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AMERIGROUP OVERVIEW
Amerigroup corporation is a wholly owned by Anthem, Inc. (Anthem). As a leader in managed health care services for the public sector, the Amerigroup subsidiary health 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.

Purpose Statement
Together, we are transforming health care with trusted and caring solutions.

Vision
To be America’s valued health partner
- Trustworthy
- Accountable
- Innovative
- Caring
- Easy to do business with

Strategy
Our strategy is to:
- Improve access to preventive primary care services by ensuring the selection of a primary care provider who will serve as doctor, service manager and coordinator for all basic medical services
- Improve the health statuses and outcomes of our members
- Educate members about their benefits, responsibilities and the appropriate use of health care services
- Encourage stable, long-term relationships between providers and members
- Encourage medically appropriate use of specialists and emergency rooms
- Commit to community-based enterprises and community outreach
- Facilitate the integration of physical and behavioral health care
- Foster quality improvement processes that actively involve providers in re-engineering health care delivery
- Encourage a customer service orientation with regular measurement of member and provider satisfaction
- Partner with providers to ensure members receive preventive services for improving our HEDIS-data collection and Star Ratings

Summary
Escalating health care costs are driven in part by a pattern of fragmented, episodic care and, quite often, unmanaged health problems of members. Amerigroup strives to educate members to encourage the appropriate use of the managed care system and to be involved in all aspects of their health care.
MEDICARE ADVANTAGE OVERVIEW
Amerivantage refers to the Medicare Advantage Special Needs Plans (SNPs) and integrated Medicare Advantage Prescription Drug (MA-PD) plans we offer. All network providers are contracted with Amerigroup through a participating provider agreement. As a participating provider in the Medicare network, your contract will have a Medicare rate sheet in addition to any rate sheets for other Amerigroup products in which you participate. We strive to incorporate expertise available nationally into operating local community-based health care plans with experienced staff to complement our operations.

Amerigroup believes hospitals, physicians and other providers play a pivotal role in managed care. Amerigroup can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, high-quality provider network. We are committed to assisting you in providing quality health care and hope the information in this manual is beneficial to you and your office staff. As a participating provider, you are invited to participate in our quality improvement committees. Most committee meetings are prescheduled at times and locations intended to be convenient for you. Please call Provider Services at the Dedicated Service Unit (DSU) at 1-866-805-4589 with any suggestions, comments or questions, or if you are interested in learning more about specific policies. Together, we can arrange for and provide an integrated system of coordinated, efficient and quality care for our members.

MEDICARE MEMBER AND ENROLLMENT INFORMATION
Members have a choice of getting their Medicare health care services through original Medicare or through one of the Amerivantage plans we offer. The Centers for Medicare & Medicaid Services (CMS) mails a copy of the document Medicare & You to Medicare beneficiaries describing Medicare benefits and plan choices every fall.

Medicare beneficiaries can enroll in Medicare Advantage plans like Amerivantage during certain time periods called election periods. Five important election periods are:

- Annual Election Period (AEP): The AEP occurs from October 15 through December 7 every year. Medicare beneficiaries can enroll into or disenroll from a Medicare Advantage plan during this time. The effective date of the change is January 1 of the following year.
- Medicare Advantage Disenrollment Period (MADP): During the MADP, Medicare beneficiaries have the opportunity to disenroll from a Medicare Advantage plan and return to original Medicare. If they choose to return to original Medicare, they have the option of enrolling into a stand-alone prescription drug plan, which Amerigroup does not offer. The time frame for this election period is January 1 through February 14 of each year.
- Initial Coverage Election Period (ICEP): When a person first becomes eligible for Medicare Part A and enrolls in Medicare Part B, he or she has a seven-month period to enroll in a Medicare Advantage plan. This usually happens around the person’s 65th birthday.
- Initial Enrollment Period for Part D (IEP): This is the period when an individual is first eligible to enroll in a Part D plan. An individual is eligible to enroll in a Part D plan when he or she is entitled to Part A or is enrolled in Part B and permanently resides in the service area of the plan. Generally, individuals will have an IEP that is the same period as the Initial Enrollment Period for Medicare Part B, a seven-month period that begins three months before the month the individual meets the eligibility requirements for Part B and ends three months after the month of eligibility.
• **Special Election Period (SEP):** CMS has identified several circumstances under which a person may change Medicare options outside of the annual or initial enrollment periods. For example, Medicare beneficiaries who are also eligible for Medicaid can enroll in or disenroll from Medicare Advantage plans throughout the year.

Note: Special Needs Plan (SNP) enrollees may change Medicare Advantage plans at any time during the year with changes effective the first of the following month, subject to CMS approval.

After CMS confirms the enrollee’s eligibility, we send the member a letter to confirm his or her enrollment. A new member will also receive:

- An ID card
- A provider directory
- A formulary (which lists the prescription drugs we cover)
- An Evidence of Coverage (EOC) document
- Summary of Benefits

Additionally, CMS can perform a retro-enrollment or retro-disenrollment in limited circumstances. Amerigroup follows CMS directives on member enrollment and disenrollment dates; they are not determined by the plan. If retro-activity occurs, this may have an impact on claims payments.

Members who choose to enroll in an Amerivantage plan will receive a member identification (ID) card containing the member’s name, member number and basic information about the member’s benefits. Members enrolled in an Amerivantage plan receive an EOC document from Amerigroup describing the Medicare benefits and services they receive. Amerivantage plan members should present their member ID cards when receiving services.

**Our Amerivantage Plans**

Amerigroup is a licensed health maintenance organization. We have contracted with CMS to provide Dual-Eligible Special Needs Plans (D-SNPs), as well as traditional Medicare Advantage Prescription Drug health plans in the following variations:

- Amerivantage Dual Coordination (HMO SNP) (i.e., a Dual Eligible Special Needs Plan [D-SNP])
- Amerivantage Classic (HMO)
- Amerivantage Select (HMO)
- Amerivantage ESRD (HMO-POS SNP) (i.e., a Chronic Special Needs Plan [C-SNP])

All four Amerivantage plans (i.e., Medicare Advantage products) include full Medicare Part D prescription drug coverage, as well as supplemental benefits covering other health care services beyond those offered by traditional fee-for-service Medicare. **Not all plans are offered in all service areas or carry the same supplemental benefits.** Please see the appropriate Summary of Benefits document online at providers.amerigroup.com for more information.

The Amerivantage Dual Coordination (HMO SNP) is available to Medicare beneficiaries who are entitled to Medicare Part A (Part A), enrolled in Medicare Part B (Part B) and eligible for coverage of Medicare cost sharing and in some cases additional Medical Assistance from the state (either as full
benefit dual-eligible, Qualified Medicare Beneficiary [QMB or QMB Plus], or Specified Low-income Medicare Beneficiary [SLMB Plus]). There are some copays for prescription drugs in all markets except New Jersey (Low-income Subsidy [LIS] copayments are by the state SNP Agreement). Any cost sharing applied to Medicare-covered medical services can be billed to the appropriate Medicaid carrier for process in accordance to the beneficiary’s Medicaid coverage. In some cases, that will be Amerigroup. Please always refer to the Explanation of Payment (EOP) sent with each claim processed.

The Amerivantage Classic (HMO) plan is available to Medicare beneficiaries who are entitled to Part A and enrolled in Part B. The Amerivantage Classic (HMO) plan has copays for most services. The Amerivantage Dual Coordination (HMO SNP) and Classic (HMO) plans do not have out-of-network benefits. All out-of-network services must be authorized prior to rendering services.

Americaantage ESRD is a Chronic Condition Special Needs Plans (C-SNPs). C-SNPs restrict enrollment to special needs individuals with specific severe or disabling chronic conditions. C-SNPs focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations and helping beneficiaries move from high risk to lower risk on the care continuum. Members are eligible for Americaantage ESRD if they have End Stage Renal Disease requiring dialysis.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Market Availability</th>
<th>Major Medical Cost Share</th>
<th>Professional Services Cost Share</th>
<th>Supplemental Benefits</th>
<th>Prescription Drugs</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amerivantage Classic (HMO)</td>
<td>New Jersey, New Mexico, Tennessee, Texas and Washington</td>
<td>Copays</td>
<td>Copays</td>
<td>Yes</td>
<td>Yes</td>
<td>Limited to urgent and emergent out-of-area renal dialysis and services prior approved by the plan</td>
</tr>
</tbody>
</table>

Our Amerivantage plans are designed to:
- Address the greater incidence of chronic disease and disability in the Medicare and Medicaid dual-eligible and Medicare-only populations
- Enhance the coordination of a member’s primary and acute care, long-term care and prescription drug benefits through a unified case management program

Our Amerivantage plans provide members with the benefits of integrated case management through a holistic approach while promoting continuity of care and preserving provider choice.

To learn more about our Amerivantage plans and the work we are doing to help our members receive quality health care, visit providers.amerigroup.com, contact your local Provider Relations representative to schedule a visit or call the Dedicated Service Unit at 1-866-805-4589.

The Provider Self-Service Website
Amerigroup provides access to a website, providers.amerigroup.com, that contains the full complement of online provider resources. The website features an online provider inquiry tool to
reduce unnecessary telephone calls by enabling easy access at your convenience to the following resources:

- **Online support services, such as:**
  - New user registration and activation, login help, and user name and password reset
  - Forms to update provider demographics and information such as tax ID or group affiliation changes
  - Provider panel reports
  - Online daily PCP quality reports
    - Hospital/inpatient admission, transfer and discharge reports
    - Healthcare Effectiveness Data and Information Set (HEDIS) measures
- **Interactive look-up tools and reference materials, such as:**
  - Provider/referral directories
  - Precertification lookup tool
  - Claims status/submission tool
  - Reimbursement policies
  - Provider manuals and quick reference cards (provider manuals are available two ways, via the provider website or through your local Provider Relations representative)

Amerigroup also offers a dedicated Provider Services team called the Dedicated Service Unit to assist with precertification and notification, health plan network information, member eligibility, claims information, and inquiries. The team can also take any recommendations you may have for improving our processes and managed care program. Below you will find additional information we hope will assist you in your day-to-day interaction with Amerigroup.
# Quick Reference Information

<table>
<thead>
<tr>
<th>Dedicated Service Unit (DSU)</th>
<th>Contact the DSU at 1-866-805-4589 for Member Eligibility, Nurse HelpLine and Pharmacy Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT&amp;T Relay Service</td>
<td>For English call 1-800-855-2880, for Spanish call 1-800-855-2884</td>
</tr>
</tbody>
</table>
| Notification/ Precertification | ● May be telephoned, submitted online or faxed to Amerigroup:  
  ○ Telephone: 1-866-805-4589  
  ○ Fax:  
    - Home health, durable medical equipment, therapies and discharge planning: 1-888-235-8468  
    - Concurrent review clinical documentation: 1-888-700-2197  
    - Behavioral health: 1-800-505-1193  
    - Initial admission notifications and all other services:  
      1-800-964-3627  
  ○ Web: providers.amerigroup.com  
  ● Data required for complete notification/precertification:  
    ○ Member ID number  
    ○ Legible name of referring provider  
    ○ Legible name of individual referred to provider  
    ○ Number of visits/services  
    ○ Dates of service  
    ○ Diagnosis  
  ● Notification is required  
    ○ 14 days in advance for standard requests  
    ○ 3 days for expedited requests  
    ○ Within one business day for all ER admits  
  ● Clinical staff is available during normal business hours from 8:00 a.m. to 5:00 p.m. local time  
  ● Clinical information is required for precertification (The Precertification Request Form is also available online.) |
| Claims Submission: Paper (for all Medicare markets; New Jersey, New Mexico, Tennessee, Texas and Washington) | Submit paper claims to:  
Amerigroup Community Care  
P.O. Box 61010  
Virginia Beach, VA 23466-1010 |
| Claims Submission: Electronic | Electronic claims Payer ID:  
| | **|** | **|** |
| **Clearinghouse** | **Payer Number** | **Phone Number** |
| Availity | 26375 | 1-877-334-8446 |
| Capario | 28804 | 1-800-792-5256 |
| Emdeon | 27514 | 1-877-469-3263 |
| For help, call the Amerigroup **Electronic Data Interchange Hotline at** |
Quick Reference Information

1-800-590-5745.

Timely filing is governed by the terms of the provider agreement. Timely filing for each market is the same as the Amerigroup timely filing requirement for its Medicaid product in each state and within the number of days listed in the table below from the date of service.

<table>
<thead>
<tr>
<th>Market</th>
<th>Timely Filing (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Jersey</td>
<td>180</td>
</tr>
<tr>
<td>New Mexico</td>
<td>90</td>
</tr>
<tr>
<td>Tennessee</td>
<td>120</td>
</tr>
<tr>
<td>Texas</td>
<td>95</td>
</tr>
<tr>
<td>Washington</td>
<td>180</td>
</tr>
</tbody>
</table>

- Amerigroup provides an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status and precertification status at providers.amerigroup.com.
- If you are unable to access the Internet, you may receive claims, eligibility and precertification status over the telephone at any time by calling our automated Provider Services number at the DSU toll-free at 1-866-805-4589.

National Provider Identifier

National Provider Identifier (NPI) — The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires the adoption of a standard unique provider identifier for health care providers. All Amerigroup participating providers must have an NPI number.

The NPI is a 10-digit intelligence-free numeric identifier. Intelligence-free means the numbers do not carry information about health care providers, such as the state in which they practice or their specialty.

Providers can apply for an NPI by completing an application:
- Online at https://nppes.cms.hhs.gov (Estimated time to complete the NPI application is 20 minutes)
- By downloading a paper copy at https://nppes.cms.hhs.gov
- By calling 1-800-465-3203 and requesting an application

Please send your NPI to:

Provider Data Management
Amerigroup
P. O. Box 62509
Virginia Beach, VA 23466-2509
Email: NPImail@amerigroup.com
Fax: 757-490-7556
<table>
<thead>
<tr>
<th><strong>Quick Reference Information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare Advantage Participating Provider Appeals and Disputes</strong></td>
</tr>
<tr>
<td>Medicare appeals are determined by the liable party, not by the initiator. The time frame to review your request will commence once your appeal is routed to the appropriate department. Please refer to the denial letter or Explanation of Payment (EOP) issued to determine the correct appeals process.</td>
</tr>
<tr>
<td><strong>Medicare Participating Provider Standard Appeal</strong></td>
</tr>
<tr>
<td>A formal request for review of a previous Amerigroup decision where a determination was made with Provider liability was assigned (see original decision letter).</td>
</tr>
</tbody>
</table>
| Medicare Complaints, Appeals & Grievances (MCAG)  
Attention: Medical Necessity Provider Appeals  
Mailstop: OH0205-A537  
4361 Irwin Simpson Road  
Mason, Ohio 45040 |
| **Medicare Provider Payment disputes (Claims Re-review)** |
| A formal request from a Provider contesting the paid amount on a claim which does not include a medical necessity or administrative denial. |
| Medicare Payment Dispute Unit  
P.O. Box 110  
145 S Pioneer Road  
Fond du Lac, WI 54935 |
| **Medicare Member Appeals** |
| Medicare appeals are determined by the liable party, not by the initiator. Please refer to the denial letter or EOP issued to determine the correct appeals process to follow. All Medicare member liability appeals should be sent to: |
| Amerigroup  
Medicare Complaints, Appeals & Grievances (MCAG)  
Attention: Member Appeals Unit  
Mailstop: OH0205-A537  
4361 Irwin Simpson Road  
Mason, Ohio 45040 |
| A physician’s signature is required on all appeals submitted on behalf of a member; otherwise an Appointment of Representative form (AOR) is required. |
| In the event that failure to provide the service is life- or limb-threatening or that waiting the standard appeal time frame would be harmful to the member, an expedited or fast appeal can be initiated by contacting us in one of the following ways: |
| Medicare Complaints, Appeals and Grievances Department  
Amerigroup – Expedited Appeals  
4361 Irwin Simpson Road  
Mason, Ohio 05040-9598  
Mail Stop: OH0205-A537 |
Quick Reference Information

|                                | Fax: 1-888-775-3065  
|                                | Phone: 1-866-805-4589 
| Please indicate if you are requesting an expedited appeal. |

| Provider Service Representatives | For more information, contact Provider Services at the DSU at 1-866-805-4589 or your local Provider Relations representative. |

Ongoing Provider Communications and Feedback
To ensure providers are up-to-date with information required to work effectively with Amerigroup and our members, we provide frequent communications to providers in the form of broadcast faxes, provider manual updates, newsletters and information posted to the website.
PARTICIPATING PROVIDER INFORMATION
The Medicare Advantage Provider Network
Amerigroup Medicare members obtain covered services by choosing a Primary Care Provider (PCP) who is part of the Amerigroup Medicare network to assist and coordinate their care. Members are encouraged to coordinate with their PCP before seeking care from a specialist, except in the case of specified services (such as women’s routine and preventive care and behavioral health care).

Note: Some services provided by a specialist may require precertification or a referral. All referrals to a provider that is not within the HealthPlus Amerigroup Medicare network requires precertification. Please refer to Provider Obligations — Precertification.

When referring a member to a specialist, it’s critical to select a participating provider within our Medicare network to maximize the members benefit and minimize their out-of-pocket expenses. If you need help finding a participating provider, please call Provider Services at the Dedicated Service Unit (DSU) at 1-866-805-4589. If you believe you must refer to a provider outside of our network, you must notify HealthPlus Amerigroup in advance of that request in order for an organization determination to be made. Failure to initiate this request may result in claims denials and member liability. This includes such services as laboratories however does not include urgent or emergent services. Please refer to Provider Obligations — Precertification.

The Primary Care Provider Role
Members are asked to select a PCP when enrolling in an Amerivantage plan and may request a change to their selected PCP at any time. Member-requested PCP changes will become effective the first day of the following month except in extenuating circumstances. Amerigroup contracts with certain physicians that members may choose as their PCPs and may be individual practitioners associated with a contracted medical group or an independent practice association. The PCP is responsible for referring or obtaining precertification for covered services for members. Medicare participating PCPs are generally physicians of internal medicine, family practitioners, general practitioners, pediatricians, obstetricians/gynecologists or geriatricians. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) may be included as PCPs.

The PCP is a network physician who has responsibility for the complete care of his or her members, whether providing it himself or herself or by referral to the appropriate provider of care within the network. Any referral to a provider outside of the network will require precertification from HealthPlus Amerigroup. Please refer to Provider Obligations — Precertification.

When coordinating member care, the PCP should refer the member to a participating provider within the Amerigroup Medicare network. To assist the specialty care provider, the PCP should provide the specialist with the following clinical information:

- Member name
- Referring PCP
- Reason for the consultation
- History of the present illness
- Diagnostic procedures and results
- Pertinent past medical history
- Current medications and treatments
• Problem list and diagnosis
• Specific request of the specialist

Any referral to a nonparticipating provider will require precertification from Amerigroup or the services may not be covered. Contact Provider Services at the DSU at 1-866-805-4589 for questions or more information.

The Specialist Role
A specialist is any licensed provider (as defined by Medicare) providing specialty medical services to members. A PCP may refer a member to a specialist when medically necessary. Specialists must obtain authorization from Amerigroup before performing certain procedures or when referring members to noncontracted providers. Please refer to the Summary of Benefits or Evidence of Coverage documents for those procedures requiring precertification. You can review precertification requirements online at providers.amerigroup.com or call Provider Services at the DSU at 1-866-805-4589.

After performing the initial consultation with a member, a specialist should:
• Communicate the member’s condition and recommendations for treatment or follow-up care with the PCP
• Send the PCP the consultation report, including medical findings, test results, assessment, treatment plan and any other pertinent information
• If the specialist needs to refer a member to another provider, the referral should be to another Amerigroup Medicare provider. Any referral to a nonparticipating provider will require precertification from Amerigroup. Please refer to Provider Obligations — Precertification.

Specialist as a PCP
In some cases, a specialist, physician assistant, nurse practitioner or certified nurse midwife under physician supervision may be a PCP. This must be authorized by the health plan’s Case Management department. Requirements and exceptions vary by market. If you have any questions, contact the DSU. To download a copy of the Specialist as a PCP Form, go to providers.amerigroup.com and click on Forms under Provider Resources & Documents.

Participating Provider Responsibilities
• Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers, providing coordination necessary for services provided by specialists and ancillary providers (both in and out-of-network), and maintaining a medical record meeting Amerigroup standards
• Provide coverage 24 hours a day, 7 days a week; regular hours of operation should be clearly defined and communicated to members
• Provide all services ethically, legally and in a culturally competent manner, and meet the unique needs of members with special health care needs
• Participate in systems established by Amerigroup to facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements
• Make provisions to communicate in the language or fashion primarily used by his or her assigned members
• Provide hearing interpreter services upon request to members who are deaf or hard of hearing
• Participate in and cooperate with Amerigroup in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by Amerigroup
• Comply with Medicare laws, regulations and CMS instructions, agree to audits and inspections by CMS and/or its designees, cooperate, assist and provide information as requested, and maintain records for a minimum of 10 years
• Participate in and cooperate with the Amerigroup appeal and grievance procedures
• Agree to not balance bill members for monies that are not their responsibility or that should be paid for by another carrier (in the case of a dually-eligible member covered both by Medicare and Medicaid, federal law requires providers may bill only the member’s health plan or the state Medicaid agency for copayments or other cost-sharing amounts. Providers may not bill such members for cost sharing.)
• Continue care in progress during and after termination of a member’s contract for up to 60 days, or such longer period of time required by state laws and regulations, until a continuity of service plan is in place to transition the member to another network provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations (for New Jersey providers, continuity of care requirements are in accordance with Attachment B – Medicare to Amerigroup New Jersey, Inc. Participating Provider Agreement)
• Comply with all applicable federal and state laws regarding the confidentiality of patient records
• Develop and have an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens
• Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act of 1990 (ADA)
• Support, cooperate and comply with Amerigroup Quality Improvement program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner
• Inform Amerigroup if a member objects to the provisions of any counseling, treatments or referral services for religious reasons
• Treat all members with respect and dignity, provide appropriate privacy, and treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release
• Provide members complete information concerning their diagnosis, evaluation, treatment and prognosis and give them the opportunity to participate in decisions involving their health care, except when contraindicated for medical reasons
• Advise members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program and advise them on treatments that may be self-administered
• When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings
• Have a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection
• Agree to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide high-quality patient care
• Agree any notation in a member’s clinical record indicating diagnostic or therapeutic intervention as part of the clinical research will be clearly contrasted with entries regarding the provision of nonresearch-related care
• Participate in the interdisciplinary care team meetings when necessary
• If a member self-refers or a provider is referring to another provider, that provider is responsible for checking the Amerigroup Medicare provider directory to ensure the specialist is in the network. Referrals to Amerigroup Medicare-contracted specialists do not require precertification, all referrals to providers outside the HealthPlus Amerigroup Medicare require precertification unless urgent or emergent services are needed. Some procedures performed by specialist physicians may require precertification. Please refer to the Summary of Benefits document for procedures that require precertification or call Provider Services at the DSU at 1-866-805-4589. If you cannot locate a provider in the Amerigroup Medicare network, you should contact Provider Services at the DSU at 1-866-805-4589. You must obtain authorization from Amerigroup before referring members to noncontracted providers. Additionally, certain services/procedures require precertification from Amerigroup.
• Provide advanced notification to members of services that are not covered by the plan or Medicare in accordance with Medicare requirements. Please refer to Provider Obligations — Precertification.

Note: Amerigroup does not cover the use of any experimental procedures or experimental medications, except under certain circumstances.

Care Transition Protocols and Management
Assisting with the management of transitions is an important part of our case management program. Members are at risk of fragmented and unsafe care during transitions between care settings and levels of care. To help members and caregivers navigate transitions successfully, assistance is provided through many touch points and through educational materials. Transitions in care refer to the movement between health care providers and settings and includes changes in a member’s level of care. Examples of transitions include transitions to and from: acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility, home, home health care, and outpatient or ambulatory care centers. A team approach is necessary to assist the member with a successful transition.

Care Transition Protocols
Transitional care management includes a comprehensive set of protocols that include logistical arrangements, providing education to the member and care giver, coordination between health care professionals and a provider network with appropriate specialists who can address the complex needs of the special needs population. Transitional care includes both the receiving and sending aspects of the transfer. Transitional care management assists in providing continuity of care by creating an environment where the member and the provider are cooperatively involved in ongoing health care management with goal of providing access to high quality, cost-effective medical care.
Personnel Responsible for Coordinating Care Transition

Managing transitions in care is a responsibility of the interdisciplinary care team (ICT). The membership of the team varies based on the complexity of the member’s needs and the desires of the member and type of transition. The team consists of providers (including other case managers or social workers), the member and/or care giver, and members of our care management team.

Providers assist members by coordinating care and communicating with members of the ICT. Members are connected to the appropriate provider to care for their individual needs including any complex medical conditions. The primary care provider (PCP) is responsible for coordinating and arranging referrals to the appropriate care provider. The provider network includes providers who have an expertise in managing the health care needs of our dual-eligible and special needs members. Some of the provider types available in our network to manage the special need of this population include but are not limited to:

- Geriatricians, physical medicine and physiatrists
- Behavioral health providers and facilities
- Skilled nursing facilities
- Ancillary providers and facilities
- Cardiologists
- Endocrinologist
- Diabetic educators
- Dialysis centers
- Social workers and nursing professionals available through home health agencies

When services are not a covered benefit, coordination with community resources occurs to meet the needs of the population. Coordination with Medicaid services includes coordination with Medicaid case managers/service coordinators and providers of long term services and supports (LTSS) to further close care gaps.

