Post Discharge Meals

- **Medicaid:**
  - Amerigroup will cover two meals a day for seven days to enrollees 21 years of age and older that have had a three-day hospital stay after surgery with physician referral.
  - This benefit is limited to members 21 years of age and older and two meals per day for the first seven days post discharge.
  - No prior authorization is required.
  - No benefit coverage for post pregnancy delivery inpatient stays (C-sections).

Primary Care Provider (PCP) Services

- Members may self-refer for these services.
- **Medicaid:** Covered services include preventive, diagnostic, therapeutic, and palliative care or treatment of an illness or disease. PCP services do not include nonclinically proven procedures or cosmetic surgery. Physician home visits for members 21 years of age and older who are homebound and require ambulance transport to access primary care are covered.
- **FHK:** No copay is required.

Radiation Therapy

- No precertification is required for radiation therapy procedures when performed by a network facility in a provider office, an outpatient hospital or an ambulatory surgery center.

Radiology

See the **Diagnostic Testing s***ection of this QRC.*

Rehabilitation Therapy (Short-Term): Occupational Therapy (OT), Physical Therapy (PT), Rehabilitation Therapy (RT) and Speech Therapy (ST)

- **Medicaid:** Precertification is required for initial evaluation. Covered services include evaluation and treatment to prevent or correct physical deficits.
- For members older than 21 years of age, the following limitations apply:
  - One initial evaluation per member per provider
  - One re-evaluation every six months per member per provider
  - Medically necessary therapy services are covered for members older than 21 only if services are provided in an outpatient hospital setting
  - ST: Refer members to an in-network provider.
- **Medicaid:** For members older than 21 years of age, limitations apply (see above).
- **FHK:** Outpatient coverage is limited to 24 sessions within a 60-day period per incident. The 60-day coverage period begins with the first visit. A $5 copay is required for each office visit.
- **Requests for members under the age of 21 enrolled in FHK and MMA, will be authorized in the office setting whenever appropriate.** Providers should contact HN1 to obtain the authorization.
- Please call Amerigroup for precertification for an outpatient hospital setting at 1-800-454-3730 and fax your preauthorization requests to 1-866-495-1981.
- For therapy in an office setting, please contact HN1 by phone at 1-888-550-8800 or by fax at 1-855-410-0121.

For more information, contact one of our ancillary Provider Relations representatives.

Respite Care Services

- Precertification is required.
- If medically needed, members can get an initial home health visit by a registered nurse and eight follow-up visits (each lasting four hours) by an aide. This benefit includes a maximum of 16 hours per month and 32 hours per year.

Sterilization

- **Medicaid:**
  - Sterilization services are a covered benefit for members 21 and older.
  - No precertification or notification is required for coverage of sterilization procedures, including tubal ligation and vasectomy.
  - **A Sterilization Consent Form is required for claims submission.**
  - Reversal of sterilization is not a covered benefit.

Transplant Services

Medicaid: Precertification is required for coverage.

Transportation

- **Medicaid:** Amerigroup will cover nonemergent transportation through its transportation vendor, LogistiCare 1-866-372-9794.
- **FHK:** Precertification is required for fixed-wing transportation.
  - A $10 copay is required per trip for emergency services only.
  - Nonemergent transportation services are not covered.

Urgent Care Center

- **Medicaid:** No notification or precertification is required for a network facility.
- **FHK:** The $10 copay should only be charged if the urgent care service is taking place in a hospital ER and the urgent care service is inappropriate (i.e., the member's situation did not meet the definition of urgent).

Vision Care (Medical)

- **Medicaid:** Precertification is required.
- **FHK:** A $5 copay per specialist visit is required.

See the **Ophthalmology** *section of this QRC.*

Vision Care (Routine)

- **Medicaid:**
  - Members may self-refer for these services.
  - Services include eye exams plus certain glasses and contact lenses if medically needed. Call eyeQuest at 1-855-418-1627. There is no age limit for vision services.
  - In lieu of covered eyewear, eligible adult members will receive coverage towards contact lenses. This benefit is available to members 21 years of age and older. Each member shall receive up to $100 in contact lens-related professional services and dispensing of contact lenses. The benefit shall be available once every 12 months.
- **FHK:**
  - Covered services include an eye exam plus corrective lenses and frames if medically needed.
  - No copay is required for routine eye exams provided by the PCP.
  - A $5 copay per specialist visit is required.
  - A $10 copay for corrective lenses is required.

