59c	Patient Relationship	R	Enter a valid Patient relationship code	
60a	Insured's Unique ID	Y	Member's Amerigroup number or state assigned Medicaid number	123456789
	Insured's Unique ID	S	Insured unique Identification number	23234545
60c	Insured's Unique ID	S		
61a	Group Name	S	Enter group name	Medicaid
61b	Group Name	S	Enter group name	For All Commercial Ins
61c	Group Name	S	Enter group name	
62a	Insurance Group Number	S	Enter group number	
62b	Insurance Group Number	S	Enter group number	F32415G
62c	Insurance Group Number	S	Enter group number	

63a	Treatment Authorization Code	S	If authorization was obtained for services, enter auth code given	1234AUTH5678
63b	Treatment Authorization Code	S	If authorization was obtained for services, enter auth code given	
63c	Treatment Authorization Code	S	If authorization was obtained for services, enter auth code given	
64a	Document Control Number	N		
64b	Document Control Number	N		
64c	Document Control Number	N		
65a	Employer Name	S	Enter Employer Name	Some Bank Name Inc
65b	Employer Name	S	Enter Employer Name	
65c	Employer Name	S	Enter Employer Name	
66	DX Indicator	N	Enter Diagnosis Qualifier	9
67	Principle Diagnosis Code	Y	Enter valid diagnosis code	821.3
67a	Other diagnosis code A	S	Enter valid diagnosis code	733.93
67b	Other diagnosis code B	S	Enter valid diagnosis code	531
67c	Other diagnosis code C	S	Enter valid diagnosis code	
67d	Other diagnosis code D	S	Enter valid diagnosis code	
67e	Other diagnosis code E	S	Enter valid diagnosis code	
67f	Other diagnosis code F	S	Enter valid diagnosis code	
67g	Other diagnosis code G	S	Enter valid diagnosis code	
67h	Other diagnosis code H	S	Enter valid diagnosis code	
67i	Other diagnosis code I	S	Enter valid diagnosis code	
67j	Other diagnosis code J	S	Enter valid diagnosis code	
67k	Other diagnosis code K	S	Enter valid diagnosis code	
67l	Other diagnosis code L	S	Enter valid diagnosis code	
67m	Other diagnosis code M	S	Enter valid diagnosis code	
67n	Other diagnosis code N	S	Enter valid diagnosis code	
67o	Other diagnosis code O	S	Enter valid diagnosis code	
67p	Other diagnosis code P	S	Enter valid diagnosis code	

67q	Other diagnosis code Q	S	Enter valid diagnosis code	
68	Local Use	N		
69	Admit Diagnosis Code	Y	Enter valid diagnosis code	733.93
70a	Patient Reason DX A	S	Enter valid diagnosis code	346.2
70b	Patient Reason DX B	S	Enter valid diagnosis code	
70c	Patient Reason DX C	S	Enter valid diagnosis code	
71	PPS Code	S	Enter valid DRG code	123
72a	ECI A	S	Enter valid diagnosis code	E812
72b	ECI B	S	Enter valid diagnosis code	
72c	ECI C	S	Enter valid diagnosis code	
73	Local Use	N		
74	Principal Procedure Code	S	Enter valid Procedure code	0032
74	Principal Procedure Date	S	MMDDYY	021108
74a	Other Procedure Code	S	Enter valid Procedure code	
74a	Other Procedure Date	S	MMDDYY	
74b	Other Procedure Code	S	Enter valid Procedure code	
74b	Other Procedure Date	S	MMDDYY	
74c	Other Procedure Code	S	Enter valid Procedure code	
74c	Other Procedure Date	S	MMDDYY	
74d	Other Procedure Code	S	Enter valid Procedure code	
74d	Other Procedure Date	S	MMDDYY	
74e	Other Procedure Code	S	Enter valid Procedure code	
74e	Other Procedure Date	S	MMDDYY	
75	Local Use	N		
76	Attending NPI	S	Valid 10 digit NPI number	2323232323
76	Attending Qualifier	S	Use corresponding qualifier for Id number submitted in 76. G2= AGP Number, 1D= Medicaid, EI or 24= Tax Id, 34= SSN	EI
76	Attending ID	S	Appropriate and valid provider id. Medicaid, AGP, Tax Id or SSN	444556666
76	Attending Last Name	S	Attending Physician's last name	Doe
76	Attending First Name	S	Attending Physician's first name	Robert
77	Operating NPI	S	Valid 10 digit NPI number	2121212121
77	Operating Qualifier	S	Use corresponding qualifier for Id number submitted in 77. G2= AGP Number, 1D= Medicaid, EI or 24= Tax Id, 34= SSN	EI