Protocols are communicated to the provider network through newsletters and published in the provider manual outlining the expectations for managing transitions. Those protocols include the following guidelines:

- Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers, providing coordination necessary for services provided by specialists and ancillary providers (both in and out-of-network)
- Provide coverage 24 hours a day, 7 days a week
- Provide all services ethically, legally and in a culturally competent manner, and meet the unique needs of members with special health care needs
- Provide members complete information concerning their diagnosis, evaluation, treatment and prognosis and give them the opportunity to participate in decisions involving their health care, except when contraindicated for medical reasons
- Advise members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program and advise them on treatments that may be self-administered
- When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings
- Participate in the interdisciplinary care team meetings
• When a member experiences a transition in care, it is the responsibility of the transferring provider to do the following:
  o Notify the member in advance of a planned transition
  o Provide documentation to the provider or facility about the member to assist in providing continuity of care
  o Communicate and follow up with the member about the transition process
  o Communicate with the member about his or her health status and plan of care to prevent any gaps post transition
  o Provide a treatment plan/discharge instructions to the member prior to being discharged from one level of care to another
• The referring physician or provider should provide the relevant patient history to the receiving provider
• Any pertinent diagnostic results should be forwarded to the receiving provider
• The receiving provider should communicate a treatment plan back to the referring provider
• Any diagnostic test results ordered by the receiving provider should be communicated to the referring provider

We assist our members and providers in the management of transitions in multiple ways within our care management programs. The actions below represent how our case managers work with our providers and members to coordinate care and assist in the management of transitions:
• Communicates with the provider to discuss the member’s care needs as identified during case management or model of care activities.
• Assist the member in making appointments
• Notify about a transition of care in or out of an inpatient facility
• Coordination between Medicaid and Medicare benefits
• Perform medication reconciliation
• Arranging transportation
• Refer to external or internal programs
• Coordinate care with behavioral health
• Arrange durable medical equipment (DME) and home health services
• Coordinate and facilitate transitions to the appropriate level of care
• Provide the member with disease specific education and self-management techniques
• Contact members post discharge to reduce unnecessary readmissions
• Communicate to the member a central point of contact to assist during any transition

Enrollment and Eligibility Verification
All health care providers are responsible for verifying enrollment and eligibility before services are rendered, except in the case of an emergency. In general, eligibility should be verified at the time of service and at least once monthly for ongoing services. In an emergency, eligibility should be determined as soon as possible after the member’s condition is stabilized. When a patient presents as a member, providers must verify eligibility, enrollment and coverage by performing the following steps:
• Request the member’s Amerigroup Medicare ID card; if there are questions regarding the information, call Provider Services at the DSU at 1-866-805-4589 to verify eligibility,
deductibles, coinsurance amounts, copayments and other benefit information or use the online provider inquiry tool at providers.amerigroup.com

- Copy both sides of the member’s Amerigroup Medicare ID card and place the copies in the member’s medical record
- Determine if the member is covered by another health plan to record information for coordination of benefits purposes
- If you are a PCP, check your Amerigroup Member Panel Listing via providers.amerigroup.com to ensure you are the member’s doctor
- If the patient does not have an identification card, use the online provider inquiry tool at providers.amerigroup.com or call Provider Services at the DSU at 1-866-805-4589

**Member Missed Appointments**

Members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. Amerigroup requires providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling. The contact must be by telephone and should be designed to educate the member about the importance of keeping appointments and to encourage the member to reschedule the appointment.

Members who frequently cancel or fail to show up for appointments without rescheduling may need additional education in appropriate methods of accessing care. In these cases, please call Provider Services at the DSU at 1-866-805-4589 to address the situation. Amerigroup staff will contact the member and provide more extensive education and/or case management as appropriate. Amerigroup’s goal is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCP.

**Noncompliant Amerigroup Medicare Members**

Amerigroup recognizes providers may need help in managing non-adherent members. If you have an issue with a member regarding behavior, treatment cooperation, completion of treatment and/or making or appearing for appointments, call Provider Services at the DSU at 1-866-805-4589.

A Member or Provider Services representative will contact the member by telephone, or a member advocate will visit the member to provide education and counseling to address the situation and will report the outcome of any counseling efforts to you.

**Second Medical or Surgical Opinion**

Members may request a second opinion if they:

- Dispute the reasonableness of a decision
- Dispute the necessity of a procedure decision
- Do not respond to medical treatment after a reasonable amount of time

To receive a second opinion, members must:

- Obtain a second opinion from a provider within the Amerigroup Medicare network
- Be responsible for the applicable copayment.

Our Dedicated Service Unit (DSU) staff at 1-866-805-4589 can assist members and providers with identifying a participating provider for obtaining a second opinion.
Access and Availability
Participating Amerigroup Medicare providers must:
- Provide coverage for members 24 hours a day, 7 days a week
- Ensure another on-call Amerigroup Medicare provider is available to administer care when the PCP is not available
- Not substitute hospital emergency rooms or urgent care centers for covering providers
- See members within 30 minutes of a scheduled appointment or inform them of the reason for delay (e.g., emergency cases) and offer an alternative appointment
- Provide an after-hours telephone service to ensure a response to emergency phone calls within 30 minutes and a response to urgent phone calls within one hour; individuals who believe they have an emergency medical condition should be directed to immediately seek emergency services from the nearest emergency facility

Access and Availability Standards Table

<table>
<thead>
<tr>
<th>Type of Appointment (Medical or Behavioral)</th>
<th>Availability Standard</th>
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<tbody>
<tr>
<td>Patient Visit with New PCP</td>
<td>Within 30 calendar days</td>
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<tr>
<td>Routine Follow-up or Preventive Care</td>
<td>As soon as possible but within 30 calendar days</td>
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<tr>
<td>Routine/Symptomatic</td>
<td>Within 7 days</td>
</tr>
<tr>
<td>Nonurgent Care</td>
<td>Within 7 days</td>
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<tr>
<td>Urgently Needed Services</td>
<td>Within 24 hours</td>
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<tr>
<td>Emergency</td>
<td>Immediately</td>
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Amerigroup monitors adherence to appointment availability standards through office visits, long-term care visits, and tracking of complaints and grievances related to access and/or discrimination. Deviations from the policy are reviewed by the medical director for educational and/or counseling opportunities and tracked for provider credentialing.

All providers and hospitals are expected to treat Amerivantage plan members with the same dignity and consideration as afforded to their non-Medicare patients.

Covering Physicians
During a provider’s absence or unavailability, the provider must arrange for coverage for his or her members. The provider will either: (i) make arrangements with one or more Amerigroup Medicare network providers to provide care for his or her members or (ii) make arrangements with another similarly licensed and qualified provider who has appropriate medical staff privileges at the same network hospital or medical group, as applicable, 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. Providers will be solely responsible for a non-network provider’s adherence to such provisions. Providers will be solely responsible for any fees or monies due and owed to any non-network provider providing substitute coverage to a Medicare member on the provider’s behalf.
Reporting Changes in Address and/or Practice Status
Any changes in a provider’s address and/or practice status can be updated online by logging in to providers.amerigroup.com or reported to your local Amerigroup office.

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<tr>
<th>MARKET</th>
<th>PROVIDER RELATIONS ADDRESS</th>
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<tr>
<td>New Jersey Providers</td>
<td>Amerigroup</td>
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<tr>
<td></td>
<td>101 Wood Ave. South, Eighth Floor</td>
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<tr>
<td>Dallas/Fort Worth</td>
<td>Amerigroup</td>
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<td>2505 N. Highway 360, Suite 300</td>
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<tr>
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<td></td>
<td>705 5th Avenue South, Suite 300</td>
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<td></td>
<td>Seattle, WA 98104</td>
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Amerigroup Medicare Plan-specific Termination Criteria
The occurrence of any of the following is grounds for termination of the Amerigroup Medicare provider’s participation:
- Loss of reputation among peers due to unethical clinical practice or attitude
- The practice of fraud, waste and/or abuse
- Adverse publicity involving the provider due to acts of omission or commission
- Substance abuse
- Loss of professional office
- Inadequate record keeping
- Unsafe environment in the provider’s office relative to inadequate access or other related issues that might cause a member injury
• An office that is improperly kept, unclean or does not present a proper appearance
• Failure to meet OSHA guidelines
• Failure to meet ADA guidelines
• Failure to meet Clinical Laboratory Improvement Amendments (CLIA) guidelines
• Customer satisfaction ratings that drop below pre-established standards as determined by the Medical Advisory Committee (MAC) (this would include complaints relative to appearance, behavior, medical care, etc.)
• Repetitive complaints about office staff demeanor, presentation and appearance
• Inclusion on the Debarred Providers Listing of the Office of the Inspector General of the Department of Health and Human Services (see Sanctioned Providers)
• Unfavorable inpatient- or outpatient-related indicators:
  o Severity-adjusted morbidity and mortality rates above established norms
  o Severity-adjusted length-of-stay above established norms
  o Unfavorable outpatient utilization results
  o Consistent inappropriate referrals to specialists
  o Improper maintenance of high-risk patients, such as those members with diabetes and hypertension
  o Underutilization relative to minimum standards of care established per medical management guidelines and/or accepted clinical practice in the community
  o Unfavorable malpractice-related issues
  o Frequent litigious activity above and beyond what would be expected for a provider in that particular specialty

Amerigroup Medicare providers have 30 calendar days to appeal a termination. The Amerigroup process is designed to comply with all state and federal regulations regarding the termination appeal process.

Incentives and Payment Arrangements
Financial arrangements concerning payment to providers for services to Medicare members are set forth in each provider’s agreement with Amerigroup. Amerigroup may also use financial incentives to reward providers for achieving certain quality indicator levels.

Amerigroup does not use or employ financial incentives that would directly or indirectly induce providers to limit or reduce medically necessary services furnished to individual enrollees. In cases where Amerigroup approves provider subcontracting arrangements, those subcontractors cannot employ any financial incentives inconsistent with this policy or with Medicare Advantage regulations.

Laws Regarding Federal Funds
Payments providers receive for furnishing services to members are derived in whole or part from federal funds. Therefore, providers and any approved subcontractors must comply with certain laws applicable to individuals and entities receiving federal funds, including but not limited to Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.
Prohibition Against Discrimination
Neither Amerigroup nor its contracted providers may deny, limit or condition the coverage or furnishing of services to members on the basis of any factor related to health status, including but not limited to the following:

- Medical condition, including mental as well as physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability

Provider Panel — Closing a Panel
When closing a provider panel to new Amerigroup Medicare members or other new patients, providers must:

- Give Amerigroup prior written notice to Provider Relations in their health plan or submission using the online portal/provider website the provider panel is closing to new members as of a specific closing date, and accept new members until that closing date. (written notice only required in Tennessee)
- Keep the provider panel open to members who were patients of that practice before the panel closed or before they were enrolled with Amerigroup
- Close the provider panel uniformly to all new Medicare patients, including all private payers and commercial or governmental insurers the practice participates with
- Give Amerigroup prior written notice when reopening the provider panel, including a specific reopening date

Provider Panel — Transferring and Terminating Members
Amerigroup will determine reasonable cause for transferring a member based on written request and documentation submitted by the provider. Providers may not transfer a member to another provider due to the costs associated with the member’s covered services.

A provider may request termination of a member due to fraud, disruption of medical services or the member’s repeated failure to make the required reimbursements for services. In such cases, the provider should contact the DSU at 1-866-805-4589.

Reporting Obligations — Cooperation in Meeting CMS Requirements
Amerigroup is required to provide information to CMS necessary to administer and evaluate the Medicare Advantage program and to establish and facilitate a process for current and prospective members to exercise their choice in obtaining Medicare services.

Amerigroup provides the following information:

- Plan quality and performance indicators such as disenrollment rates (for beneficiaries enrolled in the plan the previous two years)
- Information on member satisfaction
- Information on health outcomes
Providers must cooperate with Amerigroup in its data reporting obligations by providing Amerigroup with any information required to meet these obligations in a timely fashion.

**Reporting Obligations — Certification of Diagnostic Data**
Amerigroup is required to submit information to CMS necessary to characterize the context and purposes of each encounter between a member and provider, supplier, physician or other practitioner (encounter data). Providers that furnish diagnostic data must certify (to the best of their knowledge, information and belief) the accuracy, completeness and truthfulness of the data.

**Cultural Competency**
Cultural competency is the integration of congruent behaviors, attitudes, structures, policies and procedures that come together in a system or agency or among professionals. Cultural competency assists providers and members to:
- Acknowledge the importance of culture and language
- Assess cross-cultural relations
- Embrace cultural strengths with people and communities
- Strive to expand cultural knowledge
- Understand cultural and linguistic differences

The quality of the patient-provider interaction has a profound impact on the ability of a patient to communicate symptoms to his or her provider and to adhere to recommended treatment. Some of the reasons that justify a provider’s need for cultural competency include but are not limited to:
- The perception that illness and disease and their causes vary by culture
- The diversity of belief systems related to health, healing and wellness are very diverse
- The fact that culture influences help-seeking behaviors and attitudes toward health care providers
- The fact that individual preferences affect traditional and nontraditional approaches to health care
- The fact that patients must overcome their personal biases within health care systems
- The fact that health care providers from culturally and linguistically diverse groups are under-represented in the current service delivery system

Cultural barriers between the provider and member can impact the patient-provider relationship in many ways, including but not limited to:
- The member’s level of comfort with the practitioner and the member’s fear of what might be found upon examination
- The differences in understanding on the part of diverse consumers in the United States health care system
- A fear of rejection of personal health beliefs
- The member’s expectation of the health care provider and of the treatment

To be culturally competent, Amerigroup expects providers serving members within their geographic locations to demonstrate the following:
Cultural Awareness
- The ability to recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior
- The ability to modify one’s own behavioral style to respond to the needs of others, while at the same time maintaining one’s objectivity and identity

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

Cultural Skills
- The ability to understand the basic similarities and differences between and among the cultures of the persons served
- The ability to recognize the values and strengths of different cultures
- The ability to interpret diverse cultural and nonverbal behavior
- The ability to develop perceptions and understanding of other’s needs, values and preferred means of having those needs met
- The ability to identify and integrate the critical cultural elements of a situation to make culturally consistent inferences and to demonstrate consistency in actions
- The ability to recognize the importance of time and the use of group processes to develop and enhance cross-cultural knowledge and understanding
- The ability to withhold judgment, action or speech in the absence of information about a person’s culture
- The ability to listen with respect
- The ability to formulate culturally competent treatment plans
- The ability to use culturally appropriate community resources
- The ability to know when and how to use interpreters and to understand the limitations of using interpreters
- The ability to treat each person uniquely
- The ability to recognize racial and ethnic differences and know when to respond to culturally based cues
- The ability to seek out information
- The ability to use agency resources
- The capacity to respond flexibly to a range of possible solutions
- The acceptance of ethnic differences among people and the understanding of how these differences affect the treatment process
- The willingness to work with clients of various ethnic minority groups
Marketing
Providers may not develop or use any materials that market Amerigroup or the Amerivantage plans without Amerigroup’s prior written approval. Under Medicare Advantage program rules, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage plan unless the materials meet the CMS marketing guidelines and are first submitted to CMS for review and approval. Additionally, providers can have plan marketing materials in their office as long as marketing materials for all plans the providers participate in are represented. Providers are allowed to have posters or notifications that show they participate in the Amerivantage plans as long as the provider displays posters or notifications from all Medicare plans in which they participate.

Americans With Disabilities Act Requirements
The Amerigroup policies and procedures are designed to promote compliance with the ADA. Providers are required to take actions to remove an existing barrier and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes the following:

- Access to an examination room that accommodates a wheelchair
- Access to a lavatory that accommodates a wheelchair
- Elevator or accessible ramp into facilities
- Handicap parking clearly marked unless there is street side parking
- Street-level access
FIRST LINE OF DEFENSE AGAINST FRAUD AND ABUSE

General Obligation to Prevent, Detect and Deter Fraud, Waste and Abuse

As a recipient of funds from state and federally sponsored health care programs, Amerigroup has a duty to help prevent, detect and deter fraud, waste and abuse. Amerigroup is committed to detecting, mitigating and preventing fraud, waste and abuse as outlined in its Corporate Compliance Program. As part of the requirements of the federal Deficit Reduction Act, each provider is required to adopt Amerigroup policies on detecting, preventing and mitigating fraud, waste and abuse in all the federally and state funded health care programs in which Amerigroup participates.

The Amerigroup policy on fraud, waste and abuse prevention and detection is part of the Amerigroup Corporate Compliance Program. Electronic copies of this policy and Amerigroup Code of Business Conduct and Ethics can be found on the website at www.amerigroup.com/about-amerigroup/ethics.

Amerigroup maintains several ways to report suspected fraud, waste and abuse. As a Medicare Advantage provider and a participant in government-sponsored health care, you and your staff are obligated to report suspected fraud, waste and abuse. These reports can be made anonymously at amerigroup.silentwhistle.com or by calling 1-877-660-7890. In addition to anonymous reporting, suspected fraud, waste and abuse may also be reported via email to corpinvest@amerigroup.com or by calling the DSU at 1-866-805-4589. You can also reach out directly to the Amerigroup Chief Compliance Officer at 757-473-2711 or send an email to ethics@amerigroup.com.

In order to meet the requirements under the Deficit Reduction Act, you must adopt the Amerigroup fraud, waste and abuse policies and distribute them to any staff members or contractors who work with Amerigroup. If you have questions or would like more details concerning the Amerigroup fraud, waste and abuse detection, prevention and mitigation program, please contact the Amerigroup Chief Compliance Officer.

Importance of Detecting, Deterring and Preventing Fraud, Waste and Abuse

Health care fraud costs taxpayers increasingly more money every year. State and federal laws are designed to crack down on these crimes and impose strict penalties. Fraud, waste and abuse in the health care industry may be perpetuated by every party involved in the health care process. There are several stages to inhibiting fraudulent acts, including detection, prevention, investigation and reporting. In this section, Amerigroup educates providers on how to help prevent member and provider fraud by identifying the different types as the first line of defense.

Many types of fraud, waste and abuse have been identified, including the following:

Provider Fraud, Waste and Abuse

- Billing for services not rendered
- Billing for services that were not medically necessary
- Double billing
- Unbundling
- Upcoding
Providers can prevent fraud, waste and abuse by ensuring the services rendered are medically necessary, accurately documented in the medical records and billed according to American Medical Association 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 fraud, waste and abuse, providers can educate members about these types of fraud and the penalties levied. Also, spending time with patients and reviewing their records for prescription administration will help minimize drug fraud and abuse. One of the most important steps to help prevent member fraud is as simple as reviewing the Medicare member ID card. It is the first line of defense against fraud. Amerigroup may not accept responsibility for the costs incurred by providers rendering services to a patient who is not an Amerigroup Medicare member, even if that patient presents a Medicare member ID card. Providers should take measures to ensure the cardholder is the person named on the card.

Additionally, encourage members to protect their cards as they would a credit card or cash, carry their Amerigroup Medicare member ID card at all times, and report any lost or stolen cards to Amerigroup as soon as possible.

Amerigroup believes awareness and action are vital to keeping the state and federal programs safe and effective. Understanding the various opportunities for fraud, waste and abuse and working with members to protect their Amerigroup Medicare ID card can help prevent fraud, waste and abuse. Amerigroup encourages its members and providers to report any suspected instance of fraud, waste and abuse using the contact methods referenced earlier. No individual who reports violations or suspected fraud, waste or abuse will be retaliated against, and Amerigroup will make every effort to maintain anonymity and confidentiality.

**Health Insurance Portability and Accountability Act**
The Health Insurance Portability and Accountability Act (HIPAA, also known as the Kennedy-Kassebaum Bill) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud and simplifies the administration of health insurance.

Amerigroup strives to ensure both Amerigroup and contracted participating providers conduct business in a manner that safeguards patient/member information in accordance with the privacy regulations enacted pursuant to HIPAA. Providers must have the following procedures in effect since April 14, 2003, to demonstrate compliance with the HIPAA privacy regulations.
Amerigroup recognizes its responsibility under the HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting Amerigroup. However, please note the privacy regulations allow the transfer or sharing of member information, which may be requested by Amerigroup to conduct business and make decisions about care such as a member’s medical record to make an authorization determination or resolve a payment appeal. Such requests are considered part of the HIPAA definition of treatment, payment or health care operations.

Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to Amerigroup, verify the receiving fax number is correct, notify the appropriate staff at Amerigroup and verify the fax was appropriately received.

Internet email (unless encrypted) should not be used to transfer files containing member information to Amerigroup (e.g., Excel spreadsheets with claim information). Such information should be mailed or faxed.

Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific individual, P.O. Box or department at Amerigroup.

The Amerigroup voicemail system is secure and password-protected. When leaving messages for Amerigroup associates, providers should only leave the minimum amount of member information required to accomplish the intended purpose.

When contacting Amerigroup, providers should be prepared to verify their name, address and Tax Identification Number or National Provider Identifier number.
MEDICAL RECORDS
Requirements Overview
Amerigroup Medicare providers must maintain permanent medical records that are:

- Current, detailed and organized; permit effective, confidential patient care; and allow quality reviews
- In conformity with good professional medical practice and appropriate health management
- Located at the primary care site for every Amerigroup Medicare member
- Kept in accordance with Amerigroup and state standards as described in this manual
- Retained for 10 years from the final date of the contract or from the date of completion of any audit
- Accessible upon request to Amerigroup and/or downstream entities, any state agency and the federal government

Amerigroup will:

- Systematically review medical records to ensure compliance with standards. The health plan’s MAC oversees and directs Amerigroup in formalizing, adopting and monitoring guidelines
- Institute actions for improvement when standards are not met
- Maintain a record keeping system that is designed to collect all pertinent medical management information for each member
- Make information readily available to appropriate health professionals and appropriate state agencies
- Use nationally recognized standards of care and work with providers to develop clinical policies and guidelines of care for members

Member Medical Records Standards
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 be permanently maintained at the primary care site.

Members are entitled to one copy of their medical record each year provided at no cost. 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:
6. Medication allergies
7. Adverse reactions
8. No Known Allergies (NKA)
9. Past medical history — for patients seen three or more times. Include serious accidents, operations, illnesses and prenatal care of mother and birth for children
10. Immunizations — a complete immunization record for pediatric members age 20 and younger with vaccines and dates of administration

11. Diagnostic information

12. Significant illnesses and chronic and recurrent medical conditions are indicated in the problem list on all member medical records

13. Report contributory and/or chronic conditions if they are monitored, evaluated, addressed or treated at the visit and impact the care.

14. All diagnoses reported on the claim should be fully documented in the medical record, and each diagnosis noted in the medical record should be reported in the claim corresponding to that encounter.

15. Medical information including medication and instruction to patient

16. Identification of current problems
   o Serious illnesses
   o Medical and behavioral conditions
   o Health maintenance concerns

17. Instructions including evidence the patient was provided basic teaching and instruction for physical or behavioral health condition

18. Smoking/alcohol/substance abuse — notation required for patients age 12 and older and seen three or more times

19. 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

20. Emergencies — all emergency care and hospital discharge summaries for all admissions must be noted

21. Hospital discharge summaries — must be included for all admissions while enrolled and prior admissions when appropriate

22. Advance directive — must document whether the patient has executed an advance directive such as a living will or durable power of attorney

**Documentation Standards for an Episode of Care**

When we request clinical documentation from you to support claims payments for services, you must ensure the information provided to us:

- Identifies the member
- Is legible
- Reflects all aspects of care

To be considered complete, documentation for episodes of care will include at a minimum the following elements:

- Patient identifying information
- Consent forms
- Health history, including applicable drug allergies
- Types and dates of physical examinations
- Diagnoses and treatment plans for individual episodes of care
- Physician orders
- Face-to-face evaluations
- Progress notes
- Referrals
Consultation reports
Laboratory reports
Imaging reports (including X-ray)
Surgical reports
Admission and discharge dates and instructions
Preventive services provided or offered appropriate to the member’s age and health status
Evidence of coordination of care between primary and specialty physicians

Refer to the standard data elements to be included for specific episodes of care as established by The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A single episode of care refers to continuous care or a series of intervals of brief separations from care to a member by a provider or facility for the same specific medical problem or condition.

Documentation for all episodes of care must meet the following criteria:
- Is legible to someone other than the writer
- Contains information that identifies the member on each page in the medical record
- Contains entries in the medical record that are dated and include author identification (e.g., handwritten signatures, unique electronic identifiers or initials)

Other documentation not directly related to the member
Records should contain information relevant to support clinical practice and used to support documentation regarding episodes of care, including:
- Policies, procedures and protocols
- Critical incident/occupational health and safety reports
- Statistical and research data
- Clinical assessments
- Published reports/data

Amerigroup may request that you submit additional documentation, including medical records or other documentation not directly related to the member, to support claims you submit. If documentation is not provided following the request or notification or if documentation does not support the services billed for the episode of care, we may:
- Deny the claim
- Recover and/or recoup monies previously paid on the claim

Section 1833(e) of the Social Security Act, states that Medicare payment can be made only when the documentation supports the service/item.
Amerigroup is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

**Patient Visit Data Records Standards**
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
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
   - A plan of treatment, including:
     - Activities
     - Therapies
     - Goals to be carried out
     - Diagnostic tests
     - Evidence of family involvement in therapy sessions and/or treatment

5. Follow-up care encounter forms or notes indicating follow-up care, call or visit in weeks, months or PRN

6. Referrals and results of all other aspects of patient care and ancillary services

We systematically review medical records to ensure compliance and 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 10 years from the date of service.

