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This manual is not wholly inclusive of all Amerigroup policies and procedures. For more information on Amerigroup policies and procedures, visit the provider self-service website at https://providers.amerigroup.com/DC or contact your Provider Relations representative.
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1 GENERAL INFORMATION ABOUT THE DISTRICT OF COLUMBIA HEALTHY FAMILIES PROGRAM, ALLIANCE AND THE IMMIGRANT CHILDREN’S PROGRAM

Introduction

Amerigroup District of Columbia, Inc. is one of the managed care organizations (MCOs) serving the eligible population enrolled in the District of Columbia Healthy Families Program (DCHFP) and individuals not eligible for Medicaid who receive health care services through the Alliance and the Immigrant Children’s Program (ICP).

Amerigroup District of Columbia, Inc., doing business as Amerigroup, is a wholly owned subsidiary of Amerigroup Partnership Holding Company, LLC.

The purpose of this provider manual is to highlight and explain the program’s elements and to serve as a useful reference for providers who participate in the DCHFP, Alliance and ICP programs.

DCHFP, Alliance and ICP Eligibility

Eligibility for coverage through DCHFP, Alliance and ICP is determined through the District of Columbia Economic Security Agency (ESA).
2 PRIMARY AND SPECIALTY CARE PROVIDERS

Role of the PCP

The primary care provider (PCP) is a board-certified or board-eligible network provider who is responsible for providing primary care or arranging for the complete care of his or her patients. PCPs may include the following specialties:

- General practitioners
- Family practitioners
- Internists
- Pediatricians
- Obstetricians/gynecologists (OB/GYNs) (for pregnant women only)
- Osteopaths
- Nurse practitioner
- FQHC/clinics
- Specialists designated as PCPs (with the approval of the Amerigroup)

Services Provided by the PCP

The PCP manages or arranges for all the health care needs of Amerigroup members who select him or her as their PCP. Each PCP must regularly provide a minimum of 20 hours per week of personal availability. In this capacity as a designated PCP, all baseline physical, emergency, urgent, routine and follow-up care within the PCP’s scope of medical training and practice are provided. In addition to managing all services for office care, referrals to specialists (both network and non-network), coordination of hospital admissions and maintenance of the member’s complete medical record, PCPs are responsible for providing a wide range of services generally accepted in the community as primary care, including screening and referral as needed for behavioral health and substance abuse services. This also includes the responsibility to educate members about the appropriate use of emergency services.

PCPs must make their best effort to contact each new member to schedule an appointment for a baseline physical that is age- and gender-specific.

PCPs are also required to provide members with telephone access 24 hours a day, 7 days a week. The telephone service may be answered by a designee such as an on-call physician or a nurse practitioner with physician backup. All automated after-hours messages must offer the option to either speak to a live party or respond to patient inquiries within 30 minutes.

Arrangements for coverage while off-duty or on vacation are to be made with other network PCPs. Covering PCPs must be able to provide medically necessary services and follow Amerigroup referral and precertification guidelines. It is not acceptable to automatically direct the member to the emergency room when the PCP is not available.
Procedures for Becoming a PCP
See the Provider Credentialing section for more information.

Assignment and Reassignment of a Member

In-network PCPs receive a monthly panel listing identifying all Amerigroup members assigned to them.

The Provider Inquiry Line is available 24 hours a day, 7 days a week at 1-800-454-3730. This is an automated telephone tool that enables providers to verify member eligibility, precertification and claims status. Providers can also log in to the self-service website at https://providers.amerigroup.com/DC to verify member eligibility or call a Provider Services representative at 1-800-454-3730 to answer eligibility questions.

Procedure for Selecting a PCP

Members have the right to select their PCP as well as a primary dental provider. Upon enrollment, the member may select a PCP from the directory or call Member Services at 1-800-600-4441 for help to select a new provider. The member may consider the provider’s specialty, accessibility, gender, ethnic background and languages spoken in the selection process. The member handbook includes a description of how to choose a PCP.

Amerigroup issues a member ID card printed with the PCP’s name and telephone number.

Default Assignment of a PCP

The Amerigroup provider network will be submitted to the Member Services department to assist new members in selecting a PCP. Members who do not select a PCP will be assigned to one using the enrollment information provided (e.g., geographic proximity to the provider, age and language).

Procedure for Changing PCPs and Other Providers

Members have the right to change their PCPs at any time. The member may select a PCP from the directory or call Member Services at 1-800-600-4441 for help to change his or her PCP. The member handbook includes a description of how to change a PCP. PCP change requests will be processed generally on the same day or by the next business day. Within 10 days, the member will receive a new ID card that displays the new PCP name and phone number.

Anti-Gag Provisions

If the provider is acting within the lawful scope of practice, Amerigroup will not prohibit a provider from advising a member about his or her health status, medical care, or treatment for the member’s condition or disease regardless of whether benefits for such care or treatment
options are provided by Amerigroup. Amerigroup will not retaliate or take action against a provider for advising the member under these circumstances.

**Specialty Care Providers — Role and Responsibility of the Specialist**

Obligations of the specialist also include the following:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program
- Meeting eligibility requirements to participate in the Medicaid program
- Accepting all members referred to him or her if the referrals are within the scope of the specialist’s practice
- Submitting required claims information
- Arranging for coverage with other network providers while off-duty or on vacation
- Verifying member eligibility and precertification of services (when required) at each visit
- Providing consultation summaries or appropriate periodic progress notes to the member’s PCP on a timely basis following a referral or routinely scheduled consultative visit
- Notifying both the PCP and Amerigroup, as well as requesting precertification from Amerigroup as appropriate, when scheduling a hospital admission or any other procedure requiring Amerigroup approval

**Provider Credentialing**

Credentialing is the process performed by Amerigroup to verify and confirm that each applicant within the scope of credentialing meets the established criteria and qualifications for consideration to join an Amerigroup network. Initial credentialing is performed when an application is received and recredentialing is conducted at least every three years thereafter or as otherwise required by District regulations and at the discretion of the Amerigroup.

During recredentialing, each provider must show evidence of continuance of satisfying the requirements and must have satisfactory results relative to the Amerigroup measures for quality health care and service.

Amerigroup requires all practitioners to maintain current knowledge, ability and expertise in their practice area(s) by requiring them, at a minimum, to obtain continuing medical education (CME) credits or continuing education units (CEUs) and participate in other training opportunities as appropriate.

Amerigroup established a Credentialing Committee for the formal determination of recommendations regarding credentialing decisions. The Credentialing Committee makes decisions regarding participation of initial applicants and their continued participation at the time of recredentialing. Amerigroup will accept and acknowledge Department of Behavioral Health as the Credentials Verification Organization (CVO) for mental health providers already
certified by DBH. The providers shall not be subject to additional credentialing requirements.

**Credentialing Scope**

**Practitioner types:** Amerigroup credentials the following types of contracted health care practitioners when an independent relationship exists between Amerigroup and the practitioner, or the individual practitioner is listed individually in Amerigroup’s provider network directory. See exclusions below.

- Medical doctors (MD) and doctors of osteopathic medicine (DO)
- Doctors of podiatry (DPM)
- Chiropractors (DC)
- Optometrists (OD) providing services covered under the medical benefits plan
- Oral and maxillofacial surgeons (DMD/DDS)
- Psychologists (PhD/PsyD) who are certified or licensed by the District and have doctoral or master’s level training
- Clinical social workers (LSCW/CSW) who are certified or licensed by the District and have master’s level training
- Psychiatric nurse practitioners (PNP) who are certified or licensed nationally or by the District or behavioral nurse specialists with master’s level training
- Other behavioral health care specialists who are licensed, certified or registered by the District to practice independently
- Telemedicine practitioners who have an independent relationship with the Amerigroup and who provide treatment services under the Amerigroup’s medical benefit
- Medical therapists: physical therapists (PT), speech therapists (ST) and occupational therapists (OT)
- Licensed genetic counselors (LGC) who are licensed by the District to practice independently
- Audiologists (AUD) who are licensed by the District to practice independently
- Acupuncturists (non-MD/DO) who are licensed, certified or registered by the District to practice independently
- Nurse practitioners (NP), certified nurse midwives (CMW) and physician assistants (PA)
- Registered dieticians (RD)

Amerigroup has a contractual relationship with practitioners but **does not** require credentialing if the practitioner:

- Practices exclusively in an inpatient setting and provides care for Amerigroup members only because members are directed to the hospital or another inpatient setting; OR
- Practices exclusively in free-standing facilities and provides care for Amerigroup members only because members are directed to the facility.

Examples of this type of practitioner include but are not limited to:

- Pathologist
- Radiologists
• Anesthesiologists  
• Neonatologists  
• Emergency room physicians  
• Urgent care center physicians  
• Urgent care center mid-level providers (e.g., nurse practitioners, physician assistants)  
• hospitalists  
• Pediatric intensive care specialists  
• Other intensive care specialists

Note: Any practitioner who is contracted and practices in the office setting must be credentialed if he/she is listed individually in Amerigroup’s provider network directory.

The following behavioral health practitioner types are only subject to a certification requirement process including verification of licensure by the applicable licensing board if applicable to independently provide behavioral health services:
• Certified behavioral analysts  
• Certified addiction counselors  
• Substance abuse practitioners

Healthcare delivery organizations (HDOs): Amerigroup credentials the following types of HDOs:
• Hospitals  
• Home health agencies  
• Skilled nursing facilities (nursing homes)  
• Ambulatory surgical centers  
• Behavioral health facilities providing mental health and/or substance abuse treatment in inpatient, residential or ambulatory settings:
  i. Adult family care/foster care homes  
  ii. Ambulatory detox  
  iii. Community mental health centers (CMHC)  
  iv. Crisis stabilization units  
  v. Intensive family intervention services  
  vi. Intensive outpatient — mental health and/or substance abuse  
  vii. Methadone maintenance clinics  
  viii. outpatient mental health clinics  
  ix. Outpatient substance abuse clinics  
  x. Partial hospitalization — mental health and/or substance abuse  
  xi. Residential treatment centers (RTC) — psychiatric and/or substance abuse  
• Birthing centers  
• Convenient care centers/retail health clinics/walk-in clinics  
• Intermediate care facilities  
• Urgent care centers  
• Federally qualified health centers (FQHC)  
• Home infusion therapy when not associated with another currently credentialed HDO
• Rural health clinics

The following HDOs are only subject to a certification requirement process:
• Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
• End-stage renal disease (ESRD) service providers (dialysis facilities)
• Portable X-ray suppliers
• Home infusion therapy when associated with another currently credentialed HDO

Credentialing Application Process

Each practitioner and HDO within the scope of credentialing must complete a credentialing application deemed acceptable by Amerigroup (e.g., CAQH, Amerigroup or District) upon request by Amerigroup. Each provider must comply with other such credentialing criteria as may be established by Amerigroup.

Each provider must agree to submit for verification all requested information necessary to be credentialed or recredentialed to provide services in accordance with the standards established by Amerigroup. Each provider shall cooperate with Amerigroup as necessary to conduct credentialing and recredentialing pursuant to Amerigroup policies, procedures and rules.

The credentialing application contains the practitioner’s or the HDO authorized representative’s signature that serves as an attestation of the credentials summarized in and included with the application. The practitioner’s or the HDO authorized representative’s signature also serves as a release of information to verify credentials externally. Amerigroup is responsible for externally verifying specific items attested to on the application. Any discrepancies between information included with the application and information obtained by Amerigroup during the external verification process will be investigated and documented and may be grounds for refusal of acceptance into the network or termination of an existing provider relationship. The signed agreement also documents the provider’s agreement to comply with the Amerigroup managed care policies and procedures.

Each provider has the right to inquire about the status of his/her application. Provider Relations can be contacted via telephone: 1-800-454-3730, fax: 1-888-748-1817, or in writing:

Credentialing
Amerigroup District of Columbia, Inc.
P.O. Box 62509
Virginia Beach, VA 23466-2509

As an applicant for participation with Amerigroup, each provider has the right to review information obtained from primary verification sources during the credentialing process to the extent permitted by law. The provider will be notified if information obtained in support of the assessment or reassessment process varies substantially from the information submitted by the provider. Upon notification from Amerigroup, the provider has the right to explain information
obtained that varies substantially from that provided and to make corrections to any erroneous information submitted by another party. The provider must submit a written explanation or appear before the Credentialing Committee if deemed necessary.

The decision to approve initial or continued participation or to terminate a provider’s participation will be communicated in writing within 60 days of the Credentialing Committee’s decision. In the event the provider’s participation or continued participation is denied, the provider will be notified in writing. If continued participation is denied, the provider will be allowed 30 days to appeal the decision.

**Credentialing Eligibility Criteria**

Each provider must remain in full compliance with the Amerigroup credentialing criteria as set forth in its credentialing policies, procedures, and all applicable laws and regulations.

Each **practitioner** within the scope of the Amerigroup Credentialing Program applying for participation in the Amerigroup programs or provider network(s) shall meet the following criteria in order to be considered for participation. Applicants who do not meet the criteria below will be notified of the failure to meet criteria.

- Must not be currently sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or the Federal Employees Health Benefits Program (FEHBP).
- Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state/District(s) where he/she provides services to Amerigroup’s members.
- Possess a current, valid, and unrestricted DEA or CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Amerigroup’s members. The DEA/CDS* must be valid in the state/District(s) in which the practitioner will be seeing Amerigroup’s members.
- Application and supporting documentation must not contain any omissions or falsifications, (including any additional information requested by Amerigroup), or in the presence of omission or falsifications must not raise a reasonable suspicion of future substandard professional conduct and/or competence.
- Education, training and certification must meet criteria for the specialty in which the applicant will treat Amerigroup’s members.
- For MDs and DOs, current, in force board certification as defined by one of the following: ABMS, AOA, Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada in the clinical discipline for which they are applying.**
- For DPMs, the applicant must be certified by either the American Board of Podiatric Medicine or the American Board of Foot and Ankle Surgery.**
- For DMDs and DDSs practicing oral and maxillofacial surgery, the applicant must be certified by the American Board of Oral and Maxillofacial Surgery.**
- For NPs, CNMs and PAs, current, in force board certification in the area which reflects their scope of practice by any one of the following: the American Nurse Credentialing...
Center (ANCC), American Academy of Nurse Practitioners (AANP), National Certification Corporation (ONCC), Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner or Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) only.

- For PhDs or PsyDs practicing clinical neuropsychology, current, inforce board certification by either the American Board of Professional Neuropsychology (ABN) or American Board of Clinical Neuropsychology (ABCN).**

- For MDs and DOs, the applicant must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Some clinical disciplines may function exclusively in the outpatient setting, and the Credentialing Committee may at its discretion deem hospital privileges not relevant to these specialties.

- Site visit and medical record review results, if applicable, must meet Amerigroup standards, or in the absence of meeting such standards must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

- Complaints from members and/or other providers must be at levels deemed acceptable to Amerigroup, or if such complaints exist and/or exceed such levels must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

- Explanations for gaps in work history must be documented and meet Amerigroup standards, or in the presence of gaps that exceed such standards must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

- History of professional liability suits, arbitrations or settlements must be within established Amerigroup standards, or in the presence of suits exceeding such standards must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

- Performance indicators obtained during the credentialing, recredentialing or ongoing monitoring process that meet Amerigroup standards, or if not meeting such standards, must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

- No physical or mental impairment, (including chemical dependency and substance abuse), that would affect the health care practitioner’s ability to practice within the scope of his or her license or pose a risk or imminent harm to members. In the presence of a history of physical or mental impairment, the nature of the impairment and other information obtained during the credentialing, recredentialing or ongoing monitoring process must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

- No history of disciplinary actions or sanctions against the applicant’s license, DEA and/or CDS registration or any actions or sanctions of such nature as to raise a reasonable suspicion of future substandard professional conduct and/or competence. Determination will be based upon the nature of the disciplinary action or sanction and
other information obtained during the credentialing, recredentialing and ongoing monitoring process.

- No history of disciplinary actions, sanctions, or revocations of privileges taken by hospitals and other health care facilities or entities, HMOs, PPOs, PHOs, etc. or, in the presence of such actions or sanctions, nothing in the nature of those to raise a reasonable suspicion of future substandard professional conduct and/or competence. Determination will be based upon the nature of the disciplinary action or sanction and other information obtained during the credentialing, recredentialing or ongoing monitoring process.

- No open indictments or convictions, or pleadings of guilty or no contest to, a felony, and any open indictments or convictions to any offense involving moral turpitude, or fraud, or any other similar offense.

- No other significant information, such as information related to boundary issues or sexual impropriety or illegal drug use which might indicate a reasonable suspicion of future substandard professional conduct and/or competence.

* If the applicant can provide evidence that he has applied for a DEA/CDS, the credentialing process may proceed if all of the following are met:
  1. It can be verified that the applicant’s application is pending.
  2. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA/CDS registration is obtained.
  3. The applicant agrees to notify Amerigroup upon receipt of the required DEA/CDS.
  4. Amerigroup will verify the appropriate DEA/CDS via standard sources.
  5. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-day time frame.

** Amerigroup reserves the right, in its reasonable discretion, to waive the board certification requirement when Amerigroup determines: (1) That there are extenuating or special circumstances that warrant the waiver of such requirement and (2) The Credentialing Committee determines that there is no reasonable suspicion of future substandard professional conduct and/or competence.

In addition to the minimum criteria listed, Amerigroup may take other information into consideration when determining credentialing/network participation status. All providers are subject to the satisfaction and maintenance, in Amerigroup’s sole judgment of all credentialing standards adopted by Amerigroup.

Each health delivery organization (HDO) within the scope of the Amerigroup Credentialing Program applying for participation in Amerigroup programs or provider network(s) shall meet the following criteria in order to be considered for participation. Applicants that do not meet the criteria will be notified of the failure to meet criteria.

- Possess a current, valid, unencumbered, unrestricted and nonprobationary professional license in the state/District(s) where it provides services to the Amerigroup’s members, if such license is applicable.
• Must not be currently sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or the Federal Employees Health Benefits Program (FEHB).
• Must be in good standing with any other applicable District or federal regulatory body as defined in Credentialing Policy.
• Application and supporting documentation must not contain any material omissions or falsifications including any additional information requested by the Amerigroup.
• Complaints received from members and/or other providers may be reviewed for compliance with Amerigroup standards.
• Performance indicators obtained during the credentialing, recredentialing or ongoing monitoring process, if applicable, must meet Amerigroup standards.
• No indictments or convictions, or pleadings of guilty or no contest to, a felony or any offense involving fraud, criminal activities, abuse or neglect nor evidence of such conviction or pleadings by the principals of the facility.
• Any history of disciplinary actions or investigations including termination, warnings, or notices of potential poor performance related to the HDO’s license or accreditation must be reviewed and must not raise reasonable suspicion of future substandard performance or harm to members. Determination will be based upon the nature of the disciplinary action or sanction and other information obtained during the credentialing, recredentialing or sanction monitoring process.
• Acceptable accreditation from a recognized entity exists.

In addition to the minimum criteria listed, Amerigroup may take other information into consideration when determining credentialing/network participation status. All providers are subject to the satisfaction and maintenance, in Amerigroup’s sole judgment of all credentialing standards adopted by Amerigroup.

Each provider agrees to submit for verification all requested information necessary to credential or recredential physicians providing services in accordance with the standards established by Amerigroup. Each provider will cooperate with Amerigroup as necessary to conduct credentialing and recredentialing pursuant to Amerigroup policies, procedures and rules. At the request of Amerigroup, the provider will authorize and release to Amerigroup any and all information compiled, maintained or otherwise assembled by a network hospital for the credentialing or recredentialing of the provider by Amerigroup.

Credentialing Requirements

Each provider, applicable ancillary/facility and hospital must remain in full compliance with Amerigroup credentialing criteria as set forth in its credentialing policies, procedures and all applicable laws and regulations. Each provider, applicable ancillary/facility and hospital must complete the Amerigroup application form upon request by Amerigroup. Each provider must comply with other such credentialing criteria as may be established by Amerigroup.
Credentialing Procedures

Amerigroup is committed to operating an effective, high-quality credentialing program. Amerigroup credential the following provider types: medical doctors, doctors of osteopathy, doctors of podiatric medicine, doctors of chiropractic medicine, physician assistants, nurse practitioners, certified nurse midwives, physical/occupational therapists, speech/language therapists, hospitals and allied services (ancillary) providers, unless network need is adequately filled.

During recredentialing, each provider must show evidence of satisfying these policy requirements and must have satisfactory results relative to the Amerigroup measures for quality health care and service.

Amerigroup established a credentialing committee and a medical advisory committee for the formal determination of recommendations regarding credentialing decisions. The credentialing committee makes decisions regarding participation of initial applicants and their continued participation at the time of recredentialing. The oversight rests with the medical advisory committee.

The Amerigroup credentialing policy is periodically revised based on input from several sources, including but not limited to the credentialing committee, the medical director and the Amerigroup Chief Medical Officer. District and federal requirements are also incorporated into the credentialing policy. The policy will be reviewed and approved as needed but will be reviewed and approved at least annually.

The provider application contains the provider’s actual signature that serves as an attestation of the credentials summarized on and included with the application. The provider’s signature also serves as a release of information to verify credentials externally. Amerigroup is responsible for externally verifying specific items attested to on the application. Any discrepancies between information included with the application and information obtained by Amerigroup during the external verification process will be investigated and documented and may be grounds for refusal of acceptance into the network or termination of an existing provider relationship. The signed agreement also documents the provider’s agreement to comply with the Amerigroup managed care policies and procedures.

Each provider has the right to inquire about the status of his or her application. He or she may do so via telephone, fax, contact with the Provider Relations representative or in writing to:

Credentialing
Amerigroup District of Columbia, Inc.
P.O. Box 62509
Virginia Beach, VA 23466-2509

As an applicant for participation with Amerigroup, each provider has the right to review information obtained from primary verification sources during the credentialing process. Each
provider has the right to receive the status of their credentialing or recredentialing application upon request. Upon notification from Amerigroup, the provider has the right to explain information obtained that varies substantially from that provided and to make corrections to any erroneous information submitted by another party. The provider must submit a written explanation or appear before the credentialing committee if deemed necessary.

To the extent allowed under applicable law, District agency requirements, and per National Committee for Quality Assurance (NCQA) standards and guidelines, the medical director has the authority to approve clean files without input from the credentialing committee. All files not designated as clean will be presented to the credentialing committee for review and decision regarding participation. The following verifications are completed in addition to the application and Participating Provider Agreement as applicable prior to final submission of a provider file to the health plan medical director and/or credentialing committee:

1. Verification of provider enrollment is performed. If group enrollment applies, verification that the provider is linked appropriately to the group and is enrolled at the appropriate service locations will occur.

2. Board certification is verified by referencing the American Medical Association (AMA) provider profile, the American Osteopathic Association (AOA), the American Board of Medical Specialties (ABMS), the American Board of Podiatric Medicine (ABPM) or the American Board of Foot and Ankle Surgery (ABFAS), the American Board of Oral and Maxillofacial Surgery, the American Nurse Credentialing Center (ANCC), American Academy of Nurse Practitioners (AANP), National Certification or Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner, or Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®).

3. Education and training are verified by referencing board certification or the appropriate District licensing agency.

4. The provider must submit a curriculum vitae documenting his or her work history for the past five years. Gaps in work history greater than six months in length must be explained in writing and brought to the attention of the medical director and credentialing committee.

5. Hospital admitting privileges or comprehensive admission plans in good standing are verified for the provider as applicable. This information is obtained on the application, in the form of a written letter from the hospital, in roster format (for multiple providers), by internet access or by telephone contact. The date and name of the person spoken to at the hospital are also documented. To the extent allowed under applicable law or District agency requirements, verification of clinical privileges in good standing at an Amerigroup network hospital may be accomplished by use of an attestation signed by the provider.

6. License information is verified to ensure the provider maintains a current medical license to practice in said state/District. This information can be verified by referencing data provided to Amerigroup by the state/District via roster, telephone or the Internet.

7. The Drug Enforcement Administration (DEA) number is verified, as applicable, to ensure the provider is current and eligible to prescribe controlled substances. This information
is verified by obtaining a copy of the DEA certificate or by referencing the National Technical Information Service data. If the provider is not required to possess a DEA certificate but does hold a controlled substance certificate, the Controlled Dangerous Substance (CDS) certificate is verified to ensure the provider is current and eligible to prescribe controlled substances. This information is verified by obtaining a copy of the CDS certificate or by referencing CDS online data if applicable.

8. Provider malpractice insurance information is verified by obtaining a copy of the malpractice insurance face sheet from each provider or the malpractice insurance carrier or by attestation of coverage on the provider’s application to the extent the use of the attestation of coverage is allowed under applicable law or District agency requirements. Providers are required to maintain malpractice insurance in specified amounts as outlined in the Participating Provider Agreement.

9. Where applicable, an applicant’s history of malpractice claims is reviewed by the credentialing committee to determine whether acceptable risk exposure exists. The review is based on information provided and attested to by the applicant and information available from the National Practitioner’s Data Bank (NPDB). The credentialing committee’s policy is designed to give careful consideration to the medical facts of the specific cases, the total number and frequency of claims in the past five years, and the amounts of settlements and/or judgments.

10. Amerigroup will also verify the provider’s record is clear of any sanctions by Medicare or Medicaid. This information is verified by accessing the NPDB.

11. The Amerigroup Provider Application requires responses to the following issues:
   a. Reasons for the inability to perform the essential functions of the position with or without accommodation
   b. Any history or current problems with chemical dependency, alcohol or substance abuse
   c. History of license revocation, suspension, voluntary relinquishment, probationary status, or other licensure conditions or limitations
   d. History of conviction for criminal offenses other than minor traffic violations
   e. History of loss or limitation of privileges or disciplinary activity to include denial, suspension, limitation, termination or nonrenewal of professional privileges
   f. History of complaints or adverse action reports filed with a local, District, or national professional society or licensing board
   g. History of refusal or cancellation of professional liability insurance
   h. History of suspension or revocation of a DEA or CDS certificate
   i. History of Medicare and/or Medicaid sanctions
   j. Attestation by the applicant of the correctness and completeness of the application

Note: Identified issues must be explained in writing. These explanations are presented with the provider’s application to the credentialing committee.

12. The NPDB is queried against the list of Amerigroup-contracted providers. The NPDB will provide a report for every provider queried. These reports are shared with the medical director and the credentialing committee for review and action as appropriate.
13. The Federation of State Medical Boards for Doctors of Medicine, Doctors of Osteopathy and Physician Assistants is queried to verify restrictions or sanctions made against the provider’s license. The appropriate licensing agency is queried for all other providers. All sanctions are fully investigated and documented, including the health plan’s decision to accept or deny the applicant’s participation in the network.

14. At the time of initial credentialing, an Amerigroup representative will complete a site visit for each new office location of PCPs and OB/GYNs. Identified problems will be noted for improvement.

15. At the time of recredentialing (every three years), information for PCPs from quality improvement activities and member complaints is presented for credentialing committee review.

The provider will be notified by telephone or in writing if information obtained in support of the assessment or reassessment process varies substantially from the information submitted by the provider. Providers have the right to review the information submitted in support of the credentialing and recredentialing process and to correct any errors in the documentation. This will be accomplished by submission of a written explanation or by appearance before the credentialing committee if so requested.

The decision to approve initial or continued participation or to terminate a provider’s participation will be communicated in writing within 60 days of the credentialing committee’s decision. In the event the provider’s participation or continued participation is denied, the provider will be notified by mail. If continued participation is denied, the provider will be allowed 30 days to appeal the decision. See the Amerigroup Provider Grievance Process.

**Credentialing Organizational Providers**

The provider application contains the signature of the provider’s authorized representative. This serves as an attestation that the health care facility agrees to the assessment requirements. Providers requiring assessments are as follows: hospitals, home health agencies, skilled nursing facilities, nursing homes, ambulatory surgical centers, and behavioral health facilities providing behavioral health or substance abuse services in an inpatient, residential or ambulatory setting. The authorized representative’s signature also serves as a release of information to verify credentials externally.

In addition to the application and Network Provider Agreement, the following steps are completed before approval for participation of a hospital or organizational provider: District of Columbia licensure is verified by obtaining a current copy of the license from the organization or by contacting the District licensing agency. Primary source verification is not required. Restrictions to a license are investigated and documented, including the decision to accept or deny the organization’s participation in the network.

