Provider Manual
Amerigroup Community Care

1-800-454-3730
providers.amerigroup.com/NJ
How to apply for participation
If you are interested in applying for participation with the Amerigroup Community Care network, please visit https://www.providers.amerigroup.com and complete the online Provider Application Request. You may also call Provider Services at 1-800-454-3730.
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INTRODUCTION

Welcome to the Amerigroup Community Care network participating provider family. Incorporated as Amerigroup New Jersey, Inc., we are pleased you have joined the network, which represents some of the finest health care providers in the state.

Amerigroup is a licensed health maintenance organization (HMO). We bring the best expertise available nationally to operate local community-based health care plans with experienced local staff to complement our operations. We are committed to assisting you in providing quality health care.

We believe physicians, hospitals and other providers play a pivotal role in managed care. We can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, quality provider network. All network participating providers are contracted with Amerigroup through a Participating Provider Agreement.

If you are interested in participating in any of our quality improvement committees or learning more about specific policies, please contact us. Most committee meetings are prescheduled at times and locations intended to be convenient for you. Please call Provider Services at 1-800-454-3730 with any suggestions, comments or questions that you may have. Together, we can arrange for and provide an integrated system of coordinated, efficient and quality care for our members.
2 OVERVIEW

Who is Amerigroup?
Amerigroup Community Care is focused on meeting the health care needs of financially vulnerable Americans. Together with other Anthem, Inc. affiliated health plans, we serve approximately 4.5 million beneficiaries of state sponsored health plans in 20 states, making us the nation’s leading provider of health care solutions for public programs. We accept all eligible people regardless of age, sex, race or disability. As a leader in managed health care services for the public sector, the Amerigroup subsidiary health plans provide health care coverage exclusively to low-income families, children, pregnant women, Medicare Advantage Plans and Medicare Special Needs Plans.

Mission
Our mission is to operate a community-focused managed care company with an emphasis on the public sector health care market. We will coordinate the members’ physical and behavioral health care, offering a continuum of education, access, care and outcome programs, resulting in improved quality, lower cost and better health status for these Americans.

Strategy
Our strategy is to:
• Improve access to preventive primary care services by ensuring the selection of a Primary Care Provider (PCP) who will serve as provider, case/care manager and coordinator for all basic medical services
• Improve the health status and outcomes of the members
• Educate members about their benefits, responsibilities and the appropriate use of health care services
• Encourage stable, long-term relationships between providers and members
• Discourage medically inappropriate use of specialists and emergency rooms
• Commit to community-based enterprises and community outreach
• Facilitate the integration of physical and behavioral health care
• Foster quality improvement mechanisms that actively involve providers in re-engineering health care delivery
• Encourage a customer service orientation with regular measurement of member and provider satisfaction

Summary
Escalating health care costs are driven in part by a pattern of fragmented, episodic care and unmanaged health problems of members. We strive to educate members to encourage the appropriate use of the managed care system and to be involved in all aspects of their health care.
QUICK REFERENCE INFORMATION

Please call Provider Services at the National Customer Care department for precertifications and notifications, health plan network information, member eligibility, claims information, and inquiries and recommendations you may have about improving our processes and managed care program.