**Medical Record Review**
Federal regulations require Medicare managed care organizations and their agents review medical records to avoid over or under payment and verify documentation to support of diagnostic conditions. Additionally, the vice president or local health plan leadership for quality management and the Quality Management Committee conduct medical record audits periodically and use the results in the provider recredentialing process.

**Risk Adjustment Data Validation**
Participation in risk adjustment data validation is required of all providers, and it is important that you are aware that medical records may be requested from your office. Data validation through a review of medical record documentation ensures the accuracy of risk-adjusted payments. These medical record reviews verify the accuracy of claim and encounter data and identify additional conditions not captured through this mechanism.

Amerigroup may contract with a third-party vendor to acquire medical records or conduct onsite reviews. Under CFR 164.502 (Health Insurance Privacy and Accountability Act [HIPAA] implementation), providers are permitted to disclose requested data for the purpose of health care operations after they have obtained the “general consent” of the member. A general consent form should be an integral part of your medical record file.
More information related to risk adjustment can be found at [www.cms.gov](http://www.cms.gov).

**Clinical Practice Guidelines**

Using nationally recognized standards of care, Amerigroup works with providers to develop clinical policies and guidelines for the care of its membership. The Medical Advisory Committee (MAC) oversees and directs Amerigroup in formulating, adopting and monitoring guidelines.

Amerigroup selects at least four evidence-based Clinical Practice Guidelines (CPGs) relevant to the Medicare member population. The guidelines are reviewed and revised by the Amerigroup Quality Improvement Council at least every two years or whenever the guidelines change.

The Amerigroup CPGs are located online at providers.amerigroup.com. To access the CPGs, log in to the secure site with your user name and password and select the Clinical Practice Guidelines link from the Clinical Policy and Guidelines section on the top navigation menu. A copy of the guidelines can be printed from the website.

**Advance Directives**

Advance directives are written instructions that:
- Give direction to health care providers as to the provision of health care
- Provide for treatment choices when a person is incapacitated
- Are recognized under state law when signed by a competent person

There are three types of advance directives:
- A durable power of attorney for health care (durable power) allows the member to name a patient advocate to act on behalf of the member
- A living will allows the member to state his or her wishes in writing but does not name a patient advocate
- A declaration for mental health treatment gives instructions about a member’s future mental health treatment if the member becomes unable to make those decisions. The instructions state whether the member agrees or refuses to have the treatments described in the declaration with or without conditions and limitations

Amerigroup advance directive policies include:
- Respecting the rights of the member to control decisions relating to his or her own medical care, including the decision to have provided, withheld or withdrawn the medical or surgical means or procedures calculated to prolong his or her life; this right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession
- Adhering to the Patient Self-Determination Act and maintaining written policies and procedures regarding advance directives; providers must adhere to this Act and to all state and federal standards as specified in SSA 1902(a)(57), 1903(m)(1)(A), 42 CFR 438.6(i) and 42 CRF 489 subpart I
- Advising members of their right to self-determination regarding advance directives
- Encouraging members to request an advance directive form and education from their PCP at their first appointment
Assisting members with questions about an advance directive; no Amerigroup employee may serve as witness to an advance directive or as a member’s authorized agent or representative.

While members have the right to formulate an advance directive, an Amerigroup associate, a facility or a provider may conscientiously object to an advance directive within certain limited circumstances if allowed by state law.

Having Member Services, Health Promotion, Provider Relations and/or Health Care Management Services staff review and update advance directive notices and education materials for members on a regular basis.

Member materials will contain information, as applicable, regarding provisions for conscience objection. Materials explain the differences between institution-wide objections based on conscience and those that may be raised by individual physicians.

Amerigroup or the practitioner must issue a clear and precise written statement of this limitation to CMS and request a conscience protection waiver. The conscientious objection will be stated clearly and describes the following:

- Describes the range of medical conditions or procedures affected by the conscience objection
- Identifies the state legal authority permitting such objection

Noting the presence of advance directives in the medical records when conducting medical chart audits.

Providers must:

- Comply with the Patient Self-Determination Act requirements
- Make sure the first point of contact in the PCP’s office asks the member if he or she has executed an advance directive
- Document in the member’s medical record his or her response to an offer to execute any advance directive in a prominent place, including a do-not-resuscitate directive or the provider and member’s discussion and action regarding the execution or nonexecution of an advance directive
- Ask members who have executed an advance directive to bring a copy of the advance directive(s) to the PCP/provider at the first point of contact
- Make an advance directive part of the member’s medical record and put in a prominent place.
  - The physician discusses potential medical emergencies with the member and/or family/significant other and with the referring physician, if applicable.
  - If an advance directive has not been executed, the first point of contact at the PCP/provider’s office will ask the member if he or she would like advance directive information. If the member desires further information, member advance directive education will be provided
- Not discriminate or retaliate against a member based on whether he or she has executed an advance directive

The requirements for advance directives, to include psychiatric advance directives, vary from state to state. Specific forms that meet compliance with each state can be found on the state’s official website. Psychiatric advance directive information may be found at the following website: [http://www.nrc-pad.org/content/view/41/25/](http://www.nrc-pad.org/content/view/41/25/).
Credentialing and Recredentialing

Introduction
Credentialing is an industry-standard, systemic approach for the collection and verification of applicant’s professional qualifications. This approach includes a review of relevant training, license(s), certification(s) and/or registration(s) to practice in a health care field. 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. Our organization credentials in accordance with the credentialing standards established in the current NCQA Standards and Guidelines for the Accreditation of Managed Care Organizations, as well as state-specific and CMS 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.

Credentialing Requirements
To become a participating Amerigroup Medicare practitioner/provider, you must hold a current, unrestricted license issued by the state. You must also comply with state, CMS and Amerigroup credentialing criteria and submit all additionally requested information. A complete 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 use 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. For those practitioners who are not participating with CAQH, a paper credentialing application will be accepted.

Credentialing Procedures
The Amerigroup credentialing requirements apply only to those with whom Amerigroup directly enters or plans to contract for health care services rendered independent of professional oversight. Except as may be required by state or federal regulations, this policy does not apply to practitioners who practice exclusively within the setting of an institution or organizational setting.

Amerigroup credentials the following practitioners/providers, at a minimum: physicians, podiatrists, chiropractors, physician assistants, optometrists, dentists, nurse practitioners, certified nurse midwives, licensed professional counselors, licensed clinical social workers, licensed marriage and family therapists, advanced registered nurse practitioners, licensed chemical dependency counselors, psychologists, physical therapists, speech/language therapists and allied service (ancillary) 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 policies periodically, and no less frequently than annually, based on input from:

- Credentialing committees
- Health plan medical directors
- Chief medical officers
- State and federal requirements

By signing the application, credentialing applicants 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.

Applicants 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 should have clinical privileges, as appropriate to their scope of practice, in good standing at an Amerigroup network hospital or have an admitting plan with another participating Amerigroup practitioner who will admit patients to an Amerigroup network hospital

5. **State licensure or certification:** Initial credentialing applicants must have a current, legal state license or certification

6. **Medicare number**

7. **Drug 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
8. 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

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

10. 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).

11. CMS sanctions: All initial credentialing practitioner and provider applicants must not have any sanctions by Medicare or Medicaid.

12. 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 or Medicaid sanctions
   - Applicants must also provide a/an:
     - Attestation of the correctness and completeness of the application
     - Explanation in writing of any identified issues

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

The credentialing committee approves or denies the credentialing request based on information presented in the provider’s application and any additional documentation provided in the course of the credentialing process. Amerigroup notifies the applicant either by telephone or in writing if any information obtained in support of the assessment or reassessment process varies substantially from the information submitted by the organization. Each applicant has the right to review all information used in reaching the decision and may appeal a denied application.

Specialists acting as PCPs or physicians practicing in academic settings less than 20 hours per week must be documented. Acceptable justification includes:

- The number of members to be served as a PCP and as a specialist (if applicable)
- Full details of the services and scope of services to be provided
- Coverage arrangements documenting 24-hour-a-day, 7-day-a-week coverage
### Timing and Frequency of Credentialing

Unless otherwise mandated by state regulation, the requirement for timeliness of credentialing a practitioner/provider is 180 calendar days from the date the applicant signs an attestation to the date of the credentialing committee’s final decision. Also, the recredentialing cycle is a 36-month (three-year) cycle.

### Sanctioned Providers

The Office of the Inspector General (OIG) and System for Award Management (SAM) maintains a sanction list that identifies but is not limited to those individuals found guilty of fraudulent billing, misrepresentation of credentials, and default on student loans, etc. Amerigroup is required to review the OIG sanctions list with each new issuance of the monthly list and is prohibited from employing or contracting with any individual who is excluded from participation in the Medicare program. Providers identified on the lists will be validated before terminating the provider from the network. Sanctioned providers identified on the OIG or SAM list should not receive Medicare payments. There is a limited exception to exclusions for the provision of certain emergency items or services not provided in a hospital emergency room.

Reinstatement of a sanctioned provider or entity is not automatic. A provider who wants to regain participation in the Medicare program must apply for reinstatement and receive an authorized notice from the OIG that reinstatement has been granted.

### Sanctions Under Federal Health Programs and State Law

Providers must ensure no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare or other federal health care programs are employed or subcontracted by the provider.

Providers must disclose to Amerigroup whether they, a staff member or subcontractor have any prior violation, fine, suspension, termination or other administrative action taken by any of the following:

- Medicare or Medicaid laws
- The rules or regulations of the state
- The federal government
- Any public insurer

Providers must immediately notify Amerigroup of any imposed sanction on them or any staff member or subcontractor.
Opt-Out (Private Contract) Providers
Section 4507 of the Balanced Budget Act of 1997 permits a provider to opt out of Medicare for at least a two-year period. For a provider to opt out of Medicare, he or she must file an opt-out affidavit with his or her local Medicare Part B carrier. If the provider wishes to render services to Medicare beneficiaries, he/she must sign a private contract with each patient. When a provider opts out of Medicare, health care services rendered by the opt-out provider are not covered by Medicare, and no payments can be made to the provider or to the beneficiary, except for services for emergent and/or urgent care situations. Medicare will pay for covered, medically necessary services ordered by an opt-out provider but only if the provider has obtained a unique provider identifier number from Medicare and if the service is rendered by a provider who has not opted out.

Organizational Provider Credentialing
Amerigroup credentials organizational providers in accordance with NCQA, CMS and state-specific requirements. The following providers require assessments:

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

Additional providers may also be required to follow the credentialing process.

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 nationally recognized accreditation organizations including but not limited to:
  - Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
  - Health Care Facilities Accreditation Program
  - American Osteopathic Association
  - The Commission on Accreditation of Rehabilitation Facilities
  - Community Health Accreditation Program
  - Accreditation Association for Ambulatory Health Care

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 an organization’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 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

**Recredentialing**

Recredentialing is required every three years by NCQA. In some instances, there is a requirement to recredential every year due to state or CMS requirements. Amerigroup will perform recredentialing 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 the assessments and verifications listed above. In addition, Amerigroup will request any state-specific required documents.

**Delegation of 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 onsite 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.

**Practitioner’s Rights to Review Credentialing Information**

You can request the status of your application through your local Provider Relations team via:

- Telephone
- Fax
- Mail

Credentialing applicants 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 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.

**Credentialing Appeals Process**

Credentialing/recredentialing applicants will be notified of a denial or limitation and/or restriction of credentials, or a decision of termination for cause. Applicants will have 30 calendar days to appeal this decision in writing. The appeals process, as defined by the Amerigroup Appeals Policy, includes the right to a fair hearing when there has been termination for cause. If the written appeal is not submitted within the 30 calendar day time frame, the appeal right will expire, and the initial determination will stand.

- If the credentialing/recredentialing applicant has a current Amerigroup participation agreement that specifies a different time frame, the current contract language shall govern.

- The request for an appeal must set forth in detail those matters the credentialing/recredentialing applicant believes were improperly determined by the health plan credentialing committee and/or medical director, as well as the specific reasons why the applicant believes the decision to be improper. The applicant may include any statement, documents or other materials to be considered by the hearing committee or appointed hearing officer prior to rendering a final decision.

- When a determination leads to a contract termination, the hearing committee or appointed hearing officer shall meet within 30 calendar days of receipt of the appeals request to consider the appeal, unless a time extension is requested and mutually agreed upon by both parties, in accordance with Amerigroup policy.

- The credentialing/recredentialing applicant shall be informed when the request for appeal has been received; if an informal hearing is being offered, the time, date and location of the informal hearing will also be communicated to the physician/practitioner no less than 14 calendar days prior to the date of the informal hearing; the physician/practitioner has the right to be represented by an attorney or other representative of his or her choice.

- The appeals process provides the right of the credentialing/recredentialing applicant to appear in person before the hearing committee or appointed hearing officer, at which time the provider has the right to present his or her case.

- The credentialing/recredentialing applicant will be notified in writing of the final decision, setting forth the reasons for the decision, within 15 days of the hearing committee or appointed hearing officer meeting.

- If the hearing committee or appointed hearing officer upholds a denial, the recommendation would be made to initiate termination procedures for the credentialing/recredentialing applicant’s participation with Amerigroup.
Peer Review
The peer review process provides a systematic approach for monitoring the quality and appropriateness of care. Peer review responsibilities are to:

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

If an investigation of a member grievance results in concern regarding a physician’s compliance with community standards of care or service, the elements of peer review will be followed. Dissatisfaction severity codes and levels of severity are applied to quality issues. The medical director assigns a level of severity to the grievance. Peer review includes investigation of physician actions by or at the discretion of the medical director. The medical director takes action based on the quality issue and the level of severity, invites the cooperation of the physician and consults and informs the MAC and peer review committee as appropriate. The medical director informs the physician of the committee’s decision, recommendations, follow-up actions and/or disciplinary actions to be taken. Outcomes are reported to the appropriate internal and external entities, including the Quality Management Committee.

The peer review process is a major component of the Medical Advisory Committee’s monthly agenda. The peer review policy is available upon request.
PERFORMANCE AND TERMINATION
Performance Standards and Compliance
All providers must meet specific performance standards and compliance obligations. When evaluating a provider’s performance and compliance, Amerigroup reviews a number of clinical and administrative practice dimensions, including:

- Quality of care — measured by clinical data related to the appropriateness of care and outcomes
- Efficiency of care — measured by clinical and financial data related to health care costs
- Member satisfaction — measured by the members’ reports regarding accessibility, quality of health care, member/provider relations and the comfort of the office setting
- Administrative requirements — measured by the provider’s methods and systems for keeping records and transmitting information
- Participation in clinical standards — measured by the provider’s involvement with panels used to monitor quality of care standards

Providers must:
- Comply with all applicable laws and licensing requirements
- Furnish covered services in a manner consistent with professionally recognized standards of medical and surgical practice generally accepted in the professional community at the time of treatment
- Comply with Amerigroup standards, including:
  - Guidelines established by the Centers for Disease Control and Prevention (or any successor entity)
  - Federal, state and local laws regarding professional conduct
- Comply with Amerigroup policies and procedures regarding the following:
  - Participating on committees and clinical task forces to improve the quality and cost of care
  - Prenotification and/or precertification requirements and time frames
  - Provider credentialing requirements
  - Referral policies
  - Case Management Program referrals
  - Appropriately releasing inpatient and outpatient utilization and outcomes information
  - Providing accessibility of member medical record information to fulfill Amerigroup business and clinical needs
  - Cooperating with efforts to assure appropriate levels of care
  - Maintaining a collegial and professional relationship with Amerigroup personnel and fellow providers
  - Providing equal access and treatment to all Medicare members

The following types of noncompliance issues are key areas of concern:
- Unnecessary out-of-network referrals and utilization (which require precertification)
- Failure to provide advance notice of admissions or precertification of discharges from inpatient facilities, comprehensive outpatient rehabilitation facilities or home health care services
- Member complaints and grievances filed against the provider
- Underutilization, overutilization or inappropriate referrals
- Inappropriate billing practices, such as balance billing of Medicare members for monies that are not their responsibility
- Nonsupportive actions and/or attitude
Provider noncompliance is tracked on a calendar year basis. Corrective actions are taken as appropriate.

**Physician–Patient Communications**

Providers acting within the lawful scope of practice are encouraged to advise Amerigroup members of the following:

- Health status, medical care or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options
- Risks, benefits and consequences of treatment or nontreatment
- Opportunity for the individual to refuse treatment and to express preferences about future treatment decisions

Physician and patient communications are a necessary component of standard medical practice. Although coverage under this program is determined by Amerigroup, the provider remains responsible for all treatment decisions related to the Amerivantage plan member.

**Provider Participation Decisions: Appeal Process**

Upon a denial, suspension, termination or nonrenewal of a physician’s participation in the provider network, Amerigroup acts as follows:

- The affected physician is given a written notice of the reasons for the action, including if relevant the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by Amerigroup
- The physician is allowed to appeal the action to a hearing panel
- The physician is provided written notice of the right to a hearing and the process and timing for requesting a hearing
- Amerigroup ensures the majority of the hearing panel members are peers of the affected physician
- Amerigroup notifies the National Practitioner Data Bank, the appropriate state licensing agency and any other applicable licensing or disciplinary body to the extent required by law, if a suspension or termination is the result of quality of care deficiencies

Subcontracted physician groups must ensure these procedures apply equally to physicians within those subcontracted groups.

Amerigroup decisions subject to an appeal include decisions regarding reduction, suspension or termination of a provider’s participation resulting from quality deficiencies. Amerigroup notifies the National Practitioner Data Bank, the appropriate state licensing agency and any other applicable licensing or disciplinary body to the extent required by law. Written communication to the provider details the deficiencies and informs him or her of the right to appeal.

**Notification to Members of Provider Termination**

Amerigroup makes a good faith effort to provide at least 30 calendar days written notice of a provider’s termination to all members who are seen on a regular basis by that provider before the termination effective date, regardless of the reason for the termination. Amerigroup may provide member notification in less than 30 days notice as a result of a provider’s death or exclusion from the federal health programs.
When a termination involves a PCP, all members who are patients of that PCP are notified of the termination.
QUALITY MANAGEMENT
Amerigroup maintains a comprehensive Quality Management (QM) program to objectively and systematically monitor and evaluate care and service provided to members. The scope and content of the program reflects the demographic, epidemiologic, medical and behavioral health needs of the population served. Key components of the program include but are not limited to:

- Quality of member care and service
- Accessibility and availability of services
- Member safety and prevention
- Continuity and coordination of care
- Appropriateness of service utilization
- Cultural competency
- Member outcomes
- Member and provider satisfaction
- Regulatory and accreditation standards

Members and providers have opportunities to participate in quality management and make recommendations for areas of improvement through complaints, grievances, appeals, satisfaction or other surveys, committee participation where applicable, quality initiatives/projects, and calls to the health plans. QM program goals and outcomes are available to providers and members upon request.

Quality activities are planned across the continuum of care and service with ongoing proactive evaluation and refinement of the program.

The Amerigroup QM program tracks and trends quality of care issues and service concerns identified for all care settings. QM staff review member complaints/grievances, reported adverse events and other information to evaluate the quality of service and care provided to our members. Practitioners and providers must allow Amerigroup to use performance data in cooperation with our quality improvement program and activities.

CMS Star Ratings
The Centers for Medicare & Medicaid Services (CMS) evaluates all Medicare Advantage (MA) and Prescription Drug (MA-PD) plans using a star rating system. The CMS Five-Star Quality Rating System provides helpful information to consumers, families and caregivers for comparing MA-PD plans based on a one to five rating:

- * * * * * equals excellent
- * * * * equals very good
- * * * equals good
- * * equals fair
- * equals poor

Many of the measures included in the CMS rating system are measures of preventive care and routine disease management. Some of these are listed below and are subject to change:

1. Staying healthy — screening, tests and vaccines:
   - Colorectal cancer screening
   - Annual flu vaccine
2. Managing chronic conditions:
   - SNP Care Management
   - Care for the older adult: medication review, functional status assessment and pain screening
   - Managing osteoporosis in women who had a fracture
   - Obtaining diabetes care for eye exams, kidney disease monitoring, and blood sugar and cholesterol control
   - Controlling blood pressure
   - Managing rheumatoid arthritis
   - Improving bladder control
   - Reducing the risk of falling
   - Plan all-cause readmissions
   - Medication adherence and management (oral diabetics, hypertension and cholesterol medications)

With the growing focus on quality health care and plan member satisfaction, CMS assesses MA plan performance. The CMS assessment results in a star rating assigned to each plan. One of the assessment tools used is the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Medicare beneficiaries who receive health care services through a MA-PD plan receive CAHPS surveys through the mail in late February.

The survey asks the Medicare beneficiary to assess his or her health and the care received from his or her primary care providers and specialists over the past six months. The survey includes questions regarding providers’ communication skills and the member’s perception about his or her access to needed health care services. Several questions directly correlate to a plan’s CMS star rating. The survey questions ask the member to report his or her opinion about access to care and the health plan’s customer service. It also asks the member to rate the communication received from his or her providers.

A second assessment tool used by CMS is the Health Outcomes Survey (HOS) to evaluate all managed care organizations with a MA contract. CMS randomly samples Medicare beneficiaries from each participating MA plan. Two years after the initial HOS survey, the same Medicare beneficiaries are surveyed again. The results are part of the effectiveness of care component of the HEDIS rates for the MA plan.

The rating system empowers consumers, families and caregivers with information to compare MA-PD plans. The measures of the rating system include preventive care and routine disease management. This information gives consumers, families and caregivers results to make an educated decision about their health care needs. The ratings are posted online and may be accessed at www.medicare.gov. Please note there are separate ratings for Part C (medical) and Part D (prescription drug) services.
Amerigroup encourages participating providers to help improve member satisfaction by:

- Ensuring members receive appointments within acceptable time frames as outlined in the Access and Availability Standards Table in this manual
- Educating members and talking to them during each visit about their preventive health care needs and disease management goals
- Ensuring providers answer any questions members have regarding newly prescribed medications
- Ensuring members know to bring all medications and medical histories to their specialists and knows the purpose of a specialist referral
- Allowing time during the appointment to validate members’ understanding of their health conditions and the services required for maintaining a healthy lifestyle
- Referring members to the Member Services department at the DSU and speaking to a case manager

Committee Structure

Amerigroup maintains a comprehensive quality management committee structure as noted below with program oversight by the board of directors.

Quality Improvement Council

The purpose of the Corporate Quality Improvement Council is to provide leadership and oversight of the Corporate and health plan quality management programs, improve safety, quality of care and services, improve customer service, and improve operating efficiencies.

Responsibilities include:

- Review and approval of the program descriptions
- Work plans and annual evaluations for quality management, utilization management, health promotion, credentialing, case management, pharmacy and disease management
- Review and approval reporting of complaints, appeals and Service Level Agreements (SLAs)
- Review of regular standardized reports (at least semi-annually) delineating progress towards goals of the program, actions taken, improvements made, focused study results and follow-up actions on identified opportunities
- Evaluation of resource adequacy to ensure effective implementation of the programs and ongoing effectiveness
- Recommending policy decisions
- Instituting needed actions and ensure completion
- Ensuring practitioner participation

Quality Management Committee

The purpose of the health plan Quality Management Committee (QMC) is to maintain quality as a cornerstone of Amerigroup culture and to be an instrument of change through demonstrable improvement in care and service.

The QMC’s responsibilities are to:

- Establish strategic direction and monitor and support implementation of the Quality Management Program
• Establish processes and structure that ensure National Committee for Quality Assurance (NCQA) compliance
• Review planning, implementation, measurement and outcomes of clinical/service quality improvement initiatives/projects
• Coordinate communication of quality management activities throughout the health plans
• Review Healthcare Effectiveness Data and Information Set (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

Medical Advisory Committee
The health plan Medical Advisory Committee (MAC) has multiple purposes. The MAC assesses levels and quality of care provided to members and recommends, evaluates and monitors standards of care. The MAC identifies opportunities to improve services and clinical performance by establishing, reviewing and updating clinical practice guidelines based on review of demographic and epidemiologic information to target high-volume, high-risk and problem-prone conditions. The MAC oversees the peer review process that provides a systematic approach for the monitoring of quality and the appropriateness of care. The MAC advises the health plan administration in any aspect of the health plan policy or operation affecting network providers or members. The MAC approves and provides oversight of the peer review process, the QM Program and the Utilization Review Program. It oversees and makes recommendations regarding health promotion activities.

The MAC’s responsibilities are to:
• Utilize an ongoing peer review system to monitor practice patterns to identify appropriateness of care and to improve risk prevention activities
• Approve clinical protocols/guidelines that help ensure the delivery of quality care and appropriate resource utilization
• Review clinical study design and results
• Develop action plans/recommendations regarding clinical quality improvement studies
• Oversee member access to care
• Review and provide feedback regarding new technologies
• Approve recommendations from subordinate committees

Credentialing Committee
The health plan Credentialing Committee (CC) has been delegated authority of the credentialing program by the health plan Quality Management Committee. It is responsible for the oversight of the credentialing program, decisions regarding the credentialing and recredentialing of the practitioners and providers contracted with the health plan, and oversight of organizations for which credentialing has been delegated

The CC’s responsibilities are to:
• Consider/act in response to provider sanctions
• Approve credentialing/recredentialing policies and procedures
• Review practitioner and provider credentialing and recredentialing applicants for participation in Amerigroup provider networks
• Provide pre-delegation, ongoing oversight and annual review of delegated entities
• Approve/deny participation at initial credentialing based on credentials meeting or not meeting standards for participation
• Approve/term continuing participation at recredentialing based on credentials meeting/not meeting standards for participation
HEALTH CARE MANAGEMENT SERVICES
Amerigroup continuously seeks to improve the quality of care provided to its members. We encourage and expect our providers to participate in health promotion and disease prevention programs. Providers are encouraged to collaborate with Amerigroup in efforts to promote healthy lifestyles through member education and information sharing.