Amerigroup contracts with facilities that meet the requirements of an unbiased and recognized authority. Hospitals (e.g., acute, transitional or rehabilitation facilities) should be accredited by the Joint Commission (TJC), the Healthcare Facilities Accreditation Program or the American
Osteopathic Association. The Commission on Accreditation of Rehabilitation Facilities may accredit rehabilitation facilities. Home health agencies should be accredited by TJC or the Community Health Accreditation Program. Nursing homes should be accredited by TJC. TJC or the Accreditation Association for Ambulatory Health Care should accredit ambulatory surgical centers. If facilities, ancillaries or hospitals are not accredited, Amerigroup will accept a copy of the most recent District or Centers for Medicare & Medicaid Services (CMS) review in lieu of performing an onsite review. If accreditation or a copy of the most recent review is unavailable, an onsite review will be performed.

- A copy of the malpractice insurance face sheet is required. Organizations are required to maintain malpractice insurance in the amounts specified in the provider contract and according to Amerigroup policy.
- Amerigroup will track a facility or ancillary’s reassessment date and will reassess every 36 months as applicable using the same process as the initial assessment.

The decision to continue participation or to terminate an organization’s participation will be communicated in writing.

The organization will be notified either by telephone or in writing if information obtained in support of the assessment or reassessment process varies substantially from the information submitted by the organization.

Organizations have the right to review information submitted in support of the assessment process and to correct errors in the documentation. This will be accomplished by submission of a written explanation or by appearance before the credentialing committee if so requested. The organization is allowed 30 days to correct the information and request additional review of the corrected documentation.

**Provider Notification to Amerigroup**

The provider must notify Amerigroup in writing within five days, unless otherwise stated below, following the occurrence of any of the following events:

- The provider’s license to practice in any state/District is suspended, surrendered, revoked, terminated, or subject to terms of probation or other restrictions. Notification of any such action must be furnished in writing to Amerigroup immediately.
- The provider (i) learns that he or she has become a defendant in any malpractice action relating to a member who also names Amerigroup as a defendant or receives any pleading, notice or demand of claim or service of process relating to such a suit or (ii) is required to pay damages in any such action by way of judgment or settlement. Notification must be furnished in writing to Amerigroup immediately.
- The provider is disciplined by a District board of medicine or a similar agency.
- The provider is sanctioned by or debarred from participation with Medicare or Medicaid.
• The provider is convicted of a felony relating directly or indirectly to the practice of medicine. Notification must be furnished in writing to Amerigroup immediately.
• There is a change in the provider’s business address or telephone number.
• The provider becomes incapacitated in such a way that the incapacity may interfere with patient care for 21 consecutive days or more.
• There is any change in the nature or extent of services rendered by the provider.
• There is any material change or addition to the information and disclosures submitted by the provider as part of the application for participation with Amerigroup.
• The provider’s professional liability insurance coverage is reduced or canceled. Notification must be furnished in writing to Amerigroup no less than five days prior to such a change.
• There is any other act, event, occurrence or the like that materially affects the provider’s ability to carry out his or her duties under the Participating Provider Agreement.
• The provider’s member panel is reaching capacity according to the established capacity standards set in the Standards and Measures for Appropriate Availability to Provider – DC Policy. At least 30 days’ advance notice must be given.
• There is any change to hours of operation or staffing levels.
• There is an inability to meet timely access to care and services according to the established appointment access standards set in the Appointment Guidelines – DC Policy.

The occurrence of one or more of the events listed above may result in the termination of the Participating Provider Agreement for cause or other remedial action as Amerigroup in its sole discretion deems appropriate.

Should a provider be terminated from the network or otherwise not approved for participation through the recredentialing process, the provider has the right to appeal the Amerigroup decision consistent with the Amerigroup credentialing policies and procedures.

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.
• To review and make recommendations regarding individual provider peer review cases.
• To work in accordance with the medical director.

Should investigation of a member grievance result in concern regarding a provider’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
provider actions by or at the discretion of the medical director. The medical director takes action based on the quality issue or the level of severity, invites the cooperation of the provider, and consults with and informs the medical advisory committee and peer review committee as appropriate. The peer review process is a major component of the medical advisory committee’s monthly agenda.

The Amerigroup Quality Management Program includes review of quality of care issues identified for all care settings. Member complaints, adverse events and other information are used to evaluate the quality of care and service provided. If a quality issue should result in concern regarding a physician’s compliance with standards of care or service, all elements of peer review will be followed. The peer review process provides a systematic approach for monitoring the quality and appropriateness of care. The peer review committee will review cases and recommend disciplinary actions to be taken which may include remedial steps up to and including freeze of panel and/or provider termination. The medical director will inform the provider of the peer review committee’s recommendations and follow up. Provider participation is encouraged. Outcomes are reported to the appropriate internal and external entities, Quality Management and the medical advisory committee.

The quality of care and peer review policies are available upon request.

**Amerigroup Provider Reimbursement**

Reimbursement policies serve as a guide to assist you with accurate claims submissions and to outline the basis for reimbursements when services are covered by the member’s Amerigroup plan. Services must meet authorization and medical necessity guidelines appropriate to the procedures and diagnoses, and members’ state/District of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines, including using industry standard compliant codes on all claims submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes which indicate 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, Amerigroup policies apply to both participating and nonparticipating providers and facilities.

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

Amerigroup reviews and revises policies when necessary. The most current policies are available on the provider self-service website at [https://providers.amerigroup.com](https://providers.amerigroup.com).
Review Schedule and Updates

Reimbursement policies undergo review for updates to District contracts, or District, federal or CMS requirements. Updates are also made any time Amerigroup is notified of a mandated change or an Amerigroup business decision requires a change. Updates are posted on the provider self-service website.

Claim Submission

Clearinghouse Submissions

Providers can submit electronic claims to Amerigroup through Electronic Data Interchange (EDI).

To initiate the electronic claims submission process or obtain additional information, please visit the EDI area of the public provider website, which includes registration forms and contact information.

Web-based Claims Submissions

Participating providers have the option to use HIPAA-compliant web claim submission capabilities by registering at https://www.availity.com.

For any questions, please contact Availity Client Services at 1-800-AVAILITY (1-800-282-4548).

Paper Claims Submission

Submit claims on original claim forms (CMS-1500 or CMS-1450) printed with dropout red ink or typed (not handwritten) in large, dark font. AMA- and CMS-approved modifiers must be used appropriately based on the type of service and procedure code. Mail forms to:

  Claims
  Amerigroup District of Columbia, Inc.
  P.O. Box 61010
  Virginia Beach, VA 23466-1010

CMS-1500 and CMS-1450/UB-04 forms are available at www.cms.hhs.gov.

Encounter Data

Providers must submit encounter data within the timely filing periods outlined in the Claims Adjudication section of this manual through EDI submission methods or CMS-1500 (08-05) or 1450/UB-04 claim forms. Include the following information in submissions:

- Member name (first and last name)
- Member ID
- 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 (using current procedure codes and modifiers if applicable)
• Provider tax ID number
• NPI/API number

Amerigroup will not reimburse providers for items received free of charge or items given to members free of charge.

Providers must use HIPAA-compliant billing codes when billing or submitting encounter data. This applies to both electronic and paper claims. When billing codes are updated, providers are required to use appropriate replacement codes for submitted claims or covered services.

Providing after-hours care in an office setting helps reduce inappropriate emergency room use and encourages members to receive appropriate follow-up care. To promote greater access for members, Amerigroup provides additional reimbursement to PCPs who provide after-hours care. Additionally, Amerigroup encourages PCPs to provide efficient quality care in an office setting and will reimburse wellness visits and sick visits billed on the same day. For more information, visit the provider self-service website at https://providers.amerigroup.com/DC.

Claims Adjudication
Amerigroup is dedicated to providing timely adjudication of claims. Amerigroup processes all claims according to generally accepted claims coding and payment guidelines defined by the CPT-4 and ICD-10 manuals. Providers must use HIPAA-compliant billing codes when billing by paper or electronically. When billing codes are updated, providers are required to use appropriate replacement codes for submitted claims. Amerigroup will reject claims submitted with noncompliant billing codes. Amerigroup uses code-editing software to determine which services are considered part of, incidental to, or inclusive of the primary procedure.

Timely Filing
Paper and electronic claims must be filed within 365 calendar days. Timely filing periods begin from the date of discharge for inpatient services and from date of service for outpatient/physician services. Secondary and tertiary claims submitted for payment must be submitted within 180 days from the payment date from Medicare or the third party payer. Timely filing requirements are defined in the provider agreement. Amerigroup will deny claims submitted after the filing deadline.

Documentation of Timely Claim Receipt
Claims will be considered timely if submitted:
• By United States mail first class, return receipt requested or by overnight delivery service; you must provide a copy of the claim log that identifies each claim included in the submission
• Electronically; you must provide the clearinghouse-assigned receipt date from the reconciliation reports
• By hand delivery; you must provide a claim log identifying each claim included in the delivery and a copy of the signed receipt acknowledging the hand delivery

The claims log maintained by providers must include the following information:
• Name of claimant
• Address of claimant
• Telephone number of claimant
• Claimant’s federal tax identification number
• Name of addressee
• Name of carrier
• Designated address
• Date of mailing or hand delivery
• Subscriber name
• Subscriber ID number
• Patient name
• Date(s) of service/occurrence
• Total charge
• Delivery method

**Good Cause**

If a claim or claim dispute was filed untimely, you have the right to include an explanation and/or evidence explaining the reason for delayed submission. Amerigroup will contact you for clarification or additional information necessary to make a good cause determination.

Good cause may be found when a physician or supplier claim filing is delayed due to:
• Administrative error due to incorrect or incomplete information furnished by official sources (e.g., carrier, intermediary, CMS) to the physician or supplier.
• Incorrect information furnished by the member to the physician or supplier resulting in erroneous filing with another care management organization plan or with the District.
• Unavoidable delay in securing required supporting claim documentation or evidence from one or more third parties despite reasonable efforts by the physician/supplier to secure such documentation or evidence.
• Unusual, unavoidable or other circumstances beyond the service provider’s control that demonstrate the physician or supplier could not reasonably be expected to file timely.
• Destruction or other damage of the physician’s or supplier’s records, unless such destruction or other damage was caused by the physician’s or supplier’s willful act of negligence.
Coordination of Benefits
Amerigroup follows District-specific guidelines and all federal regulations when coordination of benefits is necessary with other health insurance (OHI), third party liability (TPL), medical subrogation or estate recovery. Amerigroup uses covered medical and hospital services whenever available or other public or private sources of payment for services rendered to members.

OHI and TPL refer to any individual, entity or program that may be liable for all or part of a member’s health coverage. The District is required to take all reasonable measures to identify legally liable third parties and treat verified OHI and TPL as a resource of each plan member.

Amerigroup takes responsibility for identifying and pursuing OHI and TPL for members and puts forth best efforts to identify and coordinate with all third parties against whom members may have claims for payments or reimbursements for services. These third parties may include Medicare or any other group insurance, trustee, union, welfare, employer organization or employee benefit organization, including preferred provider organizations or similar type organizations, any coverage under governmental programs, and any coverage required to be provided for by District law.

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

Pay-and-chase circumstances include:
- When the services are for preventive pediatric care (EPSDT)
- If the claim is for prenatal or postpartum care or if service is related to OB care

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

For questions regarding paid, denied or pended claims, call Provider Services at 1-800-454-3730.

Emergency Services and Self-Referrals

Emergency Room Medical Record Review
All emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions while the patient is part of the PCP’s panel must be noted in the emergency room medical records.
Amerigroup is not responsible for the payment of any remaining days of a hospital admission that began prior to a Medicaid participant’s enrollment in Amerigroup. However, Amerigroup is responsible for reimbursement to providers for professional services rendered during the remaining days of the admission.

In addition, providers must verify that members are assigned to Amerigroup. To validate member eligibility, call the Amerigroup Interactive Voice Response (IVR) system at 1-800-454-3730 or visit the provider self-service website at https://providers.amerigroup.com/DC.

Self-Referred and Emergency Services

Amerigroup will reimburse out-of-plan providers for the following services:

- Emergency services provided in a hospital emergency facility
- Family planning services (except for sterilizations)
- Services related to pregnancy when a member has begun receiving services from an out-of-plan provider prior to enrolling in Amerigroup
- Initial medical examination for children in District custody
- Annual diagnostic and evaluation services for members with Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS)
- Renal dialysis provided at a Medicare-certified facility
- The initial examination of a newborn by an on-call hospital physician when Amerigroup does not arrange for the service prior to the baby’s discharge
- Services performed at a birthing center including an out-of-District center located in a contiguous state

Alliance Coverage Exclusions

The following services are excluded for Alliance members:

- Screening and stabilization services for emergency medical conditions provided outside the District

Self-Referred Services for Children with Special Health Care Needs

Children with special health care needs may self-refer to providers outside the Amerigroup network under certain conditions. Self-referral for children with special needs is intended to ensure continuity of care and appropriate plans of care. Self-referral for children with special health care needs will depend on whether the condition that is the basis for the child’s special health care needs is diagnosed before or after the child’s initial enrollment in Amerigroup.
Medical services directly related to a special-needs child’s medical condition may be accessed out-of-network only if the following specific conditions are satisfied:

- **For a new member:** A child who at the time of initial enrollment was already receiving these services as part of a current plan of care may continue to receive these specialty services provided the pre-existing out-of-network provider submits the plan of care to Amerigroup for review and approval within 30 days of the child’s effective date of enrollment into Amerigroup, and Amerigroup approves the services as medically necessary.

- **For an established member:** A child who is already enrolled in Amerigroup when diagnosed as having a special health care need that requires a plan of care, including specific types of services, may request a specific out-of-network provider. Amerigroup is obligated to grant the member’s request unless a local, in-network specialty provider with the same professional training and expertise is reasonably available to provide the same services and service modalities.

If Amerigroup denies, reduces or terminates services, members have an appeal right regardless of whether they are a new or established member. Pending the outcome of an appeal, Amerigroup may reimburse for services provided.

**Specialty Referrals**

Amerigroup will maintain a complete network of adult and pediatric providers adequate to deliver the full scope of benefits covered by DCHFP, Alliance and ICP. If a specialty provider cannot be identified, please contact Amerigroup for assistance by calling 1-800-454-3730.

**PCP Contract Terminations**

If you are a PCP and your contract is terminated, members may change to another MCO because of, but not limited to, the following reasons:

- Available PCPs no longer accept new patients
- Enrollee’s desire to access a location comparable to terminated PCP
- Disruption in continuity of care

Members may contact Amerigroup Member Services to request an MCO change. Amerigroup will notify DHCF within five business days.

**Continuity of Care**

Amerigroup is responsible for providing ongoing treatment and patient care to new members until an initial evaluation is performed and until a new plan of care is developed.
The following steps are taken to ensure members continue to receive necessary health services at the time of enrollment into Amerigroup:

- Appropriate service referrals to specialty care providers will be provided in a timely manner.
- Authorization for ongoing specialty services will not be delayed while members await their initial PCP visit and comprehensive assessment. Services comparable to those the member was receiving upon enrollment into Amerigroup are to be continued during this transition period.
- If, after the member receives a comprehensive assessment, Amerigroup determines a reduction in or termination of services is warranted, Amerigroup will notify the member of this change at least 10 days before it is implemented. This notification will tell the member that he or she has the right to formally appeal to Amerigroup or to DCHFP by calling the District’s Enrollee Help Line at 1-800-620-7802 or Amerigroup. In addition, the notice will explain that if the member files an appeal within 10 days of notification and requests to continue receiving services, Amerigroup will continue to provide these services until the appeal is resolved. You will also receive a copy of this notification.
3 PROVIDER RESPONSIBILITIES

Reporting Communicable Disease

Amerigroup providers must comply with the District’s Communicable Disease Reporting requirements in accordance with the D.C. Code § 7-131, 132 (2006), Title 22 of the D.C. Code of Municipal Regulations, the District’s Childhood Lead Poisoning Screening and Reporting Legislative Review Act (2002) and D.C. Code § 7-871.3 (2006). Specific reporting requirements include but are not limited to:

- Children or adult members with vaccine-preventable diseases.
- Infants, toddlers and school-age children experiencing developmental delays, as evidenced by development assessments or interperiodic exams.
- Members with sexually transmitted and other communicable diseases including HIV.
- Members diagnosed with or suspected of being infected with tuberculosis (report must be made within 24 hours).
- Laboratories and/or provider must report results of all blood lead screening tests to the District of Columbia Department of Health Care Finance, District Department of Environment Division of Childhood Lead Prevention Program and Amerigroup within 72 hours.

Amerigroup providers must also comply with District requirements for reporting to registries and programs, include the Cancer Control Registry.

Health Promotion Programs

Amerigroup provides health promotion programs to encourage members to use health services appropriately and lead healthier lives. These programs include education about prenatal care, prevalent chronic conditions and preventive screenings. To assist your Amerigroup patients in accessing these programs, contact your Provider Relations representative or call Provider Services at 1-800-454-3730.

Appointment Scheduling And Outreach Requirements

To ensure Amerigroup members have every opportunity to access needed health-related services, PCPs must develop collaborative relationships with Amerigroup and community resources.

Contact your Provider Relations representative or call Provider Services at 1-800-454-3730 for information on how Amerigroup can help you bring your patients into care.

Prior to any appointment for an Amerigroup member, you must verify member eligibility and Amerigroup enrollment. This procedure will assist in ensuring payment for services. Eligibility can be verified through Amerigroup’s provider portal or by calling 1-800-454-3730.
The Centers for Medicare and Medicaid Services (CMS) prohibits providers from billing Medicaid participants whatsoever including for missed appointments.

**Initial Health Appointment for Amerigroup Members**

Amerigroup members 21 and over must be offered an initial appointment within 45 days of their date of enrollment with the PCP or within 30 days of request, whichever is sooner, unless one of the following exceptions applies:

- Appointments for initial EPSDT screens shall be offered to new enrollees within 60 days of the enrollee’s enrollment date with Amerigroup or at an earlier time if an earlier exam is needed to comply with the periodicity schedule or if the child’s case indicates a more rapid assessment or a request results from an emergency medical condition. The initial screen shall be completed within three months of the enrollee’s enrollment date with Amerigroup, unless Amerigroup determines that the new enrollee is up-to-date with the EPSDT periodicity schedule. To be considered timely, all EPSDT screens, laboratory tests and immunizations shall take place within 30 days of their scheduled due dates for children under the age of two and within 60 days of their due dates for children age two and older. Periodic EPSDT screening examinations shall take place within 30 days of a request.

- For pregnant and postpartum women who have not started to receive care, or individuals requesting family planning services, the initial health visit must be scheduled and occur within 10 calendar days of the date the member requests the appointment.

During the initial health visit, the PCP is responsible for documenting a complete medical history and performing and documenting results of an age-appropriate physical exam.

In addition, at the initial health visit, initial prenatal visit, or when physical status, behavior of the member or laboratory findings indicate substance use disorder, refer the member to the Department of Behavioral Health.

**Routine and Urgent Appointments for Amerigroup Members**

To ensure members receive care in a timely manner, PCPs and specialists must maintain the following appointment availability standards:

**Primary care practitioners**

<table>
<thead>
<tr>
<th>Type of visit</th>
<th>Availability standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency care (life threatening)</td>
<td>Immediately at the nearest facility</td>
</tr>
<tr>
<td>Urgent care visits</td>
<td>Within 24 hours of request</td>
</tr>
<tr>
<td>Urgent care with specialist</td>
<td>Within 48 hours of referral</td>
</tr>
<tr>
<td>Routine and preventive care visits</td>
<td>Within 30 days of request</td>
</tr>
<tr>
<td>Initial appointments for pregnant women or persons needing family planning</td>
<td>Within 10 days of request</td>
</tr>
</tbody>
</table>
### Behavioral health practitioners

<table>
<thead>
<tr>
<th>Type of visit</th>
<th>Availability standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency care (life threatening)</td>
<td>Immediately at nearest facility</td>
</tr>
<tr>
<td>Care for non-life threatening emergencies</td>
<td>Immediately at nearest facility</td>
</tr>
<tr>
<td>Urgent care/outpatient</td>
<td>Within 48 hours of request</td>
</tr>
<tr>
<td>Routine visit for routine care</td>
<td>Within 7 days of request</td>
</tr>
</tbody>
</table>

### Cultural Competency

Cultural competency is the integration of congruent behaviors, attitudes, structures, policies and procedures that come together in a system, agency or among professionals to enable effective work in cross-cultural situations. It is an awareness and appreciation of customs, values and beliefs and the ability to incorporate them into the assessment, treatment and interaction with any individual. Cultural competency assists you and members to:

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

The quality of the patient-provider interaction has a profound impact on the ability of a patient to communicate symptoms to you as his/her provider and to adhere to recommended treatment. Some of the reasons that justify your 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 underrepresented in the current service delivery system

Culture is the integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. Culture defines the preferred ways for meeting needs and may be influenced by factors such as geographic location, lifestyle and age. Cultural barriers between you and the member can impact the patient-provider relationship in many ways, including but not limited to:

- The member’s level of comfort with you and the member’s fear of what might be found upon examination
- The differences in understanding on the part of diverse consumers in the U.S. health care system
• A fear of rejection of personal health beliefs
• The member’s expectation of you and of the treatment

The Amerigroup Cultural Competency training program is available to all providers, regardless of participation status. This resource offers free tools designed to help promote health and health equity, and develop a more culturally competent practice. The online training also provides a link directly to the Think Cultural Health website, provided through the U.S. Department of Health and Human Services.

To be culturally competent, we expect you and all providers serving members within this geographic location to demonstrate the following:

Cultural Awareness
• The ability to recognize the cultural factors (norms, values, communication patterns, economic disparities and world views), which 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

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.
• 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.
• Economic disparities shape a member’s response to medical advice and attitudes about seeking help.
• Resources, such as formally trained interpreters fluent in communicating in the member’s primary non-English language, should be offered to and utilized by members with various cultural and ethnic differences; members/providers should call Amerigroup Member Services at 1-800-600-4441 at least 24 hours before their scheduled appointment and tell us they have a need for an interpreter.
• Interpreters who provide communication for deaf or hard-of-hearing members should be offered to and used by members who need these services; members should call the toll-free AT&T Relay Service at TTY 711 at least five days before the scheduled appointment, and we will set up and pay for the member to have a person who knows sign language help during the office visit.

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 others’ 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 process 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 utilize culturally appropriate community resources
The ability to know when and how to use interpreters and to understand the limitations of using family members or friends as interpreters
The ability to treat each person uniquely
The ability to recognize racial, ethnic and economic 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
Acceptance of ethnic differences among people and an understanding of how these differences affect the treatment process
A willingness to work with clients of various ethnic minority groups

Affirmative Statement
Amerigroup ensures utilization management decisions are fair, independent, and according to approved criteria and available benefits. Utilization management decisions are based only upon appropriateness of care and service and the existence of coverage. Amerigroup does not specifically reward providers or other individuals for issuing denials of coverage of care, and financial incentives for utilization management decision-makers do not encourage decisions that result in under-utilization.

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

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

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

- Through the OCR complaint portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington DC 20201
- By phone at: 1-800-368-1019 (TTY/TTD: 1-800-537-7697)

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

Amerigroup provides free tools and services to people with disabilities to communicate effectively. Amerigroup also provides a free language service to people whose primary language isn’t English (e.g., qualified interpreters and information written in other languages). These services can be obtained by calling the customer service number on their member ID card.

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

- Mail: 4433 Corporation Lane, Virginia Beach, VA 23462
- Phone: 757-473-2737, ext. 31028

**Equal Program Access on the Basis of Gender**

Amerigroup provides individuals with equal access to health programs and activities without discriminating on the basis of gender. Amerigroup must also treat individuals consistently with their gender identity, and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association with, a member of a protected class (i.e., race, color, national origin, gender, gender identity, age or disability).

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

Member Records

Amerigroup requires medical records to be maintained in a manner that is current, detailed and organized and permits effective and confidential patient care and quality review.

Providers are required to maintain medical records that conform to good professional medical practice and appropriate health management. A permanent medical record must be maintained at the primary care site for every member and be available to the PCP and other providers. Medical records must be kept in accordance with Amerigroup and District standards as outlined below.

Medical Record Standards

The records reflect all aspects of patient care, including ancillary services. Documentation of each visit must include:

1. Date of service
2. Purpose of visit
3. Diagnosis or medical impression
4. Objective finding
5. Assessment of patient’s findings
6. Plan of treatment, diagnostic tests, therapies and other prescribed regimens
7. Medications prescribed
8. Health education provided
9. Signature and title or initials of the provider rendering the service
   a. If more than one person documents in the medical record, there must be a record on file as to what signature is represented by which initials.

These standards shall, at a minimum, meet the following medical record requirements:

1. Patient identification information: Each page or electronic file in the record must contain the patient’s name or ID number.
2. Personal/biographical data: The record must include the patient’s age, gender, address, employer, home and work telephone numbers and marital status.
3. All entries must be dated and the author identified.
4. Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one provider reviewer.
5. Allergies: Medication allergies and adverse reactions must be prominently noted on the record. When clinically appropriate, the note of No Known Allergies (i.e., the absence of allergies) must be documented in an easily recognizable location.
6. Past medical history (for members seen three or more times): Past medical history must be easily identified, including serious accidents, operations and illnesses. For children, past medical history relates to prenatal care and birth.
7. **Immunizations:** For pediatric records of children age 13 and under, a completed immunization record or a notation of prior immunization must be recorded, including vaccines and dates given when possible.

8. **Diagnostic information:** Information used to arrive at a diagnosis, such as in-office examinations, laboratory and radiology reports, or specialist consultation, must be documented.

9. **Medication information:** Medication information and/or instructions to member are included.

10. **Identification of current problems:** Significant illnesses, medical and behavioral health conditions, and health maintenance concerns must be identified in the medical record.

11. **Condition Specific Education:** The member must be provided with basic teaching and instruction regarding physical and/or behavioral health conditions.

12. **Smoking/alcohol/substance abuse:** A notation concerning cigarette and/or alcohol use or substance abuse must be stated if present for members age 12 and older. Abbreviations and symbols may be appropriate.

13. **Consultations, referrals and specialist reports:** Notes from referrals and consultations must be included in the record. Consultation, laboratory and X-ray reports filed in the chart must have the ordering provider’s initials or other documentation signifying review. Consultation and any abnormal laboratory and imaging study results must have an explicit notation in the record of follow-up plans.

14. **Emergency Care:** All emergency care provided directly by the contracted provider or through an emergency room and the hospital discharge summaries for all hospital admissions while the member is enrolled.

15. **Hospital discharge summaries:** Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the member is enrolled with the provider’s panel and for prior admissions as necessary. Prior admissions pertain to admissions which may have occurred prior to the member being enrolled and are pertinent to the member’s current medical condition.

16. **Advance directive:** For medical records of adult members, the medical record must document whether the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.

17. **Documentation of evidence and results of medical, preventive and behavioral health screenings must be included.**

18. **The record must include documentation of all treatment provided and the results of such treatment.**

19. **The record must include documentation of the team of providers involved in the multidisciplinary team of a member needing specialty care.**

20. **The record must include documentation in both the physical and behavioral health records of integration of clinical care.** Documentation should include:
   a. Screening for behavioral health conditions, including those which may affect physical health care and vice versa, and referral to behavioral health providers when problems are indicated
   b. Screening and referral by behavioral health providers to PCPs when appropriate
c. Receipt of behavioral health referrals from physical medicine providers and the disposition and/or outcome of those referrals
d. A summary of the status and/or progress from the behavioral health provider to the PCP at least quarterly or more often if clinically indicated
e. A written release of information permitting specific information sharing between providers
f. Documentation that behavioral health professionals are included in the primary and specialty care service teams described in this contract when a member with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder

**Member Visit Data**

Documentation of individual encounters must provide adequate evidence of, at a minimum:

1. **History and physical exam:** Appropriate subjective and objective information must be obtained for the presenting complaints.
2. For members receiving behavioral health treatment, documentation must include at-risk factors (e.g., danger to self and/or others, ability to care for self, affect, perceptual disorders, cognitive functioning, and significant social health) and efforts to coordinate care with all behavioral health providers after obtaining the appropriate release(s) of information.
3. Admission or initial assessment must include current support systems or lack of support systems.
4. For members receiving behavioral health treatment, an assessment must be completed for each visit relating to client status and/or symptoms of the treatment process. Documentation may indicate initial symptoms of the behavioral health condition as decreased, increased or unchanged during the treatment period.
5. Plan of treatment must include the activities, therapies and goals to be carried out.
6. **Diagnostic tests**
7. **Therapies and other prescribed regimens:** For members who receive behavioral health treatment, documentation must include evidence of family involvement as applicable and include evidence that family was included in therapy sessions when appropriate.
8. **Follow-up:** Encounter forms or notes must have a notation when indicated concerning follow-up care, calls or visits. The specific time to return must be noted in weeks, months or as needed. Unresolved problems from previous visits are addressed in subsequent visits.
9. Referrals, results thereof and all other aspects of member care, including ancillary services.