77	Operating ID	S	Appropriate and valid provider id. Medicaid, AGP, Tax Id or SSN	123456789
77	Operating Last Name	S	Operating Physician's Last Name	Smith
77	Operating First Name	S	Operating Physician's First Name	Jane
78	Other (<i>Space</i>)	S	Enter qualifier for the provider reported DN- Referring, ZZ-Other Operating Physician, 82- Rendering Provider	82
78	Other NPI	S	Valid 10 digit NPI number	1112223334
78	Other Qualifier	S	Use corresponding qualifier for Id number submitted in 78. G2= AGP Number, 1D= Medicaid, EI or 24= Tax Id, 34= SSN	EI
78	Other ID	S	Appropriate and valid provider id. Medicaid, AGP, Tax Id or SSN	987654321
78	Other Last Name	S	Physician's Last Name	Jones
78	Other First Name	S	Physician's First Name	Jack
79	Other NPI	S	Valid 10 digit NPI number	
79	Other Qualifier	S	Use corresponding qualifier for Id number submitted in 79. G2= AGP Number, 1D= Medicaid, EI or 24= Tax Id, 34= SSN	
79	Other ID	S	Appropriate and valid provider id. Medicaid, AGP, Tax Id or SSN	
79	Other Last Name	S	Physician's Last Name	
79	Other First Name	S	Physician's First Name	
80	Remarks	S	Enter any free form remarks	Sample claim - Not Valid
81a	CC	N		
81b	CC	N		
81c	CC	N		
81d	CC	N		

Specialist as PCP Request Form



Date: _____
Member's Name: _____
Member's ID #: _____
PCP's Name (if applicable): _____
Specialist/Specialty: _____
Member's Diagnosis: _____

Describe the medical justification for selecting a specialist as PCP for this member.

The signatures below indicate agreement by the specialist, Amerigroup and the member for whom the specialist will function as this member's PCP, including providing to the member access 24 hours a day, 7 days a week.

Specialist's Signature: _____ Date: _____
Medical Director's Signature: _____ Date: _____
Member's Signature: _____ Date: _____

Medical Record Forms

The rest of this page intentionally left blank. Form displayed on subsequent pages.



Medical Record Review Checklist

Provider Name: _____ **Date of Review:** _____
Specialty: _____ **Reviewer:** _____
Check One: **Audit** _____ **Credentialing Visit** _____ **Recredentialing Visit** _____

Member Name:													
Date of Birth:													
Member ID:													
CRITERIA (Critical indicators are in bold type)	Y	N	NA										
1. Patient identification on each page													
2. Biographical/personal data documented													
3. Medical record entries are legible													
4. All entries are dated and signed by provider													
5. Medication log													
6. Immunization log up to date													
7. Immunization log complete (includes route, dose, lot number and expiration date)													
8. Immunization log signed by appropriate provider													
9. Allergies and adverse reactions flagged													
10. Completed problem list													
11. Past medical history													
12. Follow-up on past visit problems													
13. Mental health screening													
14. Psychosocial assessment													
15. EtOH/substance/smoking screen-counseling													
16. HIV education, counseling and screening													
17. Domestic violence/child abuse screening													
18. Pertinent history and physical exam													
19. Working diagnosis consistent with findings													
20. Tx Plan appropriate and consistent with Dx.													
21. Return date and follow-up plan on encounter with time													
22. Labs and other studies as appropriate													
23. Labs and other studies reviewed and initialed													
24. Appropriate use of specialist/consultants													
25. Continuity and coordination of care with specialist													
26. Consultative reports reviewed and initialed													
27. Preventive services rendered appropriately													
28. Age-appropriate education provided													
29. Appropriate reporting of communicable disease													

HIV Antibody Blood Forms

The rest of this page intentionally left blank. Form displayed on subsequent pages.