Providers must fully comply with:
- Health care management services policies and procedures
- Quality improvement and other performance improvement programs
- All regulatory requirements

The health care delivery system is a gatekeeper model that supports the role and relationship of the Primary Care Provider (PCP). The model includes direct contracts with PCPs, hospitals, specialty physicians and other providers as required to deliver Medicare benefits, additional benefits and Amerigroup programs for members with complex medical needs. All contracted providers are available to Medicare members by PCP or self-referral for the services identified below. There are no sub networks that limit the choice of specialist referrals based on selection of PCP.

The gatekeeper model requires all members to select a PCP upon joining the plan. Members who do not choose a PCP are assigned one. Amerigroup works with the member, the physician and the member’s representative, as appropriate, to ensure the PCP is suitable to meet the member’s special needs. Members must have access to their PCP or a covering physician 24 hours a day, 7 days a week.

Self-Referral Guidelines
Medicare members may self-refer for the following services:
- Screening mammograms
- Behavioral health
- Influenza and pneumococcal vaccinations
- All preventive services (e.g., routine physical examinations, prostate screening and preventive women’s health services, such as Pap smears)
- Disease Management Centralized Care Unit services

Except for emergent or out-of-area urgent care and dialysis services, in general, Medicare members must obtain services within the Amerigroup Medicare network or obtain a precertification for covered services outside the network. As a contracted provider with the plan you are responsible for either referring within the network or obtaining prior authorization from the plan.

Referral Guidelines
PCPs may only refer members to Amerigroup Medicare contracted network specialists to ensure the specialist receives appropriate clinical background data and is aware of the member’s ongoing primary care relationship. If a member does not have out-of-network benefits, such as an HMO member and has expressed a desire to receive care from a different specialist or you believe the required specialty is not available within the contracted network, contact Provider Services at the DSU at 1-866-805-4589. Provider must obtain precertification from Amerigroup before referring members to nonplan providers. Referring a Medicare Member out-of-network will result in the
claim denying with member liability unless unless urgent, emergent, out of area renal dialysis or if prior authorization was obtained from the plan.

**Providing Non-Covered Services Advanced Notification**
For services that require prior authorization or are non-covered by the plan (i.e. statutory exclusion), it becomes extremely important that Amerigroup authorization procedures are followed. If a member elects to receive such care the member cannot be held financially responsible unless notified in advance of the non-covered services. In such cases when the network physician fails to follow Amerigroup authorization protocols, Amerigroup may decline to pay the claim in which case the physicians will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

The Centers for Medicare & Medicaid Services (CMS) issued guidance concerning Advance Notices of Non-Coverage. The ABN is a FFS document and cannot be used for Medicare Advantage denials or notifications. Per CMS (page 4) The ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D).CMS advised Medicare Advantage plans that contracted providers are required to provide a coverage determination for services that are not covered by the member’s Medicare Advantage plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. If there is any doubt about whether a service is not covered, please seek a coverage determination from the plan.

**Precertification**
Certain services/procedures require precertification from Amerigroup for participating and nonparticipating PCPs and specialists. Please refer to the list below or the Precertification Lookup tool online, or call Provider Services at the DSU at 1-866-805-4589 for more information. You can also access information concerning precertification requirements on our website at providers.amerigroup.com.

The following are examples of services requiring precertification before providing the following nonemergent or urgent care services:
- Inpatient mental health services
- Behavioral health partial hospitalization
- Skilled Nursing Facility (SNF)
- Home health care
- Diagnostic tests, including but not limited to MRI, MRA, PET scans, etc.
- Hospital or ambulatory care center-based outpatient surgeries for certain procedures
- Elective inpatient admissions
- Transplant evaluation and services
- Referrals and services from noncontracted providers
- Durable Medical Equipment (DME)*
- Outpatient IV infusion or injectable medications
- Prosthetics
- Certain reconstructive procedures
- Occupational, speech and physical therapy services
• Referrals outside of the HealthPlus Amerigroup network
• Requests for non-covered services under the Medicare program

For services that require prior authorization or are non-covered by the plan (i.e. statutory exclusion), it becomes extremely important that all authorization procedures are followed. If a member elects to receive such care the member cannot be held financially responsible unless notified in advance of the non-covered services. In such cases when the network physician fails to follow authorization protocols, Amerigroup may decline to pay the claim in which case the physicians will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

A written coverage determination will help ensure that a claim for non-covered care from a contracted provider is paid accurately. According to CMS, if the appropriate written notice of denial of payment is not given to the Medicare Advantage member regarding a non-covered service, the claim may be denied and the member cannot be held financially responsible. Therefore, your failure to provide an appropriate coverage determination could result in a denial of payment for the non-covered service.

Please contact us prior to services being rendered to comply with this requirement and ensure appropriate claims payment and allow you to bill the Medicare Member in the event of non-coverage. As a Contracted Provider with us, you are prevented from billing the Medicare Member for any service that is deemed non-covered if you have not ensured this advanced notification has been issued.

**Medically Necessary Services and Medical Criteria**

Multiple clinical and coverage determination guidelines are utilized to review the appropriateness of a service that has been rendered or requested to determine the care is reasonable and necessary for the diagnosis or treatment of illness or injury, provided in the most appropriate level of care, and is not furnished for the convenience of the member or provider. The clinical guidelines used may include any of the following based on the type of request: CMS (Centers for Medicare & Medicaid Services) National and Local Coverage and Benefit Guidelines, current editions of InterQual® Level of Care, MCG™ Guidelines (formerly Milliman Care Guidelines®), Amerigroup Medical Policies and Clinical Utilization Management Guidelines to review the medical necessity and appropriateness of physical health services, unless superseded by state requirements or regulatory guidance. Amerigroup Behavioral Health Medical Necessity Criteria are utilized for all behavioral health services, unless superseded by state or federal requirements or regulatory guidance. The Medical Policies and Clinical Utilization Management Guidelines are developed by the Amerigroup Medical Policy and Technology Assessment Committee (MPTAC). Criteria for review of behavioral health issues are reviewed by the National Behavioral Health Clinical Advisory Committee, a subcommittee of MPTAC. In addition to policies developed and or approved through MPTAC, the Health Plan’s medical reviewers use criteria developed by AIM Specialty Health for review of selected diagnostic imaging requests in some markets.

Amerigroup Community Care is also collaborating with OrthoNet, LLC to conduct medical necessity reviews for physical therapy, occupational therapy and spine and back pain management for our Medicare Advantage members.
These criteria and guidelines are objective and provide a rules-based system for screening proposed medical and behavioral health care based on patient-specific, best medical care processes and consistently match medical services to patient needs, based upon clinical appropriateness.

The criteria’s comprehensive range of level-of-care alternatives is sensitive to the differing needs of adults, adolescents, and children. When using the criteria to match a level of care to the member’s current condition, all reviewers consider the severity of illness and co-morbidities, as well as episode-specific variables. Their goal is to view members in a holistic manner to ensure they receive necessary support services within a safe environment optimal for recovery.

Criteria and guidelines are reviewed and approved annually by members of the Medical Policy and Technology Assessment Committee, and updated when appropriate. Input from the medical community is solicited and utilized in developing and updating policies. The Health Plan Medical Advisory Committees (MACs), representing practitioners with knowledge of local delivery systems, also review and approve Medical Necessity criteria. Policies and procedures for application of medical necessity criteria are reviewed and approved annually by the Medical Operations Committee.

Getting the best care in the most appropriate setting is key to achieving the best outcomes for our HealthPlus Amerigroup Medicare Advantage members. These members rely on their health care professionals and their health plan to help coordinate this important aspect of their care. To do this, timely communication is essential.

Ensuring that you provide the correct and complete clinical information at the correct time when requesting a medical necessity review when clinical information is needed. If the information provided does not support medical necessity, the service cannot be approved under Medicare law. Please provide the necessary information to justify the services you are requesting at the time of the request to allow for an appropriate decision to be made. Any service determined to require a clinical review will be processed in accordance with:

- Section 1861(a)(1)(A) of the Social Security Act, which states that Medicare payment can only be made for services/items that are medically necessary and reasonable.
- Section 1833(e) of the Social Security Act, which states that Medicare payment can be made only when the documentation supports the service/item.

UM criteria are made available to practitioners upon request. If a medical necessity decision results in an adverse determination, practitioners are welcome to discuss the denial decision with a Medical Director. For additional information, to speak to a Medical Director, obtain UM criteria or for any inquiries, contact may be made via the Customer Services Department by calling the number on the members’ identification card.

**HOSPITAL AND ELECTIVE ADMISSION MANAGEMENT**

Amerigroup requires precertification of all inpatient elective admissions. The referring primary care or specialist physician is responsible for precertification.

The referring physician identifies the need to schedule a hospital admission and must submit the request to the Amerigroup Health Care Management Services department.

Requests for precertification with all supporting documentation should be submitted immediately upon identifying the inpatient request or at least 72 hours prior to the scheduled admission. This
Amerigroup will allow Amerigroup to verify benefits and process the precertification request. For services that require prior authorization, Amerigroup makes case-by-case determinations that consider an individual’s health care needs and medical history, in conjunction with nationally recognized standards of care.

**Interactive Care Reviewer** (currently for use in CA, CO, FL, GA, IN, KY, LA, MD, NJ, NM, OH, SC, TN, TX, WA, WI, and WV)

**Amerigroup’s Interactive Care Reviewer (ICR)** is the preferred method for the submission of pre-authorization requests offering a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for members covered by Amerigroup Florida plans. Additionally, providers can use this tool to make inquiries on previously submitted requests regardless of how they were sent (phone, fax, ICR or other online tool).

- **Initiate pre-authorization requests online**, eliminating the need to fax. ICR allows detailed text, photo images and attachments to be submitted along with your request.
- **Make inquiries** on previously submitted requests via phone, fax, ICR or other online tool.
- **Instant accessibility** from almost anywhere including after business hours.
- **Utilize the dashboard** to provide a complete view of all UM Requests with real time status updates including email notifications if requested using a valid email address.
- **Real time results** for some common procedures with immediate decisions.
- **Access ICR** under Authorizations and Referrals via the Availity Web Portal.

To register for an ICR webinar use the attached link: [ICR Webinar](#)

For an optimal experience with **Amerigroup’s Interactive Care Reviewer (ICR)** use a browser that supports 128-bit encryption. This includes Internet Explorer, Chrome, Firefox or Safari.

**Amerigroup’s Interactive Care Reviewer (ICR)** is not currently available for the following:

- Transplant services
- Services administered by vendors such as AIM Specialty Health® and OrthoNet LLC. *(For these requests, follow the same pre-authorization process that you use today.)*

Our website will be updated as additional functionality and lines of business are added throughout the year.

The hospital can confirm a precertification is on file **using the Interactive Care Reviewer (ICR)** or by calling Provider Services at the DSU at 1-866-805-4589 (see the Amerigroup website and the Provider Inquiry Line section of this manual for instructions on use of the Provider Inquiry Line). If coverage of an admission has not been approved, the facility should call Provider Services at the
Amerigroup will contact the referring physician directly to resolve the issue.

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

The precertification nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. When appropriate, the 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, an Amerigroup reference number will be issued 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 medical director will contact the requesting physician to discuss the case.

If the precertification documentation is incomplete or inadequate, the precertification nurse 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 appropriate appeal rights, will be mailed to the member and provider.

Member liability for inpatient admissions will be assigned only:
- When the denial is issued prior to the services being rendered
- When the Important Message from Medicare is delivered in accordance with CMS guidelines
- When inpatient services were rendered by a nonparticipating facility, were not precertified and are not considered services covered under the plan

Participating providers will be held liable for all other inpatient denials issued. Any subsequent appeals should follow the correct process as outlined in the denial letter.

**Emergent Admission Notification Requirements**

Amerigroup prefers immediate notification by network hospitals of emergent admissions. Network hospitals must notify Amerigroup of emergent admissions within one business day. Amerigroup Health Care Management Services staff will verify eligibility and determine benefit coverage.

Amerigroup is available 24 hours a day, 7 days a week to accept emergent admission notification at Provider Services at the DSU at 1-866-805-4589.

Coverage of emergent admissions is authorized based on review by a concurrent review nurse. When the clinical information received meets nationally recognized standards of care, an Amerigroup reference number will be issued to the hospital.
If the notification documentation provided is incomplete or inadequate, Amerigroup will not approve coverage of the request but will notify the hospital to submit the additional necessary documentation.

If the medical director denies coverage of the request, the appropriate denial letter will be mailed to the member and provider, including the appropriate appeal rights.

**Nonemergent Outpatient and Ancillary Services — Precertification and Notification Requirements**

Amerigroup requires precertification for coverage of selected nonemergent outpatient and ancillary services. Requests for precertification with all supporting documentation should be submitted immediately upon identifying the need for the request (14 days advance notification for standard requests and 3 days advance for expedited)

To ensure timeliness of the decision, the following must be provided:

- Member name and ID number
- Name, telephone number and fax number of physician performing the elective service
- Name of the facility and telephone number where the service is to be performed
- Date of service
- Member diagnosis
- Name of elective procedure to be performed with CPT-4 code
- Medical information to support requested services (medical information includes current signs/symptoms, past and current treatment plans, response to treatment plans and medications)

**Inpatient Admission Reviews**

All inpatient hospital admissions, including urgent and emergent admissions, will be reviewed within one business day. Urgent and emergent admissions require notification within one business day by the Provider. The Amerigroup utilization review clinician determines the member’s medical status through communication with the hospital’s Utilization Review department. Appropriateness of the stay is documented, and concurrent review is initiated. Cases may be referred to the medical director who renders a decision regarding the coverage of hospitalization. Diagnoses meeting specific criteria are referred to the medical director for possible coordination by the care management program.

**Affirmative Statement About Incentives**

Amerigroup, as a corporation and as individuals involved in Utilization Management (UM) decisions, is governed by the following statements: UM decision-making is based only on the appropriateness of care and service and existence of coverage.

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

Discharge planning is designed to assist the provider in the coordination of a member’s discharge when acute care (hospitalization) is no longer necessary. The Amerigroup concurrent review nurse or case manager (working with the Amerigroup medical director) will assist providers and hospitals with the discharge planning process in accordance with requirements of the Medicare Advantage program. At the time of admission and during the hospitalization, the Amerigroup case manager will discuss discharge planning with the provider, member and/or member advocate.

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

Hospital-Acquired Conditions

A Hospital-Acquired Condition (HAC) is a medical condition or complication that a patient develops during a hospital stay, which was not present at admission. Examples of HAC include but are not limited to:

- A pattern of substandard care that is likely to result in future dangers to members
- Failure to comply with accepted ethical and professional standards of behavior
- An action that represents a clear and serious breach of accepted professional standards of care, such that the continued care of members by the provider could endanger their safety or health
- Potential quality of care issues related to underutilization or overutilization

Our Quality Management staff will review the identified or potential quality of care issue, request medical records, supporting documentation and other information as appropriate relevant to the case. The medical director will make a determination.

We review and analyze the quality of care issues quarterly for the health plan and identify opportunities for improving care and making recommendations for quality improvement actions. On an annual basis, we report quality of care issues to our corporate Quality Improvement Committee. The Credentialing department uses quality of care reports to evaluate practitioners during the recredentialing process. As appropriate and required, we will report incidents to federal, state and contractual entities as required. Please contact your local Quality Management department when you identify potential incidents.
Confidentiality Statement

Members have the right to privacy and confidentiality regarding their health care records and information in accordance with the Medicare Advantage program and provisions of HIPAA concerning members’ rights with respect to their protected health information and obligations of covered entities.

Utilization management, case management, disease management, discharge planning, quality management and claims payment activities are designed to ensure patient-specific information, particularly protected health information obtained during review, is kept confidential in accordance with applicable laws, including HIPAA. Information is used for the purposes defined above and shared only with entities who have the authority to receive such information and only with those individuals who need access to such information in order to conduct utilization management and related processes.

Providers must comply with all state and federal laws concerning privacy, confidentiality, accuracy and timely maintenance of health and other member information. Providers must have policies and procedures regarding use and disclosure of health information and comply with applicable laws.

Misrouted Protected Health Information (PHI)

Providers and facilities are required to review all member information received from Amerigroup to ensure no misrouted PHI is included. Misrouted PHI includes information about members whom a provider or facility is not currently treating. PHI can be misrouted to providers and facilities by mail, fax, or email. Providers and facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or re-disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, providers and facilities must contact Provider Services to report receipt of misrouted PHI.

Emergency Services

Amerigroup provides a 24-hour-a-day, 7-day-a-week Nurse HelpLine service with clinical staff to provide triage advice and referral and, if necessary, to make arrangements for treatment of the member. The staff has access to qualified behavioral health professionals to assess behavioral health emergencies.

Amerigroup does not discourage members from using the 911 emergency system nor deny access to emergency services. Emergency services are provided to members without requiring precertification. Any hospital or provider calling for precertification for emergency services will be granted one immediately upon request. Emergency services coverage includes services needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

An emergency medical condition is defined as a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious
jeopardy; (2) serious impairment to bodily functions; and/or (3) serious dysfunction of any bodily organ or part.

Emergency response is coordinated with community services, including the police, fire and Emergency Medical Services (EMS) departments, juvenile probation, the judicial system, child protective services, chemical dependency, emergency services and local mental health authorities, if applicable.

When a member seeks emergency services at a hospital, the determination as to whether the need for those services exists will be made for purposes of treatment by a physician licensed to practice medicine or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine. The physician or other appropriate personnel will indicate in the member’s chart the results of the emergency medical screening examination. Amerigroup will compensate the provider for the screening, evaluations and examinations that are reasonable and calculated to assist the health care provider to determine whether or not the patient’s condition is an emergency medical condition.

If there is concern surrounding the transfer of a patient (i.e., whether the patient is stable enough for discharge or transfer or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) actually caring for the member at the treating facility prevails and is binding on Amerigroup. If the emergency department is unable to stabilize and release the member, Amerigroup will assist in coordination of the inpatient admission regardless of whether the hospital is network or non-network. All transfers from non-network to network facilities are to be conducted only after the member is medically stable and the facility is capable of rendering the required level of care.

If the member is admitted, the Amerigroup concurrent review nurse will implement the concurrent review process to ensure coordination of care.

**Poststabilization Care Services**

Poststabilization care services are covered services related to an emergency condition provided after a patient is stabilized to maintain the stabilized condition or improve or resolve the patient’s condition. Precertification is not required for emergency services in or out of the network. All emergency services are reimbursed at least at the Medicaid network rate. Amerigroup will adjudicate emergency and poststabilization care services that are medically necessary until the emergency condition is stabilized and maintained.

**Nonemergency Services**

For routine, symptomatic, beneficiary-initiated outpatient appointments for primary preventive medical care, the request-to-appointment time must be no greater than 30 days, unless the member requests a later time. For routine, symptomatic, beneficiary-initiated outpatient appointments for nonurgent primary medical care, the request-to-appointment time must be no greater than four to six weeks, unless the member requests a later time. Primary medical, including dental care outpatient appointments for urgent conditions, must be available within 48 hours. For specialty outpatient referral and/or consultation appointments, the request-to-appointment time must be consistent with the clinical urgency but no greater than 21 days, unless the member
requests a later time. For outpatient scheduled appointments, the time the member is seen must not be more than 45 minutes after the scheduled time, unless the member is late. For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time must be consistent with the clinical urgency but no greater than 14 days, unless the member requests a later time. For urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability will be consistent with the clinical urgency but no greater than 48 hours. The timing of scheduled follow-up outpatient visits with practitioners must be consistent with the clinical need.

**Urgent Care**

Amerigroup requests its members to contact their PCP in situations when urgent, unscheduled care is necessary. Precertification with Amerigroup is not required for a member to access an urgent care center.
MEMBER MANAGEMENT SUPPORT
Medicare covers a diverse group of people. Most are over 65, but 15 percent (nearly 7 million) are people under 65 who have a disability. Almost half (47 percent) have modest or low incomes, and over one-third (36 percent) of the Medicare population has three or more chronic conditions. Medicare also covers many people who have a cognitive or mental impairment (29 percent of the Medicare population).

A significant portion (17 percent) of the Medicare population is also enrolled in Medicaid. These beneficiaries are known as dual-eligibles.

Welcome Call
As part of our member management strategy, Amerigroup offers a welcome call to new members. During the welcome call, new members who have been identified through their health risk assessment as possibly needing additional services are educated regarding the health plan and available services. Additionally, Member Services representatives offer to assist members with any current needs, such as scheduling an initial checkup.

Appointment Scheduling
Amerigroup, through its participating providers, ensures members have access to primary care services for routine, urgent and emergency services and to specialty care services for chronic and complex care. Providers will respond to a member’s needs and requests in a timely manner. The Primary Care Provider (PCP) should make every effort to schedule members for appointments using the PCP Access and Availability guidelines.

Nurse HelpLine
The Amerigroup Nurse HelpLine is a service designed to support the provider by offering information and education about medical conditions, health care and prevention to members after normal physician practice hours. The Nurse HelpLine provides triage services and helps direct members to appropriate levels of care. The Amerigroup Nurse HelpLine telephone number is 1-866-805-4589 and is listed on the member’s ID card. This ensures members have an additional avenue of access to health care information when needed. Features of the Nurse HelpLine include:
- Availability 24 hours a day, 7 days a week for crisis and triage services
- Information based upon nationally recognized and accepted guidelines
- Free translation services for 150 different languages and for members with difficulty hearing
- Education for members about appropriate alternatives for handling nonemergent medical conditions
- Member assessment reports faxed to providers’ offices within 24 hours of the call

Interpreter Services
Amerigroup provides our members with free interpreter services. Services are available 24 hours a day, 7 days a week and include over 150 languages, as well as services for members who are deaf or hard of hearing. To arrange interpreter services for a member in your care, call Provider Services at the DSU at 1-866-805-4589.
**Health Promotion**

Amerigroup strives to improve healthy behaviors, reduce illness and improve the quality of life for our members through comprehensive programs. Educational materials are developed or purchased and disseminated to our members, and health education classes are coordinated with community organizations and network providers contracted with Amerigroup.

Amerigroup manages projects that offer our members education and information regarding their health. Ongoing projects include:

- Creation and distribution of Ameritips, the Amerigroup health education tool used to inform members of health promotion issues and topics
- Health Tips on Hold (educational telephone messages while the member is on hold)
- Health education programs offered to members
- Development of health education curricula and procurement of other health education tools (e.g., breast self-exam cards)
- Relationship development with community-based organizations to enhance opportunities for members

**Member Rewards for Health Program**

Amerigroup encourages our members to participate in their health care for living healthier lives. Our program rewards members for receiving preventive health care services and gives them the option of receiving up to a total of $50 in gift cards per calendar year. When the member visits your office for one or more of the preventive services listed below, he or she will ask you to sign the Rewards for Health reply card. The member will mail the reply card and receive a gift card. The goal of the program is to increase early detection, decrease the cost of treatment and improve members’ quality of life.

The preventive health services eligible for the Member Rewards for Health Program include:

- Adult immunizations (e.g., flu, hepatitis B and pneumonia vaccinations)
- Annual wellness visit
- Cardiovascular disease screening
- Colorectal cancer screening
- Diabetes screening
- Glaucoma screening (every two years)
- Bone mass measurement
- Smoking cessation
- Mammography
- Prostate cancer screening
Case Management
The Amerigroup Case Management Solutions Program is a member-centric, integrated continuum of care model that strives to address the totality of each member’s physical, behavioral, cognitive, functional and social needs.

The scope of the Case Management Solutions Program includes but is not limited to:
- Member identification using a prospective approach that is designed to focus case management resources for members expected to be at the highest risk for poor health outcomes
- Initial and ongoing assessment
- Problem-based, comprehensive care planning to include measurable goals and interventions tailored to the complexity level of the member as determined by initial and ongoing assessments
- Coordination of care with PCPs and specialty providers
- Member education
- Member empowerment using motivational interviewing techniques
- Facilitation of effective member and provider communications
- Program monitoring and evaluation using quantitative and qualitative analysis of data
- Satisfaction and quality of life measurement

Using a prospective systematic approach, members with a risk of poor health outcomes are identified and targeted for case management services. This continuous case finding system evaluates members of a given population based on disease factors and claims history with the goal of improving quality of life through proper utilization of necessary services and a reduction in the use of unnecessary services.

Case management member candidate lists are updated monthly and prioritized to identify members with the highest expected needs for service. Case management resources are focused on meeting listed members’ needs by using a mix of standardized and individualized approaches.

A core feature of the Amerigroup Case Management Solutions Program is the emphasis on an integrated approach to meeting the needs of members. The program considers the whole person, including the full range of each member’s physical, behavioral, cognitive, functional and social needs. The role of the case manager is to engage members of identified risk populations and to follow them across health care settings, to collaborate with other health care team members to determine goals and to provide access to resources and monitor utilization of resources. The case manager works with the member to identify specific needs and interfaces with the member’s providers with the goal of facilitating access to quality, necessary, cost-effective care.