Amerigroup will systematically review medical records to ensure compliance with standards and will institute actions, as appropriate, for improvement when standards are not met. Access to or copies of medical records must be provided, free of charge, within five days of Amerigroup’s request.
Amerigroup policies are designed to maintain an appropriate record-keeping system for services to members. This system will collect all pertinent information related to the medical management of each member and make that information readily available to appropriate health professionals and District agencies. All records will be retained in accordance with the record retention requirements of 45 CFR 74.164 (i.e., records must be retained for seven years from the date of service). Records will be made accessible upon request to agencies of the District of Columbia and the federal government.

**Advance Directive**

Amerigroup respects the right of the member to control decisions relating to his or her own medical care, including the decision to have the medical or surgical means or procedures calculated to prolong life provided, withheld or withdrawn. 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.

Amerigroup adheres to the Patient Self-Determination Act and maintains written policies and procedures regarding advance directives. Advance directives are documents signed by a competent person giving direction to health care providers about treatment choices in certain circumstances. There are two types of advance directives. A durable power of attorney for health care (i.e., durable power) allows the member to name a patient advocate to act on his or her behalf. A living will allows the member to state his or her wishes in writing but does not name a patient advocate.

Member Services and Outreach associates encourage members to request an advance directive form and education from their PCP at their first appointment. The PCP must offer an advance directive form to all members over age 18 and document each member’s response to an offer to execute the advance directive in the member’s medical record.

Members over age 18 are able to execute an advance directive by requesting it from their PCP. Their response regarding the decision on an advanced directive must be documented in the medical record. Amerigroup and/or its providers will not discriminate or retaliate based on whether a member has or has not executed an advance directive.

While each member has the right without condition to formulate an advance directive within certain limited circumstances, a facility or an individual provider may conscientiously object to an advance directive.

Member Services and Outreach associates will assist members with general questions about advance directives. However, no associate of Amerigroup may provide legal advice regarding advance directives. Additionally, no associate may serve as witness to an advance directive or as a member’s designated agent or representative.
Amerigroup notes the presence of advance directives and the member’s response to whether he or she wants to establish an advance directive in the medical records when conducting medical chart audits. A living will and durable power of attorney are located in Appendix A - Forms.

**Services for Children**

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) was originally established in 1967 for Medicaid members from birth to age 21. In D.C., these services are called HealthCheck and ensure that members under the age of 21 receive comprehensive screening, diagnostic and treatment services as early as possible in order to identify physical or behavioral health conditions. These services are based on the District of Columbia’s Medicaid Health Check Periodicity Schedule and District of Columbia’s Medicaid Dental Periodicity Schedule. The most recent D.C. Medicaid periodicity schedules can be found at [www.dchealthcheck.net](http://www.dchealthcheck.net).

A web-based EPSDT Provider Training was developed by Georgetown University’s National Center for Education in Maternal and Child Health in collaboration with the DHCF and maintained by Georgetown University. The training module is based on the Bright Futures guidelines and has been tailored to the needs of the DC Provider community. This training module satisfies the EPSDT and IDEA Provider training requirements of DC Health Check Providers. Successful completion of the Training Module is expected of all providers providing EPSDT services within 30 days of joining the Amerigroup network and every two years thereafter. This training will provide five hours of category one credits toward the AMA Physician’s Recognition Award, and is paid for by Amerigroup.

For children under age 21, Amerigroup shall assign the member to a PCP certified by the DC HealthCheck program unless the member or member’s parent, guardian or caretaker specifically requests assignment to a PCP who is not EPSDT-certified. In this case, the non-EPSDT-certified provider is responsible for ensuring the child receives well-child care according to the EPSDT schedule. If member refuses services, the PCP must document refusal in member’s health record. During the initial examination and assessment, the provider must perform applicable HealthCheck screenings and services, based on the periodicity schedule and any additional assessments needed, with the appropriate tools. If a child is identified to have special health care needs or at risk of a developmental delay by the developmental screen required by EPSDT, the provider shall refer the child to specialty care and must make a referral to Amerigroup’s Case Management Department.

The HealthCheck assessment must include the following:

- Comprehensive health and developmental history assessment including physical, oral and mental health
- Unclothed comprehensive physical exam
- Immunizations* (based off of D.C. Medicaid Health Check Periodicity Schedule and in accordance with ACIP recommendations)
• Laboratory tests including lead toxicity screenings (if lead level is greater than or equal to 5ug/dL, provider must make a referral to Amerigroup’s Case Management Department)
• Health education and explanation of EPSDT services
• Vision services (based off of D.C. Medicaid Health Check Periodicity Schedule and as needed)
• Hearing services (based off of D.C. Medicaid Health Check Periodicity Schedule and as needed)
• Dental services (based off of District of Columbia’s Medicaid Dental Periodicity Schedule and as needed)
• Mental health and substance use screening, including a maternal depression screening at the 1 month, 2 month, 4 month, and 6 month well-child visits. If a mental health issue or substance use is determined, provider must make a referral to Amerigroup’s Case Management Department.
• Provider must also include any needed diagnostic services for further evaluation and treatment or referrals, as needed to support improving health conditions

* All applicable providers must be enrolled in the Vaccines for Children (VFC) Program. Amerigroup will not reimburse providers for vaccines provided through the VFC Program unless the vaccine was unavailable through the VFC Program and can be proven through written documentation to Amerigroup.

For the EPSDT population, members must be offered an initial appointment within 45 days of their date of enrollment with the PCP or within 30 days of request, whichever is sooner, unless the following exception applies:
• Appointments for initial EPSDT screens shall be offered to new enrollees within 60 days of the enrollee’s enrollment date with Amerigroup or at an earlier time if an earlier exam is needed to comply with the periodicity schedule or if the child’s case indicates a more rapid assessment or a request results from an emergency medical condition. The initial screen shall be completed within three months of the enrollee’s enrollment date with Amerigroup, unless Amerigroup determines that the new enrollee is up-to-date with the EPSDT periodicity schedule. To be considered timely, all EPSDT screens, laboratory tests and immunizations shall take place within 30 days of their scheduled due dates for children under the age of two and within 60 days of their due dates for children age two and older. Periodic EPSDT screening examinations shall take place within 30 days of a request.

**Americans with Disabilities Act**

Providers must comply with all applicable federal and state laws in assuring accessibility to all services for members with disabilities, pursuant to the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973, maintaining the capacity to deliver services in a manner that accommodates the needs of its members. Providers contracted with Amerigroup are required
by law to provide disabled persons full and equal access to medical services. Although a review of the requirements of the law and implementing regulations can be daunting, providing full and equal access to persons with disabilities can be achieved by:

- Removing physical barriers.
- Providing means for effective communication with people who have vision, hearing or speech disabilities, including providing auxiliary aids as needed.
- Providing flexibility in scheduling to accommodate people with disabilities.
- Allowing extra time for members with disabilities to dress and undress, transfer to examination tables, and extra time with the provider in order to ensure the individual is fully participating and understands the information.
- Making reasonable modifications to policies, practices and procedures.

For more information on making changes to a practice to ensure ADA compliance, refer to these additional resources:

- [https://www.ada.gov](https://www.ada.gov)
- [https://www.ada.gov/medcare_mobility_ta/medcare_ta.htm](https://www.ada.gov/medcare_mobility_ta/medcare_ta.htm)

**Members with Special Health Care Needs**

In general, to provide care to members with special health care needs, it is important for the PCP and specialist to:

- Demonstrate their credentials and experience to Amerigroup for treatment of special populations.
- Collaborate with Case Management staff on issues pertaining to the care of a special needs member.
- Document the plan of care and care modalities and update the plan annually.

Individuals in one or more of these special needs populations must receive services in the following manner from Amerigroup and/or Amerigroup providers:

- Upon request of the member or the PCP, a case manager trained as a nurse or social worker will be assigned to the member. The case manager will work with the member, the Health Home if the member is enrolled and the PCP to plan the treatment and services needed. The case manager will not only help plan for the care but will also help keep track of the health care services the member receives during the year and serve as the coordinator of care with the PCP across a continuum of inpatient and outpatient care.
- The PCP and case manager, when required, will coordinate referrals for needed specialty care, including specialists for disposable medical supplies (DMS), durable medical equipment (DME) and assistive technology devices based on medical necessity. PCPs should follow the referral protocols established by Amerigroup for sending members to specialty care networks.
• All providers are required to treat individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990 (P.L.101-336 42 U.S.C. §12101 et. seq.) and regulations disseminated under it.

Services for Pregnant and Postpartum Women

Amerigroup and network providers are responsible for providing pregnancy-related services including:
• Completion of the DC Collaborative Perinatal Risk Screening Tool; the completed tool must be submitted with the authorization for obstetric services
• Comprehensive prenatal, perinatal and postpartum care (including high-risk specialty care)
• Development of an individualized plan of care that is based upon the risk assessment and modified during the course of care if needed
• Case management services
• Prenatal and postpartum counseling and education
• Basic nutritional education
• Special substance abuse treatment, including access to treatment within 24 hours of request and intensive outpatient programs that allow for children to accompany their mothers
• Nutrition counseling by a licensed nutritionist or dietician for nutritionally high-risk pregnant women
• Appropriate levels of inpatient care, including emergency transfer of pregnant women and newborns to tertiary care centers
• Postpartum home visits

The PCP, OB/GYN and Amerigroup are responsible for making appropriate referrals of pregnant members to community resources that may improve pregnancy outcomes. In connection with such referrals, necessary medical information will be supplied to the program for the purpose of making eligibility determinations.

Pregnancy-related service providers will follow, at a minimum, the applicable American College of Obstetricians and Gynecologists (ACOG) clinical practice guidelines. For each scheduled appointment, you must provide written and telephonic (if possible) notice to members of the prenatal appointment dates and times.

Providers must:
• Schedule prenatal appointments in a manner consistent with the ACOG guidelines.
• Provide an initial appointment within 10 days of the request.
• Complete the DC Collaborative Perinatal Risk Screening Tool.
• Refer pregnant members under age 21 to their PCP to receive EPSDT screening services.
• Keep track of missed appointments, making three attempts to contact members regarding missed appointment.
- Notify Amerigroup of pregnant women not completing needed appointments.
- Refer to the WIC program.
- Refer pregnant and postpartum members who are in need of treatment for substance use disorder for appropriate substance abuse assessments and treatment services.
- Offer HIV counseling and testing and provide information on HIV infection and its effects on the unborn child.
- Instruct the pregnant member to notify Amerigroup of her pregnancy and expected date of delivery after her initial prenatal visit.
- Instruct the pregnant member to contact Amerigroup for assistance in choosing a PCP for the newborn prior to her eighth month of pregnancy.
- Document the pregnant member’s choice of pediatric provider in the medical record.

Taking Care of Baby and Me

Taking Care of Baby and Me® is a proactive case-management program for all expectant mothers and their newborns. It identifies pregnant women as early in their pregnancies as possible through review of District enrollment files, claims data, lab reports, hospital census reports, and provider notification of pregnancy and delivery notification forms and self-referrals. Once pregnant members are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care and case management services to mitigate risk.

Experienced case managers work with members and providers to establish a care plan for our highest risk pregnant members. Case managers collaborate with community agencies to ensure mothers have access to necessary services, including transportation, WIC, breastfeeding support and counseling.

When it comes to our pregnant members, we are committed to keeping both mom and baby healthy.

That’s why we encourage all of our moms-to-be to take part in our Taking Care of Baby and Me program — a comprehensive case management and care coordination program offering:
- Individualized, one-on-one case management support for women at the highest risk
- Care coordination for moms who may need a little extra support
- Educational materials and information on community resources
- Rewards to keep up with prenatal and postpartum checkups

As part of the Taking Care of Baby and Me program, eligible members are offered the My Advocate™ program. This program provides pregnant women proactive, culturally appropriate outreach and education through Interactive Voice Response (IVR), text or smart phone application. This program does not replace the high-touch case management approach for high-risk pregnant women. However, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high-risk, to facilitate connections between them and our case managers and improve member and baby outcomes. Eligible members receive regular calls with tailored content from a voice personality (Mary Beth). For more information on My Advocate visit www.myadvocatehelps.com.
For parents with infants admitted to the neonatal intensive care unit (NICU), we offer the You and Your Baby in the NICU program and a NICU Post Traumatic Stress Disorder (NICU PTSD) program. Parents receive education and support to be involved in the care of their babies, visit the NICU, interact with hospital care providers and prepare for discharge. Parents are provided with an educational resource outlining successful strategies they may deploy to collaborate with the care team. The NICU PTSD program seeks to improve outcomes for families of babies who are in the NICU by screening and facilitating referral to treatment for PTSD in parents. This program will support mothers and families at risk for PTSD due to the stressful experience of having a baby in the NICU.

**Dental Care**

Dental services are provided by DentaQuest. Contact DentaQuest at 1-844-876-7919 with questions about dental benefits.

**Childbirth-Related Provisions**

There are special rules to determine the length of hospital stay following childbirth:

- A member’s length of hospital stay after childbirth is determined in accordance with the ACOG and American Academy of Pediatrics (AAP) guidelines for prenatal care, unless the 48-hour (for uncomplicated vaginal delivery) or 96-hour (for uncomplicated cesarean section) length of stay guaranteed by District law is longer than that required under the guidelines.
- If a member must remain in the hospital after childbirth for medical reasons, and she requests her newborn remain in the hospital while she is hospitalized, additional hospitalization of up to four days must be provided for the newborn and is covered.
- If a member elects to be discharged earlier than the conclusion of the length of stay guaranteed by District law, a home visit must be provided.
- When a member opts for early discharge from the hospital following childbirth (before 48 hours for vaginal delivery or before 96 hours for cesarean section), one home nursing visit within 24 hours after discharge and an additional home visit, if prescribed by the attending provider, are covered.
- The hospital is responsible for notifying Amerigroup of the birth of a child within 24 hours or by the next business day. The hospital must also notify Amerigroup within 24 hours or by the next business day if a newborn is transferred from the nursery to the NICU, transferred to another level of care or is detained beyond the OB global period. These changes would be documented as a separate, new admission and not part of the mother’s admission.

Postnatal home visits are to be performed by a registered nurse in accordance with generally accepted standards of nursing practice for home care of a mother and newborn and must include:

- An evaluation to detect immediate problems of dehydration, sepsis, infection, jaundice, respiratory distress, cardiac distress or other adverse symptoms of the newborn.
• An evaluation to detect immediate problems of dehydration, sepsis, infection, bleeding, pain or other adverse symptoms of the mother.
• Blood collection from the newborn for screening (unless previously completed).
• Appropriate referrals.
• Any other nursing services ordered by the referring provider.

If a member remains in the hospital for the standard length of stay following childbirth, a home visit, if prescribed by the provider, is covered.

When a service is not provided prior to discharge, a newborn’s initial evaluation by an out-of-network on-call hospital provider before the newborn’s hospital discharge is covered as a self-referred service.

It is required to schedule newborns for a follow-up visit within two weeks after discharge if a home visit has not been scheduled to occur within 30 days post-discharge.

Home visits are also performed for high risk newborns within 48 hours of discharge from the birthing hospital or center. This visit includes an assessment of the home environment; facilitation parent-child attachment; ascertaining family resources and parent risk factors; assessing the diagnostic and treatment needs of the mother and newborn; coordination of follow-up care, coordination related to early interventions from other social and educational support agencies.

**Children with Special Health Care Needs**

Amerigroup will:
• Provide the full range of medical services for children, including services intended to improve or preserve the continuing health and quality of life, regardless of the ability of services to affect a permanent cure.
• Provide case management services to children with special health care needs, as appropriate. For complex cases involving multiple medical interventions, social services or both, a multidisciplinary team must be used to review and develop the plan of care for children with special health care needs.
• Refer special needs children to specialists as needed, including specialty referrals for children found to be functioning at one-third or more below chronological age in any developmental area as identified by the developmental screen required by the EPSDT periodicity schedule.
• Allow children with special health care needs to access out-of-network specialty providers as specified in the special provisions and guidelines detailed in Section 1 titled *Self-Referred Services for Children with Special Health Care Needs*.
• Log any complaints made to the District or to Amerigroup about a child who is denied services. Amerigroup will inform the District about all denials of service to children. All
denial letters sent to children or their representatives must state that members can appeal by calling the District’s Enrollee Help Line at 1-800-620-7802.

- Work closely with the schools that provide education and family services programs to children with special needs.
- Ensure coordination of care for children in District-supervised care. If a child in District-supervised care moves out of the area and must transfer to another MCO, the District and Amerigroup will work together to find another MCO as quickly as possible.

**Individuals with HIV/AIDS**

Individuals with HIV/AIDS are enrolled in one of the District's MCOs. Children with HIV/AIDS who are enrolled in My Health GPS Health Home benefit will be managed by the assigned health home. See the Health Home section of this manual for more information.

The following service requirements apply for persons with HIV/AIDS:

- An HIV/AIDS specialist for treatment and coordination of primary and specialty care must be involved in the patient’s care.
- A Diagnostic Evaluation Service (DES) assessment can be performed once every year at the member’s request. The DES includes a physical, behavioral and social evaluation. The member may choose the DES provider from a list of approved locations or can self-refer to a certified DES provider for the evaluation.
- Substance abuse treatment within 24 hours of request.
- The right to ask Amerigroup to send him or herself to a site that performs HIV/AIDS-related clinical trials. Amerigroup may refer members with HIV/AIDS to facilities or organizations that can provide members access to clinical trials.
- The LHD will designate a single staff member to serve as a contact. In all instances, providers will maintain the confidentiality of member records and eligibility information in accordance with all federal, District and local laws and regulations and use this information only to assist the member to receive needed health care services.
- Members enrolled in the My Health GPS benefit will be case managed by the assigned health home. Amerigroup case management services are covered for any member diagnosed with HIV. These services must be provided with the member’s consent to facilitate timely and coordinated access to appropriate levels of care and to support continuity of care across the continuum of qualified service providers. Case management will link HIV-infected members with the full range of benefits (e.g., primary behavioral health care and somatic health care services) and referral for any additional needed services including specialty behavioral health services, social services, financial services, educational services, housing services, counseling and other required support services. HIV case management services include:
  - Initial and ongoing assessment of the member’s needs and personal support systems, including using a multidisciplinary approach to develop a comprehensive, individualized service plan. This includes periodic re-evaluation and adaptation of the plan.
Coordination of services needed to implement the plan.

Outreach for the member and the member’s family by which the case manager and the PCP track services received, clinical outcomes and the need for additional follow-up care.

The member’s case manager will serve as the member’s advocate to resolve differences between the member and providers of care pertaining to the course or content of therapeutic interventions.

If a member initially refuses HIV case management services, the services are to be available at any later time if requested by the member.

**Individuals with Physical or Developmental Disabilities**

Before placement of an individual with a physical disability into an intermediate or long-term care facility, Amerigroup will assess the needs of the individual and the community as supplemented by other Medicaid services. The Amerigroup medical director will conduct a second-opinion review of the case before placement. If the medical director determines the transfer to an intermediate or long-term care facility is medically necessary and the expected stay will be greater than 30 days, Amerigroup will obtain approval from DCHFP before making the transfer.

Providers who treat individuals with physical or developmental disabilities must be trained on special communication requirements of individuals with physical disabilities. Amerigroup is responsible for accommodating hearing-impaired members who require and request a qualified interpreter. Amerigroup can delegate the financial risk and responsibility to providers, and is ultimately responsible for ensuring members have access to these services.

- Amerigroup providers must be clinically qualified to provide DME and assistive technology services for both adults and children.
- Amerigroup informational materials are approved by persons with experience in the needs of members with disabilities, thereby ensuring the information is presented in a manner in which members understand the material, whether on paper or by voice translation.
- Amerigroup provides training to its triage, Member Services and Case Management staff on the special communications requirements of members with physical disabilities. Amerigroup will clearly indicate to its providers how this provision is to be implemented (See Optional Services Provided by Amerigroup on how to access these services).

**Individuals who are Homeless**

If an individual is identified as homeless, Amerigroup will provide a case manager to coordinate health care services.
Adult Members with Impaired Cognitive Ability/Psychosocial Problems

Support and outreach services are available for adult members needing follow-up care who have impaired cognitive ability or psychosocial problems and who can be expected to have difficulty understanding the importance of care instructions or difficulty navigating the health care system.

MCO Support Services (Outreach)

Amerigroup enacts a variety of outreach campaigns to support our members in getting the care they need. These campaigns are focused on topics including, but not limited to, completion of EPSDT services, preventive care, condition self-management, and medication adherence. Outreach methods include phone, texts, mailings, community events and in person.

First Line of Defense Against Fraud

We are committed to protecting the integrity of our health care program and the efficiency of our operations by preventing, detecting and investigating fraud, waste and abuse. Combating fraud, waste and abuse begins with knowledge and awareness.

- **Fraud:** Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it — or any other person. The attempt itself is fraud, regardless of whether or not it is successful.
- **Waste:** Generally defined as activities involving careless, poor or inefficient billing, or treatment methods causing unnecessary expenses and/or mismanagement of resources.
- **Abuse:** Any practice inconsistent with sound fiscal, business or medical practices that results in an unnecessary cost to the Medicaid program, including administrative costs from acts that adversely affect providers or members.

To help prevent fraud, waste or abuse, providers can educate members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the Amerigroup member identification card. It is the first line of defense against fraud. Amerigroup may not accept responsibility for the costs incurred by providers providing services to a person who is **not** a member, even if that person presents an Amerigroup member identification card. Providers should take measures to ensure the cardholder is the person named on the card.

Every Amerigroup member identification card lists the following:

- Effective date of Amerigroup membership
- Member date of birth
- Subscriber number (Amerigroup identification number)
• Carrier and group number (RXGRP number) for injectables
• PCP name, telephone number and address
• Copayments for office visits, emergency room visits and pharmacy services (if applicable)
• Behavioral health benefit
• Vision service plan telephone number and dental service plan telephone number
• Member Services and Nurse HelpLine telephone numbers

Amerigroup member identification card samples:

**DC Healthy Families**

**DC Healthcare Alliance**

**Immigrant Children's Program**
Presentation of a member ID card does **not** guarantee eligibility; providers should verify a member’s status by inquiring online or via telephone. Online support is available for provider inquiries on the website, and telephonic verification may be obtained through the automated Provider Inquiry Line at 1-800-454-3730.

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

Understanding the various opportunities for fraud and working with members to protect their health benefits ID card can help prevent fraudulent activities. If you suspect ID theft, call our Compliance Hotline at 1-877-660-7890. Providers should instruct their patients who suspect ID theft to watch the explanation of benefits (EOBs) for any errors and then contact Member Services if something is incorrect.

**Reporting Fraud, Waste and Abuse**

If you suspect a provider (e.g., provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste or abuse, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators.

You can report your concerns by:

- Visiting our website and completing the [Report Waste, Fraud and Abuse](#) form
- Calling provider services
- Calling our Special Investigations Unit fraud hotline at 1-866-847-8247

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud, but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

**Examples of Provider Fraud, Waste and Abuse**

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering or receiving kickbacks or bribes
• Unbundling — when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
• Upcoding — when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a provider (a doctor, dentist, counselor, medical supply company, etc.), include:
• Name, address and phone number of provider
• Name and address of the facility (hospital, nursing home, home health agency, etc.)
• Medicaid number of the provider and facility, if you have it
• Type of provider (doctor, dentist, therapist, pharmacist, etc.)
• Names and phone numbers of other witnesses who can help in the investigation
• Dates of events
• Summary of what happened

Examples of Member Fraud, Waste and Abuse
• Forging, altering or selling prescriptions
• Letting someone else use the member’s ID (Identification) card
• Obtaining controlled substances from multiple providers
• Relocating to out-of-service plan area
• Using someone else’s ID card

When reporting concerns involving a member, include:
• The member’s name
• The member’s date of birth, Social Security Number or case number if you have it
• The city where the member resides
• Specific details describing the fraud, waste or abuse

Investigation Process

We investigate all reports of fraud, abuse and waste for all services provided under the contract, including those that are subcontracted to outside entities. If appropriate, allegations and the investigative findings are reported to all appropriate District, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste or abuse, which may include, but is not limited to:

• **Written warning and/or education:** We send certified letters to the provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries, or may advise of further action.
• **Medical record audit:** We review medical records to substantiate allegations or validate claims submissions.
• **Special claims review:** A certified professional coder or investigator evaluates claims and places payment or system edits on file. This type of review prevents automatic claim payment in specific situations.

• **Recoveries:** We recover overpayments directly from the provider within 30 days. Failure of the provider to return the overpayment after 30 days may result in reduced payment of future claims or further legal action.

**Acting on Investigative Findings**

We refer all criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

If a provider appears to have committed fraud, abuse or waste, the provider:

- Will be referred to the Special Investigations Unit
- May be presented to the credentials committee and/or peer review committee for disciplinary action including provider termination

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a member appears to have committed fraud, waste or abuse, the member may be involuntarily dis-enrolled from our health care plan, with District approval.

**Relevant Legislation**

**Federal False Claims Act (FCA)**

The FCA is intended to prevent fraud against the government. This includes preventing fraudulent billing or the submission of fraudulent claims to any Federal health care program.

**Who is covered by the FCA?**

The FCA applies to individuals (natural persons) and business entities including, but not limited to corporations, partnerships, firms, or associations. It includes physicians and hospitals.

**Conduct Prohibited by FCA**

The FCA prohibits any person or entity from:

- Knowingly presenting, or causing to be presented, to the government, a false or fraudulent claim for payment or approval.
- Knowingly making, using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the government.
- Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid.
- Falsely certifying the type or amount of property to be used by the government.
• Certifying receipt of property used (or to be used) by the government on a document without completely knowing that the information is true.
• Knowingly buying or receiving government property from an unauthorized agent.
• Knowingly making, using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) 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.

Our company strives to ensure both Amerigroup and contracted participating providers conduct business in a manner that safeguards member information in accordance with the privacy regulations enacted pursuant to HIPAA. Contracted providers shall have the following procedures implemented to demonstrate compliance with the HIPAA privacy regulations:

• Our company recognizes its responsibility under HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose; conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting us; however, privacy regulations allow the transfer or sharing of member information. Our company may request information to conduct business and make decisions about care, such as a member’s medical record, authorization determinations or payment appeal resolutions. Such requests are considered part of the HIPAA definition of treatment, payment or health care operations.

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

• Internet email (unless encrypted and/or transferred by another secure service) should not be used to transfer files containing member information, 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 our company.

• Our company voice mail system is secure and password protected. When leaving messages for any of our associates, leave only the minimum amount of member information required to accomplish the intended purpose.

When contacting us, please be prepared to verify the provider’s name, address and tax identification number (TIN) or member’s provider number.
4 UTILIZATION MANAGEMENT

Overview

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 appropriateness of care and service and existence of coverage.
- Amerigroup does not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support denials of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization, or create barriers to care and service.
- Access to UM Staff is available. Amerigroup associates are available at least eight hours a day from 8 a.m. to 5 p.m., Monday through Friday, for inbound communications regarding UM inquiries. Clinical professionals are available twenty-four hours a day, seven days a week. Staff will identify themselves by name, title, and organizational name when initiating or returning calls regarding UM issues.
- Amerigroup offers TDD/TTY services for deaf, hard of hearing or speech-impaired members. For all members who request language services, Amerigroup provides services free of charge through bilingual staff or interpreter to help members with UM issues.

Criteria and Clinical Information for Medical Necessity

Anthem Medical Policies and Clinical UM Guidelines, which are publicly accessible from its subsidiary websites, are the primary guidelines used to determine whether services are considered to be a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive.

McKesson InterQual criteria will continue to be used to determine medical necessity for acute inpatient care. A list of the specific Anthem Medical Policies and Clinical UM Guidelines used will be posted and maintained on the websites and can be obtained in hard copy by written request. To request a copy of the criteria on which a medical decision was based, call Provider Services at 1-800-454-3730.

The policies described above will support precertification requirements, acute inpatient care, and retrospective review.