Counsel for HIV Antibody Blood Test

use patient imprint

Name: _____

In accordance with Chapter 174, P.L. 1995:

I acknowledge that _____ has counseled
(Name of physician or other provider)
and provided me with:

- A. Information concerning how HIV is transmitted
- B. The benefits of voluntary testing
- C. The benefits of knowing if I have HIV or not
- D. The treatments which are available to me and my unborn child should I test positive
- E. The fact that I have a right to refuse the test and I will not be denied treatment

I have consented to be tested for infection with HIV.

I have decided not to be tested for infection with HIV.

This record will be retained as a permanent part of the patient's medical record.

Signature of Patient

Date

Signature of Witness



Consent for the HIV Antibody Blood Test

I have been told that my blood will be tested for antibodies to the virus named HIV (Human Immunodeficiency Virus). This is the virus that causes AIDS (Acquired Immunodeficiency Syndrome), but it is not a test for AIDS. I understand that the test is done on blood.

I have been advised that the test is not 100 percent accurate. The test may show that a person has antibodies to the virus when they really don't — this is a false-positive test. The test may also fail to show that a person has antibodies to the virus when they really do — this is a false negative test. I have also been advised that this is not a test for AIDS and that a positive test does not mean that I have AIDS. Other tests and examinations are needed to diagnose AIDS.

I have been advised that if I have any questions about the HIV antibody test, its benefits or its risks, I may ask those questions before I decide to agree to the blood test.

I understand that the results of this blood test will only be given to those health care workers directly responsible for my care and treatment. I also understand that my results can only be given to other agencies or persons if I sign a release form.

By signing below, I agree that I have read this form or someone has read this form to me. I have had all my questions answered and have been given all the information I want about the blood test and the use of the results of my blood test. I agree to give a tube of blood for the HIV antibody tests. There is almost no risk in giving blood. I may have some pain or a bruise around the place that the blood was taken.

Date

Patient's/Guardian's Signature

Witness Signature

Patient's/Guardian's Printed Name

Physician Signature

Amerigroup recognizes the need for strict confidentiality guidelines.



Results of the HIV Antibody Blood Test

A. EXPLANATION

This authorization for use or disclosure of the results of a blood test to detect antibodies to HIV, the probable causative agent of Acquired Immunodeficiency Syndrome (AIDS), is being requested of you to comply with the terms of Confidentiality of Medical Information Act, Civil Code Section 56 et seq. and Health and Safety Code Section 199.21(g).

B. AUTHORIZATION

I hereby authorize _____ to furnish
(Name of physician, hospital or health care provider)
to _____ the results of the blood
(Name or title of person who is to receive results)
test for antibodies to HIV.

C. USES

The requester may use the information for any purpose, subject only to the following limitation:
_____.

D. DURATION

This authorization shall become effective immediately and shall remain in effect indefinitely or until _____, 20____, whichever is shorter.

E. RESTRICTIONS

I understand that the requester may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

F. ADDITIONAL COPY

I further understand that I have a right to receive a copy of this authorization upon my request. Copy requested and received: Yes No _____ Initial

Date: _____, 20_____

Signature

Printed Name

This form must be in at least eight-point type.



Acknowledgment of Receipt of Hysterectomy Information

**Medicaid Program
Acknowledgment of Receipt of Hysterectomy Information**

Recipient Name: _____
ID No.: _____
Physician Name: _____
Provider No.: _____

Payment by Louisiana’s Medicaid Program cannot be authorized for the performance of any hysterectomy committed solely for the purpose of rendering an individual permanently incapable of reproducing or where, if there is more than one purpose for the procedure, the hysterectomy would not be performed but for the purpose of rendering the individual permanently incapable of reproducing.

Medicaid payment for a medically indicated hysterectomy can be authorized only if:

- (1) the individual and her representative*, if any, are informed orally and in writing that the hysterectomy will render her permanently incapable of reproducing; and,
- (2) the individual and her representative*, if any, have signed a written acknowledgment of receipt of that information. The written acknowledgment must be signed and dated prior to the operation and must be attached to the claim form which is submitted for payment.