Using information gathered through the assessment process, including a review of the relevant evidence-based clinical guidelines, the case manager develops a goal-based care plan that includes identified interventions for each diagnosis, short- and long-term goals, interventions designed to assist the member in achieving these goals and identification of barriers to meeting goals or complying with the care plan.
Assessment information, including feedback from members, family/caregivers and in some cases providers, provides the basis for identification of problems. Areas identified during the assessment that may warrant intervention include but are not limited to:

- Conditions that compromise member safety
- History of high service utilization
- Use of inappropriate services
- Current treatment plan has been ineffective
- Permanent or temporary loss of function
- High-cost illnesses or injuries
- Comorbid conditions
- Medical/psychological/functional complications
- Health education deficits
- Poor or inconsistent treatment/medication adherence
- Inadequate social support
- Lack of financial resources to meet health or other basic needs
- Identification of barriers or potential barriers to meeting goals or complying with the care plan

Preparation of the care plan includes an evaluation of the member’s optimal care path, as well as the member’s wishes, values and degree of motivation to take responsibility for meeting each of the care plan goals. Wherever possible, the case manager encourages the member to suggest his or her own goals and interventions, as this may increase their investment in their successful completion.

Our case managers work closely with the member and providers to develop and implement the plan of care. As a provider, you may receive a call from the case manager, or a copy of the member’s care plan may be sent to you.

If you have identified a patient as a possible candidate for case management and wish to have them evaluated to see if they qualify, you can call in the referral for evaluation to 1-866-805-4589 and ask for someone in the Case Management department.

**Model of Care**

We have a model of care program in place for members of our Special Needs Plans (SNPs). The model of care was mandated as part of the Medicare Improvement for Patients and Providers Act of 2008. The model of care has measures that identify the most vulnerable beneficiaries’ special needs and addresses those needs in a plan of care. Our model of care program is comprised of the following elements:

1. Measurable goals designed to address the needs of the population that have multiple or complex conditions, including those who are frail/disabled, develop end-stage renal disease or are at the end of life. Specifically, the SNP model of care is designed to improve the care of our members in all of the following areas:
   - Improve access to affordable care
   - Improve coordination of care through an identified point of contact
   - Improve transitions of care across health care settings and providers
   - Improve access to preventive health services
• Assure appropriate utilization of services
• Assure cost-effective service delivery
• Improve beneficiary health outcomes

2. Our staff structure and care management roles are designed to manage the special needs population. Each SNP member will have an assigned care coordinator, as well as an individualized interdisciplinary care team which may include any of the following members: nurses, physicians, social workers, pharmacists, our member, behavioral health specialists, or other participants as determined by the member.

3. We will work to complete a telephonic health risk assessment (HRA) on each member. For new members the goal is to complete within 90 days and annually before the anniversary of the last HRA. In some situations for those members that are considered the most complex a face to face assessment may occur. As some individuals may be difficult to reach by phone, our team may contact your office for updated contact information. Our assessment covers physical, behavioral, cognitive, psychosocial, functional and environmental domains and serves as the basis for the member’s individualized care plan.

4. Based on the results of the health risk assessment, an individualized care plan will be developed by the case manager working directly with the member, and the interdisciplinary care team to address identified needs. The care plan includes interventions designed to educate, inform and serve as an advocate for our members. Use of community resources is facilitated for the member, and benefits are coordinated between Medicare and Medicaid. The member’s care plan will coordinate with and support your medical plan of care. In order to ensure optimal coordination during the care planning process, a member of our case management team may contact you requesting a care coordination conference to discuss a complex member. When you participate in a care coordination conference, you should bill CPT code 99367, and you will be reimbursed our standard rate for your participation.

5. An interdisciplinary care team is assigned to each member and is responsible for reviewing the care plans, collaborating with you and other network providers and providing recommendations for management of care. You and/or your patient may be asked to participate in the care planning and management of the plan of care.

6. We have a contracted provider network having special expertise to manage the special needs population and monitor the use of clinical practice guidelines by the contracted providers. Roles of providers include advocating, informing and educating members, performing assessments, diagnosing and treating. If you believe our local network does not meet all of your members’ specialized needs, and would like to recommend possible additions to our network, please contact provider relations at the number on the members’ identification card or discuss with the case manager.

7. We are committed to effective, efficient communication with you. We have developed a communication system to support effective information between you, your members and our care team. For example, you may receive a copy of the care plan that has been developed for your patient by either fax or mail, or by accessing the information directly from the provider portal. You may also receive a copy of the care plan or a phone call from the case manager asking you to review, make comments or recommendations about the care plan or the needs
that have been identified during the care planning process. You may reach your members’ care team by calling the number provided to you on any correspondence from us or the number on the members’ identification card. General information is available online through the provider portal on our website.

8. We support transitions in care for your patients. Special needs plan members typically have many providers and may transition into and out of health care institutions. Our care management team will be contacting you and your patient at times of transitions to ensure needs are met, services are coordinated, prescriptions are filled and medications are taken correctly. If you are aware of an upcoming care transition for your patient and would like our team to assist in the coordination, please notify us at the number provided on the members’ identification card. We have identified care transition protocols that are also documented for you in your provider manual.

9. Performance and health outcome measurements are collected, analyzed and reported to measure health outcomes and quality measures and also to evaluate the effectiveness of the model of care. These measurements are used by our Quality Management Program and include the following measures:
   - Healthcare Effectiveness Data and Information Set (HEDIS) — used to measure performance on dimensions of care and service
   - Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction survey
   - Health Outcomes Survey (HOS) member survey is multi-purpose and used to compute physician and mental component scores to measure the health status
   - CMS Part C Reporting Elements, including benefit utilization, adverse events, organizational determinations and procedure frequency
   - Medication therapy measurement measures
   - Chronic Care Improvement Program (CCIP)
   - Clinical and administrative/service quality improvement projects

10. We offer SNP model of care training to applicable providers, employees and contractors to ensure a universal understanding of the model of care. The information provided to you in your provider manual, through newsletters, provider orientation, or on our website are all ways we provide this training.

One of our desired outcomes as part of the model of care is to assist you in managing and coordinating care in order to improve the health status and outcomes of your patients. If you have any input regarding our model of care, we welcome your feedback.

Annual Program Evaluation: Each year a formal evaluation of the model of care occurs to identify any modifications that are needed and assess progress toward meeting the program goals. Throughout the year, we periodically review our program to assist us in early identification of any potential issues that may require actions. A formal evaluation is performed annually concerning the previous year’s performance.
The evaluation of the 2013 program evaluation the following changes or improvements were made or planned for execution during 2014:

- Actions to improve the outreach to our members to increase number of completed health risk assessments
- Implementation of new tools to assist our clinical team to easily access medical and utilization history on our members including certain care gaps
- Continue to reinforce processes to coordinate care between Medicare and Medicaid benefit plans
- Changes to department structure
- Enhanced behavioral health management within case management
- Modifications to goals and tracking of outcomes
- Improve reporting processes
- Modification of Health Risk Assessment Tool

Feedback on any of our programs is always welcome as we continually strive to address the needs of our members and work closely with our providers to offer real solutions in health care.

**Member Satisfaction**
Amerigroup periodically surveys members to measure overall customer satisfaction, including satisfaction with the care received from providers. Amerigroup reviews survey information and shares the results with network providers.

Members are also surveyed by CMS twice a year through the CAHPS and HOS surveys. The results of both CMS surveys are part of the Medicare Advantage plans’ HEDIS and star ratings. Amerigroup encourages its participating providers to encourage members to actively participate in their health care, to receive preventive services timely and to improve their quality of life by following the provider’s treatment plan. See the Centers for Medicare & Medicaid Services Star Ratings section of this manual.
CLAIM SUBMISSION AND ADJUDICATION PROCEDURES
Claims — Billing and Reimbursement

Clean claims for Medicare members are generally adjudicated within 30 calendar days from the date Amerigroup receives the claim. For nonclean claims, the provider receives written notification identifying the claim number, the reason the claim could not be processed, the date the claim was received by Amerigroup and the information required from the provider in order to adjudicate the claim. Amerigroup produces and mails an Explanation of Payment (EOP) on a daily basis. The EOP delineates for the provider the status of each claim that has been paid or denied during the previous week.

Medicare members must not be balance billed for services rendered as outlined in the participating provider agreement and the Attachment A rate sheet. Medicare members are also not held liable for non-covered services where the provider failed to provide advanced notice of non-coverage via the organization determination process. Reimbursement by Amerigroup constitutes payment in full except for applicable copays, deductibles and coinsurance. These amounts will be indicated on the EOP and direction provided based on whether Amerigroup is responsible for processing both the primary and secondary claims or not. In instances where Amerigroup is only responsible for processing primary claims, the provider should bill the state Medicaid agency, as would be the standard practice in the Medicare fee-for-service program for Specialty + Rx plan members. See the Billing Members section of this manual for additional details about cost sharing.

Provider must use HIPAA-compliant billing codes when billing. This applies to both electronic and paper claims. When billing codes are updated, the provider is required to use appropriate replacement codes for submitting claims for covered services. An amendment to the participating provider agreement will not be required to replace such billing codes. Amerigroup follows Strategic National Implementation Process (SNIP) level 1 through 6 editing for all claims received in accordance with HIPAA. Amerigroup will not reimburse any claims submitted using noncompliant billing or SNIP codes.

Providers resubmitting claims for corrections must clearly mark the claim “Corrected Claim.” Failure to mark the claim appropriately may result in denial of the claim as a duplicate. Corrected claims must be received within the applicable timely filing requirements of the originally submitted claim, due to the original claim not being considered a clean claim.

Claim Status
Providers should access the Amerigroup online claim status inquiry tool at providers.amerigroup.com or call Provider Services at the DSU at 1-866-805-4589 to check claim status.

Provider Claims
Providers should submit claims to Amerigroup as soon as possible after service is rendered. Claims should be filed using the CMS-1500 (08-05) or UB-04 CMS-1450 claim form or filed electronically.
Billing Differences for Medicare Advantage

CMS-1500 (08-05)
Box 9, 9A-D  Other Insurance, including Medicaid
Box 25  Federal Tax ID number
Box 33  State Medicaid number

Hospitals
Hospitals should submit claims to the Amerigroup claims address as soon as possible after service is rendered, using the standard UB-04 form or by filing electronically.

UB-04/CMS 1450
Box 5  Federal Tax ID Number
Box 51a  Amerigroup Unique Provider ID Number
Box 51b  State Medicaid Number
Box 51c  Medicare ID Number

Coordination of Benefits
If a member has coverage with another plan that is primary to Medicare, please submit a claim for payment to that plan first. The amount payable by Amerigroup is governed by the amount paid by the primary plan and Medicare secondary payer law and policies.

Electronic Submission
Amerigroup encourages the submission of claims electronically through Electronic Data Interchange (EDI). Providers must submit claims within the timely filing limits noted below from the date of discharge for inpatient services or from the date of service for outpatient services.

<table>
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<tr>
<th>Market</th>
<th>Timely Filing (days)</th>
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</tr>
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<tbody>
<tr>
<td>New Jersey</td>
<td>180</td>
<td>Tennessee</td>
<td>120</td>
</tr>
<tr>
<td>New Mexico</td>
<td>90</td>
<td>Texas</td>
<td>95</td>
</tr>
<tr>
<td>Washington</td>
<td>180</td>
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</tbody>
</table>

Electronic claims submission is available through:
- Emdeon (formerly WebMD) — Claim Payer ID 27514
- Capario (formerly MedAvant) — Claim Payer ID 28804
- Availity (formerly THIN) — Claim Payer ID 26375

Providers have the option of submitting claims electronically through EDI.

The advantages of electronic claims submission are as follows:
- Facilitates timely claims adjudication
- Acknowledges receipt and rejection notification of claims electronically
- Improves claims tracking
- Improves claims status reporting
• Reduces adjudication turnaround
• Eliminates paper
• Improves cost-effectiveness
• Allows for automatic adjudication of claims

The guide for EDI claims submission is located at providers.amerigroup.com. Simply log in to the secure site by entering your user name and password. From the RealTools menu select Claims, then Electronic Data Interchange. The EDI Claim Submission Guide includes additional information related to the EDI claim process.

To initiate the electronic claims submission process or obtain additional information, please contact the Amerigroup EDI Hotline at 1-800-590-5745.

**EDI Submission for Corrected Claims**

For corrected professional (837P) claims submitted via EDI claim professional, providers should use one the following frequency codes to indicate a correction was made to a previously submitted and adjudicated claim:

- **7** – Replacement of Prior Claim
- **8** – Void/Cancel Prior Claim

Note: A full definition of each code and confirmation of the use of these codes on a professional claim can be found on the NUBC website at www.nubc.org/FL4forWeb2_RO.pdf.

**Indicator Placement:**
- **Loop:** 2300 (Claim Information)
- **Segment:** CLM 05-03 (Claim Frequency Type Code)
- **Value:** 7, 8

For corrected institutional (837I) claims submitted via EDI, providers should use one the following Bill Type Frequency Codes to indicate a correction was made to a previously submitted and adjudicated claim:

- **0XX5** – Late Charges Only Claim
- **0XX7** – Replacement of Prior Claim
- **0XX8** – Void/Cancel Prior Claim

Note: A full definition of each code can be referenced on Pages II-111 through II-114 of the Ingenix UB04 Billing Manual.

**Indicator Placement:**
- **Loop:** 2300 (Claim Information)
- **Segment:** CLM 05-03 (Claim Frequency Type Code)
- **Value:** 5, 7, 8
Paper Claims Submission
Providers also have the option of submitting paper claims. Amerigroup uses Optical Character Recognition (OCR) technology as part of its front-end claims processing procedures. The benefits include the following:

- Faster turnaround times and adjudication
- Claims status availability within five days of receipt
- Immediate image retrieval by Amerigroup staff for claims information, allowing more timely and accurate response to provider inquiries

To use OCR technology, claims must be submitted on original red claim forms (not black and white or photocopied forms) and laser printed or typed (not handwritten) in a large, dark font. Providers must submit a properly completed UB-04 or CMS-1500 (08-05) within 90 days from the date of discharge for inpatient services or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date the third party documents resolution of the claim.

In accordance with the implementation timelines set by CMS and NUCC, Amerigroup now requires the use of the new CMS-1500 (08-05) for the purposes of accommodating the National Provider Identifier (NPI).

In accordance with the implementation timelines set by CMS and NUBC, Amerigroup now requires the use of the new UB-04 CMS-1450 for the purposes of accommodating the NPI.

CMS-1500 (08-05) and UB-04 CMS-1450 must include the following information (HIPAA-compliant where applicable):

- Patient’s ID number
- Patient’s name
- Patient’s date of birth
- ICD-9 diagnosis codes/revenue codes
- Date of service
- Place of service
- Description of services rendered CPT-4 codes/HCPC codes/DRGs
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- Amerigroup provider number
- NPI of billing provider when applicable
- Name of ordering physician
- NPI of ordering physician when applicable
- Name of performing physician
- NPI of performing provider when applicable
- State Medicaid ID number
- Coordination of Benefits/other insurance information
- Authorization/precertification number or copy of authorization/precertification
- Name of referring physician
- NPI of referring physician when applicable
- Any other state-required data

Amerigroup cannot accept claims with alterations to billing information. Claims that have been altered will be returned to the provider with an explanation of the reason for the return. Amerigroup will not accept claims from those providers who submit entirely handwritten claims, except in New Jersey where providers are permitted to submit handwritten claims.

Paper claims must be submitted within the timely filing limits noted below from the date of service:

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Submit paper claims to the following address:

<table>
<thead>
<tr>
<th>MARKET</th>
<th>SUBMIT PAPER CLAIMS TO:</th>
</tr>
</thead>
</table>
| Paper claims for all Medicare markets (New Jersey, New Mexico, Tennessee, Texas and Washington) | Amerigroup Community Care
|                                                                        | P.O. Box 61010                                                                        |
|                                                                        | Virginia Beach, VA 23466-1010                                                         |

**Encounter Data**

Amerigroup has established and maintains a system to collect member encounter data. Due to reporting needs and requirements, network providers who are reimbursed by capitation must send encounter data to Amerigroup for each member encounter. Encounter data can be submitted through EDI submission methods or on a CMS-1500 (08-05) or a UB-04 claim form, unless other arrangements are approved by Amerigroup. Data will be submitted in a timely manner but no later than 90 days from the date of service.

The encounter data will include the following:
- Medicare member ID number
- Medicare member name (first and last name)
- Medicare 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 and state Medicaid ID number

Encounter data should be submitted to the address provided on the previous page.
Through claims and encounter data submissions, Healthcare Effectiveness Data and Information Set (HEDIS) information is collected. This includes but is not limited to the following:

- Preventive services (e.g., childhood immunization, mammography, Pap smears)
- Prenatal care (e.g., low birth weight, general first trimester care)
- Acute and chronic illness (e.g., ambulatory follow-up and hospitalization for major disorders)

Compliance is monitored by the Amerigroup utilization and quality improvement staff, coordinated with the medical director and reported to the Quality Management Committee on a quarterly basis. The PCP is monitored for compliance with reporting of utilization. Lack of compliance will result in training and follow-up audits and could result in termination.

**Claims Adjudication**

Amerigroup is dedicated to providing timely adjudication of provider claims for services rendered to members. All network and non-network provider claims submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by the CPT-4 and ICD-9 manuals. Institutional claims should be submitted using EDI submission methods or an UB-04 or CMS-1450 and provider claims using the CMS-1500.

Providers must use HIPAA-compliant billing codes when billing Amerigroup. This applies to both electronic and paper claims. When billing codes are updated, the provider is required to use appropriate replacement codes for submitted claims. Amerigroup will not pay any claims submitted using noncompliant billing codes.

Amerigroup reserves the right to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure. The automated claims auditing system verifies the coding accuracy of claims for CPT and Healthcare Common Procedure Coding System (HCPCS) procedures. This system ensures the same auditing criteria is applied across all claims. Editing decisions are supported by online medical coding policy statements published by CMS as a part of the National Correct Coding Initiative (NCCI, also known as CCI).

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

- Submit claims within the number of days specified for each market from the date the service is rendered, or for inpatient claims filed by a hospital, within the number of days specified for each market from the date of discharge.
- In the case of other insurance, submit the claim within the number of days specified for each market after 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 90 days from the date the eligibility is added and Amerigroup is notified of the eligibility/enrollment.
- Claims submitted after the market specific timely filing deadline will be denied.

After filing a claim with Amerigroup, review the daily EOP. If the claim does not appear on an EOP within 30 business days as adjudicated or you have no other written indication the claim has been received, check the status of your claim by using the Amerigroup website at providers.amerigroup.com or by calling Provider Services at the DSU at 1-866-805-4589. If the claim
is not on file with Amerigroup, resubmit your claim within 90 days from the date of service, or by the timely filing requirement for your market. If filing electronically, check the confirmation reports for acceptance of the claim you receive from your EDI or practice management vendor.

**Clean Claims Payment**

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

- Is submitted in a timely manner
- Is accurate
- Is submitted on a HIPAA-compliant standard claim form, including a CMS-1500 or CMS-1450 or successor forms thereto or the electronic equivalent of such claim form
- Requires no further information, adjustment or alteration by the provider or by a third party in order to be processed and paid by Amerigroup

Clean claims are typically adjudicated within 30 calendar days of receipt. If Amerigroup does not adjudicate the clean claim within the time frames specified above, Amerigroup will pay all applicable interest as required by law.

Amerigroup produces and mails an EOP on a daily basis, which delineates for the provider the status of each claim that has been adjudicated during the previous payment cycle. Upon receipt of the requested information from the provider, Amerigroup should complete processing of the clean claim within 30 calendar days.

Paper claims determined to be unclean will be returned to the billing provider along with a letter stating the reason for the rejection. Electronic claims determined to be unclean will be returned to the Amerigroup contracted clearinghouse that submitted the claim.

In accordance with CMS requirements, Amerigroup will pay at least 95 percent of all clean claims from practitioners either in individual or group practice or who practice in shared health facilities within 30 calendar days of the date of receipt. Amerigroup will pay or deny all other claims within 60 calendar days of the receipt of the request. The date of receipt is the date Amerigroup receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

**Provider Reimbursement**

**Electronic Funds Transfer and Electronic Remittance Advice**

Amerigroup offers Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) with online viewing capability. Providers can elect to receive Amerigroup payments electronically through direct-deposit to their bank account. In addition, providers can select from a variety of remittance information options, including:

- HIPAA-compliant data file for download directly to your practice management or patient accounting system
- Paper remittance printed and mailed by Amerigroup

Some of the benefits providers may experience include:

- Faster receipt of payments from Amerigroup
- The ability to generate custom reports on both payment and claim information based on the criteria specified
Online capability to search claims and remittance details across multiple remittances
• Elimination of the need for manual entry of remittance information and user errors
• Ability to perform faster secondary billing

To register for ERA/EFT, please visit our website at providers.amerigroup.com.

**Primary Care Provider Reimbursement**
Amerigroup reimburses PCPs according to their contractual arrangement.

**Specialist Reimbursement**
Reimbursement to network specialty care providers and network providers not serving as PCPs is based on their contractual arrangement with Amerigroup.

Specialty care providers must obtain Amerigroup approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized or beyond the scope permitted under this program.

Specialty care provider services will be covered only when there is documentation of appropriate notification or prior authorization, as appropriate, and receipt of the required claims and encounter information to Amerigroup.

**Reimbursement Policies**
Reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member’s Amerigroup benefit plan. These policies can be accessed at; https://providers.amerigroup.com/QuickTools/Pages/ReimbursementPolicies.aspx

The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member’s state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup may:
• Reject or deny the claim
• Recover and/or recoup claim payment

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of
policies into the claims platforms in the same manner as described; however Amerigroup strives to minimize these variations.

Amerigroup reserves the right to review and revise its policies periodically when necessary. When there is an update we will publish the most current policy at; https://providers.amerigroup.com/QuickTools/Pages/ReimbursementPolicies.aspx

Reimbursement Hierarchy
Claims submitted for payments must meet all aspects of criteria for reimbursements. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity, authorization requirements or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

Review Schedules and Updates
Reimbursement Policies go through a review every two years for updates to state, federal or CMS contracts and/or requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to an Amerigroup business decision. When there is an update we will publish the most current policy at; https://providers.amerigroup.com/QuickTools/Pages/ReimbursementPolicies.aspx

Medical Coding
The Medical Coding department ensures that correct coding guidelines have been applied consistently throughout Amerigroup. Those guidelines include, but are not limited to:

- Correct modifier use
- Effective date of transaction code sets (CPT, HCPCS, ICD diagnosis/procedures, revenue codes, etc.)
- Code editing rules are appropriately applied and within regulatory requirements
- Analysis of codes, code definition and appropriate use

Reimbursement by Code Definition
Amerigroup allows reimbursement for covered services based on their procedure code definitions or descriptors, as opposed to their appearance under particular CPT categories or sections, unless otherwise noted by state or provider contracts, or state, federal or CMS requirements. There are seven CPT sections:
1. Evaluations and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Temporary codes for emerging technology, services or procedures

Various procedure codes are located in particular CPT categories, although the procedure may not be classified within that particular category (e.g., venipuncture is located in the CPT Surgical Section, although it is not a surgical procedure).

**Overpayment Process**

Refund notifications may be identified by two entities, Amerigroup Cost Containment Unit (CCU) or the provider. The CCU researches and notifies the provider of an overpayment by requesting a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified by Amerigroup, the CCU will notify the provider of the overpayment. The provider will submit a Refund Notification Form along with the refund check. If a provider identified the overpayment and returns the Amerigroup check, please include a completed Refund Notification Form specifying the reason for the return. This form can be found on the provider website at providers.amerigroup.com. Submission of the Refund Notification Form will allow the CCU to process and reconcile the overpayment in a timely manner. Once the CCU has reviewed the overpayment, you will receive a confirmation letter explaining the details of the reconciliation. For questions regarding the refund notification procedure, please call Provider Services at the DSU at 1-866-805-4589.

Amerigroup uses an automated claims auditing system to ensure claims are adjudicated in accordance with industry billing and reimbursement standards. Claims auditing software ensures compliance with an ever-widening array of edits and rules as well as consistency of payment for providers by ensuring correct coding and billing practices are being followed. Using a sophisticated auditing logic, our code editing system determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes and processes those services according to the NCCI. NCCI was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. NCCI code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services.

In addition to code pair edits, the NCCI includes a set of edits known as Medically Unlikely Edits (MUEs). An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a single HCPCS/CPT code billed by a provider on a date of service for a single beneficiary.
Administrative Appeals
Please reference the notification letter received for the proper dispute/appeal process to submit your request. Note the process for appeals is different depending on whether or not the member can be held liable for any payments (member liability).

Member Liability Appeals
If a provider appeals a decision rendered with member liability, then the appeal follows the CMS Member Liability Appeals process and is processed by the Medicare Complaints, Appeals and Grievance (MCAG) department. See Medicare Member Liability Appeals process.

Provider Liability Appeals
A provider liability appeal is a request for Amerigroup to review a decision by Amerigroup Health Care Management Services to deny payment (without member liability) for services already rendered. To submit a request for appeal, send in a copy of the explanation of payment received along with all medical records. The provider is responsible for sending in all necessary information, after which time the appeal will be reviewed and a determination rendered based on the information provided.

Provider Payment Disputes
If you believe Amerigroup has not paid for your services according to the terms of your provider agreement, submit a request using the Appeals Form located online under Forms at providers.amerigroup.com.

Providers will not be penalized for filing an appeal or payment dispute.