Federal and District law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over clinical policy and must be considered first when determining eligibility for coverage. As such, in all cases, District Medicaid contracts will
supersede McKesson InterQual, Anthem Medical Policy, and Anthem Clinical UM Guidelines. Medical technology is constantly evolving, and Amerigroup reserves the right to review and periodically update medical policy and utilization management criteria. The Amerigroup Utilization Management department reviews the medical necessity of medical services using:

- District guidelines
- Anthem Medical Policies
- McKesson InterQual (inpatient care)
- Anthem Clinical Utilization Management Guidelines
- *AIM Specialty Health Clinical Appropriateness Guidelines* (high-tech radiology, sleep medicine, radiation oncology)

Amerigroup follows established procedures for applying medical necessity criteria based on individual member needs and an assessment of the availability of services within the local delivery system. To learn more about these procedures, visit the provider self-service website at [https://providers.amerigroup.com/DC](https://providers.amerigroup.com/DC) or call Provider Services. These procedures apply to:

- Precertification
- Concurrent reviews
- Retrospective reviews

Requests for services/care should include current applicable and appropriate ICD and CPT codes and relevant clinical information. Appropriate clinical information includes:

- Office and/or hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic testing results
- Treatment plans and progress notes
- Psychosocial history
- Consultation notes
- Operative and pathological reports
- Rehabilitation evaluations
- Patient characteristics and information
- Estimated/anticipated length and/or frequency of treatment

Amerigroup’s Chief Medical Officer will review any denial of care for EPSDT services and services for enrollees with special health care needs. Amerigroup’s Chief Psychiatric Medical Officer will review all denials of care for mental health treatment services.

**Referral/Precertification Process**

Referrals to in-network specialists are not required for payment; however, Amerigroup highly recommends PCPs supply the member with instructions for follow-up care. Visit [https://providers.amerigroup.com/DC](https://providers.amerigroup.com/DC) to download a *Personalized Treatment Plan* form under Provider Documents & Resources > Forms.
Precertification and Notification — General

Some covered services require **precertification** prior to services being rendered, while other covered services require **notification** prior to being rendered.

Notification is a communication received from a provider informing Amerigroup of the intent to render covered medical services to a member. For services that are emergent or urgent, notification must be provided within 24 hours or by the next business day. Notifications may be submitted by telephone or fax.

Prospective means the coverage request occurred prior to the service being provided. Precertification is the prospective process whereby licensed clinical associates apply specific criteria sets against the intensity of services and severity of illness to determine the medical necessity and appropriateness of the request.

Services requiring precertification include but are not limited to:
- Elective inpatient admissions
- Select outpatient and specialty care provided outside of the PCP’s scope of practice
- High-tech radiology
- Durable medical equipment
- Home health services
- Out-of-network services

The following information should be provided to the Medical Management department for precertification at 1-800-454-3730:
- Member’s name
- Member’s address
- Member’s Amerigroup ID number
- Member’s date of birth
- Member’s PCP
- Scheduled date of admission and/or surgery
- Name of hospital
- Member’s diagnosis
- Attending provider
- Clinical information (if applicable)

All Amerigroup members scheduled for inpatient surgery must be admitted to the hospital on the day of the surgery except in preapproved medically necessary cases. Amerigroup will **not** pay for any costs associated with admissions on the day before surgery unless specific medical justification is provided and approved. Each member’s case will be examined individually in this respect.

The following are **not** acceptable reasons for an admission before surgery:
- Member, provider or hospital convenience
• Routine laboratory or X-ray
• NPO (i.e., nothing by mouth)
• Distance or transportation to the hospital
• Most preps

Upon notification, Amerigroup reviews the clinical basis for admission and authorizes benefits for the admission. The medical director reviews any potential denial of coverage after evaluating the member’s medical condition, and medical criteria.

To verify whether or not a particular service requires precertification, use the Precertification Look-up Tool under the Quick Tools menu at https://providers.amerigroup.com/DC.

Precertification is not required for the following services:
• Routine laboratory tests (excluding genetic testing) performed in the PCP’s office or contracted laboratory
• Routine X-rays, EKGs, EEGs or mammograms at a network specialist office at a freestanding radiology facility or at some network hospitals
• Routine outpatient behavioral health therapy services (excluding psychological testing) at a network specialist office.

The medical director will periodically review and revise this list with the expectation that additional services will be added as practice patterns of the network warrants.

Interactive Care Reviewer (ICR)

The Amerigroup Interactive Care Reviewer (ICR) is the preferred method for the submission of preauthorization requests, offering a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for Amerigroup members. Additionally, providers can use this tool to inquire about previously submitted requests regardless of how they were submitted (phone, fax, ICR or other online tool).
• Initiate preauthorization requests online, eliminating the need to fax. ICR allows detailed text, photo images and attachments to be submitted along with your request.
• Review requests previously submitted 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.
• Real-time results for some common procedures.
• Access ICR under Authorizations and Referrals via the Availity Web Portal.


Register for Interactive Care Reviewer access at https://www.availity.com.
For an optimal experience with Amerigroup ICR, use a browser that supports 128-bit encryption. This includes Internet Explorer 11, Chrome, Firefox or Safari.

Amerigroup 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 preauthorization process that you use today.)

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

**Precertification Determination Time Frames**

For services that require precertification, Amerigroup will make a determination in a timely manner so as not to adversely affect the health of the member. For nonurgent preservice requests, the determination will be made within 14 calendar days of receipt of the request. For urgent preservice requests, the determination will be made with 72 hours of receipt of the requests.

Members or their authorized representative may agree to extend the decision-making timeframe for preservice requests. If the request lacks clinical information, the organization may extend the decision time frame up to an additional 14 calendar days for both routine and urgent preservice requests.

**Utilization Management — Inpatient Services**

**Elective Inpatient Admission Notification Time Frames**

All elective admissions must receive prior approval through Provider Services at least 72 hours prior to the admission or scheduled procedure. Failure to comply with notification rules will result in an administrative denial.

The hospital is responsible for notifying Amerigroup of the birth of a child within one business day of the date of birth. For transfer of a newborn from the nursery to the NICU or to another level of care, or to detain a newborn beyond the OB global period, the hospital must notify Amerigroup within one business day. These circumstances are considered separate, new admissions and are not part of the mother’s admission.

Emergent admissions require notification to Amerigroup within one business day following the admission. Failure to comply with notification rules will result in an administrative denial.

**Administrative Denial**

Administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of precertification or failure by the provider to submit clinical
when requested. Appeals for administrative denials must address the reason for the denial (i.e., why precertification was not obtained or why clinical was not submitted).

If Amerigroup overturns its administrative decision, then the case will be reviewed for medical necessity and if approved, the claim will be reprocessed or the requestor will be notified of the action that needs to be taken.

Inpatient Specialist Referrals
Referrals to in-network specialists are not required for payment; however, Amerigroup highly recommends PCPs supply the member with instructions for follow-up care. Log in at https://providers.amerigroup.com/DC to download the Personalized Treatment Plan form under Provider Documents & Resources > Forms.

Acute Inpatient Admission
- All medical inpatient hospital admissions will be reviewed for medical necessity within one business day of the facility notification to Amerigroup.
- Clinical information for the initial (admission) review will be requested by Amerigroup at the time of the admission notification.
- For medical admissions, the facilities are required to provide the requested clinical information within 24 hours of the request.
- If the information is not received within 24 hours, an administrative adverse determination (i.e., a denial) will be issued.

Inpatient Concurrent Review
Each network hospital will have an assigned concurrent review clinician. The concurrent review clinician will conduct a review of the medical records electronically or by telephone to determine the authorization of coverage for an admission.
- When the clinical information is received, a medical necessity review will be conducted using applicable nationally recognized clinical criteria, and a determination will be communicated to the facility.
- The Amerigroup concurrent review clinician will conduct a discharge planning review every 7-10 days and help coordinate discharge planning needs with the designated facility staff and the attending provider. The attending provider is expected to coordinate with the member’s PCP or outpatient specialty provider regarding follow-up care and services after discharge. The PCP or outpatient specialty provider is responsible for contacting the member to schedule all necessary follow-up care.

If the medical director/physician reviewer denies authorization for an inpatient stay based upon applicable guidelines or criteria, a notice of intent to deny will be provided to the facility and to the attending provider.

Upon notification of the intention to deny, the member’s treating physician can request a physician-to-physician review to provide additional information not previously submitted to
Amerigroup. The request for this review must be made within one business day of the notification of intent to deny. To initiate this request, the physician or a physician representative may contact Amerigroup at 1-844-421-5656 from 8:30 a.m. to 5:30 p.m. Eastern time.

All notifications of intent to deny will be followed with a written adverse determination. Hospital representatives must follow the provider payment dispute process to appeal inpatient adverse determination decisions. See the Provider Claims/Payment Dispute Process for additional information.

**Inpatient Retrospective Review**

Inpatient admissions may be retrospectively reviewed after the member is discharged. If Amerigroup is notified of the admission while the member is still in the hospital, the review will be considered concurrent and subject to concurrent time frames and guidelines. For additional questions and a quick reference guide, visit the provider website.

**Discharge Planning**

Discharge planning is designed to assist the provider with coordination of the member’s discharge when acute care (i.e., hospitalization) is no longer necessary.

When a lower level of care is necessary, Amerigroup works with the provider to help plan the member’s discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital setting such as:

- Hospice facility
- Skilled nursing facility
- Residential treatment facilities (RTF)
- Partial hospitalization programs (PHP)
- Intensive outpatient programs (IOP)
- Home health care

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

Discharge plan authorizations follow the applicable precertification process and determinations are made using nationally recognized clinical criteria or guidelines. Authorizations include, but are not limited to, home health, durable medical equipment (DME), follow-up visits to providers or outpatient procedures.
Utilization Management — Outpatient Services

Outpatient Precertification
Precertification is required and must be requested at a minimum of 72 hours before the service/procedure/etc. must be provided. Failure to comply with notification rules will result in an administrative denial.

Administrative Denial
Administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of precertification or failure by the provider to submit clinical when requested. Appeals for administrative denials must address the reason for the denial (i.e., why precertification was not obtained or why clinical was not submitted).

If Amerigroup overturns its administrative decision, then the case will be reviewed for medical necessity and if approved, the claim will be reprocessed or the requestor will be notified of the action that needs to be taken.

This applies to the following types of care (the list may be modified periodically):
- Home health care
- Physical and speech therapy beyond the initial evaluation (subsequent visits require clinical documentation and precertification from Amerigroup)
- DME
- Cardiac rehabilitation
- Outpatient diagnostic radiology

In addition, precertification is required for all out-of-network care (certain exclusions apply) and for specialty visits (i.e., services beyond the initial evaluation and management) if performed by a nonparticipating provider.

For code-specific precertification requirements for dermatology, genetics, otolaryngology, podiatry, plastic surgery and pain management performed in a participating clinic/outpatient facility/ambulatory surgery center, visit https://providers.amerigroup.com and select Precertification Lookup from the Quick Tools menu.

For precertification requirements for behavioral health services, please refer to the Behavioral Health section in this manual.

Precertification Requirement Review and Updates
Amerigroup will review and revise policies when necessary. The most current policies are available on the provider self-service website.
Specialist as PCP Referral

Under certain circumstances, a specialist may be approved by Amerigroup to serve as a member’s PCP when a member requires the regular care of the specialist. The criteria for a specialist to serve as a member’s PCP include the existence of a chronic, life-threatening illness or condition of such complexity whereby:

- The need for multiple hospitalizations exists
- The majority of care must be provided by a specialist
- The administrative requirements of arranging for care exceed the capacity of the PCP. This would include members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis, etc.

The specialist must meet the requirements for PCP participation (including contractual obligations and credentialing), provide access to care 24 hours a day, 7 days a week and coordinate the member’s health care including preventive care. When such a need is identified, the member or specialist must contact the Amerigroup Case Management department and complete a Specialist as PCP Request Form. An Amerigroup case manager will review the request and submit it to the Amerigroup medical director. Amerigroup will notify the member and the provider of the determination in writing within 30 days of receiving the request. Should Amerigroup deny the request, Amerigroup will provide written notification to the member and provider of the reason(s) for the denial of the request. Specialists serving as PCPs will continue to be paid under fee-for-service while serving as the member’s PCP. The designation cannot be retroactive. For further information, see the Specialist as PCP Request Form in Appendix A – Forms.

Reporting Changes in Address and/or Practice Status

Please report any status changes either via fax to 1-866-920-1873 or mail to:
Provider Services
Amerigroup District of Columbia, Inc.
609 H Street NE, Suite 200
Washington, DC 20002

Second Opinions

A member or the member’s PCP may request a second opinion for serious medical conditions or elective surgical procedures at no cost to the member. Also, a member of the health care team and/or the member’s parents or guardians may also request a second opinion. These conditions and/or procedures include but are not limited to the following:

- Treatment of serious medical conditions such as cancer
- Elective surgical procedures such as hernia repair (simple) for adults (age 18 or older), hysterectomy (elective procedure), spinal fusion (except for children under age 18 with a diagnosis of scoliosis) and laminectomy (except for children under age 18 with a diagnosis of scoliosis)
- Other medically necessary conditions as circumstances dictate
The second opinion must be obtained from a network provider (see the Provider Referral Directory at https://providers.amerigroup.com/DC). A second opinion can be obtained from a non-network provider if there is not a network provider with the expertise required for the condition. Once approved, the PCP will notify the member of the date and time of the appointment and will forward copies of all relevant records to the consulting provider. The PCP will notify the member of the outcome of the second opinion.

Amerigroup may also request a second opinion at its own discretion. This includes but is not limited to the following scenarios:

- There is concern about care expressed by the member or the provider.
- Potential risks or outcomes of recommended or requested care are discovered by the plan during its regular course of business.
- Before initiating denial of coverage of service.
- Denied coverage is appealed.
- An experimental or investigational service is requested.

When Amerigroup requests a second opinion, Amerigroup will make the necessary arrangements for the appointment, payment and reporting. Once the second opinion is completed, Amerigroup will inform the member and the PCP of the results and the consulting provider’s conclusion and recommendation(s) regarding further action.

Claim Submission

Claims must be submitted in accordance with timely filing guidelines and must include all necessary information as outlined in the following sections. In addition, all codes used in billing must be supported by appropriate medical record documentation.

Paper Claim Submission

Amerigroup encourages electronic claim submission; however, providers have the option to submit paper claims. Amerigroup utilizes optical character recognition (OCR) technology as part of its front-end claims processing procedures. The benefits of this technology include:

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

To use OCR technology, claims must be submitted on original, red claim forms (not black and white or photocopied forms) that are laser-printed or typed (not handwritten) in large, dark font. Providers must submit a properly completed UB-04 or CMS-1500 (08-05) claim form within 365 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. For cases of retroactive eligibility, the time frames for filing a claim will begin on the date Amerigroup receives notification from DCHFP of the member’s eligibility/enrollment.

In accordance with the implementation timelines set by CMS, the National Uniform Claim Committee (NUCC) and the National Uniform Billing Committee (NUBC), Amerigroup requires the use of the new CMS-1500 (08-05) form for the purpose of accommodating the National Provider Identifier (NPI).

CMS-1500 (08-05) and UB-04 CMS-1450 claim forms must include the following information prior to the District of Columbia becoming compliant with the NPI federal rule. Amerigroup has aligned its NPI and taxonomy code requirements with the District of Columbia (HIPAA-compliant where applicable):

- Member’s name
- Member’s ID number
- Member’s date of birth
- Provider name according to contract
- Provider tax ID number and District Medicaid ID number
- Amerigroup provider number
- NPI of billing provider when applicable
- Date of service
- Place of service
- ICD-10 diagnosis code/revenue codes
- Procedures, services or supplies rendered, CPT-4 codes/HCPCS codes/diagnosis-related groups (DRGs) with appropriate modifiers, if necessary
- Itemized charges
- Days or units
- Modifiers as applicable
- Coordination of benefits (COB) and/or other insurance information
- The precertification number or copy of the precertification
- Name of referring provider
- NPI of referring provider when applicable
- Any other District-required data

Amerigroup cannot accept claims with alterations to billing information. Amerigroup does not accept computer-generated or typewritten claims with information that has been marked through, handwritten, or appears to have been covered by correction fluid or tape. Claims that have been altered will be returned to the provider with an explanation of the reason for the return.

Paper claims must be submitted to:

Amerigroup District of Columbia, Inc.
P.O. Box 61010
Virginia Beach, VA 23466-1010
Please note: AMA- and CMS-approved modifiers must be used appropriately based on the type of service and procedure code.

Electronic Claim Submission

Amerigroup prefers the submission of claims electronically through Electronic Data Interchange (EDI). Providers must submit claims within 365 days from the date of discharge for inpatient services or from the date of service for outpatient services.

To initiate the electronic claims submission process or obtain additional information, please visit the EDI area of the public provider website which includes registration forms and contact information.

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

Web Portal Submissions — Participating Providers Only

Participating providers have the option to use HIPAA-compliant web claim submission capabilities by registering at https://www.availity.com.

For any questions, please contact Availity Client Services at 1-800-AVAILITY (1-800-282-4548).

Encounter Data Reporting Requirements

Amerigroup maintains a system to collect member encounter data. All capitated providers and/or sites must report all member encounters. This is a key component of the Amerigroup information system, and electronic reporting is encouraged. Failure to submit accurate and timely reports may result in corrective action up to and including termination of the Participating Provider Agreement.

If a provider is capitated, the provider will receive a monthly check based on a number of factors (e.g., member’s age, gender, number of members in provider’s panel) that includes payment for all capitated services rendered.
Due to reporting needs and requirements, Amerigroup network providers reimbursed by capitation must send encounter data to Amerigroup for each member encounter. This is performed through use of the CMS-1500 (08-05) claim form. Data must be submitted in a timely manner. Failure to provide information can result in delayed capitation payment.

The encounter data must include:
- Member ID number
- Member’s first and last name
- Date of member’s birth
- Date of encounter
- Diagnosis code
- Types of services provided (utilizing current procedure codes and modifiers, if applicable)
- Provider’s tax ID number and District Medicaid ID number
- NPI

Submit encounter data to:
Amerigroup District of Columbia, Inc.
P.O. Box 61010
Virginia Beach, VA 23466-1010

HEDIS® outcomes are also collected through claim and encounter data submissions. This includes but is not limited to:
- Preventive services (e.g., childhood immunization, mammography and Pap smears)
- Prenatal care (e.g., the number and frequency of prenatal visits)
- 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 an annual basis. The PCP is monitored for compliance with reporting of utilization. Lack of compliance will result in training and follow-up audits and may 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-10 manuals. Hospital facility claims should be submitted using the UB-04 form, and provider services claims should be submitted using the CMS-1500 (08-05) form.
For claims payment to be considered, providers must adhere to the following time limits:

- Submit claims within 365 days of the date of service (for inpatient claims filed by a hospital, within 365 days from the date of discharge)
- In the case of other insurance, submit the claim within 180 days of receiving a response from the third-party payer
- Claims for members whose eligibility has not been added to the District’s eligibility system must be received within 365 days from the date the eligibility is added

Claims submitted after the 365 day filing deadline will be denied.

After filing a claim with Amerigroup, providers should review the weekly explanation of payment (EOP). If the claim does not appear on an EOP within 15 business days as adjudicated, or you have no other written indication the claim has been received, check the status of your claim using the Provider Inquiry Line at 1-800-454-3730 or the Amerigroup website. If the claim is not on file with Amerigroup, resubmit your claim within 365 days from the date of service. If filing electronically, check for acceptance of the claim via the confirmation reports you receive from your EDI or practice management vendor.

The Interactive Voice Response System

Amerigroup provides an automated interactive voice response (IVR) system to better serve members and participating providers. This IVR technology allows Amerigroup to provide more detailed enrollment, claims and authorization status information along with self-service features for members. These features allow each member to:

- Update his or her address and telephone number.
- Request a new member ID card.
- Search for and/or change his or her PCP name.

Amerigroup recognizes that in order for you to provide the best service to members, accurate, up-to-date information must be shared. As a result, Amerigroup offers an automated inquiry line for accessing claims status, member eligibility and precertification determination status 24 hours a day, 365 days a year.

The toll-free automated Provider Inquiry Line (1-800-454-3730) can be used to verify member status, claim status and precertification determination. This tool also offers the ability to be transferred to the appropriate department for other needs such as requesting new precertification, ordering referral forms or directories, seeking advice in case management, or obtaining a member roster. Detailed instructions for use of the Provider Inquiry Line are outlined below.
To access member eligibility information:
Electronic eligibility and benefits are available at https://www.availity.com. For manual calls to the Provider Inquiry Line:
1. Dial 1-800-454-3730. After saying your NPI or provider ID and TIN for the prompt, you can say, “member status,” “eligibility” or “enrollment status.”
2. Be prepared to say the member’s Amerigroup ID number, ZIP code and date of service.
3. You can search by Medicaid ID, Medicare ID or Social Security number.
   a. Say, “I don’t have it” when asked to say the member’s Amerigroup ID number, then say the ID type you would like to use when prompted.
4. The system will verify the member’s eligibility and PCP name.

To review claim status:
Electronic claim status inquiry is available at https://www.availity.com. For manual calls to the Provider Inquiry Line:
1. Dial 1-800-454-3730 and listen for the prompt.
   a. At the main menu, say, “claims.”
   b. You can get the status of a single claim or the five most recent claims.
   c. You can speak to someone about a Payment Appeal Form or an EOP.
2. Be prepared to say the claim number.
   a. If you don’t have it, you can hear the five most recent claims by saying recent claims.

To review referral authorization status:
1. Dial 1-800-454-3730 and listen for the prompt.
   a. At the main menu, say, “authorizations” or “referrals.”
   b. Say “authorization status” to hear up to 10 outpatient or one inpatient authorization determination.
   c. Say “new authorization” to be transferred to the correct department based on the authorization type.
2. Be prepared to say the member’s Amerigroup ID number, ZIP code, date of birth and date of service.
   a. Say the admission date or the first date for the start of service in MM/DD/YYYY format.

CMS-1500 (08-05) Claim Form
Health care practitioners and other persons entitled to reimbursement must use the CMS-1500 (08-05) form and instructions provided by CMS for use of the CMS-1500 (08-05) as the sole instrument for filing claims with Amerigroup for professional services. This does not apply to dental services billed by dentists using the J 512 Form or its equivalent or pharmacists or pharmacies filing claims for prescription drugs.

Except for parties to a global contract, Amerigroup may not require a health care practitioner or other person entitled to reimbursement to use any code or modifier to file claims for health
care services different from, or in addition to, what is required under the applicable standard code set for the professional services provided.

Except as noted, Amerigroup may not use and may not require a health care practitioner or other person entitled to reimbursement to use another descriptor with a code or to furnish additional information with the initial submission of a *CMS-1500 (08-05)* that is different from, or in addition to, the applicable standard code set for the professional services provided.

A health care practitioner or other person entitled to reimbursement whose billing is based on the amount of time involved will indicate the start and stop time or number of minutes in Field 24G, currently titled Day or Units, of the *CMS-1500 (08-05)* if it is not used to specify the number of days of treatment.

This form is available at [www.cms.hhs.gov](http://www.cms.hhs.gov).

**UB-04 Claim Form**

Hospitals or persons entitled to reimbursement must use the *UB-04*, and instructions provided by CMS for use of the *UB-04*, as the sole instrument for filing claims with Amerigroup for hospital and other health care services.

Except for parties to a global contract, Amerigroup may not use and may not require a hospital or other person entitled to reimbursement to use any code or modifier for the filing of claims for hospital and other health care services that is different from, or in addition to, what is required under the applicable standard code set for hospital or other health care services provided.

Except as noted, Amerigroup may not use and may not require a hospital or other person entitled to reimbursement to furnish additional information with the initial submission of a *UB-04* that is different from, or in addition to, the applicable standard code set for the hospital or other health care services provided.

This form is available at [www.cms.hhs.gov](http://www.cms.hhs.gov).

**Claim Form Attachments**

Amerigroup requires the following attachments for a claim to qualify as a clean claim:

- Explanation of benefits statement from the primary payer to the secondary payer, unless an electronic remittance notice has been sent by the primary payer to the secondary payer
- Medicare remittance notice if the claim involves Medicare as a primary payer, and Amerigroup provides evidence it does not have a crossover agreement to accept an electronic remittance notice
• Description of the procedure or service which may include the medical record, if a
  procedure or service rendered has no corresponding CPT or HCPCS code
• Operative notes if the claim is for multiple surgeries or includes modifier 22, 58, 62, 66,
  78, 80, 81 or 82
• Anesthesia records documenting time spent on the service if the claim for anesthesia
  services rendered includes modifiers P4 or P5
• Documents referenced as contractual requirements in a global contract (if applicable)
• Ambulance trip report if the claim is for ambulance services submitted by an ambulance
  company licensed by the District of Columbia Emergency Medical Services Systems
• Office visit notes if the claim includes modifiers 21 or 22
• Information related to an audit as specified in writing by Amerigroup if the Amerigroup
  audit demonstrated a pattern of fraud, improper billing or improper coding
• Admitting notes, if the claim is for inpatient services provided outside of the time or
  scope of the authorization
• Physician notes, if the claim for services provided is outside of the time or scope of the
  authorization or if the authorization is in dispute
• Itemized bills, if the claim is for services rendered in a hospital, and the hospital claim
  has no precertification for admission or the claim is for services inconsistent with the
  Amerigroup concurrent review determination rendered before the delivery of services
  regarding the medical necessity of the service

Adjunct Claims Documentation

The following are permissible categories of disputed claims for which Amerigroup may request
additional information:
• If there is no authorization or there was a precertification and Amerigroup disputes the
  claim consistent with the Amerigroup basis for denial or because the claim is for services
  provided outside the time or scope of the authorization and the applicable attachment
  was not submitted with the claim
• Eligibility for benefits or coverage
• Necessity of a service, procedure or DME rendered or provided by a specialist and not
  requested by a network PCP on a referral form or consultant treatment plan
• Information necessary to adjudicate the claim consistent with the global contract
• Reasonable belief of incorrect billing
• Additional information not obtained by Amerigroup from the member within 30 days of
  receipt of the claim
• Legibility of the claim in a material manner
• Reasonable belief of fraudulent or improper coding, consistent with the Amerigroup
  retroactive denial
• Reasonable belief that a claim for emergency service may not meet the standards for an
  emergency service
• Category approved by the commissioner by regulation
Amerigroup may not request additional information if an attachment containing the same type of information was submitted with the claim.

Amerigroup may not request additional information for the following categories of disputed claims:

- Except for global contracts, a description of the procedure or service that is inconsistent with the applicable standard code set
- Reimbursement for hospital services in accordance with the rates approved by the Health Services Cost Review Commission
- Services that were precertified by Amerigroup

**Encounter Data Format**

Amerigroup utilizes the *CMS-1500 (08-05)* claim form to obtain encounter data. See the [Encounter Data Reporting Requirements](#) section for more information.

**Claim Forms**

A **clean claim** is defined as a claim for reimbursement submitted to Amerigroup by a health care practitioner, pharmacy or pharmacist, hospital or person entitled to reimbursement that contains the required data elements and any attachments requested by Amerigroup.

An **applicable code set** is defined as the most recent version, as of the date of service, of the following:

- For services rendered by health care practitioners, the Current Procedural Terminology (CPT) maintained and distributed by the American Medical Association, including its codes and modifiers and codes for anesthesia services
- For dental services, the Code on Dental Procedures and Nomenclature (CDT), maintained and distributed by the American Dental Association
- For all professional and hospital services, the International Classification of Diseases, Clinical Modification (ICD-10 CM)
- For all other health-related services, the CMS’ HCPCS levels I and II and modifiers, maintained and distributed by the U.S. Department of Health and Human Services
- For prescribed drugs, the National Drug Codes (NDC), maintained and distributed by the U.S. Department of Health and Human Services
- For anesthesia services, the codes maintained and distributed by the American Society of Anesthesiologists
- For psychiatric services, the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)* codes, distributed by the American Psychiatric Association
- For hospital and other applicable health care services including home health services, the District *UB-04 Uniform Billing Data Elements Specification Manual*
• For hospital services pursuant to a Maryland contract or insurance policy, a revenue code approved by the Health Services Cost Review Commission for a hospital located in the District or by the National or State Uniform Billing Data Elements Specifications for a hospital not located in the District

An **auto code** is defined as an ICD-10 code designed by Amerigroup as a diagnosis that is an emergency service.

A **modifier** is defined as a code appended to a CPT or HCPCS code to provide more specific information about a medical procedure.

For a paper claim, Amerigroup will date-stamp the claim with the date received or assign a batch number to the electronic claim that includes the date received. Amerigroup will maintain a written or electronic record of the date of the receipt of a claim. If a provider requests verification, Amerigroup will provide verification of the date of claim receipt within five working days. The claim is presumed to have been received by Amerigroup within three working days from the date the provider placed the claim in the U.S. mail if the provider maintains the stamped certificate of mailing for the claim or on the date recorded by the courier, if the claim was delivered by courier.

Amerigroup utilizes auto codes to determine emergency services and provides them to all network practitioners or hospitals rendering emergency services and to all health care practitioners or hospitals rendering emergency services that request the auto codes. If the auto codes are updated, the codes will be distributed 30 days prior to implementation.

**International Classification of Diseases, 10th Revision (ICD-10) Description**

ICD-10 is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9) which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes. In the United States, the codes are the foundation for documenting the diagnosis and associated services provided across health care settings.