* A representative is that person who has the legal authority to act for an individual. For purposes of this acknowledgment, a representative shall be defined as either the curator of an interdicted woman or the tutor or parent of an unmarried minor. A minor emancipated by marriage is deemed capable of acting for herself in the matter.

I hereby acknowledge that I have been informed orally and in writing that a hysterectomy (surgical removal of the uterus) will render the individual on whom the procedure is performed permanently incapable of bearing children.

Signature of Recipient

Date

Signature of Representative, if any

Date

Consent for Sterilization

Form Approved OMB No. 0937-0166
Expiration date: 11/30/2009

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____, When I first asked _____, *doctor or clinic*

for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal Funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: _____ *Month Day Year*

I, _____, hereby consent of my own free will to be sterilized by _____, *doctor*

by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

Signature *Date: Month Day Year*

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

- | | |
|---|--|
| <i>Ethnicity:</i> | <i>Race (mark one or more):</i> |
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> American Indian or Alaska Native |
| <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> Asian |
| | <input type="checkbox"/> Black or African American |
| | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| | <input type="checkbox"/> White |

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter's Signature *Date*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____, *name of individual*, signed the consent form, I explained to him/her the nature of sterilization operation _____, the fact that it is

intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

Signature of person obtaining consent *Date*

Facility

Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____, *name of individual* on _____, *date of sterilization*

I explained to him/her the nature of the sterilization operation _____, the fact that it is

intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- Premature delivery
Individual's expected date of delivery: _____
- Emergency abdominal surgery *(describe circumstances):*

Physician's Signature *Date*

Abortion Form

DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE OF PUBLIC HEALTH
DIVISION OF RECORD AND STATISTICS

Instructions for Completing the
Certification of Informed Consent – Abortion

Acts 2007, No. 281 Section 1 amends and reenacts R.S. 40:1299.35.6 to provide for:

...Informed consent of a woman upon whom an abortion is to be performed or induced; to require that certain information be provided to such a woman, except in case of medical emergency; to require certain certification; to require publication and provision of certain information and materials; to require certain information in cases of medical emergency; to require certain reports; to provide for civil and criminal penalties and sanctions; to provide for severability, construction, and right of intervention; and to provide for related matters.

The CERTIFICATION OF INFORMED CONSENT – ABORTION form is an important legal document. Properly prepared, it is proof that the physician or qualified agent of the physician complied with the statutory requirement that the pregnant woman received complete information about her alternatives and voluntarily consented to an abortion at least twenty-four hours prior to having the abortion. Complete the form in accordance with the following instructions:

- All entries must be in ink. Type, print or stamp all entries other than the pregnant woman's confirmation initials.
- In the upper left, enter the name and the address of the facility. A stamped name and address is acceptable.
- In Sections I and II, type, print or stamp the name of the individual who presented the information and indicate whether that person is the physician who will perform the abortion, a referring physician, or a qualified agent of the physician (if applicable) by entering check marks in the appropriate spaces. Have the pregnant woman read the sections and initial in the space provided to acknowledge receipt of information.
- In Section III, type, print or stamp the name of the individual who presented the information and indicate whether that person is the physician who will perform the abortion, a referring physician, or a qualified agent of the physician by entering a check mark in the appropriate space. Have the pregnant woman read the section and initial in the space provided to acknowledge receipt of the printed materials, and complete the date/time that the printed materials were received.

The CERTIFICATION OF INFORMED CONSENT – ABORTION form is a snapset composed of an instruction sheet, and an original and two copies of the consent form. Submit the original to:

Abortion Registration Clerk
Vital Records Registry
P.O. Box 60630
New Orleans, LA 70160
(504) 219-4500

If information or materials are provided by a referring physician, submit the original to the above-referenced. Give the first and second copies to the patient, with verbal instructions to bring one copy to the physician who is to perform the abortion. It is recommended that the referring physician retain a photocopy of the consent form and make it a part of the patient's medical record.