Submit provider liability appeals/payment disputes to:

Medicare Payment Dispute Unit
P.O. Box 110
145 S Pioneer Road
Fond du Lac, WI 54935

The Provider Disputes Unit will receive, distribute and coordinate all payment disputes and appeals.
1. Submit a written request with supporting documentation, such as an EOP and a copy of the claims or denial letter received along with other written documentation; a full explanation of the dispute/appeal is required and must be submitted within 120 days of when Amerigroup notice of initial determination was generated or we will not accept the request; the provider is responsible to submit all necessary documentation at the time of the request.
2. The Amerigroup Claims department conducts the review, and/or the health plan medical director reviews the second level dispute if medical information is involved; if additional information is submitted that would support payment, the denial is overturned.
3. An internal review is conducted and results communicated in a written decision to the provider within 60 calendar days; the written decision includes:
   • A statement of the provider’s dispute
   • The reviewer’s decision along with a detailed explanation of the contractual and/or medical basis for such decision
   • A description of the evidence or document that supports the decision
PROVIDER COMPLAINT AND GRIEVANCE PROCEDURE
Amerigroup has a formal process for the handling of disputes pertaining to administrative issues and nonpayment-related matters. For payment disputes, see “Provider Payment Disputes”. For Medicare member liability appeals, see “Medicare Member Appeals”. Providers may access this process by filing a written grievance. Provider grievances will be resolved fairly and consistent with Amerigroup policies and covered benefits.

Providers are not penalized for filing complaints. Supporting documentation should accompany the complaint and be forwarded to the nearest Amerigroup office location.

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COORDINATION OF BENEFITS
Amerigroup and its providers agree Medicare coverage is secondary and the Medicaid program is the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicare members. When Amerigroup is aware of third-party resources prior to paying for a medical service, it will follow appropriate coordination of benefits standards by either rejecting a provider’s claim and redirecting the provider to bill the appropriate insurance carrier or, if Amerigroup does not become aware of the resource until sometime after payment for
the service was rendered, by pursuing post payment recovery of the expenditure. Providers must not seek recovery in excess of the applicable Medicare and/or Medicaid payable amounts.

Amerigroup will follow appropriate coordination of benefits standards for trauma-related claims where third-party resources are identified prior to payment. Otherwise, Amerigroup will follow a pay and pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched post-payment to determine likely cases based on information obtained through communications with members and providers. Amerigroup handles the filing of liens and settlement negotiations both internally and externally via its subrogation vendor, Optum.

Amerigroup requires members to cooperate in the identification of any and all other potential sources of payment for services.

Any questions or inquiries regarding paid, denied or pended claims should be directed to Provider Services at the DSU at 1-866-805-4589.
PROVIDER OBLIGATIONS — DENIAL NOTIFICATION AND MEMBER COMPLAINTS, APPEALS AND GRIEVANCES

Providers are required to adhere to Centers for Medicare & Medicaid Services (CMS) and Amerigroup requirements concerning issuing letters and notices. This includes advanced notice of denials that will result in member liability or cost in accordance with Medicare guidelines for Medicare Advantage Plans.

Skilled Nursing Facilities and Home Health Agencies

The Notice of Medicare Non-Coverage (NOMNC) is a statutorily required notice that is issued to Medicare Advantage members to alert them of a discontinuation of skilled nursing facility, comprehensive outpatient rehabilitation facility or home health services. This notice explains the determination that continued coverage after a specific effective date will no longer be covered by the plan. A NOMNC should be issued to a Medicare member at least two days prior to discharge, or in advance of the last two covered visits. This notice informs the member his or her stay or visits no longer meet coverage criteria and will end in two days or after two visits. In most cases, the notice is required to be issued by the provider, and Amerigroup is required to ensure proper delivery and that the member’s signature is obtained. The member’s signature is not an agreement with the denial; however, it is documentation he or she has received the notification. If a member refuses to sign the notice, the provider may contact the member’s representative to have that person sign. If no representative is available, the provider may annotate the notice to indicate the refusal and document that notification was provided to the member, but the member refused to sign. If in-person notification cannot be provided to a representative, he or she can be contacted telephonically to advise him or her of the notice and their appeal rights. If agreed by both parties, the notice can then be emailed or faxed (in accordance with HIPAA privacy and security requirements). The notice should be annotated by the person providing the notification to the representative indicating the date, time, person name, relation to the member, telephone number called, and that the notice was read to the representative, including all appeal rights. If a member (or representative) elects to exercise his or her right to an immediate review, the member (or representative) must submit a request to the appropriate Quality Improvement Organization (QIO) for the state by the deadline indicated in the notice. The provider is responsible for submitting any documents or medical records as requested by the QIO or Amerigroup Medicare Complaints, Appeals and Grievance department within the time frame indicated on the request.

Hospitals

The Important Message from Medicare (IMM) is a statutorily required notice issued to Medicare Advantage members to alert them of a discontinuation of acute inpatient hospital services. Within two days after an admission or at the preadmission visit (but not more than seven calendar days in advance of the admission), the hospital providing the inpatient services is required to issue the IMM. This statutorily required notice explains the Medicare beneficiary's rights as a hospital inpatient, including discharge appeal rights. The hospital is required to deliver the notice in person and obtain the signature of the member or representative and provide them with a copy at that time. The hospital is also responsible for ensuring the member can comprehend the contents of the notice before obtaining the signature. It is the responsibility of the hospital to explain the notice, if necessary, and be able to answer any questions about the notice the member or representative may have. Notices should not be delivered while the member is receiving emergency treatment but should be delivered once the patient is stable. If a member refuses to sign the notice, the hospital may annotate the notice to indicate the refusal and document notification was attempted.
If in-person notification cannot be provided to a representative, the hospital is responsible for telephonically contacting the representative to advise him or her of their appeal rights. If agreed by both parties, the notice can be emailed or faxed (in accordance with HIPAA privacy and security requirements). In addition, prior to discharge (but not more than two days in advance of discharge), the hospital must deliver another copy of the signed notice to the member or representative in person. If the notice is being given on the day of discharge, the member must be provided at least four hours to consider his or her rights and to request the QIO review. Hospitals should not routinely provide the notice on the day of discharge. If the member requests additional information on the discharge, the detailed notice can be issued prior to an immediate review request being initiated. If discharge occurs within two calendar days of the original notice, no additional copy needs to be delivered. If a member elects to exercise his or her right to an immediate review, he or she must submit a request to the appropriate QIO, as outlined in the notice, by midnight of the day of discharge, either verbally or in writing, before that person leaves the hospital.

**Provider Obligations — In-office Denials**

In the event a member disagrees with the provider’s decision about a request for service or a course of treatment or is requesting or in need of services that are not covered by the Plan or Medicare. At each patient encounter with a Medicare member, the provider must notify the member of his or her right to receive, upon request, a detailed written notice from Amerigroup regarding the member’s services. The provider must request us to provide a detailed notice of a provider’s decision to deny a service in whole or part; in turn, we must give the member advanced written notice of the determination, by following the Precertification process (outlined below).

For services that require prior authorization or are non-covered by the plan (i.e. statutory exclusion), it becomes extremely important that Amerigroup authorization procedures are followed. If a member elects to receive such care the member cannot be held financially responsible unless notified in advance of the non-covered services. In such cases when the network physician fails to follow Amerigroup authorization protocols, Amerigroup may decline to pay the claim in which case the physicians will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

The Centers for Medicare & Medicaid Services (CMS) have established guidelines concerning Advance Notices of Non-Coverage (ABN). The ABN is a FFS document and cannot be used for Medicare Advantage denials or notifications. Per CMS (page 4) The ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). CMS advised Medicare Advantage plans that contracted providers are required to provide a coverage determination for services that are not covered by the member’s Medicare Advantage plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. If there is any doubt about whether a service is not covered, please seek a coverage determination from the plan.

A written coverage determination will help ensure that a claim for non-covered care from a contracted provider is paid accurately. According to CMS, if the appropriate written notice of denial of payment is not given to the Medicare Advantage member regarding a non-covered service, the claim may be denied and the member cannot be held financially responsible. Therefore, your failure to provide an appropriate coverage determination could result in a denial of payment for the non-covered service.
Please contact Amerigroup prior to services being rendered to comply with this requirement and ensure appropriate claims payment and allow you to bill the Medicare Member in the event of non-coverage. As a Contracted Provider with Amerigroup, you are prevented from billing the Medicare Member for any service that is deemed non-covered if you have not ensured this advanced notification has been issued.

Provider Obligations — Precertification

Providers are responsible for obtaining precertification from Amerigroup before performing certain procedures, when rendering non-covered services or when referring members to noncontracted providers. Please refer to the Summary of Benefits document for those procedures that require precertification or call Provider Services at the DSU at 1-866-805-4589. Amerigroup will render a determination on the request within the appropriate timeframe and provide notification of the decision. Requests that are denied will generate a notice that includes the denial rationale and applicable appeal rights. Medicare members will receive a denial letter as well that includes appeal rights. Denials that are the result of contractual issues between Amerigroup and the provider will not generate a member denial letter.

• An initial organization determination is any determination (e.g., an approval or denial) made by Amerigroup for coverage of medical services (Part B-covered services).
• An initial coverage determination is any determination (e.g., an approval or denial) made by Amerigroup for coverage of prescription drugs (Part D-covered services).

Amerigroup Medicare Advantage Complaints, Appeals, Grievances and Disputes

Distinguishing between Provider and Medicare Advantage Member Complaints, Appeals & Grievances

Amerigroup has separate and distinct processes for requests to reconsider an Amerigroup decision on an authorization or request for payment upon claims submission. Upon processing of each request, assignment of liability for the service is determined. All Medicare Member liability denials are subject to the Medicare Complaint, Appeal & Grievance (MCAG) process as outlined in the Member Appeals and Grievances section. Disputes between the Health Plan and the Provider that do not involve an adverse determination or liability for the Medicare Member would follow the Amerigroup Medicare Advantage Participating Provider Appeals and Dispute or Non-Participating Provider Payment Dispute processes.

Providers must cooperate with Amerigroup and with members in providing necessary information to resolve the appeals within the required time frames. Providers must provide the pertinent medical records and any other relevant information upon request and when initiating an appeal. In some instances, providers must provide the records and information very quickly in order to allow Amerigroup to make an expedited decision. Your participation in, along with the member’s election of the Medicare Advantage plan, are an indication of consent to release those records as part of the health care operations.
Medicare Member Liability – Amerigroup has determined that a Medicare Member is responsible for payment as the service(s) are determined to be not covered under the plan to which they are enrolled or is considered Medicare Member cost-share. Any time a member liability denial letter is issued, the Member Appeals process should be followed and NOT the Provider Appeals process. Medicare Member liability is assigned when:

- the Integrated Denial Notice (IDN) is issued as per the Medicare Managed Care Manual Chapter 13 Appeal rights with subsequent review by the Independent Review Entity (IRE).
- Notice of Medicare Non-Coverage (NOMNC) is issued as per the Medicare Managed Care Manual Chapter 13 Appeal rights with rights to pursue an appeal via the Quality Improvement Organization (QIO) or the plan directly.
- an Explanation of Benefits (EOB) indicates there is member responsibility assigned to a claim processed.
- an Explanation of Payment (EOP) indicates there is member responsibility assigned to a claim processed.

NOTE: Members that are dually eligible, either as full benefit dual eligible or as part of a Medicare Savings Program, are protected from liability of Medicare premiums, deductible, coinsurance and copayment amounts. This includes cost share being applied to this/these claims. Providers may not bill a dual eligible that has this coverage for any balance left unpaid (after submission to Medicare, a Medicare carrier and subsequently Medicaid) as specified in the Balanced Budget Act of 1997. Providers that service dual eligible beneficiaries must accept the amounts paid by Medicare as payments in full, as well as any payment under the State Medicaid processing guidelines. Providers who balance bill the dual eligible beneficiary are in violation of these regulations and are subject to sanctions. Providers also may not accept dual eligible beneficiaries as ‘private pay’ in order to bill the patient directly and Providers identified as continuing to bill dual eligible beneficiaries inappropriately will be reported to the Centers for Medicare & Medicaid Services (CMS) for further action/investigation.

Participating Provider Liability – Amerigroup has determined that the Participating Provider has failed to follow the terms and conditions of their contract either administratively or by not providing the clinical information needed to substantiate the services being requested for approval of payment. Participating Providers are prohibited from billing a Medicare Member for services unless the plan has determined Member liability and issued the appropriate notices as above.

Non-Participating Provider Liability – Amerigroup has determined that the Non-Participating Provider with the plan has failed to follow Medicare processing guidelines Non-Participating Providers are prohibited from billing a Medicare Member for services unless the plan has determined Member liability and issued the appropriate notices as above and has procedures for Non-Participating Provider to follow.

Amerigroup Medicare Advantage Participating Provider Appeals and Disputes

Participating Provider Appeals follow the standard Amerigroup process for provider appeals
Amerigroup participating providers may initiate provider appeals under the Provider Complaint and
Appeal Procedures. The processing of a particular provider appeal may vary depending on whether or not it involves a review of medical necessity. The Provider Complaint and Appeals Procedures contain alternative steps, based on product and state, as necessary to comply with regulatory and accreditation requirements.

The Provider Complaint and Appeal Procedures are designed to permit Amerigroup to examine issues fully and fairly before completion of Amerigroup’s internal review process. Special processes apply to appeals that involve utilization review decisions on clinical benefits. Amerigroup typically determines provider appeals within 60 days (for utilization review cases) or 60 days (for other cases) when sufficient information is received to make a decision.

Medicare Participating Provider Standard Appeal
A formal request for review of a previous Amerigroup decision where medical necessity was not established where Provider liability was assigned (see original decision letter) for services already rendered.

Provider Medical Necessity Appeals Responsibility
All requests must be:
- Submitted in writing
- Submitted within *180 days from the Amerigroup decision letter date
- Include a cover letter with:
  - Member Identifiable information
  - Date(s) of service in question
  - Specific rationale as to why the services did in fact meet medical criteria and reference specifics within the medical record to refute Amerigroups original decision
- Include necessary attachments:
  - Copy of the original Amerigroup decision
  - All applicable medical records

NOTE: Amerigroup will not request additional records to support the provider’s argument and expects the provider to submit the necessary information to substantiate their request for payment.

Appeals should be mailed to:
Medicare Complaints, Appeals & Grievances (MCAG)
Attention: Medical Necessity Provider Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

Providing the above information will enable Amerigroups Participating Provider Appeals team to properly and timely review requests within 60 business days. Requests that do not follow the above may be delayed.

*Days from original denial date may differ, depending upon the contract and/or state requirement (MMP/DSNP)

Medicare Participating Provider Administrative Ptca/Appeal
A formal request for review of a previous Amerigroup decision where a determination was made that the Participating Provider failed to follow administrative rules and Provider liability was assigned (see original decision letter) where services have already been rendered.

Appeals for failure to provide timely notification will not be reviewed clinically until the late notification denial is resolved.

Provider Administrative Plea / Appeals Responsibility
All requests must be:
- Submitted in writing
- Submitted within *180 days from the Amerigroup decision letter date
- Include a cover letter with:
  - Member Identifiable information
  - Date(s) of service in question
  - Specific rationale as to why the administrative rules were not followed and requires an exception to be made or extenuating circumstance that warrants a re-review of the request for provision of payment.
- Include necessary attachments:
  - Copy of the original Amerigroup decision
  - All applicable medical records

NOTE: In the event Amerigroup waives the administrative requirement, should your request require a medical review, Amerigroup will not request additional records to support the providers argument and expects the provider to submit the necessary information to substantiate their request for payment.

Requests should be mailed to:
Medicare Complaints, Appeals & Grievances (MCAG)
Attention: Administrative Provider Plea /Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

Providing the above information will enable Amerigroup’s Participating Provider Appeals team to properly and timely review requests within 60 business days. In the event Amerigroup waives the administrative requirement, the request will be transferred to the appropriate area for review under that process and applicable timeframes.

Requests that do not follow all of the above may be delayed.

*Days from original denial date may differ, depending upon the contract and/or state requirement (MMP/DSNP)

Medicare Provider Payment disputes (Claims Re-review)
A formal request from a Provider contesting the paid amount on a claim which does not include a medical necessity or administrative denial and claims payment determinations have already been rendered.

All Payment Disputes must be:
- Submitted in writing
• Submitted within 60 days from the Amerigroup original payment
• Include a cover letter with:
  o Claim Identifiable information
  o Specific rationale as to why the payment made is not appropriate or needs adjustment
• Include necessary attachments:
  o Copy of the original Amerigroup payment (EOP)
  o All applicable medical records or other attachments supporting additional payment

NOTE: Amerigroup will not request additional information and expects the provider to submit the necessary information to substantiate their request for additional payment

Disputes should be mailed to:
Medicare Payment Dispute Unit
P.O. Box 110
145 S Pioneer Road
Fond du Lac, WI 54935

Providing the above information will enable Amerigroup's Payment Dispute Unit to properly and timely review requests. Requests that do not follow all of the above may be delayed.

*NOTE: Days from original denial date may differ, depending upon the contract and/or state requirement (MMP/DSNP)

Amerigroup Medicare Advantage Non-Participating Provider Payment Disputes & Appeals

Non-Participating Provider Payment Disputes
If, after a claim has been adjudicated, a non-participating provider contends that our decision to pay for a different service from the one originally billed or believe they would have received a different payment under Original Medicare, the Non-Participating Provider Payment Dispute Resolution Process can be utilized. Notification will be provided to the Non-Participating Provider at each step of the process.

Non-Participating Provider Appeals Rights
If a claim is partially or fully denied for payment, the non-participating provider must request a reconsideration of the denial within 60 calendar days from the remittance notification. When submitting the reconsideration of the denial of payment on a claim, a signed Waiver of Liability form must be included. To obtain this form, please click here.

The purpose of the Waiver of Liability form is to hold the enrollee harmless regardless of the outcome of the appeal.
With the appeal, the non-participating provider should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider’s argument for reimbursement. The appeal must be in writing and mailed.

Please mail the appeal to this address:
Grievances and Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Rd
Mason, Ohio 45040

Amerigroup Medicare Member Complaints, Appeals and Grievances

_Distinguishing Between Member Appeals and Member Grievances_
Complaints are considered any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. There are two procedures for resolving MA member complaints: the Medicare Member appeals process and Medicare Member grievance process. All member concerns are resolved through one of these mechanisms. The member’s specific concern dictates which process is used. Thus, it is important for the physician to be aware of the difference between appeals and grievances.

_Medicare Member Liability Appeals_
A member appeal is the type of complaint a member (or authorized representative) makes when the member wants Amerigroup to reconsider and change an initial coverage/organization determination (by Amerigroup or a provider) about what services, benefits or prescription drugs are necessary or covered, or whether Amerigroup will reimburse for a service, benefit, or a prescription drug.

An appeal refers to any of the procedures that deal with a request to review a denial of payment or services. If a member believes he or she is entitled to receive a certain service and Amerigroup denies it, the member has the right to appeal the decision. It is important to follow the directions in the denial letter issued to ensure the proper appeals process is followed.

A member may appeal:
- An adverse initial organization determination by Amerigroup or a provider concerning authorization for or termination of coverage of a health care service
- An adverse initial organization determination by Amerigroup concerning reimbursement for a health care service
- An adverse initial organization determination by Amerigroup concerning a refusal to reimburse for a health service already received if the refusal would result in the member being financially liable for the service
- An adverse coverage determination by Amerigroup or a provider concerning authorization for prescription drugs

Appeals should be sent to:
Medicare Complaints, Appeals & Grievances (MCAG)
Attention: Member Appeals Unit
All Medicare Member concerns that do not involve an initial determination are considered grievances and are addressed through the grievance process.

**Participating Provider Responsibilities in the Medicare Member Appeals Process**

- Physicians can request standard service or expedited appeals on behalf of their members; however if not requested specifically by the attending, an Appointment of Representative Form to submit an appeal on behalf of a Medicare member, may be required. The Appointment of Representative Form can be found online and downloaded at [www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf](http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf).
- When submitting an appeal, provide all medical records and/or documentation to support the appeal at that time. Please note that if additional information is requested, it will delay processing of the appeal.
- Expedited appeals should only be requested if the normal time period for an appeal could jeopardize the member’s life, health or ability to regain maximum function.
- The CMS guidelines should be utilized when requesting services and initiating the appeals process.

**Appeal timeframes**

- Members or their Authorized Representatives have 60 days from the date of the denial of service to file an appeal. The 60-day filing deadline may be extended if good cause can be shown.
- For standard service appeals, service and payment issues must be resolved within 30 calendar days from the date the request was received.
  - If the normal time period for an appeal could jeopardize the member’s life, health or ability to regain maximum function, a request for an expedited appeal may be submitted orally or in writing. Such appeals generally resolved within 72 hours, unless it is in the member’s interest to extend this time period.
- For payment appeals, service and payment issues must be resolved within 60 calendar days from the date the request was received. All payment appeals must be submitted in writing.

**Further Appeal Rights**

If Amerigroup is unable to reverse the original denial decision in whole or part, the following additional steps will be taken:

- Amerigroup will forward the appeal to an Independent Review Organization (IRO) contracted with the federal government. The IRO will review the appeal and make a decision:
  - Within 72 hours if expedited
  - Within 30 days* if the appeal is related to authorization for health care
  - Within 60 days* if the appeal involves reimbursement for care
  - Prescription drug appeals are not forwarded to the IRO by Amerigroup but may be requested by the member or representative; information will be provided on this process during the Amerigroup Medicare member appeals process.
• If the IRO issues an adverse decision (not in the member’s favor) and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ)

• If the member is not satisfied with the ALJ’s decision, the member may request review by the Medicare Appeals Council. If the Medicare Appeals Council refuses to hear the case or issues an adverse decision, the member may be able to appeal to a federal court

*Some plans may have different turnaround times due to state requirements.

**Hospital discharge appeals and QIO review process**

_Hospital discharges are subject to the expedited member appeal process._ The Centers for Medicare Medicaid Services (CMS) has determined that Medicare Advantage members wishing to appeal an inpatient hospital discharge must request an immediate review from the appropriate Quality Improvement Organization (QIO) authorized by Medicare to review the hospital care provided to Medicare patients.

When an MA member does not agree with the physician’s decision of discharge from the inpatient hospital setting, then the member must request an immediate review by the QIO. The member or their authorized representative, attorney, or court-appointed guardian must contact the QIO by telephone or in writing. This request must be made no later than noon of the first working day after the member receives the Notice of Discharge and Medicare Appeal Rights. The QIO will make a decision within one full working day after it receives the member’s request, the appropriate medical records, and any other information it needs to make a decision. While the member remains in the hospital, Amerigroup continues to be responsible for paying the costs of the stay until noon of the calendar day following the day the QIO notifies the member of its official Medicare coverage decision.

If the QIO agrees with the physician’s discharge decision, the member will be responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO provides notification of its decision. If the QIO disagrees with the physician’s discharge decision, the member is not responsible for paying the cost of additional hospital days.

If an MA member misses the deadline to file for an immediate QIO review, then he/she may request an expedited appeal. In this case, the member does not have automatic financial protection during the course of the expedited appeal and may be financially liable for paying for the cost of the additional hospital days if the original decision to discharge is upheld upon appeal.

**Medicare Member Grievance**

A Medicare member grievance is the type of complaint a member makes regarding any other type of problem with Amerigroup or a provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room and the cleanliness of the provider’s facilities are grievances.

Amerigroup must accept grievances from members orally or in writing within 60 days of the event. Amerigroup must make a decision and respond to the grievance within 30 days*. A member can request an expedited grievance, in which case Amerigroup has 24 hours to respond. An expedited grievance can only be initiated if Amerigroup refuses to grant the member an expedited organization/coverage determination or an expedited reconsideration/redetermination. Amerigroup can request up to 14 additional days to respond to a grievance with good reason.
*Some plans may have different turnaround times due to state requirements.

**Resolving Medicare Member Grievances**
If a Medicare member has a grievance about Amerigroup, a provider or any other issue, providers should instruct the member to call Member Services at the number located on the back of their ID card or send a written grievance to:

Medicare Complaints, Appeals & Grievances (MCAG)
Attention: Member Grievance Unit
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

**Billing Members & Balance Billing**

**Cost Sharing**
An important protection for beneficiaries when they obtain plan-covered services in an HMO, PPO, or RPPO is that they do not pay more than plan-allowed cost-sharing. Providers who are permitted to balance bill must obtain this balance billing from the MAO. **Providers may not collect any additional payment for cost-sharing obligations from Medicare members other than those specified in a member’s plan Summary of Benefits.**

Note: Under Original Medicare rules, an Original Medicare participating provider (hereinafter referred to as a participating provider) is a provider that signs an agreement with Medicare to always accept assignment. Participating providers may never balance bill because they have agreed to always accept the Medicare allowed amount as payment in full. An Original Medicare non-participating provider (hereinafter referred to as a non-participating, or non-par, provider) may accept assignment on a case-by-case basis and indicates this by checking affirmatively field 27 on the CMS 5010 claims form; in such a case, no balance billing is permitted.