Although the term ICD-10 is often used alone, there are actually two parts to ICD-10:

- **Clinical modification (CM):** ICD-10-CM is used for diagnosis coding
- **Procedure coding system (PCS):** ICD-10-PCS is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaces the code sets ICD-9-CM, volumes one and two for diagnosis coding, and ICD-10-PCS replaces ICD-9-CM, volume three for inpatient hospital procedure coding.
5 MEMBER BENEFITS AND SERVICES

Overview

Amerigroup must provide a complete and comprehensive benefit package equivalent to the benefits available to Medicaid participants through the Medicaid fee-for-service delivery system. Carve-out services, which are not subject to capitation and are not an Amerigroup responsibility, are still available for members. Medicaid will reimburse these services directly on a fee-for-service basis.

An Amerigroup PCP serves as the entry point for access to covered health care services. The PCP is responsible for providing members with medically necessary covered services or for referring a member to a specialty care provider to furnish the needed services. The PCP is also responsible for maintaining medical records and coordinating comprehensive medical care for each assigned member.

A member has the right to access certain services without prior referral or authorization by a PCP. This applies to specified self-referred services and emergency services. Amerigroup is responsible for reimbursing out-of-plan providers who have furnished these services to members (see Self-Referral Services).

Only benefits and services that are medically necessary are covered.

Covered Benefits and Services

The following covered benefits and services are listed alphabetically.

**Audiology Services**

Audiology services are covered.

**Blood and Blood Products**

Blood, blood products, derivatives, components, biologics and serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin and albumin are covered.

**Case Management Services**

Case management services are covered for members who need such services, including but not limited to members with special health care needs.

Case Management focuses on the timely, proactive, collaborative, and member-centric coordination of services for individuals. These individuals can be identified with complex medical conditions, repeated admissions for the same condition, or high risk obstetrics.
Amerigroup assists members who are found to have potentially preventable emergency department utilization and those who qualify for the Lock-In Program.

The defining features of Amerigroup case management programs are:

- A collaborative process that includes contact with the member, family member, caregiver and physician or other health care providers.
- A process carried out using communication and available resources with the goal of promoting quality and effective outcomes.
- A process that assists in optimizing the members’ health care outcomes through plans designed to empower members to use the benefits, services and options available to meet individual health needs.

**Case Management Programs**

Complex Case Management is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

**Stabilization Case Management** is part of the continuum of care provided to Amerigroup members. Stabilization helps Case Managers focus interventions on behaviors that can help prevent readmissions. This program focuses member education which leads to self-management of post discharge needs including completion of a personal health record, medication reconciliation and follow-up appointments, necessary home care and community resources.

**High-Risk OB (HROB) and NICU Case Management** are focused on pregnant members identified by early OB assessment as being at risk for an early delivery or poor birth outcome influenced by a known maternal or fetal condition or risk factor.

**The Case Management Process:** Amerigroup Case Managers perform the activities of assessment, planning, facilitation and support throughout the continuum of care and provide evidenced-based, member-centric care planning that is consistent with recognized standards of case management practice and accreditation requirements.

Case managers consider Amerigroup members’ needs for:

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

The Amerigroup Case Management team will also provide:

- Education and counseling with regard to member compliance with prescribed treatment programs and compliance with EPSDT appointments.
A case manager will perform home visits as necessary as part of the Amerigroup Case Management program and will have the ability to respond to a member’s urgent care needs during this home visit. Call Provider Services to refer a member to case management.

Members enrolled in the MY DC Health Home or My Health GPS Health Home benefits will be managed by the assigned Health Home Provider. See the Health Home section for referral details.

Amerigroup welcomes provider referrals of patients who can benefit from the case management support, as well as member self-referral or caregiver referrals. Please call the Provider Services toll-free number at 1-800-454-3730 and request the Case Management team. All Case Managers are licensed RNs and social workers. Case Managers are available from 8 a.m. to 5 p.m. local time. Confidential voicemail is available 24 hours a day.

**Clinical Trials**

Clinical trials and experimental treatment are not covered.

**Dental Services**

Dental services are covered and provided through DentaQuest.

**Diabetes Care Services**

Amerigroup covers all medically necessary diabetes care services. For members who have been discharged from a hospital inpatient stay for a diabetes-related diagnosis, these diabetes care services include:

- Diabetes nutrition counseling
- Diabetes outpatient education
- Diabetes-related DME and disposable medical supplies including:
  - Blood glucose meters for home use
  - Finger-sticking devices for blood sampling
  - Blood glucose monitoring supplies
  - Diagnostic reagent strips and tablets used in testing for ketone, glucose in urine, and glucose in blood
  - Therapeutic footwear and related services to prevent or delay amputation that would be highly probable in the absence of specialized footwear
- Routine foot care
**Disease Management Centralized Care Unit**

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

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disorder (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder
- Schizophrenia
- Substance abuse disorder

In addition to our 11 condition-specific disease management programs, our member-centric, holistic approach also allows us to assist members with managing their weight.

DMCCU also offers smoking cessation services.

Members enrolled the MY DC Health Home or My Health GPS Health Home benefits will be managed by the assigned health home provider. See the Health Home section of this manual for referral details.

**Program Features**

- Proactive identification processes
- Chronic disease care gap identification
- Evidence-based clinical guidelines from recognized sources
- Collaborative practice models to include physician and support providers in treatment planning
- Continuous self-management education
- Ongoing process and outcomes measurement, evaluation and management
- Ongoing communication with providers regarding patient status

Disease Management Clinical Practice Guidelines are located at [https://providers.amerigroup.com/DC](https://providers.amerigroup.com/DC). Select **Clinical Practice Guidelines** in the Provider Resources & Documents section.

**Objectives**

Disease Management programs are designed to:

- Address gaps in care.
- Improve the understanding of disease processes.
- Improve the quality of life for our members.
- Collaborate to develop member-centered goals and interventions.
- Support relationships between member and network providers.
- Increase network provider awareness of Disease Management programs.
- Reduce acute episodes requiring emergent or inpatient care.

**Who Is Eligible?**
All members with the listed conditions are eligible. We identify them through:
- Continuous case finding welcome calls.
- Claims mining.
- Referrals.

**How Can You Use DMCCU Services?**
As a valued provider, we welcome your referrals of patients who can benefit from additional education and case management support. Our case managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk stratified based on the severity of their disease. They are provided with continuous education on self-management concepts, which include primary prevention, behavior modification and compliance/surveillance as well as case/care management for high-risk members. Program evaluation, outcome measurement and process improvement are built into all the programs. Providers are given telephonic and/or written updates regarding patient status and progress.

**Disease Management Centralized Care Unit Provider Rights and Responsibilities**
You have the right to:
- Have information about Amerigroup including:
  - Provided programs and services
  - Our staff
  - Our staff’s qualifications
  - Any contractual relationships
  - Decline to participate in or work with any of our programs and services for your patients
  - Be informed of how we coordinate our interventions with your patients’ treatment plans
  - Know how to contact the person who manages and communicates with your patients
  - Be supported by our organization when interacting with patients to make decisions about their health care
  - Receive courteous and respectful treatment from our staff
  - Communicate complaints about DMCCU as outlined in the Amerigroup provider complaint and grievance procedure

**Hours of Operation**
Our DMCCU case managers are licensed nurses. They are available:
- 8:30 a.m. to 5:30 p.m. local time
- Confidential voicemail is available 24 hours a day. The Nurse Helpline is available for our member 24 hours a day, 7 days a week.
Contact Information
You can call a DMCCU team member at 1-888-830-4300. DMCCU program content is located at https://providers.amerigroup.com/DC. Printed copies are available upon request. Members can obtain information about DMCCU program by visiting www.myamerigroup.com or calling 1-888-830-4300.

Disposable Medical Supplies/Durable Medical Equipment

Authorization
Authorizations for durable medical equipment (DME) and/or disposable medical supplies (DMS) will be provided in a timely manner so as not to adversely affect the member’s health. Determinations are made within two business days of receipt of the necessary clinical information but no later than seven calendar days from the date of the initial request.

No precertification is required for coverage of purchased glucometers and nebulizers, dialysis and ESRD equipment, gradient pressure aids, infant photo/light therapy, UV light therapy, sphygmomanometers, walkers, orthotics for arch support, heels, lifts, shoe inserts and wedges ordered by a network provider. Precertification is required for coverage of certain prosthetics, orthotics and DME, including all rentals.

For code-specific precertification requirements for DME, prosthetics and orthotics ordered by network providers or facilities, go to https://providers.amerigroup.com > Quick Tools > Precertification Lookup.

Precertification may be requested by completing a Certificate of Medical Necessity (CMN) — available on the Amerigroup website — or by submitting a physician order and an Amerigroup Referral and Authorization Request form. A properly completed and physician-signed CMN must accompany each claim for the following services: hospital beds, support surfaces, motorized wheelchairs, manual wheelchairs, continuous positive airway pressure devices, lymphedema pumps, osteogenesis stimulators, transcutaneous electrical nerve stimulator units, seat-lift mechanisms, power-operated vehicles, external infusion pumps, parenteral nutrition equipment, enteral nutrition equipment and oxygen. Amerigroup and the provider must agree on HCPCS and/or other codes for billing covered services. All custom wheelchair precertifications require the medical director’s review. All DME billed with an RR modifier (i.e., rental) requires precertification.

DMS are covered, including incontinency pants, disposable underpants for medical conditions associated with prolonged urinary or bowel incontinence if necessary to prevent institutionalization or infection, and all supplies used in the administration or monitoring of prescriptions by the member.

DME is covered when medically necessary, including but not limited to all equipment used in the administration or monitoring of prescriptions by the member. Amerigroup pays for any DME authorized for members, even if delivery of the item occurs within 90 days after the
member’s disenrollment from Amerigroup, as long as the member remains Medicaid-eligible during the 90-day time period.

**Early and Periodic Screening, Diagnostic and Treatment Services**

For members under age 21, all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services rendered by an EPSDT-certified provider are covered and recorded in accordance with the EPSDT periodicity schedule. Providers rendering EPSDT service receive training on these services through the District’s HealthCheck Program. Services include:

- Annual comprehensive physical examination, health and developmental history, including an evaluation of both physical and behavioral health development; the implementation of an approved developmental screening tool (e.g., Ages and Stations Questionnaire [ASQ] or Parents Evaluation of Developmental Status [PEDS]) should begin at the 9-month, 18-month, and 24-30 month visit. The results of the developmental surveillance and screening and the screening tool used should be documented in the patient’s chart. Children identified as being at risk for developmental delays should have documented counseling and referral for additional evaluation services.
- Immunizations and review of required documentation.
- Laboratory tests for at-risk screening including Tb risk assessment, hematocrit and blood lead level test and assessments.
- Health education/anticipatory guidance including a dental referral at 12 months old.

Partial or interperiodic well-child services and health care services necessary to prevent, treat or ameliorate physical, behavioral or developmental problems or conditions with services in sufficient amount, duration and scope to treat the identified condition, and are subject to limitation only on the basis of medical necessity, including:

- Chiropractic services
- Nutrition counseling
- Audiological screening when performed by a PCP
- Private-duty nursing
- Durable medical equipment including assistive devices
- Any other benefit listed in this section

Providers and Amerigroup are responsible for making appropriate referrals for community resources not covered by Medicaid like the Women, Infants and Children (WIC) nutritional program.

**Family Planning Services**

Comprehensive family planning services are covered including:

- Office visits for family planning services
- Laboratory tests, including Pap smears
- Contraceptive devices such as Mirena, Paraguard and Implanon (Precertification is not required.)
• Voluntary sterilization (including Essure Micro-Insert if done in an obstetrician’s office)

Members may see any provider they choose, without referral, for family planning services, including out of network providers.

**Home Health Services**

Home health services are covered when the member’s PCP or attending provider certifies the services are medically necessary on a part-time, intermittent basis by a member who requires home visits. Precertification is required for coverage of procedures and services. Amerigroup may choose to provide coverage of home health services to a non-homebound member, but this is not a mandatory benefit. Covered home health services are delivered in the member’s home and include:

- Skilled nursing services including supervisory visits
- Home health aide services (including biweekly supervisory visits by a registered nurse in the member’s home and with observation of aide’s delivery of services to member at least every second visit)
- Physical therapy services
- Occupational therapy services
- Speech pathology services
- Medical supplies used in a home health visit

**Hospice Care Services**

Hospice care services are covered for members who are terminally ill with a life expectancy of six months or less. Hospice services can be provided in a hospice facility, a long-term care facility or at home. Notification is required for coverage of outpatient hospice services. Precertification is required for home health care and most DME.

**Inpatient Hospital Services**

Inpatient hospital services are covered. Elective admissions require precertification for coverage. Emergency admissions require notification within 24 hours or by the next business day. To be covered, preadmission testing must be performed by an Amerigroup-preferred laboratory vendor or network facility outpatient department. See the [Provider Referral Directory](https://providers.amerigroup.com/DC) at [https://providers.amerigroup.com/DC](https://providers.amerigroup.com/DC) for a complete listing of participating vendors. Same-day admission is required for surgery.

For special rules for length of stay for childbirth, see the [Childbirth-Related Provisions](#) section.

**Laboratory Services**

Diagnostic and laboratory services performed by providers who are Clinical Laboratory Improvement Act of 1998 (CLIA)-certified or have a waiver of certificate registration and a CLIA identification number are covered. However, viral-load testing, genotypic, phenotypic or drug resistance testing used in treatment of HIV/AIDS are reimbursed directly by DCHFP and must be rendered by a DCHFP-approved provider and be medically necessary. Precertification is
required for genetic testing. All laboratory services furnished by nonparticipating providers require precertification by Amerigroup, except for hospital laboratory services for an emergency medical condition. If a convenient alternative is not available, precertification is required for members to access network hospital outpatient departments for blood drawings and/or specimen collection.

To ensure outpatient diagnostic laboratory services are directed to the most appropriate setting, laboratory services should be sent to an Amerigroup-preferred laboratory vendor (e.g., Lab Corp or Quest Diagnostics). Laboratory services provided in a District hospital will be reimbursed under certain circumstances including:

- Services identified by Amerigroup as stat laboratory procedures (for a list of identified stat laboratory procedure codes, refer to the provider website)
- Services rendered in an emergency room setting with an emergent diagnosis
- Services rendered in conjunction with ambulatory surgery services (RV0360-RV0369, RV0481, RV0490-RV0499, RV0720-RV0729, RV0750-RV0759, and RV0790-RV0799)
- Services rendered in conjunction with observation services (RV0760-RV0769)
- Services billed with certain chemotherapy, obstetric and sickle cell diagnosis codes (C00-C14.8, C15.3-C26.9, C30.0-C39.9, C40.0-C41.9, C43.0-C44.9, C45.0-C49.9, C50.01-C50.92, C51.0-C58, C60.0-C63.9, C6.1-C68.9, C69.0-C72.9, C73-C75.9, C76.0-C80.2, C81.00-C96.9, D00.00-D09.9, D37.01-D48.9, D49.0-D49.9, D57.00-D57.819, O01.0-O01.9, O02.0-O02.81, O02.1, O00.0-O00.9, O03.0-O03.9, O08.0-O08.9, O09.00-O09.93, O10.011-O10.02, O10.111-O10.12, O10.211-O10.22, O10.311-O10.32, O10.411-O10.42, O10.911-O10.92, O11.1-O15.1, O15.9-O16.9, O20.0-O24.02, O24.111-O24.12, O24.311-O24.32, O24.410-O24.429, O24.811-O24.82, O24.911-O24.92, O25.10-O25.2, O26.00-O26.62, O26.711-O26.72, O26.811-O29.93, O30.00-O48, O60.00-O77.9, O80-O82, Z331, Z3400-Z3493, Z390-Z392, Z51.11-Z51.12)

Physicians may continue to perform laboratory testing in their office but must otherwise direct outpatient diagnostic laboratory tests to an Amerigroup-preferred laboratory vendor (e.g., LabCorp or Quest Diagnostics).

Laboratory codes for drug testing or urine drug screening related to a substance use disorder are not the payment responsibility of the MCOs.

**Long-Term Care Facility Services/Nursing Facility Services**

Long-term care facilities include chronic hospitals, rehabilitation hospitals and nursing facilities. The first 30 days in a long-term care facility are the responsibility of Amerigroup, subject to specific rules. Precertification is required for coverage from Amerigroup.

When a member is transferred to skilled nursing or long-term care facility and the length of the member’s stay is expected to exceed 30 days, medical eligibility approval of the Department of Health for long-term institutionalization must be secured as soon as possible.
Amerigroup covers the first 30 days or until medical eligibility approval is obtained, whichever is longer. If required disenrollment procedures are not followed, financial responsibility continues until the District’s requirements for the member’s disenrollment are satisfied. In order for a member to be disenrolled from Amerigroup based on a long-term care facility admission, all of the following must first occur:

- A DCHFP 3871 application for a departmental determination of medical necessity must be filed. If a length of stay of more than 30 days is anticipated at the time of admission, the application should be filed at the time of admission.
- DCHFP must determine the member’s long-term care facility admission was medically necessary, in accordance with the District’s criteria.
- The member’s length of stay must exceed 30 consecutive days.
- Amerigroup must file an application for disenrollment with DCHFP, including documentation of the member’s medical and utilization history if requested.

Inpatient acute care services provided within the first 30 days following admission to a long-term care facility are not considered an interruption of the Amerigroup-covered 30 continuous days in a long-term care facility, as long as the member is discharged from the hospital back to the long-term care facility.

A member with serious behavioral illness, intellectual disability or a related condition may not be admitted to a nursing facility (NF) unless the District determines NF services are appropriate for coverage. For each member seeking NF admission, a preadmission screening and resident review (PASRR) ID screen must be completed.

The first section of the PASRR ID screen exempts a member if both:

1. NF admission is directly from a hospital for the condition treated in the hospital.
2. The attending provider certifies, prior to admission to the NF, that the member is likely to require less than 30 days of NF services.

**Newborn Coordinator and Provider Responsibilities**

Amerigroup will designate a newborn coordinator (NC) to serve as a point of contact for providers who have questions or concerns related to the eligibility of services for newborns during the first 60 days after birth.

**Outpatient Hospital Services**

Medically necessary outpatient hospital services are covered.

**Oxygen and Related Respiratory Equipment**

Oxygen and related respiratory equipment are covered.

**Personal Care Services**

Personal Care Services are covered for those members who meet functional eligibility requirements.
Pharmacy Services

Amerigroup will expand the drug formulary to include new products approved by the Food and Drug Administration (FDA) in addition to maintaining drug formularies that are at least equivalent to the standard benefits of the District of Columbia Department of Health Care Finance. This requirement pertains to new drugs or equivalent drug therapies, routine childhood immunizations, vaccines prescribed for high-risk and special-needs populations, and vaccines prescribed to protect individuals against vaccine-preventable diseases. If a generic equivalent drug is not available, a new brand-name drug rated as P (priority) by the FDA will be added to the formulary. Coverage may be subject to precertification to ensure medical necessity for specific therapies. For formulary drugs requiring precertification, a decision will be provided in a timely manner so as not to adversely affect the member’s health. Decisions are made within 72 hours of receipt of necessary clinical information, and no later than seven calendar days from the date of the initial request. If the service is denied, Amerigroup will notify the prescriber and the member in writing of the denial.

When a prescriber believes a nonformulary drug is medically indicated, Amerigroup has procedures in place for nonformulary requests. The District expects a nonformulary drug to be approved if documentation is provided indicating the formulary alternative is not medically appropriate.

The Amerigroup pharmacy benefit provides coverage for medically necessary medications from licensed prescribers for the purpose of saving lives in emergency situations or during short-term illness, sustaining life in chronic or long-term illness or limiting the need for hospitalization. Members have access to most national pharmacy chains and many independent retail pharmacies. Amerigroup contracts with Express Scripts, Inc. as the pharmacy benefits manager. All members must utilize a contracted Express Scripts, Inc. network pharmacy when filling prescriptions in order for benefits to be covered. Several large chains and most independent pharmacies are contracted with Express Scripts, Inc. For specialty drugs, please continue to use the Accredo Specialty Pharmacy at 1-866-892-9976. Prescriptions for specialty products can only be filled through the Accredo Specialty Pharmacy as described below.

Except for specialty drugs, members are not required to use mail-order pharmacy providers.

Monthly Limits
All prescriptions are limited to a maximum 30-day supply per fill.

Covered Drugs
The Amerigroup Pharmacy program utilizes a preferred drug list (PDL), which has been reviewed and approved by DHCF. This is a list of the preferred drugs within the most commonly prescribed therapeutic categories. The medications included in the PDL are reviewed and approved by the Pharmacy and Therapeutics (P&T) committee. The P&T committee is comprised of practicing physicians and pharmacists from the Amerigroup provider community who evaluate safety, efficacy, adverse effects, outcomes and total pharmacoeconomic value for
each drug product reviewed. The goal of the PDL is to provide cost-effective pharmacotherapy choices based on prospective, concurrent and retrospective review of medication therapies and utilization. Many over-the-counter (OTC) medications are also included in the PDL and should be considered for first-line therapy when appropriate. To access the PDL, go to https://providers.amerigroup.com/DC > Pharmacy > Medicaid Preferred Drug List. To access our searchable formulary, go to https://providers.amerigroup.com/DC > Pharmacy > Medicaid Formulary.

The following are examples of covered items:

- Legend drugs
- Insulin
- Disposable insulin needles/syringes
- Disposable blood/urine glucose/acetone testing agents
- Contraceptives
- Latex condoms (to be provided without any requirement for a provider’s order)
- Lancets and lancet devices
- Compounded medication of which at least one ingredient is a legend drug and listed on the Amerigroup PDL
- Any other drug which under applicable District law may only be dispensed upon the written prescription of a physician or other lawful prescriber and is listed on the Amerigroup PDL
- PDL listed legend contraceptives

Exclusions: Neither the District nor Amerigroup cover the following:

- Drugs not approved by the FDA
- Drugs not on the OTC Drug Formulary
- Drugs to help members get pregnant
- Drugs used for cosmetic reasons
- Drugs for hair growth
- Drugs used to treat erectile problems
- Drugs used for weight loss
- Experimental or investigational drugs

Carve-Out Drugs: Managed directly by the District’s Department of Health

- HIV/AIDS medications except Truvada for PrEP

Pharmacy Restriction (Lock-in)

Amerigroup’s pharmacy restriction process limits members to a single pharmacy to obtain their medications. The need for restriction is determined as a result of medication claims review. Members identified with uncoordinated care, excessive utilization or suspected patterns of fraud and abuse may also be referred to the pharmacy department.
Using predefined queries, the Pharmacy department identifies members that meet the criteria for lock-in. These members are notified in advance of the lock-in and provided a period of time to appeal or request additional information. All providers that have prescribed for this member in the previous 90 days will be notified of the member’s lock-in as well as receiving a 6 month profile regarding the member’s utilization. The network pharmacy provider will also receive a letter identifying the members that are restricted to their pharmacy.

**Pharmacy Prior Authorization Drugs**

Providers are strongly encouraged to write prescriptions for preferred products as listed on the PDL. If for medical reasons a member cannot use a preferred product, providers are required to contact Amerigroup Pharmacy Services to obtain prior authorization in one of the following ways:

- Call 1-800-454-3730 Monday through Friday from 8 a.m. to 8 p.m. Eastern time, or 10 a.m. to 2 p.m. on Saturdays.
- Fax all information required and a prior authorization form to 1-844-487-9292 for general pharmacy and 1-844-487-9294 for medical injectable request. The form is located at [https://providers.amerigroup.com/DC > Pharmacy > Prior Authorization Form.](https://providers.amerigroup.com/DC)
- Use the online Precertification Lookup Tool, which allows you to:
  - Submit requests for general pharmacy — medications dispensed directly to a member from retail pharmacy or shipped from a specialty pharmacy.
  - Request medical injectables for those medications obtained by your office/facility for onsite infusion or administration.
  - Check precertification status.
  - Appeal denied requests.
  - Upload supporting documents and review appeal status.

To access the Precertification Lookup Tool, log in at [https://providers.amerigroup.com/DC](https://providers.amerigroup.com/DC) and go to Precertification > Precertification Lookup Tool; you must be a registered user to access the tool. The site also offers tutorials to guide you through the medication prior authorization process and other helpful functions.

The information will be reviewed by a clinical pharmacist and/or medical director for medical necessity and the provider will be notified within 72 hours of receipt of the necessary clinical information, and no later than seven calendar days from the date of the initial request.

If the service is denied, the prescriber and the member are notified in writing of the denial. All decisions are based on medical necessity and are determined according to certain established medical criteria. Amerigroup does not cover brand name medications where there is an FDA-approved therapeutically equivalent generic. Requests for brand name medications when there is a generic available will follow the precertification process to determine medical necessity. Some drugs have daily quantity and/or dosage limits and are identified as such on the PDL.
Request for drugs exceeding the limits will require precertification to determine medical necessity.

Examples of medications that require precertification are listed below (this list is not all-inclusive and is subject to change):

- Drugs not listed on the PDL
- Brand-name products for which there are therapeutically equivalent generic products available
- Self-administered injectable products
- Drugs that exceed certain limits (for information on these limits please contact the Pharmacy department)

**Specialty Drug Program**

Amerigroup contracts with Accredo Specialty Pharmacy Services as its exclusive supplier of high-cost, specialty and/or injectable drugs that treat a number of chronic or rare conditions. To obtain one of the listed specialty drugs, fax your prescription to Accredo Specialty at 1-800-824-2642 or call 1-866-892-9976.

**Note: This is not a complete list and is subject to change, but represents the most commonly prescribed injectables. Call the Amerigroup Pharmacy department at 1-800-454-3730 for precertification of the drugs in the following table.**

<table>
<thead>
<tr>
<th>MEDICATIONS SUPPLIED BY ACCREDO SPECIALTY PHARMACY SERVICES</th>
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<tbody>
<tr>
<td><strong>Disease or treatment</strong></td>
</tr>
<tr>
<td>Allergic asthma</td>
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<tr>
<td>Crohn’s disease</td>
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<tr>
<td>Enzyme replacement for lysosomal storage disorders</td>
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<tr>
<td>Gaucher disease</td>
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<td>Growth hormone disorders</td>
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<tr>
<td>Hematopoietics</td>
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<tr>
<td>Hepatitis C</td>
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<tr>
<td>Disease or treatment</td>
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<tr>
<td>• Intron®-A</td>
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<tr>
<td>• Pegasys®</td>
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<td>• Peg-Intron®</td>
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<tr>
<td>Hormonal therapies</td>
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<tr>
<td>• Eligard™</td>
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<tr>
<td>• Lupron Depot®</td>
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<tr>
<td>• Lupron Depot – Ped®</td>
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<td>• Trelstar Depot™</td>
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<tr>
<td>Immune deficiencies</td>
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<tr>
<td>• Baygam®</td>
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<td>• Carimune® NF</td>
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<td>• Cytogam®</td>
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<td>• Flebogamma®</td>
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<td>• Gamimune® N</td>
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<td>• Gammagard® S/D</td>
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<td>• Gammar® – P I.V.</td>
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<td>• GammaSTAN®</td>
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<td>Multiple sclerosis</td>
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<td>• Avonex®</td>
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<td>• Betaseron®</td>
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<td>• Copaxone®</td>
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<td>Oncology</td>
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<td>• Gleevec®</td>
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<td>• Herceptin®</td>
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<td>• Nexavar®</td>
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<td>• Novantrone®</td>
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<td>• Revlimid®</td>
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<td>• Rituxan®</td>
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<tr>
<td>• Sprycl™</td>
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<tr>
<td>Osteoarthritis</td>
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<tr>
<td>• Euflexxa™</td>
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<tr>
<td>• Hyalgan®</td>
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<tr>
<td>• Orthovisc®</td>
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<tr>
<td>Pulmonary arterial hypertension</td>
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<tr>
<td>• Remodulin®</td>
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<tr>
<td>• Revatio™</td>
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<tr>
<td>Pulmonary disease</td>
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<td>• Aralast™</td>
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<td>• Pulmozyme®</td>
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<td>• TOBI®</td>
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<td>Psoriasis</td>
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<td>• Synagis®</td>
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<tr>
<td>Respiratory syncytial virus</td>
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<td>Disease or treatment</td>
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<tr>
<td>Rheumatoid arthritis</td>
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**Physician and Advanced Practice Nurse Specialty Care Services**

Specialty care services provided by a physician or an advanced practice nurse (APN) are covered when such services are medically necessary and are outside of the PCP’s customary scope of practice.