Well-Woman Exam

- **Medicaid:**
  - Members may self-refer for these exams.
  - Well-woman exams are covered once every 365 days by either a PCP or network GYN. Services include exam, physical, blood work, routine lab work, STD screening and Pap test, and mammogram (one baseline exam at age 35 or older, one per year at age 40 and older).
- **FHK:** No copay required.

Revenue (RV) Codes

- **Medicaid:** To the extent the following services are covered benefits, precertification or notification is required for all services billed with the following RV codes:
  - All Inpatient and Behavioral Health Accommodations
  - 0023 – Home Health Prospective Payment System
  - 0240-0249 – All-inclusive Ancillary Psychiatric
  - 0570-0572, 0579 – Home Health Aide
  - 0632 – Pharmacy Multiple Source
  - 0901, 0905-0907, 0913, 0917 – Behavioral Health Treatment Services
  - 0944-0945 – Other Therapeutic Services
  - 0961 – Psychiatric Professional Fees
  - 3101-3109 – Adult Day Care and Foster Care

Amerigroup RealSolutions® in healthcare

Provider Quick Reference

Precertification/notification requirements

Important phone numbers ■ Revenue codes

Florida

Florida Medicaid/MedKids Program and Florida Healthy Kids (FHK)

https://providers.amerigroup.com/FL

FLPEC-1572-18

Important contact information

Our Service Partners

AIM (CAT scans, CT scans, MRAs, MRIs, PET scans and nuclear cardiology)	1-800-714-0040
Health Network One – Dermatology	1-800-595-9621
Health Network One – In office-based therapy	1-800-595-9621
HearUSA (Hearing services)	1-800-731-3277
DentaQuest (Dental services)	1-866-516-0957
Chiro Alliance (Chiropractic services)	727-319-2434
Express Scripts (Pharmacy services)	1-844-367-6117
LabCorp (Laboratory services)	1-800-877-5227
Quest Diagnostics (Laboratory services)	1-800-377-8448
eyeQuest (Vision services)	1-855-418-1627
LogistiCare (Transportation services)	1-866-372-9794
Mom's Meals (Post-surgical discharge meals)	1-866-224-9485

Provider Experience Program

Our Provider Services team offers precertification, case and disease management, automated member eligibility, claims status, health education materials, outreach services and more. Call 1-800-454-3730 Monday through Friday from 8 a.m. to 6 p.m. Eastern time.

Provider website and IVR available 24/7/365

To verify eligibility, check claims and referral authorization status, and look up precertification/notification requirements, visit https://providers.amerigroup.com/FL.

Can't access the internet? Call Provider Services and simply say your National Provider ID when prompted by the recorded voice. The recording guides you through our menu of options. Simply select the information or materials you need when you hear it.

Claims Services

Timely filing is within 180 calendar days of the date of service.

Electronic Data Interchange (EDI)

Call our EDI hotline at 1-800-590-5745 to get started. We accept claims through three clearinghouses:

- Availity (payer ID 26375)
- Capario (payer ID 28804)
- Emdeon (payer ID 27514)

Paper Claims

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 to:

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

Payment Disputes

Claims payment disputes, or grievances, must be filed within 120 days of the date of action that initiated the grievance (120 days of the date of coverage denial). Forms for provider appeals are available on our website. Mail to:

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

To appeal an Amerigroup final grievance decision, call 1-888-419-3456 or send your written complaint to:

AHCA Bureau of Managed Health Care
2727 Mahan Drive, Bldg. #1
Tallahassee, FL 32308-5408

Medical Appeals

Medical appeals, or medical administrative reviews, can be initiated by members or providers on behalf of members and must be submitted within 120 calendar days of receipt of an adverse determination. Nonparticipating providers have 365 days to submit an appeal. Submit appeals in writing to:

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

A provider submitting on behalf of a member can write a letter or use the Provider Appeals Form on our website.