In the case of dual-eligible members covered by both Medicare and Medicaid, federal law requires providers to bill only the member’s Medicaid health plan or the state Medicaid agency for copayments or other cost-sharing amounts. Providers may not bill such members for cost sharing. The chart below indicates how cost sharing is paid, either by Amerigroup or the state Medicaid agency. Amerigroup processes the claim for reimbursement when Amerigroup has an arrangement with state Medicaid to pay Medicare cost sharing for dual-eligible members in its Special Needs Plans (SNP). The state retains responsibility for cost sharing when Amerigroup does not have an arrangement with the state Medicaid agency. In states where Amerigroup pays cost sharing, claims will be processed under the member’s account for both Medicare and Medicaid benefits. In the states where Amerigroup does not have an arrangement with the state Medicaid agency, providers should bill cost sharing to the appropriate Medicaid carrier or state Medicaid agency for payment once the claim has been processed by Amerigroup. Please check your EOP upon claims adjudication.
## Cost-Sharing Responsibility for Special Needs Plan Members

<table>
<thead>
<tr>
<th>State</th>
<th>Amerivantage SNP + Rx Member</th>
<th>Amerivantage Classic + Rx Member</th>
<th>Amerivantage Balance + Rx Member</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Jersey</td>
<td>Claim is processed applying standard Medicare deductible and/or coinsurance under the Medicare account, and any Medicare cost sharing is processed as per Medicaid payment rules under a separate claim. You will receive notification of claims payment under both.</td>
<td>N/A</td>
<td>N/A</td>
<td>Amerigroup pays cost sharing as filed in our Medicare bids. The provider does not bill the state.</td>
</tr>
<tr>
<td>New Mexico</td>
<td>N/A</td>
<td>Claim is processed according to your contracted rate minus any applicable cost sharing as filed in the member’s benefit package.</td>
<td>N/A</td>
<td>Bill the state Medicaid program or the member’s Medicaid plan.</td>
</tr>
<tr>
<td>Tennessee*</td>
<td>Claim is processed applying standard Medicare deductible and/or coinsurance under the Medicare account.</td>
<td>Claim is processed according to your contracted rate minus any applicable cost sharing as filed in the member’s benefit.</td>
<td>N/A</td>
<td>Amerigroup will process your claim as primary payer, issue any appropriate payment, an explanation of payment/remittance advice and submit the secondary claim to TennCare on your behalf. TennCare will</td>
</tr>
<tr>
<td>State</td>
<td>Amerivantage SNP + Rx Member</td>
<td>Amerivantage Classic + Rx Member</td>
<td>Amerivantage Balance + Rx Member</td>
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</tr>
<tr>
<td>Texas</td>
<td>Claim is processed at 100 percent of the provider’s contracted rate.</td>
<td>Claim is processed according to your contracted rate minus any applicable cost sharing as filed in the member’s benefit package.</td>
<td>N/A</td>
<td>Amerigroup pays cost sharing as filed in our Medicare bids. The provider does not bill the state.</td>
</tr>
<tr>
<td>Washington</td>
<td>Claim is processed applying standard Medicare deductible and/or coinsurance under the Medicare account.</td>
<td>Claim is processed according to your contracted rate minus any applicable cost sharing as filed in the member’s benefit package.</td>
<td>N/A</td>
<td>Bill state Medicaid program for any cost sharing applied to the claim.</td>
</tr>
</tbody>
</table>

*Providers should refer to the TennCare Bureau Medicare and Medicaid Crossover Claims directions outlined on the TennCare Bureau website at www.tn.gov/tenncare/pro-claims.html for claims submission requirements.

Please refer to the Tennessee Provider Addendum on pages [XXX–XXX] of this manual for more information about cost-sharing responsibilities for Tennessee providers.

**NOTE:** Members that are dually eligible, either as full benefit dual eligible or as part of a Medicare Savings Program, are protected from liability of Medicare premiums, deductible, coinsurance and copayment amounts. This includes cost share being applied to this/these claims. Providers may not bill a dual eligible that has this coverage for any balance left unpaid (after submission to Medicare, a Medicare carrier and subsequently Medicaid) as specified in the Balanced Budget Act of
Providers that service dual eligible beneficiaries must accept as payment in full the amounts paid by Medicare as well as any payment under the State Medicaid processing guidelines. Providers who balance bill the dual eligible beneficiary are in violation of these regulations and are subject to sanctions. Providers also may not accept dual eligible beneficiaries as ‘private pay’ in order to bill the patient directly and Providers identified as continuing to bill dual eligible beneficiaries inappropriately will be reported to the Centers for Medicare & Medicaid Services (CMS) for further action/investigation.

The rules governing balance billing as well as the rules governing the MA payment of MA-plan, non-contracting and Original-Medicare, non-participating providers are listed below by type of provider.

**Contracted provider.**
There is no balance billing paid by either the plan or the enrollee.

**Non-contracting, Original Medicare, participating provider.** There is no balance billing paid by either the plan or the enrollee.

**Non-contracting, non-(Medicare)-participating provider.** The MAO owes the non-contracting, non-participating (non-par) provider the difference between the member’s cost-sharing and the Original Medicare limiting charge, which is the maximum amount that Original Medicare requires an MAO to reimburse a provider. The enrollee only pays plan-allowed cost-sharing, which equals:

- The copay amount, if the MAO uses a copay for its cost-sharing; or
- The coinsurance percentage multiplied by the limiting charge, if the MAO uses a coinsurance method for its cost-sharing.

**MA-plan, non-contracting, non-participating DME supplier.** The MAO owes the non-contracting non-participating (non-par) DME supplier the difference between the member’s cost-sharing and the DME supplier’s bill; the enrollee only pays plan-allowed cost-sharing, which equals:

- The copay amount, if the MAO uses a copay for its cost-sharing; or
- The coinsurance percentage multiplied by the total provider bill, if the MAO uses a coinsurance method for its cost-sharing. Note that the total provider bill may include permitted balance billing.

Additional useful information on payment requirements by MAOs to non-network providers may be found in “MA Payment Guide for Out-of-network Payments,” at [http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf](http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf)

MA plans must clearly communicate to enrollees through the Evidence of Coverage (EOC) and Summary of Benefits (SB) their cost-sharing obligations as well as their lack of obligation to pay more than the allowed plan cost-sharing as described above.
If you are a non-contracting non-participating (Medicare) provider, who does not accept Medicare assignment, please contact us if there are any questions regarding your claim(s) payments.

**Loss of Medicaid Coverage for Special Needs Plan Members**

Amerivantage Dual Coordination (HMO SNP) members are either full dual-eligible beneficiaries (FBDE) with both Medicare and full Medicaid benefits, or they have Medicare and are considered Qualified Medicare Beneficiaries (QMB or QMB Plus). In New Jersey, New Mexico and Texas, individuals considered Specified Low-Income Medicare Beneficiaries (SLMB Plus) can also enroll in the Amerivantage Dual Coordination (HMO SNP). Medicare members who temporarily lose their Medicaid coverage may be required to pay cost sharing and copayments for services until their Medicaid coverage is re-established. Members are encouraged to be cognizant of their eligibility to ensure there is no loss or gap in coverage that would result in liability of cost share.

Note: If the Part A deductible and Part B deductible are not already met at the time of the beneficiary’s loss of coverage, the member will be responsible for the extended Length Of Services (LOS) per diem cost share for inpatient facilities and/or any coinsurance on professional and outpatient services.

**Amerigroup Self-Service Website and the Provider Inquiry Line**

The Amerigroup self-service website at providers.amerigroup.com provides a host of online resources, such as our Online Provider Inquiry Tool for real-time claim status, eligibility verification and precertification status. You can also submit a claim or precertification request, print referral forms or directories or obtain a member roster. Detailed instructions for use of the Online Provider Inquiry Tool can be found on our website.

**Toll-Free Automated Provider Services at the DSU**

To support our providers and members, we have established the Dedicated Service Unit (DSU) to assist with questions and concerns about the Amerivantage plans. The DSU is comprised of Medicare subject matter experts and specializes in first-call resolution for provider and member inquiries. Our DSU representatives can help:

- Resolve payment disputes, appeals and other claims issues
- Verify claims status, member eligibility, preauthorization requirements and the status of health care services
- Identify participating Amerivantage providers for referring members to specialty services
- Refer members to our Disease Management Centralized Care Unit for interpreter services, transitions, care coordination, transfers and terminations
- Support noncompliant members (e.g., members who repeatedly miss appointments, members who are noncompliant with their treatment plans, etc.)

The DSU is available Monday through Friday from 8:00 a.m. until 10:00 p.m. Eastern time toll free at 1-866-805-4589. Information is available through the automated system, or you can be transferred to the appropriate department for other needs, such as seeking advice in case/care management.
MEMBER RIGHTS AND RESPONSIBILITIES

Providers are required to adhere to Centers for Medicare & Medicaid Services (CMS) and Amerigroup requirements concerning issuing letters and notices.

Amerigroup members have the right to timely quality care and treatment with dignity and respect. Each member receives a copy of the Explanation of Coverage which outlines the member’s rights and responsibilities. Providers must respect the rights of all Amerigroup members.

Members have the right to:

- Be treated with dignity, respect and fairness at all times
- Receive information about the health plan, services, practitioners, providers and member rights and responsibilities
- Receive information in a way that works for them (in languages other than English spoken in the plan service area, in Braille, large print or other alternate formats)
- Ensure the privacy of their medical records and personal health information
- Choose a plan provider
- Receive care from a women’s health care provider
- Have timely access to their providers and to receive services from specialists when appropriate
- Obtain information from providers and be advised about all medically appropriate or necessary treatment options available for their condition, regardless of cost or benefit coverage
- Participate fully in decisions about their health care and be informed about any risks involved in their care
- Refuse treatment, leave a hospital or medical facility or stop taking medications; the member must accept responsibility and the consequences of his or her decision
- Complete an advance directive (living will or power of attorney) to help them with decisions related to their health care if they are unable
- Voice complaints or appeals about the health plan or the care provided
- Make recommendations regarding the health plan’s member rights and responsibilities policy
- Receive information about the appeals and grievances members have filed against Amerigroup in the past
- Receive information about the Medicare Advantage plan, plan providers, drugs, health care coverage and costs, including an explanation about any bills received for services or drugs not covered
- Request information regarding provider compensation by Amerigroup
- Receive a written or binding advance-coverage determination for health care services, even if the care is requested from a nonparticipating provider

Members have the responsibility to:

- Be familiar with their coverage and the rules they must follow to obtain health care
- Notify Amerigroup if they have additional health insurance coverage
- Notify providers when seeking care that they are Medicare members and present their Amerigroup Medicare member ID cards
- Provide the health plan, doctors and practitioners with accurate information to render care and follow the treatment plans and instructions they agreed to with the provider
- Understand their health problems and participate in identifying mutually agreed-upon treatment goals to the extent possible
- Treat their doctor, their doctor’s staff and Amerigroup employees with respect and dignity
• Not be disruptive in the doctor’s office
• Pay their copayment for covered services
• Notify Amerigroup if they have questions, concerns, problems or suggestions (Members may call Member Services at the DSU at 1-866-805-4589 and TTY users should call 1-800-855-2880.)
**BENEFITS**

**Summary of Benefits Tables**

Amerigroup Medicare member benefits are summarized in the Summary of Benefits. To view the Summary of Benefits tables, click the link below for the appropriate market.

<table>
<thead>
<tr>
<th>MARKET</th>
<th>CLICK THE LINK TO ACCESS THE BENEFITS TABLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Mexico</td>
<td><a href="https://www.myamerigroup.com/Medicare2017/Pages/New%20Mexico/DocumentLibrary.aspx">https://www.myamerigroup.com/Medicare2017/Pages/New%20Mexico/DocumentLibrary.aspx</a></td>
</tr>
<tr>
<td>Texas</td>
<td><a href="https://www.myamerigroup.com/Medicare2017/Pages/Texas/DocumentLibrary.aspx">https://www.myamerigroup.com/Medicare2017/Pages/Texas/DocumentLibrary.aspx</a></td>
</tr>
</tbody>
</table>

Notations regarding some benefit categories are listed below. Please note availability and limitations of Medicare Advantage supplemental benefits may vary by product and market. Please refer to the appropriate Summary of Benefits documents listed above for detailed information.

Precertification requirements are described in later sections and in detail on the Medicare Advantage provider website. All services from noncontracted providers with the exceptions of urgent and emergent care and out-of-area dialysis require precertification.

The medical benefits are further explained in the following sections.

**Emergency Care**

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Amerigroup covers emergency services if they are:

- Furnished by a provider qualified to provide emergency services
- Needed to evaluate or stabilize an emergent medical condition in accordance with the prudent layperson standard
Members with an emergency medical condition should be instructed to call 911 and/or go to the nearest emergency hospital. Precertification for an emergency medical condition is not required.

**Urgently Needed Care**
Members needing urgent care (but not emergent care) are advised to call their PCP, if possible, prior to obtaining services. However, precertification is not required.

Urgently needed services are defined as those that are covered but are not emergent services and are provided:
- When the member is temporarily absent from the Amerivantage service area and such services are medically necessary and immediately required
- As a result of an unforeseen illness, injury or condition
- If it is not reasonable given the circumstances to obtain the services through an Amerivantage network provider

Under unusual and extraordinary circumstances, services may be considered urgently needed services when the member is in the service area but the appropriate provider within the Amerivantage provider network is temporarily unavailable or inaccessible.

**Out-Of-Area Dialysis Services**
Members may obtain medically necessary dialysis services from any qualified provider when they are temporarily absent from the Amerivantage service area and cannot reasonably access contracted Amerivantage dialysis providers. Members can obtain dialysis services without precertification or notification when outside of the Amerivantage service area.

We suggest members advise Amerigroup if they will temporarily be out of the service area, so a qualified dialysis provider may be recommended.

**Hospital Services**
There are two types of admissions:
- Elective inpatient admissions — precertification is required for all elective inpatient admissions
- Emergency admissions — admitting physicians must notify us within 24 hours or by the next business day of the admission

The Amerigroup Health Care Management Services, in coordination with admitting physicians and hospital-based physicians, is in charge of:
- Coordinating and conducting continued-stay coverage reviews
- Providing appropriate referrals for extended-care facilities
- Coordinating coverage of all services required for adequate discharge

Amerigroup case managers assist in coordinating all needed services in the discharge planning process, as well as coordinating the required follow-up by the appropriate providers.

**Preventive Services**
The following preventive services are offered to members with no member copayment or cost sharing:
• Preventive visit
  o Annual physical examination (in addition to the Medicare preventive visits)
    ▪ You may bill for one routine annual visit per year (e.g., 99385–99387, 99395–99397) with diagnosis code V70.0
  o Welcome to Medicare exam
  o Annual wellness exam
• Bone mass measurements
• Colorectal screening
• Diabetic monitoring training
• Cardiovascular disease testing
• Mammography screening
• Pap smear, pelvic exams and clinical breast exams
• Prostate cancer screening exams
• Abdominal aortic aneurysm screening
• Diabetes screening
• EKG screening
• Flu shots
• Glaucoma tests
• Hepatitis B shots
• HIV screenings
• Medical nutrition therapy services
• Pneumococcal shots
• Smoking cessation (counseling to stop smoking)
• Depression screening

Domestic Violence Services
It is especially important that network providers be vigilant in identifying members who may have been subjected to domestic violence. Domestic violence screening tools are included. are included on the next page of this manual. Member Services can help members identify resources to protect themselves from further domestic violence. Providers should report all suspected domestic violence.

State law requires reporting of child abuse. Such reporting can be done anonymously. Report any injuries from firearms and other weapons to the police. Report suspected child abuse or neglect immediately.

State law encourages individuals to report suspected cases of elder or partner abuse, neglect, or exploitation that occurs in the community. Report suspected elder or partner abuse immediately to the state’s Division of Aging and Community Services or to the particular county Adult Protective Services office. An individual can access the National Domestic Violence Hotline number by calling 1-800-799-7233. For text telephone assistance, call 1-800-787-3224.

State law provides immunity from any criminal or civil liability as a result of good faith reports of child abuse or neglect. Any person who knowingly fails to report suspected abuse or neglect may be subject to a fine up to $1,000 or imprisonment up to six months.
DOMESTIC VIOLENCE SCREENING TOOLS

Domestic Violence — Framing Statements
1. Because violence is so common in many people’s lives, I have begun to ask all my members about it.
2. I’m concerned that someone hurting you may have caused your symptoms.
3. I don’t know if this is a problem for you, but many of the people I see as members are dealing with abusive relationships.

Domestic Violence — Direct Verbal Questions
1. Are you in a relationship with a person who physically hurts or threatens you?
2. Did someone cause these injuries? Was it your partner or spouse?
3. Has your partner or ex-partner ever hit you or physically hurt you? Has he or she ever threatened to hurt you or someone close to you?
4. Do you feel controlled or isolated by your partner?
5. Do you ever feel afraid of your partner? Do you feel you are in danger? Is it safe for you to go home?
6. Has your partner ever forced you to have sex when you did not want to? Has your partner ever refused to practice safe sex?

Domestic Violence — New Member
Option 1:
1. Have you ever been hurt or threatened by your friend, spouse or partner?
2. Have you ever been hit, kicked, slapped, pushed or shoved by your friend, spouse or partner?
3. Have you ever been hit, kicked, slapped, pushed or shoved by your friend, spouse or partner during this pregnancy?
4. Have you ever been raped or forced to engage in sexual activity against your will?

Option 2:
1. Are you currently or have you ever been in a relationship where you were physically hurt, threatened or made to feel afraid?

Option 3:
1. Have you ever been forced or pressured to have sex when you did not want to?
2. Have you ever been hit, kicked, slapped, pushed or shoved by your friend, spouse or partner?

Sexual Abuse
It is required that each provider contact your local state agency at 1-800-792-8610 when sex abuse is suspected. Referrals should be made to the DYFS-designated sex abuse specialty centers. If a suspected abuse case arises and a referral is required, the provider or member may call a specialty center directly or may call Amerigroup Member Services at 1-866-805-4589 for a list of the specialty centers near them.
SUPPLEMENTAL BENEFITS

Supplemental benefits are those benefits in addition to the basic Medicare services offered through Medicare Part A and B, they are not benefits offered under the Federal Medicare program. Amerigroup offers limited supplemental benefits to covered members as outlined in the Summary of Benefits documents. Please refer to the applicable Summary of Benefits for specific supplemental benefits being offered for each plan, as well as any limitations and requirements to utilize specific vendors for services. Providers will not be reimbursed for supplemental benefits that they are either not contracted for or that are required to be rendered by a specific vendor under HealthPlus Amerigroup. Members cannot be billed for non-covered services unless notified in advance. See Provider Obligations — In-office Denials.

Supplemental benefits vary by plan, product and state. Below is a list of supplemental benefits we may chose to offer each calendar year in certain states and plans. Please refer to the Summary of Benefits documents for details on which plans cover certain supplemental benefits.

- Routine foot and nail care
- Routine eye examinations and eyeglasses
- Routine hearing examinations and hearing aids
- Dental examinations and cleanings
- Coverage of Over-The-Counter (OTC) items
- Generic drugs covered in the Part D coverage gap with the applicable generic prescription
- Nonemergency transportation
- Personal Emergency Response Systems (PERS) coverage for the service and monitoring equipment but not the actual telephone line
- Acupuncture services
- Fitness program through Silver Sneakers within their network of centers
- All plans have a Maximum Out-of-Pocket (MOOP) limit for medical services. The MOOP does include out-of-pocket costs for Part B drugs but does not include Part D (pharmacy prescriptions) cost-sharing amounts. Once a member reaches his or her MOOP limit, all covered medical services will be covered at 100 percent for the remainder of the year.
- Weight management is available to help members with changing eating habits, understanding caloric intake and providing support for healthy eating. No food or meal preparation is included, but members are able to enroll in the program through a designated access toll-free number and obtain services online or at a local meeting.
- Telemonitoring is available in all plans. See telemonitoring section for more details.
- Out-of-country emergency care

Providers **contracted with the vendor network** associated with that supplemental benefit must bill that vendor directly.

Providers **not contracted with the vendor network** to render such a benefit, please note you will only reimbursed or able to bill a member for non-covered services if you have provided the member with advanced notice of non-coverage. Please note that contracted providers are required to provide a coverage determination for services that are not covered by the member’s MA plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. As per the Medicare Advantage HMO & PPO Provider Guidebook CMS has stated that the use of an Advanced Beneficiary Notice or a similar document is not sufficient in many instances with
Medicare Advantage members. Therefore you are required to seek a coverage determination prior to rendering such services.

Providers are encouraged to call the toll free customer service number on the back of the member ID card with any questions around services that may or may not be covered.

**Note:** Not all supplemental benefits are available in all plans, and some limitations and restrictions apply. Some supplemental benefits must be rendered by the delegated Vendor to be covered.

**Dental Services**
Some of our plans include preventive dental services that are covered by Amerigroup through a contracted dental vendor, except for dental services covered as emergency services. The Amerigroup managed care programs and dental health benefits complement one another because both emphasize prevention, quality and cost-effectiveness. Amerigroup works with contracted dental providers to ensure access to the full range of preventive, primary and specialty oral health services. Please see the Summary of Benefits documents for more information on dental benefits.

**Optometry And Audiology Services**
Some of our plans include coverage of routine vision and hearing services, including:
- Routine yearly visual exams
- Screening for glaucoma
- Hearing screening

Contracted network providers, assisted by the Amerigroup Case Management Program, coordinate benefits for lenses and hearing aid devices when covered by the plan. Please see the Summary of Benefits documents for more information on vision and hearing benefits.

**Over-The-Counter Items**
Some of our plans include coverage of OTC items and health-related supplies. For those plans that include this benefit, members are provided with a monthly or quarterly allowance to obtain the items and supplies. For plans with a quarterly allowance, the benefit replenishes at the beginning of each quarter and carries across quarters, but any unused portion of the benefit does not carry over to the next year. For plans with a monthly allowance, the benefit replenishes at the beginning of each month, but any unused portion does not carry over to the next month. OTC products are described in a printed catalogue available to members.

**Nonemergent Transportation**
In many markets and benefit plans, Amerigroup provides nonemergent transportation through a contracted vendor. In other markets, these services must be arranged through the Amerigroup Case Management Program. See the Summary of Benefits documents for more information. Some plans have coverage of trips to obtain the following preventive services:
- Preventive visits
  - Annual physical examination (in addition to the Medicare preventive visits)
    - You may bill for one routine annual visit per year (e.g., 99385–99387, 99395–99397) with diagnosis code V70.0
  - Welcome to Medicare exam
- Annual wellness exam
- Bone mass measurements
- Colorectal screening
- Diabetic monitoring training
- Cardiovascular disease testing
- Mammography screening
- Pap smear, pelvic exams and clinical breast exams
- Prostate cancer screening exams
- Abdominal aortic aneurysm screening
- Diabetes screening
- EKG screening
- Flu shots
- Glaucoma tests
- Hepatitis B shots
- HIV screening
- Medical nutrition therapy services
- Pneumococcal shot
- Smoking cessation (counseling to stop smoking)
- Depression screening

**Telemonitoring**

Telemonitoring is the coverage of in-home equipment (e.g., BP cuff, scale, glucometer and pulse OC) and telecommunication technology from contracted vendors to monitor enrollees with specific health conditions as determined by their physician. Conditions must be appropriate for this service, such as monitoring of weight for CHF and other chronic conditions that require regular monitoring of vital signs and/or other data as required by a physician. This service requires an initial physician visit and a physician’s order for data transmission; however, the data will be transmitted at least on a weekly basis. Physicians are trained on monitoring protocols, and follow-up actions are required. The member is instructed on the use of the equipment, proper transmission and related processes. Telemonitoring services supplement but do not replace a face-to-face physician visits.
PRESCRIPTION DRUG COVERAGE
All AmeriVantage plans (Dual Coordination (HMO SNP), Classic HMO and ESRD (HMO-POS SNP) plans) include coverage of Medicare Part D prescription drugs, as well as those covered under Medicare Part B.

Part D Prescription Drugs
Medicare Part D prescription drugs are only available by prescription, are used or sold in the United States and must be used for medically accepted indications. Part D prescription drugs covered by AmeriVantage are listed in the Amerigroup Medicare five-tier formulary. The formulary includes all generic drugs covered under the Part D program, as well as many brand-name drugs, nonpreferred brands and specialty drugs. One can view a copy of the formulary on the Amerigroup website at providers.amerigroup.com. From the Provider Resources & Documents library, select Pharmacy Tools, then Medicare Formulary or request a copy from the Provider Relations department. Some of these drugs have precertification or step-therapy requirements or quantity limits. Providers may request authorization for a drug or coverage of a drug not on the formulary by contacting the Provider Services at the DSU at 1-866-805-4589. Members should obtain Part D covered drugs from a network pharmacy pursuant to a physician’s prescription.

Please refer to the formulary when prescribing for Amerigroup Medicare members. Though most medications on the formulary are covered without Prior Authorization (PA), a few agents will require you to obtain an authorization. For AmeriVantage Part B, contact Provider Services department 1-866-805-4589 Option 5, from 8 a.m. to 8 p.m. local time, Monday through Friday. For AmeriVantage Part D, contact Express Scripts Provider Services at 1-800-338-6180 24 hours a day, 7 days a week.

Prescription Drugs by Mail Order
Members can use the mail-order service to fill prescriptions for maintenance drugs (i.e., drugs taken on a regular basis for a chronic or long-term medical condition). For mail-order prescriptions, the physician must write on the maintenance drug prescription whether it is for a 31-, 62- or 93-day supply. When mailing in a prescription to the mail-order service for the first time, the member should allow up to two weeks for the prescription to be filled. For refills of the same prescription, members should allow up to two weeks for mailing and processing.

If a member runs out of a medication before receiving a new supply from the mail-order pharmacy, please call the DSU at 1-866-805-4589. They will assist with obtaining an emergency supply of the member’s medication until he or she receives the new mail-order supply.