Specialty care services covered under this section also include:

- Services performed by nonphysicians or non-APN practitioners within their scope of practice, employed by a physician to assist in the provision of specialty care services and working under the physician’s direct supervision
- Services provided in a clinic by or under the direction of a physician or dentist
- Services performed by a dentist or dental surgeon when the services are customarily performed by physicians

Amerigroup shall clearly define and specify referral requirements to all providers.

A member’s PCP is responsible for making the determination based on Amerigroup referral requirements (i.e., whether a specialty care referral is medically necessary).
PCPs must follow Amerigroup specialty referral protocol for children with special health care needs who suffer from a moderate to severe chronic health condition that:

- Has significant potential or actual impact on health and ability to function.
- Requires special health care services.
- Is expected to last longer than six months.

A child who is functioning one third or more below chronological age in any developmental area must be referred for specialty care services intended to improve or preserve the child’s continuing health and quality of life, regardless of the services ability to affect a permanent cure.

**Podiatry Services**

Amerigroup provides its members medically necessary podiatry services when furnished by a licensed podiatrist within the scope of practice under District of Columbia law.

No precertification is required for network providers for in-office evaluation & management services, testing and procedures.

**Primary Care Services**

Primary care is generally received through a member’s PCP who acts as a coordinator of care and has the responsibility to provide accessible, comprehensive and coordinated health care services covering the full range of benefits for which a member is eligible. In some cases, members will opt to access certain primary care services by self-referral to providers other than their PCPs (e.g., school-based health centers). Primary care services include:

- Addressing the member’s general health needs
- Coordination of the member’s health care
- Disease prevention and health promotion and maintenance
- Treatment of illness
- Maintenance of the members’ health records
- Referral for specialty care

**For female members:** If the member’s PCP is not a woman’s health specialist, she may see a participating woman’s health specialist, without a referral, for covered services necessary to provide women’s routine and preventive health care services.

**Primary Behavioral Health Services (Mental Health and Substance Use Disorders)**

Primary behavioral health services required by members, including clinical evaluation and assessment, provision of primary behavioral health services, and/or referral for additional services as appropriate are covered. Reference the Behavioral Health Services section for specific services.
The PCP of a member requiring behavioral health services may elect to treat the member if the treatment, including visits for buprenorphine treatment, falls within the scope of the PCP’s practice, training and expertise. Neither the PCP nor Amerigroup may bill the Behavioral Health System for the provision of such services because these services are included in the capitation rates.

When, in the PCP’s judgment, a member’s need for behavioral health treatment cannot be adequately addressed by primary behavioral health services provided by the PCP, the PCP should, after determining the member’s eligibility based on probable diagnosis, refer the member to the Behavioral Health at 1-800-600-4441 for specialty behavioral health services.

**Rehabilitative Services**

Rehabilitative services, including but not limited to medically necessary physical therapy, speech therapy and occupational therapy are covered.

Prior authorization must be obtained from OrthoNet for physical therapy, speech therapy, and occupational therapy services beyond the initial evaluation. OrthoNet conducts medical necessity reviews for therapy services and medical necessity criteria must be met. Providers can request authorization from OrthoNet by calling 1-855-596-7618 or by faxing clinical information to 1-855-596-7626.

**Second Opinions**

Upon member request, Amerigroup will provide for a second opinion from a qualified health care professional within the network and, if necessary, will arrange for the member to obtain a second opinion outside of the Amerigroup network.

**Transplants**

Medically necessary transplants pre- and post-surgery benefits covered.

**Transportation**

Transportation services for Medicaid members is covered related to the provision of triage and stabilization services for emergency medical conditions and as described in 42 C.F.R. §440.170(a) for medical examinations and treatment.

For assistance with scheduling transportation, please call Medical Transportation Management, Inc. (MTM) at 1-888-828-1071.

Transportation services for Alliance members only cover emergency transport service within the District.
Vision Care Services

Routine and medically necessary vision care services are covered. Amerigroup is responsible, at a minimum, for providing the following:

Routine Eye Exams
- For members under age 21, coverage includes one eye examination every 12 months.
- For members under age 21, coverage includes more frequent eye exams as needed in accordance with EPSDT guidelines. Amerigroup arranges for the provision of at least one eye examination every year.
- For members age 21 and older, coverage includes one pair of eyeglasses every two years except when lost or when the prescription has changed by more than 0.5 diopters.

Vision Hardware
- Coverage includes standard spectacle lenses with a retail allowance for frames every 24 months (contact lenses are covered in lieu of eyeglasses). EPSDT guidelines allow one pair of lenses and frames once per year and contact lenses if medically necessary. Replacement frames and lenses are covered if they are lost, stolen or broken or if enrollee’s prescription has changed more than one-half (0.5) diopters.

Benefit Limitations

Excluded Medicaid Services
The following items and services are excluded from coverage:
- The service is not included as a covered service in the District plan
- The service is of an amount, duration, and scope in excess of a limit expressly set forth in section C.5.20.2 of the MCO contract between District of Columbia and Amerigroup
- The service is not medically necessary as defined in section C.3.137 of the MCO contract between District of Columbia and Amerigroup
- The service is a prescription drug for which Amerigroup has received prior approval in writing from DHCF to exclude from the Amerigroup Formulary
- The service is an inpatient transplantation surgery: Amerigroup shall cover pre and postoperative costs of the transplant surgery
- The service is cosmetic, except that the following services shall not be considered cosmetic:
  - Surgery required correcting a condition resulting from surgery or disease
  - Surgery required to correct a condition created by an accidental injury
  - Surgery required to correct a congenital deformity
  - Surgery required correcting a condition that impairs the normal function of a part of the body
  - Surgery to address gender dysphoria as identified in DHCF policy
- The service is sterilization for an enrollee under age 21
• The service is an abortion that does not meet the standard of the applicable Appropriations Act for the District of Columbia; the standard applicable for federal Fiscal Year ending September 30, 2016 is that:
  o None of the funds appropriated under this act, and none of the funds in any trust fund to which funds are appropriated under this act, shall be expended for health benefits coverage that includes coverage of abortion
  o The limitations established in the preceding sections shall not apply to an abortion:
    ▪ If the pregnancy is the result of an act of rape or incest
    ▪ In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed
  o Nothing in this section shall be construed as prohibiting the expenditure by a District, locality, entity, or private person of District, local, or private funds (other than a District’s or locality’s contribution of Medicaid matching funds)
  o Nothing in this section shall be construed as restricting the ability of Amerigroup from offering abortion coverage or the ability of a District or locality to contract separately with such a provider for such coverage with District funds (other than a District’s or locality’s contribution of Medicaid matching funds)
• The service is described as a non-MCO covered service, which is covered by the Medicaid State Plan for Medical Assistance but not described as an Amerigroup covered service, and therefore not the responsibility of Amerigroup under the contract
• The service is an investigational or experimental treatment if it is a diagnostic or treatment service that, in accordance with relevant evidence, is not considered to fall within the range of professionally accepted clinical practice with respect to illness, disability, or condition that is the focus of a coverage determination; Amerigroup shall, within 24 hours of identifying or receiving a request for experimental treatment, submit the request to DHCF’s Medical Director for review
• The services are part of a clinical trial protocol; Amerigroup shall cover all inpatient and outpatient services furnished over the course of a clinical trial but shall not cover the services included in the clinical trial protocol

Alliance Coverage Exclusions

The following services are excluded for Alliance members:
• Screening and stabilization services for emergency medical conditions provided outside the District
• Emergency medical conditions as described in DHCF Policy Number HCPRA-2013-02R
• Services furnished in schools
• Any covered services when furnished by providers that are not in the Amerigroup provider network
• Services and supplies related to surgery and treatment for temporal mandibular joint problems (TMJ)
• Cosmetic surgery
• Open heart surgery
• Sclerotherapy
• Therapeutic abortions
• Vision care for adults
• Treatment for obesity
• Infertility treatment
• Experimental treatment and investigational services and items
• Treatment for behavioral health and alcohol or substance abuse services, except services related to medical treatment received in a hospital for life threatening withdrawal or withdrawal symptoms from alcohol or narcotic drugs
• Deliveries
• Nonemergency transportation services

Health Home Benefits

Health Home for Persons with Mental Health Care needs — MY DC Health Home

On January 1, 2016, DHCF launched a new benefit for Medicaid beneficiaries with mental health care needs, called My DC Health Home, that will help coordinate a person’s full array of health and social service needs — including primary and hospital health services; mental health care, substance abuse care and long-term care services and supports. My DC Health Homes are community-based mental health providers, as known as core services agencies, which have hired nurses, primary care doctors and others with social and health-related backgrounds, to create care teams. Each person that decides to receive services through the My DC Health Home benefit will be linked with a care team who will work with the person’s doctors, family and anyone else the person selects.

My DC Health Homes are located across the District. To refer a member to these free services, call the DC Access HELPLINE at 1-888-7WE-HELP or 1-888-793-4357 24 hours a day, 7 days a week to be connected with a My DC Health Home.

Health Home for Persons with Multiple Chronic Conditions — My Health GPS

The District of Columbia Department of Health Care Finance (DHCF) launched a care coordination benefit for Medicaid beneficiaries with multiple chronic conditions, called My Health GPS on July 1, 2017. As part of the District’s My Health GPS program, interdisciplinary teams embedded in the primary care setting will serve as the central point for integrating and coordinating the full array of eligible beneficiaries’ primary, acute, behavioral health, and long-term services and supports to improve health outcomes and reduce avoidable and preventable hospital admissions and ER visits. Unlike DHCF’s initial Medicaid Health Home benefit (My DC Health Home) where individuals must have a severe mental illness to receive services, the My
Health GPS program will deliver care coordination services to beneficiaries who have three or more chronic conditions and are enrolled in either fee-for-service or managed care.

Eligible conditions are:
- Mental health condition (depression, personality disorders)
- Substance use disorder
- Asthma (and chronic obstructive pulmonary disease [COPD])
- Diabetes
- Heart disease (congestive heart failure [CHF])
- Conduction disorders/cardiac dysrhythmias
- Myocardial infarction (pulmonary heart disease)
- Morbid obesity only
- Cerebrovascular disease
- Chronic renal failure (on dialysis)
- Hepatitis
- HIV
- Hyperlipidemia
- Hypertension
- Malignancies
- Paralysis
- Peripheral atherosclerosis
- Sickle cell anemia

What are the My DC and My Health GPS Health Home services?
- Comprehensive care management, where information about a person’s health and social needs are gathered and a care plan to support the person’s health is written
- Care coordination, includes the activities that help a person follow his or her care plan — such as scheduling doctor visits and transportation to these visits;
- Health promotion, includes helping a person understand what he or she can do to keep good health — such as stopping smoking, joining walking groups, and cooking with fresh foods
- Comprehensive transitional care/follow-up, ensures that if a person is admitted to a hospital, the person has access to needed services when he or she leaves the hospital
- Patient and family support, helps the person and his or her support team (such as family and friends) connect with medical and social service providers, better understand papers on health care, and other activities that ensure that both the person and his or her support team stay healthy
- Referral to community and social support services, link the person to neighborhood, church and other helpful activities that can help keep the person healthy
Over-the-Counter Drugs

Amerigroup offers an extra benefit for certain over-the-counter (OTC) drugs. Each member can receive up to $15 of these drugs each quarter. Quarters begin on the first day of January, April, July and October. The provider must write a prescription for these drugs. If the member reaches his or her maximum within the quarter, the pharmacy will notify the member. The following drugs are covered as part of this benefit (the brand names listed serve as a reference only):

<table>
<thead>
<tr>
<th>OTC drug type</th>
<th>Brand name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antacid</td>
<td>Tums, Alternagel, Maalox, Mylanta, Maalox Plus and Prilosec OTC</td>
</tr>
<tr>
<td>Antidiarrheals</td>
<td>Kapectate, Pepto-Bismol, Pedialyte and Imodium A-D</td>
</tr>
<tr>
<td>Antiemetics</td>
<td>Dramamine and Emetrol</td>
</tr>
<tr>
<td>Antihistamines</td>
<td>Chlor-Trimeton, Tavist-1, Benadryl, Alavert</td>
</tr>
<tr>
<td>Bacitracin</td>
<td>Polysporin, Neosporin</td>
</tr>
<tr>
<td>Cough and cold preparations</td>
<td>Dimetapp, Delsym, Vicks 44D, Robitussin, Robitussin DM, Robitussin-CF, Robitussin-PE, and Actifed Cold and Allergy</td>
</tr>
<tr>
<td>Decongestants</td>
<td>Sudafed</td>
</tr>
<tr>
<td>Ibuprofen</td>
<td>Advil</td>
</tr>
<tr>
<td>Laxatives</td>
<td>Dulcolax, Colace, Peri-Colace, Citroma, Phillips’ Milk of Magnesia, Fleet Phospho-Soda, Metamucil, Senokot and Senokot-S</td>
</tr>
<tr>
<td>Miscellaneous, oral</td>
<td>Cepastat, Gas-X and Mylicon</td>
</tr>
<tr>
<td>Miscellaneous, topical</td>
<td>Amlactin, Debrox, Cortizone and Naphcon-A</td>
</tr>
<tr>
<td>Nutritionals/Supplements</td>
<td>Os-Cal, Niferex, Niferex-150, Fergon, Feosol, Fer-In-Sol, Strovite, Poly-Vi-Sol, Vi-Daylin, One-A-Day, Centrum, Slo-Niacin, Stuart Prenatal and Nephrovite</td>
</tr>
<tr>
<td>Pediculicide</td>
<td>RID, NIX</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Broncho Saline</td>
</tr>
</tbody>
</table>

Interpreter Services

Oral interpretive services are available either in-office or telephonically at no cost to you or the member. If you serve an Amerigroup member with whom you cannot communicate, call Member Services at 1-800-600-4441 to access an interpreter. For immediate needs, Amerigroup has Spanish-language interpreters available without delay and can provide access to interpreters of other languages within minutes.

Amerigroup recommends that requests for in-office interpreter services be arranged at least one business day in advance of the appointment. If a member with special needs requires an interpreter to accompany him or her to a clinic appointment, a case manager/care coordinator can make arrangements for the interpreter to be present.
Providers are required to offer interpretive services to members who may require assistance. Providers should document the offer and the members’ response and reiterate that interpretive services are available at no cost. Family and friends should not be used to provide interpretation services, except at a member’s request.

**Guidelines for Working with an Interpreter**
Use the following guidelines for better communication when speaking through an interpreter:
- Keep your sentences short and concise — the longer and more complex your sentences, the less accurate the interpretation.
- When possible, avoid using medical terminology, which is unlikely to translate well.
- Ask key questions in several different ways to ensure the questions are fully understood, and you get the information you need.
- Be sensitive to potential member embarrassment, reticence or confusion. It is possible your questions or statements were not understood.
- Ask the member to repeat the instructions you have given as an effective review of how well the member has understood.

**Services for the Deaf and Hard of Hearing**
Members have the right to receive assistance through a text telephone/telecommunications device for the deaf (TTY/TDD) line. Amerigroup can help you telephonically communicate with members with impaired hearing via a translation device. Call the Member Services using the TTY relay service at 711. In-office sign language assistance is also available. Call Member Services at 1-800-600-4441 to arrange for the service.

**Additional Communication Options for Members and Providers**
Amerigroup policies are designed to ensure meaningful opportunities for members with limited-English proficiency (LEP) to obtain access to health care services and to help members with LEP overcome language barriers and fully use services or benefits.

The Amerigroup provider directory includes a list of languages spoken by participating primary and specialty care providers. Translation assistance options are available at no cost to the member or provider. Upon request, written materials are available in large print, on tape and in languages other than English (dependent upon the plan’s population). Member materials are written at a fifth-grade reading level per District requirement.

Amerigroup will not prohibit a provider, acting within the scope of his practice, from advising a member about his or her medical care or treatment for the condition or disease regardless of whether benefits are provided by Amerigroup. Amerigroup will not retaliate against a provider for advising the member.
6 BEHAVIORAL HEALTH SERVICES

Overview

Behavioral health services are covered services for the treatment of mental, emotional or substance use disorders.

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

- Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care.
- Are furnished in the most appropriate and least restrictive setting in which services can be safely provided.
- Are the most appropriate level or supply of service that can safely be provided.
- Could not be omitted without adversely affecting the member’s mental and/or physical health or the quality of care rendered.
- Are not experimental or investigative.
- Are not primarily for the convenience of the member or provider.

For more information about behavioral health services, providers should call 1-800-454-3730 and members should call 1-800-600-4441 (TTY 711).

Coordination of Physical and Behavioral Care

We recognize treatment and recovery can be complicated by comorbid conditions. Additionally, we believe essential ambulatory care should continue unabated while a member is hospitalized; therefore, PCPs and behavioral health providers are required to communicate directly to ensure continuity of care.

- When a member, who is being treated for a comorbid behavioral health condition is admitted for treatment of a physical health condition, the attending physician will attempt to secure a release of information and review the admission with the PCP. This is necessary to ensure that essential treatment will continue unabated.
- When a member who is being treated for a comorbid physical health condition is admitted for treatment of a behavioral health condition, the attending physician will attempt to secure a release of information and review the admission with the behavioral health provider. This is necessary to ensure that essential treatment will continue unabated.

We require that physical and behavioral health providers share relevant case information in a timely, useful and confidential manner. We require that the behavioral health provider be notified of the member’s physical examination and laboratory and radiological tests within 24 hours of receipt for urgent cases and within five business days in nonurgent cases. This notification will be made by telephone with follow-up in writing. The provider will obtain a release of information from any member or his or her legal representative (e.g., parent,
guardian or conservator) before releasing confidential health information. The release of information must contain, at a minimum, the following:

- Name and identification number of the member whose health information is being released
- Name of provider releasing the information
- Name of provider receiving the information
- Information to be released
- Period for which the authorization is valid
- Statement informing the signatory that he or she can cancel the authorization at any time
- Printed name of the signatory
- Signature or mark of the signatory
- Date of signature

A physical health provider who recognizes concomitant behavioral health needs requiring treatment by a behavioral health provider will facilitate the member’s access to a behavioral health service. A non-network provider who recognizes concomitant physical health needs requiring treatment by a physical health provider is expected to facilitate the member’s access to a primary provider by contacting us.

For members who are hospitalized and receive both behavioral and physical health services, primacy (i.e., the form of care that is primary) will be determined by the principle diagnosis, type of attending physician and location of service. Either type of provider may initiate consultation with the other and coordinate further and/or ongoing care. A physical and behavioral health provider should exchange health information at the following junctures:

- When the member first accesses a physical or behavioral health service
- When a change in the member’s health or treatment plan requires an alteration of the other provider’s treatment plan (e.g., when a member who has been taking lithium becomes pregnant)
- When the member is admitted to or discharged from the hospital
- When the member discontinues care
- When a member is admitted and a consultation is warranted
- Once a quarter if not otherwise required

Information should contain at a minimum:

- Provider’s name and contact information
- Member’s name, date of birth, gender, ID number and contact information
- Reason for referral (initial contact only)
- Current diagnosis
- History of the presenting illness and other relevant medical and social histories (initial contact only)
- Level of suicide, homicide, physical harm or threat
- Current treatment plan
• Special instructions (e.g., diagnostic questions to be answered, treatment recommendations)

The provider will maintain a copy of the release of information form and document care coordination in the member’s medical record. We will coordinate inpatient behavioral health consultations and services, as well as discharge planning and follow-up with the member’s behavioral health provider (both network and non-network).

**Behavioral Health Covered Services**

<table>
<thead>
<tr>
<th>Service*</th>
<th>Benefit Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician and mid-level visits including:</td>
<td>As medically necessary</td>
</tr>
<tr>
<td>• Diagnostic and assessment services</td>
<td></td>
</tr>
<tr>
<td>• Individual counseling</td>
<td></td>
</tr>
<tr>
<td>• Group counseling</td>
<td></td>
</tr>
<tr>
<td>• Family counseling</td>
<td></td>
</tr>
<tr>
<td>• FQHC services</td>
<td></td>
</tr>
<tr>
<td>• Medication/somatic treatment</td>
<td></td>
</tr>
<tr>
<td>Crisis services provided in a higher level of care (this may not be necessary to differentiate to this degree)</td>
<td>As medically necessary</td>
</tr>
<tr>
<td>Inpatient hospitalization and emergency department services</td>
<td>As medically necessary</td>
</tr>
<tr>
<td>Day services and intensive day treatment for mental health conditions</td>
<td>As medically necessary</td>
</tr>
<tr>
<td>Case management services</td>
<td>As medically necessary</td>
</tr>
<tr>
<td>Inpatient psychiatric facility services</td>
<td>Individuals under age of 21</td>
</tr>
<tr>
<td>Pregnancy-related services</td>
<td>Treatment for any mental condition that could complicate the pregnancy</td>
</tr>
<tr>
<td>Psychiatric residential treatment facility (PRTF)</td>
<td>Individuals under age of 22</td>
</tr>
<tr>
<td>Access to mental health services</td>
<td>Education regarding how to access mental health services provided by Amerigroup and Department of Behavioral Health (DBH)</td>
</tr>
<tr>
<td>Pediatric mental health service</td>
<td>All mental health services for children that are included in an IEP or IFSP during holidays, school vacations or sick days from school</td>
</tr>
<tr>
<td>Inpatient detoxification</td>
<td>As medically necessary</td>
</tr>
<tr>
<td>Routine outpatient alcohol and drug abuse treatment</td>
<td>Referrals to Department of Behavioral Health (DBH) as medically necessary</td>
</tr>
</tbody>
</table>
Behavioral health service to students in school setting

Provider must meet the following conditions:
- Meet fee schedule requirements for children and youth without an IEP
- Must be credentialed as an in-network provider
- Must have office in the school and provided services in that office

Behavioral Health Covered Services Chart

The following services are covered by the D.C. Department of Behavioral Health (DBH)

<table>
<thead>
<tr>
<th>Service*</th>
<th>Benefit Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-based interventions</td>
<td>As medically necessary</td>
</tr>
<tr>
<td>Multi-systemic therapy (MST)</td>
<td>As medically necessary</td>
</tr>
<tr>
<td>Assertive community treatment (ACT)</td>
<td>As medically necessary</td>
</tr>
<tr>
<td>Community support</td>
<td>As medically necessary</td>
</tr>
<tr>
<td>Day treatment services for alcohol and drug abuse treatment</td>
<td>As medically necessary</td>
</tr>
<tr>
<td>Outpatient crisis stabilization services</td>
<td>As medically necessary</td>
</tr>
<tr>
<td>Methadone treatment</td>
<td>As medically necessary</td>
</tr>
<tr>
<td>Ambulatory detoxification</td>
<td>As medically necessary</td>
</tr>
</tbody>
</table>

Behavioral Health Access Standards

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Geographic Access Requirement</th>
<th>Maximum Time for Admission/Appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Inpatient Hospital Services</td>
<td>Travel distance does not exceed 30 minutes by public transportation for at least 98 percent of members.</td>
<td>24 hours (involuntary)/24 hours (voluntary)</td>
</tr>
<tr>
<td>24-hour Psychiatric Residential Treatment</td>
<td>Not subject to geographic access standards.</td>
<td>Within 14 calendar days of receipt of the request for service; if urgent, no later than 72 hours of receipt of the request for service</td>
</tr>
<tr>
<td>Service Type</td>
<td>Geographic Access Requirement</td>
<td>Maximum Time for Admission/Appointment</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>--------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>Not subject to geographic access standards.</td>
<td>Within 14 calendar days; if urgent, within 72 hours of receipt of the request for service</td>
</tr>
<tr>
<td><strong>Intensive Outpatient</strong> (may include day treatment (adult), intensive day treatment (children and adolescent) or partial hospitalization)</td>
<td>Not subject to geographic access standards.</td>
<td>Within 14 calendar days; if urgent, within 72 hours of receipt of the request for service</td>
</tr>
<tr>
<td><strong>Inpatient Facility Services (substance abuse)</strong></td>
<td>Not subject to geographic access standards.</td>
<td>24 hours (involuntary)/24 hours (voluntary)</td>
</tr>
<tr>
<td><strong>24-hour Residential Treatment Services (substance abuse)</strong></td>
<td>Not subject to geographic access standards.</td>
<td>Within 14 calendar days; if urgent, within 72 hours of receipt of the request for service</td>
</tr>
<tr>
<td><strong>Outpatient Treatment Services (substance abuse)</strong></td>
<td>Not subject to geographic access standards.</td>
<td>Within 14 calendar days; if urgent, within 72 hours of receipt of the request for service</td>
</tr>
<tr>
<td><strong>Crisis Stabilization</strong></td>
<td>Not subject to geographic access standards.</td>
<td>Within four hours of referral</td>
</tr>
</tbody>
</table>

**Behavioral Health Precertification**

We require precertification for all elective behavioral health inpatient admissions and certain outpatient services. We use Amerigroup’s Behavioral Health Medical Policies and Clinical UM Guidelines. The following all-inclusive list of services that must be precertified:

- Inpatient admission
- Non-routine outpatient BH services (i.e., intensive outpatient)
- Routine outpatient BH services for out-of-network providers only
- Partial hospital programs
- Electroconvulsive therapy
- Psychological and neuropsychological testing
Coordination of Behavioral Health and Physical Health Treatment

Amerigroup emphasizes the coordination and integration of physical and behavioral health services, wherever possible. Key elements of the Amerigroup model of coordinated care include:

- Ongoing communication and coordination between PCPs and specialty providers, including behavioral health (mental health and substance use) providers
- The expectation that providers screen for co-occurring disorders including:
  - Behavioral health screening by PCPs
  - Medical screening by behavioral health providers
  - Screening of mental health patients for co-occurring substance use disorders
  - Screening of consumers in substance use disorder treatment for co-occurring mental health and/or medical disorders
- Screening tools for PCPs and behavioral health providers can be located at https://providers.amerigroup.com/DC
- Referrals to PCPs or specialty providers, including behavioral health providers, for assessment and/or treatment for consumers with co-occurring disorders
- Involving members, as well as caregivers and family members, as appropriate, in the development of patient-centered treatment plans. Case management and disease management programs to support the coordination and integration of care between providers
- As an Amerigroup network provider, you are required to notify a member’s PCP when a member first enters behavioral health care and anytime there is a significant change in care, treatment or need for medical services, provided that you have secured the necessary release of information. The minimum elements to be included in such correspondence are:
  - Patient demographics
  - Date of initial or most recent behavioral health evaluation
  - Recommendation to see PCP, if medical condition identified or need for evaluation by a medical practitioner has been determined for the member (e.g., EPSDT screen, complaint of physical ailments)
  - Diagnosis and/or presenting behavioral health problem(s)
  - Prescribed medication(s)
  - Vital signs
  - Allergy/drug sensitivity
  - Pregnancy status
  - Behavioral health clinician’s name and contact information

Recovery and Resiliency

Amerigroup believes physical and behavioral health services should be rendered in a manner that supports the recovery of persons experiencing mental illness and enhances the development of resiliency of those who are impacted by mental illness, serious emotional
disturbance and/or substance use disorder issues. Recovery is a consumer-driven process in which consumers find their paths to work, learn and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life despite the continued presence of a disability.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has released a consensus statement on mental health recovery. The components listed in this consensus statement are reflective of our desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency. The ten fundamental components of recovery as elucidated by SAMHSA include:

The 10 fundamental components of recovery include:

1. **Self-direction:** Consumers lead, control, exercise choice over and determine their own path of recovery by optimizing autonomy, independence and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.

2. **Individualized and person-centered:** There are multiple pathways to recovery based on an individual’s unique strengths and resiliency, as well as his or her needs, preferences, experiences (including past trauma) and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result, as well as an overall paradigm for achieving wellness and optimal mental health.

3. **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions — including the allocation of resources — that will affect their lives and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

4. **Holistic:** Recovery encompasses an individual’s whole life, including mind, body, spirit and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and health care treatment and services, complementary and naturalistic services (e.g., recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation and family supports as determined by the person. Families, providers, organizations, systems, communities and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

5. **Nonlinear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

6. **Strengths-based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals. By building on
these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, and employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

7. **Peer support**: Mutual support including the sharing of experiential knowledge and skills and social learning plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles and community.

8. **Respect**: Community, systems and societal acceptance and appreciation of consumers including protecting their rights and eliminating discrimination and stigma are crucial in achieving recovery. Self-acceptance and regaining belief in one’s self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

9. **Responsibility**: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

10. **Hope**: Recovery provides the essential and motivating message of a better future- that people can and do overcome the barriers and obstacles that confront them. Hope is internalized but can be fostered by peers, families, friends, providers and others. Hope is the catalyst of the recovery process.

Resiliency is a dynamic developmental process for children and youth that encompasses positive adaptation and is manifested by traits of self-efficacy, high self-esteem, maintenance of hope and optimism within the context of significant adversity.