Health Services

Care Management Services • 1-800-454-3730

We offer care management services to members who are likely to have extensive health care needs. Our nurse care managers work with you to develop individualized care plans, including identifying community resources, providing health education, monitoring compliance, assisting with transportation, etc.

Disease Management Centralized Care Unit (DMCCU) Services • 1-888-830-4300

DMCCU services include educational information like local community support agencies and events in the health plan's service area. Services are available for members with the following medical conditions:

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disease
- Congestive heart failure
- Coronary artery disease
- Diabetes
- HIV/AIDS
- Hypertension
- Obesity
- Major depressive disorder
- Schizophrenia
- Substance use disorder
- Transplants

24-hour Nurse HelpLine • 1-866-864-2544

Members can call the 24-hour Nurse HelpLine if they need to speak with a licensed nurse for health advice 24 hours a day, 7 days a week, 365 days a year. Members can also call this number if they need help setting up an appointment with a doctor for an urgent medical issue.

Member Services • 1-800-600-4441

Easy access to **precertification/notification requirements** and other important information

Visit our provider website to get the most recent, full version of our provider manual. In it you'll find more information about:
■ Requirements ■ Benefits ■ Services
We want to hear from you! If you have questions about this *Quick Reference Card (QRC)* or recommendations to improve it, call your local Provider Relations representative. Your feedback can help improve our service so you can focus on serving your patients!

Precertification/notification instructions and definitions

Request precertifications and give us notifications:

- **Online:** https://providers.amerigroup.com/FL
- **By phone:** 1-800-454-3730
- **By fax:** 1-800-964-3627; fax behavioral health information to 1-800-505-1193

For code-specific requirements for all services, visit https://providers.amerigroup.com/FL and select Precertification Lookup from our Quick Tools menu.

Requirements listed are for network providers. In many cases, out-of-network providers may be required to request precertification for services when network providers do not.

Precertification — the act of authorizing specific services or activities before they are rendered or occur.

Notification — telephonic, fax or electronic communication received from a provider to inform us of your intent to render covered medical services to a member.

- Give us notification prior to rendering services outlined in this document.
- For emergency or urgent services, give us within 24 hours or the next business day.
- There is no review against medical necessity criteria; however, member eligibility and provider status (network and non-network) are verified.

Behavioral Health/Substance Abuse

- Members may self-refer to a network provider.
- Covered services include medically necessary mental health treatment for all members and inpatient alcohol/drug treatment.
- Emergency behavioral health care services are covered 24 hours a day, 7 days a week.
- Call Provider Services at 1-800-454-3730 for nonemergent assistance.
- **Medicaid:**
  - Adults age 22 and older may have 45 days inclusive of medical day(s) as well as unlimited emergency inpatient care.
  - Children and adolescents up to age 21 and pregnant adults have unlimited inpatient days.
  - Amerigroup will provide up to 28 inpatient hospital days (calendar) in an inpatient hospital substance abuse treatment program for substance abusers who meet intensity, severity, discharge screens (ISDs) criteria with modifications.
  - Outpatient services are covered.
  - Precertification is required for limited therapeutic behavioral services.

Cardiac Rehabilitation

Precertification is required for coverage of all services.

Chemotherapy

- Precertification is required for coverage of inpatient services.
- No precertification is required for coverage of chemotherapy procedures when performed in a participating facility or office, outpatient hospital or ambulatory surgical center.

For information on coverage of chemotherapy drugs, see the **Pharmacy** *section of this QRC.*

Child Health Check-Up

- Members may self-refer for these visits.
- **Medicaid:** Preventive visits are required once a year for members from birth through age 20. Use the well-child screening schedule and document Child Health Check-Up visits.
- **FHK:** Preventive visits as needed for members ages 5 through 18. No copayment is required.

Chiropractic Services

- **Medicaid:** Members may self-refer to a network provider for a total of 24 visits during a calendar year.
  - Coverage of a new patient visit is limited to one per provider per recipient. A new patient is one who has not received any professional services from a provider or provider group within three years.
  - Precertification is not required for use of a network physician.
- **FHK:** $5 copay per visit is required. Coverage is limited to 24 visits per calendar year.