The physician accepting referral and who performs the abortion is responsible for reporting the abortion on standard form PHS 16-ab (Report of Induced Termination of Pregnancy) within 15 days of the abortion. Attach the Certification of Informed Consent – Abortion received by referral to the PHS 16-ab and submit the documents within the prescribed filing time to the mailing address listed above.

If information or materials are provided by the physician who will perform the abortion, retain the first copy of the consent form in the patient's medical record and give the second copy to the patient. Attach the Certification of Informed Consent – Abortion to the PHS 16-ab and submit the documents within the prescribed filing time to the mailing address listed above.



Practitioner Clinical Medical Record Review

Physician Name: _____ Office Manager: _____

Office Address: _____

Specialty: _____ Date: _____ Reviewer Name: _____

Patient Name: _____ Chart/Member #: _____

	Point Value	Y	N	N/A	Point Score
1. Is chart accessible?	3				
2. Do all pages contain patient ID (name/ID#)?	4				
3. Are there personal/biographical data?	3				
4. Is the provider identified on each entry?	4				
5. Are all entries dated?	3				
6. Is the record legible?	4				
7. Are significant illnesses and medical conditions indicated on the problem list or, if patient has no known allergies or history of adverse reaction, is this appropriately noted in the record? *	3				
8. Are allergies and adverse reactions to medications prominently displayed or, if patient has no known allergies or history of adverse reaction, is this appropriately noted in the record? *					
9. Is there an appropriate past medical history in the record (for patients seen three or more times) which includes serious accidents, operations or illnesses, emergency care and discharge summaries? Age 18 and under should include prenatal care, birth, operations and childhood illnesses. *	3				
10. Is there documentation of smoking habits and history of alcohol or substance abuse (age 12 and over)?	3				
11. Is there a pertinent history and physical exam?	4				
12. Are lab and other studies ordered, as appropriate, and reflect PCP review?	4				
13. Are working diagnoses consistent with findings? *	3				
14. Do plans of action/treatment appear consistent with diagnosis(es)? *	3				
15. Is there a date for a return visit or other follow-up plan for each encounter?	4				
16. Are problems from previous visits addressed?	3				
17. Is there evidence of appropriate use of consultants?	3				
18. Is there evidence of continuity and coordination of care between primary and specialty physicians?	4				
19. Do consultant summaries, lab and imaging study results reflect PCP review?	4				
20. Does the care appear to be medically appropriate? (There is no evidence that patient was placed at inappropriate risk by diagnostic or therapeutic procedure.)*					
21. Is there a completed immunization record (ages 13 and under)?	4				
22. Are preventive services appropriately used?	3				
23. Does documentation of advance directive include: 3 points total					
- Is there evidence advance directive was offered/discussed with patient (21 and older)?	1				
- If patient desires advance directive, is it present in the chart (21 and older)?	2				
24. Does pediatric documentation include: (4 points total)					
- Growth chart (1.5 pts.)	1.5				
- Head circumference chart (1 pt.)	1				
- Developmental milestones (1.5 pts.)	1.5				
25. Is there a list of current medications?	4				
26. If a mental health problem is noted, was a referral made, or was treatment performed by the PCP?	3				
27. If a substance abuse problem is noted, was a referral made, or was treatment or education noted?	3				
28. Are abnormal test results acknowledged?	2				
29. Are copies of any emergency treatment and/or hospital admission (including discharge summaries and/or ancillary services care) present in the chart?	1				
30. INTENTIONALLY LEFT BLANK					
TOTAL	100				

* These critical elements must be met, in addition to receiving an average score of 80 percent to achieve an acceptable rating on the Clinical Medical Record review.



17 Alpha-Hydroxyprogesterone Caproate Pharmacy Referral for Amerigroup Members

- ❖ Use this form ONLY for office-administered compounded 17P. For home administration, use the Alere Home Healthcare referral form.
- ❖ For a commercially available form of 17P (Makena™), prior authorization is required. Please call 1-800-454-3730 to initiate a request.