Services that are provided to children and youth with serious emotional disturbances and their families should be delivered based on the System of Care Values and Principles that are endorsed by the SAMHSA and the Center for Mental Health Services (CMHS). Services should be:

- Child centered and family focused with the needs of the child and family dictating the types and mix of services provided
- Community based with the focus of services as well as management and decision making responsibility resting at the community level
- Culturally competent with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve
- The guiding principles of a system of care include:
- Children should have access to a comprehensive array of services that address the child’s physical, emotional, social, educational and cultural needs.
- Children should receive individualized services in accordance with their unique needs and potential, which is guided by an individualized service plan.
- Children should receive services within the least restrictive, most normative environment that is clinically appropriate.
• Children should receive services that are integrated, with linkages between child serving agencies and programs and mechanisms for planning, developing and coordinating services.
• Children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated, therapeutic manner and adapted in accordance with the changing needs of the child and family.
• Children should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics.

**Member Records and Treatment Planning**

Member records must meet the following standards and contain the following elements, if applicable, to permit effective service provision and quality reviews:

• Information related to the provision of appropriate services to a member must be included in his or her record to include documentation in a prominent place whether there is an executed declaration for mental health treatment.
• For members in the priority population, a comprehensive assessment that provides a description of the consumer’s physical and mental health status at the time of admission to services. This comprehensive assessment covers:
  o A psychiatric assessment that includes:
    ▪ Description of the presenting problem.
    ▪ Psychiatric history and history of the member’s response to crisis situations.
    ▪ Psychiatric symptoms.
    ▪ Diagnosis using the most current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM).
    ▪ Mental status exam.
    ▪ History of alcohol and drug abuse.
  o A medical assessment that includes:
    ▪ Screening for medical problems.
    ▪ Medical history.
    ▪ Present medications.
    ▪ Medication history.
  o A substance use assessment that includes:
    ▪ Frequently used over-the-counter medications.
    ▪ Alcohol and other drugs and history of prior alcohol and drug treatment episodes.
    ▪ History reflecting the impact of substance use in the domains of the community functioning assessment.
  o A community functioning assessment or an assessment of the member’s functioning in the following domains:
    ▪ Living arrangements, daily activities (vocational/educational)
    ▪ Social support
- Financial
- Leisure/recreational
- Physical health
- Emotional/behavioral health
- An assessment of the member’s strengths, current life status, personal goals and needs
  - A patient-centered, wellness-oriented care plan, which is based on the psychiatric, medical, substance use and community functioning assessments listed above, must be completed for any member who receives behavioral health services.
- The patient-centered care plan must be completed within the first 14 days of admission to behavioral health services and updated every 90 days, or more frequently as necessary based on the member’s progress towards goals or a significant change in psychiatric symptoms, medical condition and/or community functioning.
- There must be documentation in every case that the member and, as appropriate, his or her family members, caregivers, or legal guardian, participated in the development and subsequent reviews of the treatment plan.
- For providers of multiple services, one comprehensive treatment/care/support plan is acceptable as long as at least one goal is written, and updated as appropriate, for each of the different services that are being provided to the member.
- The treatment/support/care plan must contain the following elements:
  - Identified problem(s) for which the member is seeking treatment
  - Member goals related to problem(s) identified, written in member-friendly language
  - Measurable objectives to address the goals identified
  - Target dates for completion of objectives
  - Responsible parties for each objective
  - Specific measurable action steps to accomplish each objective
  - Individualized steps for prevention and/or resolution of crisis, which includes identification of crisis triggers (situations, signs and increased symptoms); active steps or self-help methods to prevent, de-escalate or defuse crisis situations; names and phone numbers of contacts that can assist the member in resolving crisis; and the member’s preferred treatment options, to include psychopharmacology, in the event of a mental health crisis
  - Signatures of the member as well as family members, caregivers, or legal guardian as appropriate
  - Clinical progress notes written to document status related to goals and objectives indicated on the treatment plans
  - Correspondence concerning the member’s treatment and signed and dated notations of telephone calls concerning the member’s treatment
- A brief discharge summary must be completed within 15 calendar days following discharge from services or death.
• Discharge summaries for psychiatric hospital and residential treatment facility admissions that occur while the member is receiving behavioral health services should also be included.
• Amerigroup will monitor provider compliance with treatment plan requirements through medical record reviews or other measures. Providers who do not meet the goal of 100-percent compliance with treatment plan requirements may be subject to corrective action and may be asked to submit a plan for meeting the 100-percent requirement.

**Provider Roles and Responsibilities**

We believe the success of providers is necessary to achieve our goals. We are committed to supporting and working with qualified providers to ensure that we jointly meet quality and recovery goals. Our commitment includes:

- Improving communication of the clinical aspects of behavioral health care to improve outcomes and recovery
- Supporting providers in delivering integrated, coordinated physical and behavioral health services to meet the needs of the whole person
- Simplifying precertification rules, referrals, claims and payment processes to help providers reduce administrative time and focus on the needs of members
- Monitoring the quality of the behavioral health provider network in accordance with the standards and expectations outlined in the Amerigroup provider manual
- A team of clinical care managers, case managers and support staff providing high-quality care management and care coordination services to our members, and striving to work collaboratively with all providers
- Amerigroup case management and care coordination teams acting as a liaison between the physical and behavioral health providers to ensure communication occurs between providers in a timely manner, and facilitating coordinated discussions (when indicated) to meet the health outcome goals of the member’s care plan

Our experienced behavioral health care staff is available 24 hours a day, 7 days a week to help identify the closest and most appropriate behavioral health service provider. Providers can call Provider Services at 1-800-454-3730, and members can call Member Services at 1-800-600-4441 for help with finding a provider.

At Amerigroup, our behavioral health care benefit is fully integrated with the rest of our health care programs. This coordination of health care resources requires certain roles and responsibilities for behavioral health providers, including:

- Participating in the care management and coordination process for each Amerigroup member under their care
- Seeking prior authorization for all services that require it.
For more information on prior authorization, visit our provider website at https://providers.amerigroup.com/DC and use our Precertification Lookup Tool to search for services by code.

**Behavioral Health Emergency Services**

Behavioral health emergency services are those services that are required to meet the needs of an individual who is experiencing an acute crisis resulting from a mental illness, which is at a level of severity that would meet the requirements for involuntary examination and who, in the absence of a suitable alternative or psychiatric medication, would require hospitalization.

Examples of behavioral health and alcohol and drug abuse emergency medical conditions are when:

- The member is suicidal
- The member is homicidal
- The member is violent with objects
- The member has suffered a precipitous decline in functional impairment and is unable to take care of his or her activities of daily living
- The member is alcohol- or drug-dependent and there are signs of severe withdrawal

In the event of a behavioral health and/or alcohol and drug abuse emergency, the safety of the member and others is paramount. The member should be instructed to seek immediate attention at an emergency room or behavioral health and alcohol and drug abuse crisis service facility. An emergency dispatch service or 911 should be contacted in the event that the member is a danger to self or others and is unable to go to an emergency setting.

**Behavioral Health Medically Necessary Services**

Amerigroup defines medically necessary behavioral health services as those that are:

- Reasonably expected to prevent the onset of an illness, condition or disability; reduce or ameliorate the physical, behavioral or developmental effects of an illness, condition, injury or disability; and assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities appropriate for members of the same age
- Reasonably expected to provide an accessible and effective course of treatment or site of service that is equally effective in comparison to other available, appropriate and substantial alternatives and is no more intrusive or restrictive than necessary
- Sufficient in amount, duration and scope to reasonably achieve their purpose as defined in federal law
- Of a quality that meet standards of medical practice and/or health care generally accepted at the time services are rendered
QUALITY ASSURANCE PERFORMANCE IMPROVEMENT

Amerigroup embraces quality assurance and improvement. Amerigroup’s Quality Assurance Performance Improvement Program is embedded across all aspects of operation. The program develops goals to improve our members’ health outcomes, access to care and services, health equity, quality of life, and satisfaction with care services. Amerigroup’s standards and goals are based on District and Federal rules and regulations, other regulatory requirements, and NCQA standards. Overall performance is measured using HEDIS®, CAHPS®, and other industry standard methods of measurement. As providers, you play a vital role in achieving quality improvement.

As part of its Quality Assurance activities, Amerigroup may conduct random sampling of provider medical records to assess documentation in accordance with established standards. Amerigroup may also review quality metrics by provider and communicate specific opportunities for improvement.

For more information about the Amerigroup Quality Management program, call Provider Services at 1-800-454-3730.

Reportable Diseases and Conditions


Providers are also responsible for complying with all reporting requirements related to District registries and programs, including the Cancer Control Registry.

A complete list of reportable communicable diseases is available at https://doh.dc.gov/publication/communicable-and-reportable-diseases.

Examples of reporting requirements, include, but are not limited to reporting of:

- Individuals with vaccine preventable diseases.
- Infants, toddlers, and school-age children experiencing developmental delays
- Individuals with sexually transmitted and other communicable diseases, including HIV
- Individuals diagnosed or suspected of being diagnosed with tuberculosis must be reported within 24 hours.
- Results of all blood lead screening tests to the District of Columbia Department of Health Care Finance (DHCF), District Department of the Environment Division of Childhood Lead Prevention Program and Amerigroup within 72 hours of result.
Patient Safety

Amerigroup provides information and resources for providers regarding health care safety and standards. An example of a resource is [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov), a CMS website providing specific information on hospitals. This user-friendly site compiles quality indicators for all Medicare-certified hospitals and provides a comparison of quality indicators for services rendered by the selected hospital.

Amerigroup Member Hotline

The Member Hotline can be reached at 1-800-600-4441, Monday through Friday from 8 a.m. to 6 p.m. Eastern time. This unit handles, resolves and/or properly refers members’ inquiries and complaints to other departments. Additionally, Amerigroup provides members with information about how to access the Member Services department and Consumer Services Hotline to obtain information and assistance.

Member Complaint Policies and Procedures

Amerigroup has written complaint policies and procedures whereby a member dissatisfied with Amerigroup or its network may seek recourse verbally or in writing from the National Call Center Help Line staff. Amerigroup must submit its written internal complaint policies and procedures to the District of Columbia Healthy Families Program for approval.

Member Complaint/Grievance Procedure

A grievance is an oral or written expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee’s right regardless of whether remedial action is requested.

An enrollee or authorized representative may file a grievance with Amerigroup, either orally, or in writing, at any time.

If members have a question or grievance about their health care, such as not being able to schedule an appointment, the way in which they were treated or having to travel too far to get health care services, they should call Member Services toll-free at 1-800-600-4441 Monday-Friday between 8 a.m. and 5:30 p.m. The member service representative will:

1. Take the grievance.
2. Answer any questions.
3. Tell the member when he/she will have an answer.
   a. Amerigroup has up to 30 days to provide a response to the grievance.
   Amerigroup may ask for additional time (up to an additional 14 days) to resolve
the grievance if requested by the member, provider or if Amerigroup can show that additional time would be beneficial to the member.

4. Amerigroup will provide written acknowledgement of the receipt of the grievance within two business days of receipt.

5. Forward the grievance to the appropriate person, who will:
   a. Investigate the grievance.
   b. Decide what steps will be taken.
   c. Respond to the grievance.

6. If the member is not satisfied with the resolution of the complaint/grievance he/she may request a fair hearing.

Amerigroup internal complaint materials are developed in a culturally sensitive manner, at a suitable reading comprehension level and in the member's native tongue if the Amerigroup member is also a member of a substantial minority. Amerigroup delivers a copy of its complaint policies and procedures to each new member at the time of initial enrollment and at any time upon request.

The Amerigroup written internal complaint process includes the procedures for registering and responding and grievances in a timely fashion. These procedures include resolving emergency medically related grievances within 24 hours, nonemergency medically related grievances within five days and administrative grievances within 90 days. In addition, the written procedures:

- Require documentation of the substance of the complaints and steps taken to resolve them.
- Include participation by the provider, if appropriate.
- Allow participation by the ombudsman, if appropriate.
- Ensure the participation of individuals within Amerigroup who have the authority to require corrective action.
- Include a documented procedure for written notification on the outcome of the determination.
- Include a procedure for immediate notice to DCHFP of all disputed denials of benefits or services in emergency medical situations.
- Include a documented procedure for reporting of all complaints received by Amerigroup to appropriate parties.
- Include a protocol for the aggregation and analysis of complaints and grievance data and use of the data for quality improvement.

No punitive action will be taken against the member for making a complaint against Amerigroup or DCHFP.

No punitive action will be taken against a provider for utilizing the provider complaint process.
Appeals

If Amerigroup DC decides to deny, reduce, limit, suspend, or terminate a service the member is receiving, the member will receive a written Notice of Action.

If the member does not agree with Amerigroup DC’s determination as outlined in the Notice of Action, he/she may file an appeal. The member may ask an authorized representative (i.e., his/her doctor, a family member or friend) to file the appeal for them. Or, the provider may file the appeal, with the member’s written consent.

The member, or an authorized representative with written consent, may also ask for a fair hearing at any time during the appeals process.

If the member wants to file an appeal with Amerigroup, he or she has to file it orally or in writing within 60 calendar days from the date of the adverse determination letter. Providers can also file an appeal for the member if he or she signs a form giving permission to do so. Other people, such as a family member or lawyer, can also help the member file an appeal.

When the member files an appeal, or at any time during a review, the member should provide Amerigroup with any new information the member has that will help make a decision. The medical necessity appeals should be mailed to:

Centralized Appeals Processing
Amerigroup District of Columbia, Inc.
7550 Teague Road
Suite 500
Hanover, Maryland 21076

When reviewing the member’s appeal, Amerigroup will:

- Use providers with appropriate clinical expertise in treating the member’s condition or disease.
- Not use the same Amerigroup staff to review the appeal that denied the original request for service.
- The provider making the appeal decision will not be subordinate to the previous reviewer or decision maker.
- Make a decision about appeals within 30 calendar days after receipt of the appeal
- The appeal process may take up to 44 days if the member asks for more time to submit information or if Amerigroup needs to obtain additional information from other sources. A notice will be sent to the member if additional information is needed

Expedited Resolution of an Appeal

If the member, member’s provider or Amerigroup feels the member’s appeal should be reviewed quickly due to the seriousness of the member’s condition, the member will receive a decision about the appeal within 72 hours from the date that Amerigroup received the appeal.
If the member’s appeal is about a service already authorized and already being received, the member may be able to continue to receive the service while Amerigroup reviews the member’s appeal. The member should call 1-800-600-4441 within 10 days if he or she would like to continue receiving services while the appeal is being reviewed.

Once Amerigroup completes the review, a notice will be sent to the member to advise him or her of the decision. If Amerigroup decided the member should not receive the denied service, that letter will tell the member how to file another appeal through Amerigroup or how to ask for a District fair hearing.

**District Fair Hearings**

At any point before, during or after the appeal process, the member who is the subject of an action may request a district fair hearing. Amerigroup will provide each member with information about their right to request a fair hearing, the method by which they may obtain a fair hearing, and their right to represent themselves or to be represented by their family caregiver, legal counsel or other representative. Within five days of receiving notice from DHCF that a fair hearing request has been filed, Amerigroup will submit all documents regarding the action and the member’s dispute to DHCF. The District Office of Administrative Hearings will issue a decision within 90 days of the date the member filed the appeal for standard resolution or within three working days for expedited resolution. The District’s decision will be final and cannot be appealed by Amerigroup.

While the appeal or District fair hearing is pending, the member is entitled to have his/her benefits continued if the following requirements are met:

1. The member filed an appeal or requested a fair hearing on or before 10 days of the date on the Notice of Action or on the intended effective date of the proposed action.
2. The appeal or fair hearing involves the termination, suspension or reduction of a course of treatment previously authorized by an authorized provider.
3. The authorization period has not expired.

If an appeal or fair hearing results in a reversal of a decision to deny, limit or delay services that were not furnished while the appeal was pending, Amerigroup will authorize or provide the disputed services as expeditiously as the member’s health condition requires and no later than two business days after the reversal of the decision for standard appeals and services shall begin within 24 hours of the reversal for expedited appeals.
To request a fair hearing:

**Write to:**
District of Columbia, Office Administrative Hearings
Clerk of the Court
One Judiciary Square
441 Fourth Street, NW
Suite 4150 North
Washington, DC 20001

**Telephone to:**
202-442-9094

**Provider Claims/Payment Dispute Process**

A claims/payment dispute is a claim or any portion of a claim that is denied for any reason or underpaid. Providers may access a timely claims/payment dispute resolution process. A claims/payment dispute could be but not limited to:

- Denials for timely filing
- Amerigroup failure to pay in a timely manner
- Contractual payment issues
- Denials related to benefit coverage
- Lost or incomplete claim forms or electronic submissions
- Requests for additional explanation as to services or treatment rendered by a provider
- Inappropriate or unapproved referrals initiated by providers (i.e., a provider payment dispute may arise if a provider was required to get precertification for a service, did not request the precertification, provided the service and submitted the claim)
- Provider appeals without members’ consent
- Emergency room payment disputes
- Retrospective review after a claim denial or partial payment
- Requests for supporting documentation

To submit a payment dispute, complete the *Payment Dispute Form* located in Appendix A – Forms or online at [https://providers.amerigroup.com/DC](https://providers.amerigroup.com/DC) and mail to:

Payment Dispute Unit
Amerigroup District of Columbia, Inc.
P.O. Box 61599
Virginia Beach, VA 23466-1599
Amerigroup must receive the payment dispute within 90 business days of the paid date of the explanation of payment (EOP). The provider must submit a written request, including an explanation of the issue in dispute, the reason for dispute and supporting documentation such as an EOP, a copy of the claim, medical records or contract page.

A determination will be sent to the provider within 30 business days from receipt of the payment dispute. If the decision is made to adjust the claim to allow full reimbursement, an EOP will be mailed to the provider. If the decision is made to partially adjust the claim or uphold the previous decision, a first-level payment dispute response letter will be mailed to the provider. The response letter will include:

- Provider name
- Member name, ID number and date of birth
- Date of service
- Claim number
- Dispute number
- Date of initial filing of concern
- Written description of the concern
- Decision
- Further dispute options

If a provider is dissatisfied with the Level I payment dispute resolution, the provider may file a Level II payment dispute in the form of a written dispute submitted and received by Amerigroup within 30 business days of the date of the Level I determination letter.

At the Level II appeal, the provider can request a hearing with the Amerigroup chief executive officer or his or her designee.

**Claims Payment Inquiries**

The Amerigroup Provider Experience program helps providers with claims payment and issue resolution. Call 1-800-454-3730 and select the Claims prompt to be connected to the Provider Service Unit (PSU) and ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact, issue resolution rates.
- Significantly improved turnover time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

The PSU is available to assist providers in determining the appropriate process to follow for resolving a claim issue. Refer to the Amerigroup quick reference card (QRC) at https://providers.amerigroup.com/DC > Provider Resources & Documents > Manuals and QRCs for guidance on issues considered claim correspondence, which should not go through the payment appeal process.
Payment Appeals

A payment appeal is any dispute between a provider and Amerigroup for reason(s) including:

- Contractual payment issues
- Inappropriate or unapproved referrals initiated by providers
- Inpatient services
- Retrospective services
- Disagreements over reduced or zero-paid claims
- Authorization issues
- Timely filing issues
- Other health insurance denial issues
- Claim code editing issues
- Duplicate claim issues
- Retro-eligibility issues
- Experimental/investigational procedure issues
- Claim data issues

Claims correspondence is a response to itemized bill requests, submission of corrected claims and submission of COB/third-party liability information are not considered payment disputes. These are considered correspondence and should be addressed to claims correspondence.

Administrative Appeals

An administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of precertification or failure by the provider to submit clinical information when requested.

Appeals for administrative denials must address the reason for the denial (i.e., why precertification was not obtained or why clinical information was not submitted).

If Amerigroup overturns its administrative decision, the case is reviewed for medical necessity and, if approved, the claim will be reprocessed or the requestor will be notified of the action that needs to be taken.

Medical Necessity Appeals

A medical necessity appeal is the request for a review of an adverse decision. An appeal encompasses requests to review adverse decisions of care denied (after services are rendered (post service), such as medical necessity decisions, benefit determination related to coverage, rescission of coverage or the provision of care or service.

Amerigroup offers a medical necessity appeal process that provides members, member representatives and providers the opportunity to request and participate in the re-evaluation of adverse actions. The member, member representatives and providers will be given the
opportunity to submit written comments, medical records, documents or any other information relating to the appeal. Amerigroup will investigate each appeal request, gathering all relevant facts for the case before making a decision. Appeal letters and other related clinical information should be sent to within 60 calendar days from the date of the denial or EOP.

Centralized Appeals Processing
Amerigroup District of Columbia, Inc.
P.O. Box 61599
Virginia Beach, VA 23466-1599

District of Columbia Fair Hearings
The District shall grant an opportunity for a fair hearing to any enrollee who is the subject of an adverse benefit determination.

Amerigroup shall notify the enrollee or the enrollee’s designee of the right to a fair hearing with a District Administrative Hearing Officer at the time of any adverse benefit determination affecting an enrollee’s claim.

For appeals not resolved wholly in favor of the enrollee, Amerigroup will inform the enrollee of:
- The enrollee’s right to request a district fair hearing and how to do so
- The enrollee’s right to receive benefits while the Fair Hearing is pending and how to assure continuation of benefits

An enrollee may request a fair hearing before, during or after the Amerigroup appeal process, but no more than 90 days from the date the Notice of Adverse Benefit Determination. Amerigroup will assist the enrollee with the filing or any request for a fair hearing and send a copy of the request filed to the enrollee’s home address.

The parties to a District fair hearing include Amerigroup as well as the enrollee and his or her representative or the representative of a deceased enrollee’s estate.

Amerigroup will designate an individual responsible for the Amerigroup defense of the adverse benefit determination at issue.
8 CONTACT INFORMATION

Important Telephone Numbers

Department of Health Care Finance
Member Enrollment: 1-202-727-5355
Provider Inquiry: 1-202-906-8319

Amerigroup Phone Numbers

Provider Services (telephone): 1-800-454-3730
Provider Services (fax): 1-800-964-3627
TTY Relay Line: 711
Interpretive Services: 1-800-600-4441
Provider Inquiry Line: 1-800-454-3730
Nurse HelpLine: 1-800-600-4441
Member Services: 1-800-600-4441

Call Amerigroup Provider Services for:
- Precertification
- Health plan network information
- Member eligibility
- Claims information
- Inquiries or member issues
- Suggestions you may have to improve Amerigroup processes

Other Services

Transportation: Medical Transportation Management, Inc. (MTM)
- Provider Services: 1-888-828-1071
- Member Services: 1-888-828-1081

Vision: Avesis
- Provider Services: 1-833-554-1013
- Member Services: 1-833-554-1012

Dental: DentaQuest
- Provider Services: 1-844-876-7919
- Member Services: 1-844-876-7918
The Amerigroup website ([https://providers.amerigroup.com](https://providers.amerigroup.com)) has general information for providers such as forms, the preferred drug list (PDL) and credentialing and recredentialing information.

**Claims processing information**

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<td>Mequon, WI 53092</td>
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<td>1-800-341-8478</td>
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<td>Pharmacy</td>
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<td>St. Louis, MO 63121</td>
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<td>1-800-600-4441 (Amerigroup Member Services)</td>
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<td>Vision</td>
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<td>P.O. Box 38300</td>
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<td>Phoenix AZ 85069-8300</td>
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9 MEMBER RIGHTS AND RESPONSIBILITIES

Members have rights and responsibilities when participating in a managed care organization (MCO). Member Services representatives serve as advocates for Amerigroup members.

Members have the right to:

- Receive health care and services that are culturally competent and free from discrimination.
- Be treated respectfully and with due consideration for dignity and privacy.
- Privacy during a visit with their doctor.
- Talk about their medical record with their PCP, ask for a summary of that record and request to amend or correct the record as appropriate.
- Ask for and get a copy of their medical record(s).
- (Female enrollees only) Have direct access to a women’s health specialist within the network for the covered care necessary to provide women’s routine and preventive health care services. Also, female enrollees have a right to designate as their PCP a participating provider or an advanced-practicing registered nurse who specializes in obstetrics (OB) and gynecology (GYN).
- Ask for a chaperone to be present when they receive health care.
- Be properly educated about and helped to understand their illness and available health care options, including a candid discussion of appropriate clinically or medically necessary treatment options, including medication treatment options regardless of the cost or benefit coverage.
- Participate in decision making about the health care services they receive.
- Refuse health care (to the extent of the law) and understand the consequences of their refusal.
- Be free from any form of restraint, seclusion as a means of coercion, discipline, inconvenience or retaliation as specified in other federal regulations on the use of restraints and seclusion.
- Decide ahead of time regarding the kinds of care they want if they become sick, injured or seriously ill by making a living will.
- Expect their records (including medical and personal information) and communications will be treated confidentially.
- If under age 18 and married, pregnant or have a child, be able to make decisions about his or her own health care and/or his or her child’s health care.
- Choose their PCP from the Amerigroup network of providers.
- Make a complaint to Amerigroup and get a response within 30 days.
- Have information about Amerigroup, its services, practitioners, and provider and member rights and responsibilities.
- Receive information on the Notice of Privacy Practices as required by Health Insurance Portability and Accountability Act (HIPAA).
- Get a current member handbook and a directory of health care providers within the Amerigroup network.
Choose any Amerigroup network specialist after getting a referral from their PCP.
Change their doctor to another Amerigroup network doctor if the doctor is unable to refer them to the Amerigroup network specialist of their choice.
Be referred to health care providers for ongoing treatment of chronic disabilities.
Have access to their PCP or a backup 24 hours a day, 365 days a year for urgent or emergency care.
Receive care right away from any hospital when their medical condition meets the definition of an emergency.
Receive post-stabilization services following an emergency condition in some situations.
Call the Amerigroup toll-free Nurse HelpLine 24 hours a day, 7 days a week.
Call the Amerigroup toll-free Member Services telephone line from 8 a.m. to 6 p.m. Eastern time, Monday through Friday.
Know what payment methodology Amerigroup utilizes with health care providers.
Receive assistance in filing a grievance and/or appeal and appeal through the Amerigroup internal system.
File a grievance or appeal if the member is not happy with the results of his or her grievance and receive acknowledgement within 10 days and a resolution within 30 days.
Ask Amerigroup to reconsider previously denied coverage; upon receipt of the member’s medical information, Amerigroup will review the request.
Freely exercise the right to file a grievance or appeal such that exercising of these rights will not adversely affect the way the member is treated.
Receive notification to present supporting documentation for their appeal.
Examine files before, during and after their appeal.
Request a fair hearing when dissatisfied with the Amerigroup decision.
Continue to receive benefits pending the outcome of an appeal decision or District administrative hearing if the appropriate rules are followed.
To make recommendations regarding the Amerigroup Rights and Responsibilities Policy.
Expect providers’ offices to have wheelchair access and the ability to accommodate Member disabilities.

Members have the responsibility to:

- Treat their providers, their providers’ staff and Amerigroup employees with respect and dignity.
- Not behave in a disruptive manner while in the provider’s office.
- Respect the rights and property of all providers.
- Cooperate with people providing health care.
- Tell their PCP about their symptoms and problems and ask questions.
- Get information and consider treatments before they are performed.
- Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Discuss anticipated problems with following their provider’s directions.
- Consider the outcome of refusing treatment recommended by a provider.
• Follow plans and instructions for care they have agreed on with their providers.
• Help their provider obtain medical records from the previous provider and help their provider complete new medical records as necessary.
• Supply information (to the extent possible) the organization and its practitioners and providers need in order to provide care.
• Respect the privacy of other people waiting in providers’ offices.
• Call Amerigroup and change their PCP before seeing a new PCP.
• Make and keep appointments and arrive on time; members should always call if they need to cancel an appointment, change an appointment time or if they will be late.
• Discuss complaints, concerns and opinions in an appropriate and courteous way.
• Tell their provider who they want to receive their health information.
• Obtain medical services from their PCP.
• Learn and follow the Amerigroup policies outlined in the member handbook.
• Read the member handbook to understand how Amerigroup works.
• Notify Amerigroup when a member or family member who is enrolled in Amerigroup has died.
• Become involved in their health care and cooperate with their provider about recommended treatment.
• Learn the correct method by which his or her medications should be taken.
• Carry his or her Amerigroup ID card at all times and quickly report any lost or stolen cards to Amerigroup; members should contact Amerigroup if information on the ID card is wrong or if there are changes to their name, address or marital status.
• Show their ID cards to each provider.
• Report to Amerigroup if they have another other health insurance.
• Tell Amerigroup about any providers they are currently seeing.
• Provide true and complete information about their circumstances.
• Report change(s) in their circumstances.
• Notify his or her PCP as soon as possible after they receive emergency services.
• Go to the emergency room only when they have an emergency.
• Report suspected fraud and abuse.
10 GLOSSARY OF TERMS

Abuse: Provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to the Medicaid program or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care; abuse also includes member practices that result in unnecessary cost to the Medicaid program.