Circumcisions

- **Medicaid:**
  - Amerigroup will provide coverage for elective circumcisions for male members up to 28 days of age.
  - Circumcision will be a one-time, lifetime benefit available to all categories of Medicaid members 28 days of age and younger.

Dental Services

- Members may self-refer for these visits.
- **Medicaid:**
  - Members under the age of 21: Amerigroup will provide dental coverage through DentaQuest.
  - Members 21 years and older: Amerigroup will provide one exam and one cleaning every six months.
  - Supplemental Security Income (SSI) adult members 21 years and older: Amerigroup will cover one fluoride treatment every six months, one set of bitewing X-rays every 12 months and fillings as medically required for SSI nondual members. Coverage for a single tooth is limited to one filling every 36 months.
- **FHK:** Dental services are covered outside of the Amerigroup contract for FHK members. Call 1-800-821-5437 for benefit information.

Dermatology Services

- **Medicaid:**
  - No precertification is required for a network provider for evaluation and management (E&M), testing and procedures.
  - Services considered cosmetic in nature are not covered.
  - Services related to previous cosmetic procedures are not covered.

See the **Diagnostic Testing** *section of this QRC.*

Diagnostic Testing

- **Medicaid:**
  - No precertification is required for routine diagnostic testing.
  - Precertification is required for coverage of MRAs, MRIs, CAT scans, nuclear cardiology, PET scans and video EEGs.

Contact AIM for more information.

Dialysis

- **Medicaid:**
  - No precertification is required for coverage of outpatient dialysis procedures.
  - Precertification is required for medications related to dialysis treatment.

Disposable Medical Supplies

No precertification is required for coverage of disposable medical supplies.

Durable Medical Equipment

Medicaid and FHK: Use the Precertification Lookup Tool on our provider portal at https://providers.amerigroup.com/FL under Quick Tools. It contains a list of durable medical equipment (DME), home health and home infusion therapy HCPCS codes for which Amerigroup requires authorization.

- You can request authorizations online at https://providers.amerigroup.com/FL, by calling Provider Services at 1 800 454-3730 or by faxing a request to 1-844-528-3687.
- All DME billed with an RR modifier (rental) requires precertification.
- No precertification is required for coverage of glucometers and nebulizers, dialysis and end-stage renal disease equipment, gradient pressure aids, infant photo/light therapy, UV light therapy, sphygmomanometers, walkers and orthotics for arch support, heels, lifts, shoe inserts and wedges by a network provider.
- Precertification may be requested by completing a Certificate of Medical Necessity (CMN), available on our website, or by submitting a physician order with an Amerigroup Precertification Request Form. A properly completed and physician-signed CMN must accompany each claim.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

See the **Child Health Check-Up** *section of this QRC.*

Educational Consultation

No notification or precertification is required for coverage.

Emergency Room (ER)

- **Medicaid:**
  - Members may self-refer for services.
  - No notification is required for emergency care given in the emergency room (ER). If emergency care results in admission, notification is required within 24 hours or the next business day.
- **FHK:** The $10 copay should only be charged:
  - If the urgent care service is taking place in a hospital ER, and
  - If the urgent care service is inappropriate (i.e., the member's situation did not meet the definition of urgent)

ENT Services (Otolaryngology)

- **Medicaid:**
  - No precertification is required for a network provider for E&M, testing and most procedures.
  - Precertification is required for tonsillectomy and/or adenoidectomy, nasal/sinus surgery, and cochlear implant surgery and services.

See the **Diagnostic Testing** *section of this QRC.*

Family Planning/STD Care

- **Medicaid:**
  - Members may self-refer for these services.
  - Infertility treatment is not covered.
  - Covered services include information and referral for learning and counseling, diagnostic procedures, contraceptive drugs and supplies, and medically needed sterilization and follow-up care.
  - Services are not covered for a member under the age of 18 unless married, a parent, pregnant or will suffer health hazards if services are not provided.
- **FHK:** Coverage of family planning is limited to one annual visit and one supply visit per 90 days.

Gastroenterology Services

- **Medicaid:**
  - No precertification is required for a network provider for E&M, testing and most procedures.
  - Precertification is required for bariatric surgery, including insertion, removal and/or replacement of adjustable gastric restrictive devices and subcutaneous port components and upper endoscopy.