Please complete and fax to 1-877-546-5780, or you can mail the form to:

The Apothecary Shops Specialty Pharmacy
 23620 N. 20th Drive, Suite 12
 Phoenix, AZ 85085
 Phone: 1-877-LINKSRX (546-5779)

Today's Date ____/____/____ Patient Contact Telephone Number (Required) _____
 Patient's Name _____ Date of Birth ____/____/____
 Home Address _____ City _____ State _____ ZIP Code _____
 Medicaid ID _____ Amerigroup ID _____ Amerigroup Group ID _____
 Primary Diagnosis _____ ICD-9 Code _____
 Current EGA _____ Weeks EDC ____/____/____ Indications for 17P Administration _____

Prescription Information

17 alpha-hydroxyprogesterone caproate in cottonseed oil or sesame oil (if none selected, default is cottonseed oil) 250 mg per ml, 5mL vial for intramuscular injection

Sig: Inject 1 ml into muscle once weekly as instructed for _____ weeks
Typically started between weeks 16 and 20 and continued until week 37 for women with singleton pregnancy and a history of prior preterm delivery.

Deliver medication to the physician's office below.

All orders will be delivered by two-day FedEx. Allow three days for receipt of medication. No precertification is required for compounded 17P.

Date of first administration appointment ____/____/____

Prescriber Information

Doctor's Name _____ Phone Number _____
 Office Name _____ Address _____
 NPI _____ DEA Number _____ State Medical License Number _____
 Date of Rx ____/____/____ Number of Prescriptions _____

Substitution Permissible

Dispense as Written

Prescriber Signature (We cannot accept signature stamps)

Prescriber Signature (We cannot accept signature stamps)

*****Faxed forms are valid only when sent directly from a prescriber's office. Prescriptions faxed by patients cannot be accepted.*****

Confidentiality Notice: This telecopy transmission contains confidential information that belongs to the sender and is legally privileged. This information is intended for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document. The Apothecary Shops facsimile machines are secure and in compliance with HIPAA privacy standards. Please use a new form for additional items.

Sample Louisiana State WIC Referral Forms

Once manual is finalized and converted to PDF, the state's full-page WIC forms will be inserted here:

- One for women
- One for infants

Additional Forms

Durable Power of Attorney and Advance Directives

The Patient Self Determination Act of 1990 requires health care providers to disseminate information to patients concerning their rights under state law to accept or refuse medical treatment and identify advanced medical directives.

Louisiana law regarding advance directives and template for Declaration may be found in Revised Statute 40:1299.58.3. Per Louisiana law, "declaration means a witnessed document, statement or expression voluntarily made by the declarant authorizing the withholding or withdrawal of life-sustaining procedures in accordance with the requirements of this part". A declaration may be made in writing, orally or by other means of nonverbal communication.

The Louisiana Mental Health Advance Directive form is available at:

http://www.dhh.louisiana.gov/offices/publications/pubs-62/Advance_Directive_Forms_02.pdf

The Louisiana Secretary of State's office maintains a **registry** of "living will" declarations. Information regarding the registry may be found at: <http://www.sos.la.gov/tabid/208/Default.aspx> and at

http://www.sos.la.gov/Portals/0/publications/pdf/Liv_Will_Dec_form.pdf

The following forms are available for download at www.amerigroupcorp.com/providers.

Well Care Forms

- Well Care Form (Birth – 15 months)
- Well Care Form (18 months – 12 years)
- Well Care Form (13 years – 18 years)

Referral and Claim Submission Forms

- Authorization Request Form
- Maternity Notification Form
- CMS-1500 (08-05) Claim Form
- UB-04-Claim Form

Encounter Forms

- Family Practice Encounter Form
- OB/GYN Encounter Form
- Internal Medicine Encounter Form
- Pediatric Encounter Form

Physical Therapy Forms

- Outpatient Therapy Initial Evaluation Form
- Outpatient Therapy Progress Form

Provider Grievance and Appeals

- Provider Payment Dispute and Correspondence Submission

Update and Change Your Information

- Change Information Form

Growth Hormone Clinical Management Forms

- Initial Request Adults Form
- Follow-up Adults Form
- Initial Request Pediatric and Adolescents Form
- Follow-up Pediatrics Form

Screening Tools

- Behavioral health screening tools and criteria for referrals to specialty care

Cost Containment Form

- Refund Notification Form