Action: Denial or limited authorization of a requested service, including the type or level of service; reduction, suspension or termination of a previously authorized service; a denial, in whole or part, of payment for a service; failure to provide services in a timely manner; failure of Amerigroup to act within the required time frames.

ACIP: Advisory Committee in Immunization Practices. A federal advisory committee convened by the Center for Disease Control, Public Health Service, Health and Human Services to make recommendations on the appropriate use and scheduling of vaccines and immunizations for the general public.

Adjudicate: Payment or denial of a clean claim.

Administrative denial: Administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of precertification or failure by the provider to submit clinical when requested.

Adverse benefit determination: The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirement for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service; or the denial, in whole or in part, of payment for a service.

Advance directive: a written instruction, such as a living shall or durable power of attorney for health care, recognized under District of Columbia law (whether statutory or as recognized by the courts of the District), relating to the provision of health care when the individual is incapacitated.

Alternative birthing center: A facility offering a nontraditional setting for giving birth; while alternative birthing centers can range from freestanding centers to special areas within hospitals, birthing centers are generally known for a more comfortable, home-like atmosphere, allowing more participation by the other parent and more procedural flexibility than commonly found in hospital births.

Ambulatory care: A general term for care that does not involve admission to an inpatient hospital bed. Visits to a doctor’s office are a type of ambulatory care.
**Ancillary care:** Diagnostic and/or support services (e.g., radiology, physical therapy, pharmacy or laboratory work)

**Appeal:** A request to review an adverse benefit determination

**Assertive community treatment (ACT):** Intensive, integrated rehabilitative, crisis, treatment and mental health rehabilitative community support provided by an interdisciplinary team to children and youth with serious emotional disturbance and to adults with serious and persistent mental illness by an interdisciplinary team. ACT is provided with dedicated staff time and specific staff to consumer ratios. Service coverage by the ACT team is required twenty-four (24) hours per day, seven (7) days per week. ACT is a specialty service. More information: 29 DCMR § 3499

**Behavioral care services:** Assessment and therapeutic services used in the treatment of mental health and substance use disorders

**Benefits:** List of health and related services provided in a health plan

**Business day:** Any day other than a Saturday, Sunday, or holiday recognized by the federal government or the District

**Brand-name drug:** Drug manufactured by a pharmaceutical company that has chosen to patent the drug’s formula and register its brand name

**Capitation:** A method of payment in which a provider receives a fixed per member per month (PMPM) amount of reimbursement, regardless of the services used by the enrolled member

**Care coordination:** Services that ensure all Medicaid, Alliance and ICP Enrollees gain access to necessary medical, social and other health-related services (including education-related health services)

**Care plan:** A multidisciplinary care plan for each enrollee in case management. It includes specific services to be delivered, the frequency of services, expected duration, community resources, all funding options, treatment goals, and assessment of the Enrollee environment. The plan is updated at least annually and when the Enrollee condition changes significantly. The plans are developed in collaboration with the attending physician and Enrollee and/or Guardian/personal representative.

**Case management plan:** Comprehensive plan that must include: an assessment of an eligible individual, development of a specific care plan, referral to services including the coordination of such services, and monitoring the activities of the individual and effectiveness of services rendered. More information found in 42 C.F.R. § 440.169.
Centers for Medicare & Medicaid Services (CMS): Federal agency responsible for administering Medicare and federal participation in Medicaid

Certified nurse midwife: A registered professional nurse who is licensed under District of Columbia Health Occupations Regulatory Act and acting within the scope of his/her practice and complies with the requirements set forth in 42 C.F.R. §440.165.

Children with special health care needs: A child under 21 who has a chronic, physical, developmental or behavioral condition and requires health and related services of a type or amount beyond that which is required by children generally, including a child who receives Supplemental Security Income (SSI), a child whose disabilities meets the SSI definition, a child in foster care and a child with developmental delays or disabilities who needs special education and related services under the individuals with Disabilities Education Act.

Claim: A bill for services, a line item of service, or all services for one beneficiary within a bill.

Clean claim: a claim that can be processed without obtaining additional information from the Provider of the service or from a third party. It includes a claim with errors originating in the District’s claims system. It does not include a claim from a Provider who is under investigation for Fraud or abuse, or a claim under review for Medical Necessity.

Clinical Laboratories Improvement Act (CLIA): Federal legislation found in Section 353 of the federal Public Health Services Act, including regulations adopted to implement the Act

Community-based intervention (CBI) services: Time limited, intensive mental health services delivered to children and youth ages 6 through 20 and intended to prevent the utilization of an out-of-home therapeutic resource or a detention of the consumer, as defined in 29DCMR § 3499. CBI is primarily focused on the development of consumer skills to promote behavior change in the child or youth’s natural environment and empower the child or youth to cope with his or her emotional disturbance.

Community support services: Rehabilitation and environmental support considered essential to assist a consumer in achieving rehabilitation and recovery goals. Community support services focus on building and maintaining a therapeutic relationship with the consumer. More information in 29 DCMR § 3499.

Complaint: Expression of dissatisfaction that results in either an appeal or a grievance

Concurrent review: A review to determine extending a previously approved, ongoing course of treatment or number of treatments. Concurrent reviews are typically associated with inpatient care, residential Behavioral Health care, intensive outpatient Behavioral Health care and ongoing ambulatory care.
Consultation: Discussion with another health care professional when additional feedback is needed during diagnosis or treatment; consultation is usually by PCP referral

Coordination of Benefits (COB): Contract provision that applies when a person is covered under more than one group’s health benefits program. COB requires payment of benefits be coordinated by all programs to eliminate duplication of benefits.

Copayment (copay): Amount a member pays at the time of service (i.e., predetermined fees for provider office visits, prescriptions or hospital services)

Core Services Agency: Provider that contracts with the Department of Behavioral Health to provide mental health rehabilitation services.

Covered services: The items and services, transportation, and case management services described herein that, taken together, constitute the services that Amerigroup must provide to enrollees under District and federal law.

D.C. Health Care Alliance: A public program designed to provide medical assistance to needy District residents who are not eligible for federally-financed Medicaid benefits. The Alliance provides comprehensive coverage of health care services for eligible residents of the District.

Department of Health Care Finance (DHCF): The Agency within the District of Columbia Government responsible for administering all Medicaid services under Title XIX (Medicaid) and Title XXI (CHIP) of the Social Security Act, for eligible beneficiaries, including the DC Medicaid Managed Care Program and oversight of its managed care contractors, as well as the Alliance and including all agents and Contractors of DHCF. For purposes of the contract, the CA shall be authorized to act on behalf of DHCF unless other individuals are specifically otherwise noted.

Department of Behavioral Health (DBH): The Department of Behavioral Health provides prevention, intervention and treatment services and supports for children, youth and adults with mental and/or substance use disorders including emergency psychiatric care and community-based outpatient and residential services. DBH serves eligible adults, children and youth and their families through a network of community based Providers and unique government delivered services. It operates Saint Elizabeth’s Hospital—the District’s inpatient psychiatric facility.

Developmental delay: When a child does not reach their developmental milestones at the expected times. It is an ongoing major or minor delay in the process of development. This includes delays with intellectual disability, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities.
**Discharge planning:** Identifying a member’s health care needs after discharge from inpatient care

**Disease Management and Disease Management programs:** A multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions. Disease management supports the practitioner-patient relationship and plan of care, and emphasizes prevention of complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies such as self-management. The organization’s disease-specific or condition-specific package of ongoing services and assistance that includes education and interventions.

**District of Columbia Healthy Families Program (DCHFP):** District of Columbia Healthy Families Program is the District’s combination of the Medicaid program and the Children’s Health Insurance Program (CHIP).

**Disenrollment:** Terminating member participation in a health plan

**Durable medical equipment:** Medical equipment that can withstand repeated use, is primarily and customarily used to serve a purpose consistent with the amelioration of physical, mental, or developmental conditions that affect healthy development and functioning, is generally not useful in the absence of a physical, mental, or developmental health condition, and is appropriate for use in a home or community setting.

**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services:** The health benefit for individuals under age 21, combined with informational, scheduling and transportation services required under federal law. The EPSDT benefit is defined in 42 U.S.C. §§1396a (a)(43), 1396d(a)(4)(B), and 1396d(r). The EPSDT benefit encompasses regularly scheduled assessments beginning at birth and continuing through age 20 inter-periodic (as needed) assessments when a physical, developmental, or mental condition is suspected, comprehensive vision care (including regularly scheduled and as needed eye exams and eyeglasses), hearing care (including regularly scheduled and as-needed exams and hearing aids and batteries), dental care needed to treat emergencies, restore the teeth and maintain dental health and the items and services set forth in 42 U.S.C. § 1396d(a) that are needed to meliorate or correct any physical or mental condition identified through a periodic or inter-periodic assessment, whether or not included in the District’s State Medicaid Plan.

**Eligible:** Qualifying for coverage under a health plan

**Emergency medical condition:** A medical condition characterized by sudden onset and symptoms of sufficient severity, including severe pain, where the absence of immediate medical attention could reasonably be expected by a prudent layperson possessing an average knowledge of health and medicine to result in placing the patient’s health, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy
Emergency services: Health care services provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, where the absence of immediate medical attention could reasonably be expected by a prudent layperson possessing an average knowledge of health and medicine to result in placing the member’s health or with respect to a pregnant member, the health of the member, or her unborn child, in serious jeopardy.

Experimental treatment: Diagnostic or treatment services that, in accordance with relevant evidence, are not considered to fall within the range of professionally accepted clinical practice with respect to illness, disability, or condition that is the focus of a coverage determination.

Extended care facility (ECF): Medical care institution for patients who require long-term custodial or medical care, especially for chronic disease or a condition requiring prolonged rehabilitation therapy

Fair hearing: An administrative process run by the District of Columbia that gives applicants and Enrollees the opportunity to contest adverse benefit determinations regarding eligibility and benefits.

Federally qualified health center (FQHC): CMS-certified medical facility that meets the requirements of §1861 (aa) (3) of the Social Security Act as a federally qualified health center and is enrolled as a provider in the Medicaid program

Fee-for-service (FFS): Payment to Providers on a per-service basis for health care services provided to Medicaid beneficiaries not enrolled in a Medicaid Managed Care Program.

Formulary: List of preferred, commonly prescribed prescription covered drugs chosen by a team of doctors and pharmacists because of their clinical superiority, safety, ease of use and cost

Fraud: As defined in 42 C.F.R. § 455.2, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes Fraud under applicable federal, State, or District law.

Generic drug: Prescription drug with the same active ingredient formula as a brand name drug; known only by its formula name, and its formula is available to any pharmaceutical company; rated by the Food and Drug Administration (FDA) to be as safe and effective as brand name drugs and are typically less costly

Grievance: An oral or written expression of dissatisfaction about any matter other than as adverse benefit determination.
Health maintenance organization (HMO): Organization that arranges a wide spectrum of health care services (e.g., hospital care, providers’ services and many other kinds of health care services with an emphasis on preventive care)

Health maintenance services: Health care service or program that helps maintain a member’s good health; include all standard preventive medical practices (e.g., immunizations and periodic examinations, health education and special self-help programs)

Health education: Consciously constructed opportunities for learning, involving some form of communication designed to improve health literacy, including improving knowledge and developing life skills, which are conducive to individual and community health. Health education as not limited to the dissemination of health-related information but also “fostering the motivation, skills and confidence (self-efficacy) necessary to take action to improve health”, as well as “the communication of information concerning the underlying social, economic and environmental conditions impacting on health, as well as individual risk factors and risk behaviors and use of the health care system.

Health Check Provider Training Module: A web-based EPSDT Provider training used for the EPSDT and IDEA Provider training requirements of Health Check Providers. See EPSDT Services for a review of topic content.

Health home:
- Programs: A service delivery model that focuses on providing individualized, person-centered recovery oriented case management and care coordination.
- Provider: Core Services Agency that has been certified as a DC Medicaid health home provider by the DC Department of Behavioral Health (DBH).
- Services: Addresses the full spectrum of individuals’ health needs (i.e., primary care, behavioral health, specialty services, long-term care services and supports). There are six types of core health home services that DC Medicaid health home providers must deliver at a minimum.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Federal legislation establishing health insurance portability and coverage protections for qualified individuals and authorizing the promulgation of federal regulations related to health information privacy, health information security, information simplification, and the transfer of electronic health information among health care payers, plans, and Providers and certain third parties. HIPAA also refers to the federal regulations promulgated in at 45 C.F.R. § 160-164.

Identification (ID) card: Provided to all members for proper identification under Amerigroup; ID card information helps providers verify member eligibility for coverage

Immigrant child: As defined in 29 DCR §7399, any child who is ineligible for Medicaid by virtue of the child’s immigration status.
**Immigrant Children’s Program (ICP):** In accordance with 29 DCR § 57A00, a health coverage program that is offered to children under age twenty-one (21), who are not eligible for Medicaid due to citizenship or immigration status who meet the income guidelines as determined by the Economic Security Administration. The beneficiaries enrolled in the ICP are only eligible for medical services when enrolled in a managed care organization.

**Individuals with Disabilities Education Act (IDEA):** Federal law governing the rights of infants and toddlers to receive Early Intervention and the educational rights of school-age children and youth with education-related disabilities.

**Individualized education program (IEP):** A legally binding document that describes the educational program that has been designed to meet that child's unique needs in accordance with the IDEA that is developed, reviewed, and revised in a meeting in accordance with 34 C.F.R. §300.320 through 300.324.

**Individualized Family Service Plan (IFSP):** A legally binding document that guides the Early Intervention process for children with disabilities and their families in accordance with the IDEA.

**Inpatient care:** Care given to a member who is admitted to a hospital, extended care facility, nursing home or other facility.

**Inpatient mental health service:** Residence and treatment provided in a psychiatric hospital or unit licensed or operated by the District of Columbia.

**Intensive day treatment:** Facility-based, structured, intensive mental health, and coordinated acute treatment program which serves as an alternative to acute inpatient treatment or as a step-down service from inpatient care. Its duration is time-limited. Intensive Day Treatment is provided in an ambulatory setting.

**Intensive outpatient program services (IOP):** A structured, intensive, mental health outpatient treatment program which serves as a step up from outpatient services or a step down service from inpatient hospital care, intensive day services, or Partial Hospitalization. Services are rendered by an interdisciplinary team to provide stabilization of psychiatric impairments to patients that typically cannot be stabilized with outpatient therapy.

**Interpreter:** An individual who is proficient in both English and another language who has had orientation or training in the ethics of interpreting, the ability to interpret accurately and impartially, and has the ability to interpret for medical Encounters using medical terminology in English and his/her other non-English language.

**Limited or no English proficiency individual:** An individual whose primary language is other than English and as a result, does not speak, read, write, or understand the English language at a level that permits effective interaction with Contractor or its Provider network.
**Long-term care**: Services typically provided at skilled nursing, intermediate care, personal care or elder care facilities

**Managed care organization (MCO)**: Managed care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs).

**Medicaid**: Federal program that provides payment of medical expenses for eligible persons who meet income and/or other criteria.

**Medical record**: Documents, whether created or stored in paper or electronic form, which correspond to and contain information about the medical health care, or allied care, goods, or services furnished in any place of service. The records may be on paper or electronic. Medical records must be dated, signed, or otherwise attested to (as appropriate to the media) and be legible.

**Medically necessary**: Services for individuals that promote normal growth and development and prevent, diagnose, detect, treat, ameliorate the effects or a physical, mental, behavioral, genetic, or congenital condition, injury, or disability and in accordance with generally accepted standards of medical practice including clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the enrollee’s illness, injury, disease, or physical or mental health condition.

**Medicare**: Title XVIII of the Social Security Act that provides payment for medical and health services to individuals age 65 and older, regardless of income, as well as certain disabled persons and persons with end-stage renal disease (ESRD).

**Mental health and substance use disorder services**: Services for the treatment of mental or emotional disorders and treatment of chemical dependency disorders.

**Mileage and travel time standards**: A source of treatment within five (5) miles of an enrollee Enrollee’s residence or no more than thirty (30) minutes Travel Time.

**National Committee for Quality Assurance (NCQA)**: Independent, nonprofit organization that assesses the quality of managed care plans, managed behavioral health care organizations and credential verification organizations.

**Network**: Group of contracted or employed health care providers by the health plan to provide covered services to members.

**Out-of-area benefits**: Benefits the health plan provides to members for covered services obtained outside of the network service area.
Outpatient care: Health care service provided to a member not admitted to a facility; may be provided in a provider’s office, clinic, member’s home or hospital outpatient department

Physical therapy: Rehabilitation concerned with the restoration of function and prevention of physical disability following disease, injury or loss of a body part

Post-stabilization care services: Covered services related to an emergency medical condition provided after a member is stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 CFR 438.114(e) as amended, to improve or resolve the member’s conditions

Preadmission certification: Assessment conducted prior to elective inpatient hospital care to determine whether the proposed health care services meet the medical necessity criteria under a health plan

Prescription drug: FDA-approved drug that can only be dispensed according to a provider’s prescription order

Preventive care: Medical and dental services aimed at early detection and intervention

Primary care: Basic, comprehensive, routine level of health care typically provided by a member’s general or family practitioner, internist, or pediatrician

Primary care provider (PCP): Family or general practitioner, internist, pediatrician, OB/GYN (for pregnant women only), nurse practitioner or specialists designated as PCPs (with the approval of an Amerigroup medical director) who provides a broad range of routine medical services and refers members to specialists, hospitals and other providers as necessary

Primary dental provider: A dental professional who provides comprehensive oral health by treating dental concerns and diseases and promotes prevention and oral health literacy.

Prior approval: Permission needed from a PCP or the health plan before a service can be delivered or paid

Provider directory: Listings of providers who have contracted with a managed care network to provide care to its members; members use to select network providers

Psychiatric residential treatment facility (PRTF): In accordance with 42 C.F.R.§483.352, a facility other than a hospital that provides inpatient psychiatric services to individuals under age 21.

Referral: When a PCP determines a member has a condition that requires the attention of a specialist
Residential treatment facility: 24-hour treatment facility primarily for children with significant behavioral problems that need long-term treatment.

School-based health center: A health care site located on school building premises which provides, at a minimum, on-site, age-appropriate primary and preventive health services with parental consent, to children in need of primary health care.

Service area: Geographical area covered by a network of health care providers

Severe mental illness (SMI): Diagnosable mental, behavioral, or emotional disorder (including those of biological etiology) which substantially impairs the mental health of the person or is of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) or its international Statistical Classification of Diseases and Related Health Problems, 9th Revision (ICD-9-CM) equivalent (and subsequent revisions) with the exception of DSM-IV “V” codes, substance abuse disorders, intellectual disabilities and other developmental disorders, or seizure disorders, unless those exceptions co-occur with another diagnosable mental illness.

Somatic: Physical

Specialists: Providers whose practices are limited to treating a specific disease (e.g., oncologists), specific parts of the body (e.g., ear, nose and throat specialists), a specific age group (e.g., pediatrician) or specific procedures (e.g., oral surgery)

Substance abuse treatment services: Management and care of a patient suffering from alcohol or drug abuse, a condition which is identified as having been caused by that abuse, or both, in order to reduce or eliminate the adverse effects upon the patient.

Transportation services (non-emergency): Mode of transportation that is appropriate to an Enrollee’s medical needs. Acceptable forms of transportation include, but are not limited to bus, subway, or taxi vouchers, wheelchair vans, and ambulances.

Travel time: The time required in transit to travel to a source of treatment from the enrollee’s residence. Travel Time does not include the time that is spent waiting for the arrival of regularly scheduled public transportation vehicles (i.e., bus or metro) but does include waiting times for specially arranged modes of transportation including wheelchair vans, ambulances, and taxis.

Urgent medical care: The diagnosis and treatment of a medical condition, including mental health and/or substance use disorder which is severe and/or painful enough to cause a prudent layperson possessing an average knowledge of medicine to believe that his or her condition requires medical evaluation or treatment within 24 hours in order to prevent serious deterioration of the individual’s condition or health. Contractors shall provide urgent medical care within 24 hours of an enrollee’s request.
APPENDIX A – FORMS

The rest of this page is intentionally left blank.
# Specialist as PCP Request Form

<table>
<thead>
<tr>
<th>Date:</th>
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</thead>
<tbody>
<tr>
<td>Member name:</td>
<td></td>
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<tr>
<td>Member ID number:</td>
<td></td>
</tr>
<tr>
<td>PCP name (if applicable):</td>
<td></td>
</tr>
<tr>
<td>Specialist/specialty:</td>
<td></td>
</tr>
<tr>
<td>Member diagnosis:</td>
<td></td>
</tr>
</tbody>
</table>

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

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

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

Specialist signature: ______________________________  Date: ___________________

Medical director signature: __________________________  Date: ___________________

Member signature: _________________________________  Date: ___________________
Living Will

You can make a living will by completing this form. You can choose another form or use the one your doctor gives you. If you make a living will, give it to your Amerigroup network provider. If you need help to understand or complete this form, call Member Services at 1-800-600-4441.

I, (Print your name here) ____________________________________________, am of sound mind. I want to have what I indicate here followed. I am writing this in the event something happens to me and I cannot make decisions about my medical care. These instructions are to be used if I am not able to make decisions. I want my family and doctors to honor what I say here. These instructions will tell what I want to have done if 1) I am in a terminal condition (going to die), or 2) I am permanently unconscious and have brain damage that is not going to get better. If I am pregnant and my doctor knows it, then my instructions here will not be followed during the time I am still pregnant and the baby is living.

TREATMENT I DO NOT WANT
I do not want (put your initials by the services you do not want):
_____ Cardiac resuscitation (start my heart pumping after it has stopped)
_____ Mechanical respiration (machine breathing for me if my lungs have stopped)
_____ Tube feeding (a tube in my nose or stomach that will feed me)
_____ Antibiotics (drugs that kill germs)
_____ Hydration (water and other fluids)
_____ Other (indicate what it is here)

TREATMENT I DO WANT
I want (put your initial by the services you do want):
_____ Medical services
_____ Pain relief
_____ All treatment to keep me alive as long as possible
_____ Other (indicate what it is here)

__________________________________________________________________

What I indicate here will happen, unless I decide to change it or decide not to have a living will at all. I can change my living will anytime I wish. I just have to let my doctor know I want to change it or forgo a living will entirely.

Signature: ________________________________________________________
Date: __________________
Address: __________________________________________________________

Statement of witness
I am not related to this person by blood or marriage. I know that I would not get any part of the person’s estate when he or she dies. I am not a patient in the health care facility where this person is a patient. I am not a person who has a claim against any part of this person’s estate when he or she dies. Furthermore, if I am an employee of a health facility in which this person is a patient, I am not involved in providing direct patient care to him or her. I am not directly involved in the financial affairs of the health facility.

Witness: __________________________________________________________
Date: __________________
Address: __________________________________________________________
Durable Power of Attorney

You can name a durable power of attorney by filling out this form. You can use another form or use the one your doctor gives you. If you name a durable power of attorney, give it to your Amerigroup network provider. If you need help to understand or complete this form, call Member Services at 1-800-600-4441.

I, (Name) ____________________________________, want

(Name of person I want to carry out my wishes) ____________________________

(Person’s address)

(Name of second person I want to carry out my wishes) ____________________________

(Second person’s address)

TREATMENT I DO NOT WANT

I do not want (put your initials by the services you do not want):
_____ Cardiac resuscitation (start my heart pumping after it has stopped)
_____ Mechanical respiration (machine breathing for me if my lungs have stopped)
_____ Tube feeding (a tube in my nose or stomach that will feed me)
_____ Antibiotics (drugs that kill germs)
_____ Hydration (water and other fluids)
_____ Other (indicate what it is here)

TREATMENT I DO WANT

I want (put your initial by the services you do want):
_____ Medical services
_____ Pain relief
_____ All treatment to keep me alive as long as possible
_____ Other (indicate what it is here)

What I indicate here will happen, unless I decide to change it or decide not to have a durable power of attorney at all. I can change my durable power of attorney anytime I wish. I just have to let my doctor know I want to change it or not have it at all.

Signature: ___________________________________________________________

Date: ___________________

Address: ____________________________________________________________

Statement of witness

I am not related to this person by blood or marriage. I know that I would not get any part of the person’s estate when he or she dies. I am not a patient in the health care facility where this person is a patient. I am not a person who has a claim against any part of this person’s estate when he or she dies. Furthermore, if I am an employee of a health facility in which this person is a patient, I am not involved in providing direct patient care to him or her. I am not directly involved in the financial affairs of the health facility.

Witness: ___________________________________________________________

Date: ___________________

Address: ____________________________________________________________
**Provider Payment Dispute and Correspondence Submission Form**

This form should be completed by providers for payment disputes and claim correspondence only.

Member first/last name __________________________________________ Date of birth ______________

Member Amerigroup, Medicaid or Medicare ID (circle one) _________________________________________

Provider first/last name ______________________________________ NPI #___________________________

☐ Participating ☐ Nonparticipating*

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

Provider contact first/last name __________________________ Contact phone (__) _______

Provider street address ________________________________________________________________________

City_______________________ State______ ZIP_____________ Phone (_______) ______________________

Claim #________________________ Billed amount $____________ Amount received $__________________

Start date of service _________________ End date of service ________________ Auth #_________________

To ensure timely and accurate processing of your request, please complete the payment dispute or claim correspondence section below by checking (✓) the applicable determination or request reason provided on the Amerigroup determination letter or Explanation of Payment (EOP).

**PAYMENT DISPUTE:** Check (✓) One → ☐ First-level dispute ☐ Second-level dispute

A payment dispute is defined as a dispute between the provider and Amerigroup in reference to a claim determination where the member cannot be held financially liable. All disputes with member liability must follow the applicable appeals process. Please refer to the EOP to ensure you are following the correct process.

Clearly and completely indicate the payment dispute reason(s). You may attach an additional sheet if necessary. Please include appropriate medical records.

**CLAIM CORRESPONDENCE:** Check (✓) appropriate box below.

Claim correspondence is defined as a request for additional and/or needed information for a claim to be considered clean, to be processed correctly or for a payment determination to be made.

☐ Itemized bill/medical records (In response to an Amerigroup claim denial or request)

☐ Corrected claim ☐ Other insurance/third-party liability information ☐ Other correspondence

Clearly and completely indicate the reason(s) for your correspondence. You may attach an additional sheet, if necessary. Mail this form and supporting documentation to:

Payment Disputes
Amerigroup District of Columbia, Inc.
P.O. Box 61599
Virginia Beach, VA 23466-1599
As part of its quality improvement process, Amerigroup adopts nonpreventive and preventive clinical practice guidelines for acute and chronic medical and behavioral health conditions that are scientific and evidenced-based. This is determined by scientific evidence, review of government research sources, review of clinical or technical literature, involvement of board-certified practitioners from appropriate specialties or professional standards. Recognized sources of the evidenced-based guidelines include national organizations such as the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH), professional medical-specialty organizations such as the American Academy of Pediatrics (AAP), American College of Obstetrics and Gynecologists (ACOG), American Academy of Family Practice (AAFP) and voluntary health organizations as the American Diabetes Association (ADA) and American Cancer Society (ACS). The American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), Texas Implementation of Medication Algorithm (TIMA) and Texas Medicaid Algorithm Project (TMAP) are currently more specific sources recognized for behavioral health guidelines. Other sources that may be referenced in developing or updating behavioral health guidelines include organizations such as the Substance and Mental Health Services Administration (SMHSA) and National Institute of Mental Health (NIMH). The guidelines are based on valid and reliable clinical evidence, a consensus of health care professionals in a particular field and the needs of the members. The guidelines are adopted and approved in consultation with network health care professionals. They are reviewed and updated periodically as appropriate, but at a minimum of every two years. Amerigroup will disseminate the guidelines to all affected providers and, upon request, to members and potential members. The Amerigroup decisions regarding disease management, case management, utilization management, member education, coverage of services and other areas included in the guidelines, will be consistent with Amerigroup guidelines. Data is gathered and monitored using HEDIS, ad hoc medical records review and other sources to measure performance against the guidelines and improve the clinical care process.

Visit https://providers.amerigroup.com/DC and log in to the secure site by entering your login name and password. On the homepage, go to Clinical Policy & Guidelines and select Clinical Practice Guidelines. A copy of the guidelines can be printed from the website or you can contact Provider Services at 1-800-454-3730 to receive a copy.