See the **Diagnostic Testing** *section of this QRC.*

Gynecology

- **Medicaid:**
  - No precertification is required for a network provider in office for E&M, testing and procedures.
  - Members may self-refer to a network provider.

Hearing Services

- **Medicaid:**
  - Precertification is not required for coverage of services.
  - Precertification is required for digital hearing aids.
  - Members should contact HearUSA at 1-800-731-3277 or see a participating ENT or audiologist. Covered services include hearing evaluations, hearing aids, hearing aid fitting and dispensing, hearing aid repairs and accessories, selective amplification services, and diagnostic testing.
  - Coverage is limited to one evaluation every three years from the date of the last evaluation.
  - Coverage of newborn screenings for members from birth to 12 months is limited to a maximum of two screenings.
  - Routine maintenance, batteries, cord or wire replacement, or cleaning is not covered.
  - There is no age limit for hearing services.
  - Upon medical necessity approval, members can upgrade from behind-the-ear hearing aids to digital canal hearing aids up to $600.
  - Amerigroup will provide hearing aid batteries for common hearing aid battery sizes of 10, 13, 312, and 675, for members with a medically necessary hearing device. We will provide 60 batteries of the member's choice, which will last approximately one year, depending on use. After initial use of the benefit, members must wait 12 months to regain benefit eligibility. The benefit is per member, not per hearing aid.
- **FHK:** No copay is required.

Home Health Care

- **Medicaid:**
  - Precertification is required for coverage of all services.
  - Members may contact Amerigroup for benefit information.
- **FHK:**
  - A $5 copay per visit is required.
  - Coverage is limited to skilled nursing services.

Hospice Care

- **Medicaid:**
  - Amerigroup will cover hospice care. Please refer to Provider Directory for participating hospice groups.
  - Notification is required for inpatient hospice care.
  - Precertification is required for coverage of inpatient hospice services.

See the **Home Health Care** *section of this QRC.*

Hospital Admission

- **Medicaid:**
  - Precertification is required for coverage of an elective admission.
  - Notification is required for coverage of emergency and obstetric admissions within 24 hours or the next business day.
  - To be covered, preadmission testing must be performed by an Amerigroup-preferred lab vendor or network facility outpatient department. See your Provider Referral Directory for a complete listing of participating vendors.
  - For all child/adolescent enrollees (up to age 21) and pregnant adults, Amerigroup is responsible for providing up to 365 calendar days of health-related inpatient care, including behavioral health, for each state fiscal year.
  - For all nonpregnant adults, Amerigroup will be responsible for up to 45 calendar days of inpatient coverage and unlimited emergency inpatient care, including behavioral health.
  - Nonpregnant adults (ages 22 and older) have 45 days of coverage inclusive of medical day as well as unlimited emergency inpatient care.
  - Children, adolescents up to age 21 and pregnant adults have unlimited inpatient days.
- **FHK:**
  - Amerigroup case managers will coordinate services that are medically necessary.
  - Covered services include 15 days per contract year for preapproved rehabilitation and physical therapy stays.
  - No copay is required.

Laboratory Services (Outpatient)

- **Medicaid:**
  - All laboratory services furnished by non-network providers require precertification except for hospital laboratory services in the event of an emergency medical condition.
  - For offices with limited or no office laboratory facilities, lab tests may be referred to one of our preferred lab vendors.

See your ***Provider Referral Directory*** *for a complete listing of participating vendors.*

Neurology

- **Medicaid:**
  - No precertification is required for a network provider for E&M and most testing.
  - Precertification is required for neurosurgery, spinal fusion and artificial intervertebral disc surgery.

See the **Diagnostic Testing** *section of this QRC.*

Nutritional Counseling

- **Medicaid:**
  - Limited to one session every three months or four sessions per calendar year.
  - Open to all Medicaid membership (see Provider Directory for participating providers).

Observation

- No precertification or notification is required for in-network observation.
- If observation results in admission, notification is required within 24 hours or the next business day.
- If admission occurs, all charges for observation services roll up into the admission.