<table>
<thead>
<tr>
<th>Contact information</th>
<th>Hours of operation*</th>
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<tbody>
<tr>
<td>Provider Services at the National Contact Center: 1-800-454-3730</td>
<td>Monday–Friday 8 a.m.–6 p.m.</td>
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<tr>
<td>UM issues or questions about the UM process: 1-800-454-3730</td>
<td>Monday–Friday 8 a.m.–6 p.m.</td>
</tr>
<tr>
<td>Notification/Precertification: 1-800-454-3730 Fax: 1-800-964-3627</td>
<td>Available 24 hours a day, 7 days a week</td>
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<tr>
<td>TTY services for the hearing impaired: 711</td>
<td>Available 24 hours a day, 7 days a week</td>
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<tr>
<td>Automated Provider Inquiry Line for Member Eligibility: 1-800-454-3730</td>
<td>Available 24 hours a day, 7 days a week</td>
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<tr>
<td>Nurse HelpLine: 1-800-600-4441, TTY 711</td>
<td>Available 24 hours a day, 7 days a week</td>
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<tr>
<td>Member Services: 1-800-600-4441, TTY 711</td>
<td>Available Monday–Friday 7 a.m.–7 p.m.</td>
</tr>
<tr>
<td>Electronic Data Interchange (EDI) Hotline: 1-800-590-5745</td>
<td>Available 24 hours a day, 7 days a week; voice mail capability for after normal business hours</td>
</tr>
<tr>
<td>Healthplex (dental services): All dental communication should be directed directly to Healthplex. Provider Hotline: 1-888-468-2183 Provider Relations fax: 516-228-9571 Provider Relations email: <a href="mailto:ProviderRelations@healthplex.com">ProviderRelations@healthplex.com</a> Website: <a href="https://www.healthplex.com">https://www.healthplex.com</a></td>
<td>Available Monday–Friday, 8 a.m.–5 p.m.</td>
</tr>
<tr>
<td>AIM Specialty Health (Radiology Management): 1-800-714-0040 <a href="http://www.aimspecialtyhealth.com">www.aimspecialtyhealth.com</a></td>
<td>Available Monday–Friday, 8 a.m.–8 p.m.</td>
</tr>
<tr>
<td>LabCorp (Laboratory Services): 1-888-LABCORP <a href="https://www.labcorp.com">https://www.labcorp.com</a></td>
<td>Available Monday–Friday, 8 a.m.–5 p.m.</td>
</tr>
<tr>
<td>OrthoNet (Back Pain/Spine Only) 1-844-874-6691</td>
<td>Available Monday – Friday, 8 a.m.–7 p.m. Eastern Time</td>
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<tr>
<td>Contact Information</td>
<td>Hours of Operation*</td>
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<tr>
<td>Therapy Network of New Jersey (TNNJ) Physical Therapy (PT), Occupational Therapy (OT) and Speech-language Pathology Therapy (SPT): 1-855-825-7818 <a href="http://mytnnj.com">http://mytnnj.com</a></td>
<td>Available Monday–Friday, 8:30 a.m.–5 p.m. UM Representative on call for emergencies.</td>
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*All hours of operation are Eastern time.

**Provider Services and Ancillary Claims**

<table>
<thead>
<tr>
<th>Contact</th>
<th>Contact Information</th>
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<tbody>
<tr>
<td>Provider Services team</td>
<td>1-800-454-3730</td>
</tr>
<tr>
<td>MLTSS Department</td>
<td>1-855-661-1996</td>
</tr>
<tr>
<td>NJ MLTSS Provider Help</td>
<td><a href="mailto:nj1mltssprovhelp@amerigroup.com">nj1mltssprovhelp@amerigroup.com</a> 732-452-6000, ext. 66190</td>
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</tbody>
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**Hospital Billing Inquiries**

<table>
<thead>
<tr>
<th>Contact</th>
<th>Contact Information</th>
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<tbody>
<tr>
<td>Lisa Cunningham-Hill</td>
<td><a href="mailto:Lisa.Cunningham-Hill@amerigroup.com">Lisa.Cunningham-Hill@amerigroup.com</a> 732-452-6000, ext. 66301</td>
</tr>
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**Managed Long-Term Services and Supports (MLTSS) Additional Provider Services Contacts for MLTSS Services: Assisted Living, Home and Community Based Services and Nursing Facilities**

<table>
<thead>
<tr>
<th>Contact</th>
<th>Contact Information</th>
<th>Counties</th>
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<tbody>
<tr>
<td>Carol Diprisco Network Relations Rep</td>
<td><a href="mailto:Carol.Diprisco@amerigroup.com">Carol.Diprisco@amerigroup.com</a> 732-452-6000, ext. 65832</td>
<td>Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Gloucester, Hunterdon, Monmouth, Morris, Ocean, Salem</td>
</tr>
<tr>
<td>Alex Valentin Network Relations Rep</td>
<td><a href="mailto:Alejandro.Valentin@amerigroup.com">Alejandro.Valentin@amerigroup.com</a> 732-452-6000, ext. 65837</td>
<td>Essex, Hudson, Mercer, Middlesex, Passaic, Somerset, Sussex, Union, Warren</td>
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**Ancillary Contracting**

<table>
<thead>
<tr>
<th>Contact</th>
<th>Contact Information</th>
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<tbody>
<tr>
<td>Yvonne Capraun, Manager</td>
<td><a href="mailto:Yvonne.Capraun@amerigroup.com">Yvonne.Capraun@amerigroup.com</a></td>
</tr>
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**Other Important Telephone Numbers**