Members are not required to use mail-order prescription drug services to obtain an extended supply of maintenance medications. Members also have the option of using a retail pharmacy in the AmeriVantage network to obtain their maintenance medications. Some retail pharmacies may agree to accept the mail-order reimbursement rate for an extended supply of medication, which may result in no out-of-pocket payment difference to the member. The member pays one copayment for each 31-day supply or a reduced copayment for a 62- or 93-day supply when obtaining maintenance drugs via mail order, unless the member has a Low-Income Subsidy (LIS) level that helps them pay for their Part D prescription drugs. In such cases, one LIS copayment applies for the transaction.
Part B Prescription Drugs

Prescription drugs covered under the Medicare Part B benefits are very limited. These include the following:

- Injectable medications provided incidental to a physician’s service
- Drugs administered through covered durable medical equipment, such as a nebulizer or infusion pump in the home
- Certain oral cancer medications
- Antiemetic drugs administered within 48 hours of chemotherapy
- Immunosuppressive drugs prescribed following a Medicare-covered organ transplant
- Erythropoietin for individuals undergoing chronic renal dialysis
- Parenteral nutrition for members with a permanent dysfunction of the digestive tract

Other drugs may be covered under Part B in certain limited situations. Many Part B drugs and injectable medications provided incidental to a physician’s service require precertification from Amerigroup. Please call the DSU for additional information.

Covered Vaccines

CMS and Amerigroup, through the Amerivantage plans, cover vaccines and vaccine administration for Medicare recipients. Listed below are the vaccine benefits covered under Medicare Part B, Medicare Part D and those covered under either Medicare Part B or Part D coverage.

Vaccines and Vaccine Administration Coverage Under Medicare Part B (Medical) Benefits

Medicare Part B benefits include the following routine immunizations:

- Pneumococcal pneumonia vaccine
- Influenza virus vaccine
- Hepatitis B vaccine

Claims for Medicare Part B benefits should be submitted to Amerigroup for processing and reimbursement at:

Attn: Claims Department
Amerigroup Community Care
P.O. Box 61010
Virginia Beach, VA 23466-1010

Vaccines and Vaccine Administration Coverage Under Medicare Part D (Pharmacy) Benefits

Medicare Part D generally covers vaccines not available under Medicare Part B. Medicare Part D vaccines are included in the Amerigroup Medicare Formulary located online at providers.amerigroup.com. From the Quick Tools link, select Pharmacy Tools, then Medicare Formularies. Providers who do not have access to a vaccine on the formulary can call the prescription into a participating pharmacy. If the vaccine is administered in a network pharmacy, the pharmacy will transmit the claim to the Pharmacy Benefit Manager for processing and reimbursement.
Providers who have a supply and administer the vaccine in their office should collect the member’s copay at the time of service and submit the claim for the vaccine and administration on a CMS 1500 (08-05) form to:

Attn: Claims Department
Amerigroup Community Care
P.O. Box 61010
Virginia Beach, VA 23466-1010

To streamline your claim processing and payment (as applicable) for these and other preventive vaccines covered under Part D, providers may use TransactRX, a clearinghouse for claims submission.

To use TransactRX please contact the clearinghouse at the web site (http://www.transactrx.com) or call Customer Service at 866-522-3386. Physicians, facilities, health clinics and pharmacies may use this clearinghouse to process Part D claims. There is no charge to providers who use electronic funds deposit to receive payment. There is a service fee of $2.50 for check payments on claims.

For member copayment information, please contact the DSU at 1-866-805-4589.

**Vaccines Covered Under Either Part B (Medical) or Part D (Pharmacy) Benefit Coverage**

Vaccines administered directly related to the treatment of an injury or direct exposure to a disease or condition would be covered under Part B. Vaccines administered for prevention of an illness and not covered under Medicare Part B (influenza or pneumococcal) would be covered under Part D. Vaccines that may be Part B or Part D are:

- Hepatitis A vaccine
- Anthrax vaccine
- Rabies vaccine
- Tetanus toxoid, tetanus-diphtheria toxoids

For reimbursement of a vaccine and vaccine administration that could be either Part B or Part D, indicate the reason for immunization (injury and/or direct disease exposure or prevention of an illness) on a CMS 1500 (08-05) claims form and submit to:

Amerigroup Community Care
P.O. Box 61010
Virginia Beach, VA 23466-1010

Additional information can be found on the CMS website under the Medicare Learning Network General Information page at www.cms.hhs.gov/MLNGenInfo.

**Coverage Determinations for Part D Prescription Drug Benefits**

Coverage determinations: The first decision made by a plan regarding the prescription drug benefits an enrollee is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request and a decision on the amount of cost sharing for a drug.
A coverage determination is any decision Amerigroup makes regarding:

- A decision about whether to provide or pay for a Part D drug, including a decision not to pay because the drug is not on the plan’s formulary, the drug is determined not to be medically necessary, the drug is furnished by an out-of-network pharmacy or we determine the drug is otherwise excluded, but the member believes it may be covered by the plan.
- Failure to provide a coverage determination in a timely manner, when a delay would adversely affect the member’s health.
- A decision concerning a tiering exception request.
- A decision concerning a formulary exception request.
- A decision on the amount of cost sharing for a drug.
- A decision on whether a member has satisfied a precertification or other utilization management requirement.

Two decisions govern the need for prescription drugs the member has not yet received:

- A standard decision made within the standard 72-hour time frame.
- An expedited decision made within 24 hours.

An expedited decision can only be requested if the member or any physician believes waiting for a standard decision could jeopardize the member’s life, health or ability to regain maximum function. This is called the expedited criteria.

The member or a physician can request an expedited decision. If a physician requests an expedited decision or supports a member in asking for one and if the physician indicates the situation meets the expedited criteria, Amerigroup will automatically provide an expedited decision within 24 hours from the initial request.

**Formulary Exceptions**

If a prescription drug is not listed in the Amerigroup formulary, please check the updated formulary on the Amerigroup website. The website formulary is updated frequently with any changes. In addition, providers may contact the Amerigroup Pharmacy department to be sure a drug is covered. If the Pharmacy department confirms the drug is not on the formulary, there are two options:

- The prescribing physician can prescribe another drug that is covered on the formulary.
- The patient or prescribing physician may ask Amerigroup to make an exception (a type of coverage determination) to cover the non-formulary drug. If the member pays out-of-pocket for a non-formulary drug and requests an exception Amerigroup approves, Amerigroup will reimburse the member. If the exception is not approved, the member may appeal the plan’s denial. See the Medicare Member Liability Appeals section for more information on requesting exceptions and appeals.

In some cases, Amerigroup will contact a member who is taking a drug that is not on the formulary. Amerigroup will give the member the names of covered drugs used to treat his or her condition and encourage the member to ask his or her physician if any of those drugs would be appropriate options for treatment. Also, members who recently joined an Amerigroup plan may be able to get a temporary supply of a drug they are taking if the drug is not on the Amerigroup formulary.
Transition Policy

New members in Amerigroup Medicare plans may be taking drugs that are not on the formulary or that are subject to certain restrictions, such as precertification or step-therapy. Current members may also be affected by changes in the formulary from one year to the next. Members are encouraged to talk to their providers to decide if they should switch to a different drug Amerigroup covers or request a formulary exception in order to get coverage for the drug (as described above).

During the period of time members are talking to their providers to determine the right course of action, Amerigroup may provide a temporary supply of the nonformulary drug if those members need a refill for the drug during the first 90 days of new membership in an Amerigroup plan. For current members affected by a formulary change from one year to the next, Amerigroup will provide a temporary supply of the nonformulary drug for members needing a refill for the drug during the first 90 days of the new plan year.

When a member goes to a network pharmacy and Amerigroup provides a temporary supply of a drug that is not on the formulary or that has coverage restrictions or limits (but is otherwise considered a Part D drug), Amerigroup will cover at least a one time, 30-day supply (unless the prescription is written for fewer days). After we cover the temporary 30-day supply, Amerigroup generally will not pay for these drugs again as part of the transition policy. Amerigroup will provide the member and the provider with a written notice after it covers a temporary supply. The notice will explain the steps the member can take to request an exception and the way to work with the prescribing physician to decide if switching to an appropriate formulary drug is feasible.

If a new member is a resident of a long-term care facility (like a nursing home), Amerigroup will cover a temporary 31-day transition supply (unless the prescription is written for fewer days). If necessary, Amerigroup will cover more than one refill of these drugs during the first 90 days a member is enrolled in our plan. If the member has been enrolled in the plan for more than 90 days and needs a drug that is not on the formulary or is subject to other restrictions such as step therapy or dosage limits, Amerigroup will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new member requests a formulary exception.

This policy also applies to current Medicare members who experience a change in the level of their care. For example, if a member leaves the hospital and enters a long-term care facility or leaves hospice status and reverts back to standard care, the member may receive a temporary transition supply of the nonformulary drug for up to 31 days, unless the prescription is written for fewer days.

Please note the Amerigroup transition policy applies only to those prescription drugs that are Part D drugs.

Medication Therapy Management

The Medicare Modernization Act of 2003 requires Medicare Part D prescription drug plans to include medication therapy management services delivered by a qualified health care professional, including pharmacists. MTM services target beneficiaries who have multiple chronic conditions (such as diabetes, asthma, hypertension, hyperlipidemia and congestive heart failure), take multiple medications or are likely to incur annual costs above a predetermined level. Amerigroup supports Medicare MTM in a variety of ways:
Reimbursement Policies

Reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member’s Amerigroup benefit plan. These policies can be accessed at [Brand website]. The determination that a service, procedure, item, etc. is covered under a member’s benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member’s state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities. If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup may:

- Reject or deny the claim
- Recover and/or recoup claim payment

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider or State contracts, or State, Federal, or Centers for Medicare and Medicaid Services (CMS) requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however Amerigroup strives to minimize these variations.

Amerigroup reserves the right to review and revise its policies periodically when necessary. When there is an update we will publish the most current policy at [Brand website].

Reimbursement Hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursements. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity, authorization requirements or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.
Review Schedules and Updates
Reimbursement Policies go through a review every two years for updates to state contracts, or state, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to an Amerigroup business decision. When there is an update we will publish the most current policy at [Brand website].

Medical Coding
The Medical Coding department ensures that correct coding guidelines have been applied consistently throughout Empire. Those guidelines include, but are not limited to:

- Correct modifier use
- Effective date of transaction code sets (CPT, HCPCS, ICD diagnosis/procedures, revenue codes, etc.)
- Code editing rules are appropriately applied and within regulatory requirements
- Analysis of codes, code definition and appropriate use

Reimbursement by Code Definition
Amerigroup allows reimbursement for covered services based on their procedure code definitions or descriptors, as opposed to their appearance under particular CPT categories or sections, unless otherwise noted by state or provider contracts, or state, federal or CMS requirements. There are seven CPT sections:

8. Evaluations and management
9. Anesthesia
10. Surgery
11. Radiology (nuclear medicine and diagnostic imaging)
12. Pathology and laboratory
13. Medicine
14. Temporary codes for emerging technology, services or procedures
Various procedure codes are located in particular CPT categories, although the procedure may not be classified within that particular category (e.g., venipuncture is located in the CPT Surgical Section, although it is not a surgical procedure.
Provider authorization to adjust claims and create claim offsets

Please submit this completed authorization form with all supporting documentation to ensure proper processing of your request to adjust claims as detailed below. The adjustments will result in overpayments being withheld from future claims payments.

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Cost Containment project number (if applicable):

Document identification number (if applicable):

Total recoupment dollar amount:

Please list claim information below if the Cost Containment letter or other supporting claim/member detail is not provided with this request.

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If your request for recoupment exceeds the space provided, please attach an excel file that includes all the data noted above. For questions related to the completion of this form, please call Provider Services at 1-800-454-3730.

I authorize Amerigroup to proceed with adjusting the claims as listed on this form or per separate document that supports this request.

______________________________________  __________________________________
Print name  Signature

Mail this form to:
Attn: Cost Containment – Disputes
Amerigroup
P. O. Box 62427
Virginia Beach, VA 23466-2437

Note: Do not use this form if you are submitting a refund check. If you would like to submit a refund, please use the refund notification form on the provider website. Mail a check along with the supporting documentation to:
Attn: Cost Containment – Payments
Amerigroup
P.O. Box 933657
Atlanta, GA 31193-3657
OVERPAYMENT REFUND NOTIFICATION FORM

In order for an overpayment refund to be processed in a timely manner, please submit a completed form with all refund checks and supporting documentation. If the refund check you are submitting is an Amerigroup check, please include a completed form specifying the reason for the check return.

Provider Name/Contact __________________________________________________________________________________
Contact Number ________________________________________________________________________________________
Provider ID ____________________________________________________________________________________________
Provider Tax ID _________________________________________________________________________________________
Subscriber ID ____________________________
DCN Number (Displayed on CCU Letter) _____________________________________________________________________
Member Name ______________________________________________________________________
Member Account Number ________________________________________________________________________________
Date of Service: [to] _____________________________________________________________________________________
Total Billed Charges: $____________________________________________________________________________________
Total Check Amount: $____________________________________________________________________________________

Claim Number(s):

Reason for Refund or Check Return:
□ Health Plan Letter
□ Contract Rate Change
□ Duplicate Payment
□ Incorrect Member
□ Incorrect Provider
□ Negative Balance
□ Other Health Insurance/Third-Party Liability
□ Payment Error
□ Billed in Error/Adjusted Charge
□ Other: ____________________________________________________________________________________________

All refund checks should be mailed with a copy of this form to:

Amerigroup
P.O. Box 933657
Atlanta, GA 31193-3657

Once the Amerigroup Cost Containment Unit has reviewed the overpayment, you will receive a letter explaining the details of the reconciliation. Thank you for completing this Overpayment Refund Notification Form.
GLOSSARY OF TERMS

Appeal: Appeals are any of the procedures that deal with the review of adverse organization or coverage determinations on the health care services or prescription drug benefits a member is entitled to receive or any amounts the member must pay for a covered service. These procedures include reconsiderations by Amerigroup, the Part D Quality Improvement Council, hearings before an administrative law judge, reviews by the Medical Appeals Council and federal judicial reviews. This process is separate from the provider administrative appeals/dispute process.

Balance + Rx Plan: The Balance + Rx Plan provides coverage of major medical services after satisfaction of an annual deductible. Outpatient services, such as primary care and specialist visits, are covered with reasonable copayments for professional services outside of the deductible. This includes Medicare Part D prescription coverage. This plan has no out-of-network benefits.

Basic benefits: services covered for all Medicare beneficiaries under Medicare Part A and Part B. All Medicare Advantage members receive all basic benefits, including all health care services covered under Medicare Part A and B programs, except for hospice services. Amerigroup Medicare also provides supplemental benefits not covered by fee-for-service Medicare.

CMS: Centers for Medicare & Medicaid Services; the federal agency responsible for administering the Medicare program.

Classic + Rx Plan: The Classic + Rx Plan has copays for most services, and includes Medicare Part D prescription coverage.

Contracting hospital: a hospital that has a contract to provide services and/or supplies to Medicare members.

Contracting medical group: a group of physicians organized as a legal entity for the purpose of providing medical care with a contract to provide medical services to Medicare members.

Contracting pharmacy: a pharmacy that has a contract to provide Medicare members with medications prescribed by their providers in accordance with the Amerigroup contract.

Coverage determination — the first decision made by a plan regarding the prescription drug benefits an enrollee is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request and a decision on the amount of cost sharing for a drug.

Covered services: those benefits, services or supplies that are:
- Provided or furnished by providers or authorized by Amerigroup or its providers
- Emergency services and urgently needed services that may be provided by nonproviders
- Renal dialysis services provided while members are temporarily outside the service area
- Basic and supplemental benefits

Dual-eligible: a Medicare enrollee who is eligible for Medical Assistance from the state and for whom the state has a responsibility for payment of Medicare cost-sharing obligations under the state plan. Dual-eligibles are limited to the following categories of recipients: Qualified Medicare Beneficiary (QMB)
Only, QMB Plus, Specified Low-income Medicare Beneficiary (SLMB) Plus and other Full Benefit Dual-Eligible (FBDE) recipients.

**Emergency medical condition**: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

**Emergency services**: covered inpatient or outpatient services furnished by a provider qualified to furnish emergency services and needed to evaluate or stabilize an emergency medical condition in accordance with the prudent layperson standard.

**Experimental procedures and items**: procedures and items determined by Amerigroup and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, Amerigroup will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable or CMS guidance already made by Medicare. Section 1862(a)(1)(E) of the Social Security Act, prohibits payment for procedures that are deemed experimental and/or investigational in nature.

**Exceptions**: An exception request is a type of coverage determination request. Through the exception process, the member can request an off-formulary drug, an exception to the Amerigroup tiered cost-sharing structure or an exception to the application of a cost utilization management tool (e.g., step therapy requirement, dose restriction or precertification requirement).

**Fee-for-service Medicare**: a payment system by which doctors, hospitals and other providers are paid for each service performed (also known as traditional and/or original Medicare).

**Full Benefit Dual-Eligible (FBDE)**: an individual who is eligible for both Medicare Part A and/or Part B and for state benefits (services), including those who are categorically eligible and those who qualify as medically needy under the state plan.

**Grievance**: a complaint or dispute other than one involving an organization determination. Examples of issues involving a complaint that is resolved through the grievance rather than the appeal process are: waiting times in physician offices and rudeness or unresponsiveness of customer service staff.

**Home health agency**: a Medicare-certified home health agency is one that provides intermittent skilled nursing care and other therapeutic services in a member’s home when medically necessary, when members are confined to their home and when authorized by their primary care physician.

**Hospice**: a Medicare-certified organization or agency primarily engaged in providing pain relief, symptom management and support services to terminally ill people and their families.
**Hospital:** a Medicare-certified institution licensed by the state that provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term hospital does not include a convalescent nursing home, rest facility or facility for the aged that furnishes primarily custodial care, including training in routines of daily living.

**Hospitalist:** a member of a growing medical specialty who has chosen a field of medicine that specifically focuses on the care of the hospitalized patient. Before selecting this new medical specialty, hospitalists complete education and training in internal medicine. As a key member of the health care team and an experienced medical professional, the hospitalist takes primary responsibility for inpatient care by working closely with the patient’s primary care physician during the member’s inpatient stay.

**Independent practice association:** a group of physicians that function as a contracting medical provider/group but in which the individual member physicians operate their respective independent medical offices.

**Medicaid:** the federal health insurance program established by Title XIX of the Social Security Act and administered by states for low-income individuals.

**Medically necessary:** medical services or hospital services determined by Amerigroup to be:
- Rendered for the diagnosis or treatment of an injury or illness
- Appropriate for the symptoms, consistent with diagnosis and otherwise in accordance with sufficient scientific evidence and professionally recognized standards
- Not furnished primarily for the convenience of the member, the attending provider or other provider of service

We make determinations of medical necessity based on peer-reviewed medical literature, publications, reports and evaluations; regulations and other types of policies issued by federal government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by Amerigroup. Section 1862(a)(1)(A) of the Social Security Act, states that Medicare payment can only be made for services/items that are medically necessary and reasonable.

**Medicare** — the federal health insurance program established by Title XVIII of the Social Security Act and administered by the federal government for elderly and disabled individuals.

**Medicare Part A:** Medicare Part A covers hospital insurance benefits, including inpatient hospital care, skilled nursing facility care, home health agency care and hospice care offered through Medicare.

**Medicare Part A premium:** Medicare Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the self-employment tax paid by self-employed persons. If members are entitled to benefits under either the Social Security or Railroad Retirement systems or worked long enough in federal, island or local government employment to be insured, they do not have to pay a monthly premium. If members do not qualify for premium-free Part A benefits, members may buy the coverage from Social Security if they are at least 65 years old and meet certain other requirements.
Medicare Part B: optional, supplemental medical insurance requiring a monthly premium. Medicare Part B covers physician (in both hospital and nonhospital settings) and certain nonphysician services. Other Part B services include lab testing, durable medical equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services and blood products not covered under Part A.

Medicare Part B premium: a monthly premium paid to Medicare (usually deducted from a member’s Social Security check) to cover Part B services. Members must continue to pay this premium to Medicare to receive covered services, whether members are covered by a Medicare Advantage plan or by original Medicare.

Medicare Part C: optional coverage that can be elected by the Medicare beneficiary. Coverage under Part C is provided by health maintenance organizations. The health maintenance organization must provide all Part A and B services in its plan and may offer additional benefits to the beneficiary.

Medicare Part D: the prescription drug coverage provided by a Medicare Advantage (MA) plan or by a stand-alone Prescription Drug Plan (PDP) contracted with CMS. The MA plan or PDP may charge the beneficiary premiums and cost sharing for this coverage. Amerigroup offers MA-PD plans in specific markets.

Medicare Advantage (MA) agreement: the agreement between Amerigroup and the Centers for Medicare & Medicaid Services (CMS) to provide Medicare Part C and other health plan services to Amerigroup members.

Medicare Advantage (MA) plan: a policy or benefit package offered by a Medicare Advantage Organization (MAO) in which a specific set of health benefits are offered at a uniform premium level of cost sharing to all Medicare beneficiaries residing in the corresponding service area. An MAO may offer more than one benefit plan in the same service area. The Amerivantage plan is a kind of MA plan.

Member: a Medicare beneficiary entitled to receive covered services who has voluntarily elected to enroll in the Amerivantage plan and whose enrollment has been confirmed by CMS.

Noncontracting medical provider or facility: any professional person, organization, health facility, hospital or other person or institution that is licensed and/or certified by the state and/or Medicare to deliver or furnish health care services; and that is neither employed, owned, operated by nor under contract with Amerigroup to deliver covered services to Medicare members.

Provider: any professional person, organization, health facility, hospital or other person or institution licensed and/or certified by the state and/or Medicare to deliver or furnish health care services. This individual or organization has a contract directly or indirectly with Amerigroup to provide services directly or indirectly to Medicare members pursuant to the terms of the participating provider agreement.

Provider liability appeal: a request for Amerigroup to review a decision by the Amerigroup Health Care Management department for services already rendered and denied without Medicare member liability.
Provider payment dispute: a request for Amerigroup to review the claim adjudication as the provider feels payment was not rendered as per the contractual agreement between Amerigroup and the provider.

Primary Care Provider (PCP): a provider physician selected by a member to coordinate the member’s health care. The PCP is responsible for providing covered services for Medicare members and coordinating referrals to specialists. PCPs usually practice internal medicine, family practice or general practice medicine.

Specified Low-income Medicare Beneficiary (SLMB) without other Medicaid (SLMB only): an individual who is entitled to Medicare Part A, has an income of greater than 100 percent of the Federal Poverty Level (FPL) but less than 120 percent of the FPL, and his or her resources do not exceed twice the limit for Supplement Security Income (SSI) eligibility and who is not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only.

Specified Low-income Medicare Beneficiary with full Medicaid (SLMB Plus): an individual who is entitled to Medicare Part A, has an income of greater than 100 percent of the FPL but less than 120 percent of the FPL, and his or her resources do not exceed twice the limit for SSI eligibility and who is eligible for full Medicaid benefits. Medicaid pays their Medicare Part B premiums and provides full Medicaid benefits.

Qualified Medicare Beneficiary (QMB): an individual who is entitled to Medicare Part A, has income that does not exceed 100 percent of the FPL and whose resources do not exceed twice the SSI limit. A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, coinsurance and copayments (except for Medicare Part D). Collectively these benefits (services) are called QMB Medicaid benefits (services). Categories of QMBs covered by this contract are as follows:

- QMB Only — QMB who is not otherwise eligible for full Medicaid
- QMB Plus — QMB who also meets the criteria for full Medicaid coverage and is entitled to all benefits (services) under the state plan for fully eligible Medicaid recipients

Service area: a geographic area approved by CMS within which an eligible individual may enroll in a Medicare Advantage plan. The geographic area for each Medicare Advantage plan is located in the Summary of Benefits document.

Special Needs Plan (SNP): a type of Medicare Advantage plan that also incorporates services designed for a certain class of members. In the case of the Amerigroup SNP, the special class of members is comprised of persons who are both Medicare and Medicaid eligible. Plans offering SNPs receive special approval from CMS. A SNP also provides Medicare Part D drug coverage.

Specialty + Rx Plan: the Amerigroup dual-eligible special needs plan available to full benefit dual-eligibles, Qualified Medicare Beneficiaries (QMB/QMB Plus), and Specified Low-Income Medicare Beneficiaries (SLMB Plus), depending on the state. Although this plan has cost sharing for certain services, cost sharing is paid by the state Medicaid agency or by Amerigroup through an arrangement with Medicaid. There are low copayments for Medicare Part D prescription coverage. This plan has no out-of-network benefits.
**Urgently needed services:** those covered services provided when the member is temporarily absent from the Medicare Advantage service area, or under unusual and extraordinary circumstances, services provided when the member is in the service area but the member’s PCP is temporarily unavailable or inaccessible, when such services are medically necessary and immediately required as a result of an unforeseen illness, injury or condition; and it is not reasonable given the circumstances to obtain the services through the PCP.

*In New Mexico, Amerigroup Community Care of New Mexico, Inc. In Texas, Amerigroup members in the Medicaid Rural Service Area are served by Amerigroup Insurance Company; all other Amerigroup members are served by Amerigroup Texas, Inc. In Washington, Amerigroup Washington, Inc.*

Amerivantage is a DSNP plan with a Medicare contract and a contract with the State Medicaid program. In New Mexico: Amerivantage is an HMO with a Medicare contract. Enrollment in Amerivantage depends on contract renewal.