Obstetrical Care

- **Medicaid:**
  - Member may self-refer to a network OB/GYN provider.
  - No precertification/PCP referral is required for coverage of obstetrical services, including obstetrical visits, diagnostic tests and laboratory services when performed by a participating provider. This includes prenatal office visits (10 for normal pregnancy or 14 for high-risk pregnancy), postpartum office visits and lab work.
  - Prenatal ultrasounds do not require prior authorization; however, payment is based on medical necessity. For more information, go to our provider website at https://providers.amerigroup.com/FL and select Medical Coverage Policies from the Quick Tools menu.
  - Notification is required at the first prenatal visit.
  - Notification is required for coverage of emergency and obstetric admissions within 24 hours or the next business day.
  - Notification is required for coverage of labor and delivery.
- **FHK:**
  - Notification is required.
  - We cover 48 hours postdelivery for vaginal births and 96 hours postdelivery for C-section deliveries.

Ophthalmology

- **Medicaid:**
  - Precertification must be obtained through eyeQuest at 1-855-418-1627 or from a participating eyeQuest optometrist.
  - There is no age limit for vision services.

See the **Vision Care** *section of this QRC.*

Oral Maxillofacial

See the **Plastic/Cosmetic/Reconstructive Surgery** *section of this QRC.*

Out-of-Area/Out-of-Network Care

Precertification is required for any out-of-area/out-of-network care except for coverage of emergency care (including self-referral) and obstetrical care.

Outpatient/Ambulatory Surgery

- **Medicaid:** Precertification requirements are based on the service performed.

Pain Management

- **Medicaid:**
  - No precertification is required for E&M services.
  - Precertification is required for all other services.

See the **Diagnostic Testing** *section of this QRC.*

Pharmacy

- **Medicaid:**
  - The pharmacy benefit covers medically necessary prescriptions prescribed by a licensed provider. Exceptions and restrictions exist as the benefit is provided under a closed formulary/Preferred Drug List (PDL). Please refer to the PDL on our website for the preferred products within therapeutic categories, as well as requirements around generics, prior authorization, step therapy, quantity edits and the prior authorization process. Quantity and day supply limits apply.
  - Most self-injectable drugs are available through Accredo Specialty pharmacy and require prior authorization. Please call Amerigroup at 1-800-454-3730 to start the prior authorization process. Once you receive approval, please call Accredo at 1-844-420-3565 for delivery of the medication. For a complete list of drugs available through Accredo Specialty, please visit the Pharmacy section of our website.
  - The following injectable drugs and their counterparts in the same therapeutic class require precertification when administered from a provider's supply: Epogen, Procrit, Aranesp, Neupogen, Neulasta, Leukine, IVIG, Enbrel, Remicade, Kineret, Amevive, Raptiva, Synvisc, Hyalgan, Erbitux, Avastin, Rituxan, Camptosar, Eloxatin, Gemzar, Ixempra, Tasigna, Taxol, Taxotere and growth hormone.
  - Covered prescription drugs are no cost.
  - Over-the-counter drug benefit is subject to $25 per household per month.
- **FHK:**
  - $5 per prescription for up to a 31-day supply.
  - Over-the-counter drug benefit does not exceed $10 per family per month.

Physiatry

- **Medicaid:**
  - No precertification is required for E&M services.
  - Precertification is required for all other services.

See the **Diagnostic Testing** *section of this QRC.*

Plastic/Cosmetic/Reconstructive Surgery

(including Oral Maxillofacial Services)

- **Medicaid:**
  - No precertification is required for network providers for E&M and oral maxillofacial E&M services.
  - Precertification is required for coverage of trauma to the teeth and oral maxillofacial medical and surgical conditions, including TMJ.
  - All other services require precertification for coverage.
  - Services considered cosmetic in nature are not covered.
  - Services related to previous cosmetic procedures are not covered (e.g., scar revision, keloid removal resulting from pierced ears).
  - Reduction mammoplasty requires our medical director's review and approval.

Podiatry

- **Medicaid:** No precertification is required for a network provider in office for E&M, testing and most procedures. Coverage includes:
  - Open access.
  - One podiatrist-recipient contact per day not to exceed two per month, except for emergencies.
  - One long-term care facility service per month per recipient, except for emergencies.
  - One new patient E&M service per recipient every three years.

See the **Diagnostic Testing** *section of this QRC.*