<table>
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<tr>
<th>Business</th>
<th>Contact Information</th>
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<tr>
<td>Behavioral Health for Division of Developmental Disabilities (DDD) members</td>
<td>1-800-832-9173</td>
</tr>
<tr>
<td>NJ FamilyCare Enrollment</td>
<td>1-800-701-0710</td>
</tr>
<tr>
<td>NJ FamilyCare HelpLine</td>
<td>1-800-356-1561</td>
</tr>
<tr>
<td>NJ Medicaid Fraud Division Hotline</td>
<td>1-888-937-2835</td>
</tr>
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Our Provider Website: https://providers.amerigroup.com
Our provider self-service website contains a full complement of resources, including an inquiry tool for real-time eligibility, claims status and precertification/notification status. In addition, our provider self-service site offers general information you’ll find helpful, such as forms, a complete Amerigroup Medication Formulary, an abbreviated list of preferred drugs within the most commonly prescribed therapeutic categories referred to as a Preferred Drug List (PDL), drugs requiring prior authorization, provider manuals, referral directories, provider newsletters, claims status, Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT) information, updates, clinical guidelines, and other information to help you do business with us quickly and easily. Visit us on the web at https://providers.amerigroup.com.

Ongoing Provider Communications
To keep you up-to-date with information required to work effectively with us and our members, we send you messages through a variety of channels: broadcast faxes, provider manual updates, quarterly newsletters and information posted to the website.

Here’s some more information to help you in your day-to-day interaction with us:

<table>
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<tr>
<th>Member Eligibility</th>
<th>• Call the Provider Inquiry Line at 1-800-454-3730</th>
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</thead>
</table>
| Enrollment/Disenrollment | • For NJ FamilyCare enrollment, call the State of New Jersey at 1-800-701-0710  
| | • NJ FamilyCare HelpLine: 1-800-356-1561 |
| Notification/Precertification | • Submit to us by phone, fax or Web:  
| | Telephone: 1-800-454-3730  
| | Fax: 1-800-964-3627  
| | Website: providers.amerigroup.com  
| | • Data required for complete notification/precertification:  
| | o Member ID number  
| | o Legible name of referring provider  
| | o Legible name of individual referred to provider  
| | o Number of visits and/or services  
| | o Dates of service  
| | o Diagnosis  
| | o Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) code(s)  
| | • In addition, clinical information is required for precertification within one business day.  
| | • Referral and precertification forms are located on our website. |
| Claims Information | • Submit paper claims to:  
| | Amerigroup Community Care  
| | P.O. Box 61010  
| | Virginia Beach, VA 23466-1010 |
- **Electronic claims Payer ID:**
  - Emdeon is 27514
  - Availity is 26375
  - Capario is 28804

- Timely filing is within 180 days of the last date of service of the course of treatment, according to state law (N.J.A.C. 11:22-3.6).

- On our provider self-service site, we offer resources designed to save you time on eligibility verification, claims status and precertification status.

- If you can’t access the Internet, you can get claims, eligibility and precertification status over the phone by calling our toll-free automated Provider Inquiry Line at 1-800-454-3730.

### Medical Appeal Information

- Medical appeals must be filed within 60 days of the date of the adverse determination letter.

- Medical appeals require medical documentation and may be initiated with or without member consent.

- **File an appeal to:**

  Appeals Department  
  Amerigroup Community Care  
  101 Wood Ave. South, 8th Floor  
  Iselin, NJ 08830

### Provider Payment Dispute

- File provider payment disputes within 60 calendar days of the date of the Explanation of Payment (EOP). We’ll send a determination letter within 30 calendar days of receiving all necessary information. If you’re dissatisfied with the resolution, submit a dispute regarding the resolution within 30 calendar days of receipt of the notification.

- **File a payment dispute to:**

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

### Provider Grievances

- **Submit provider grievances to:**

  Amerigroup Community Care  
  P.O. Box 62509  
  Virginia Beach, VA 23466-2509

### Member Grievances

- A member may call Amerigroup Member Services at 1-800-600-4441 (TTY 711) or write to the following address:

  Quality Management Department  
  Amerigroup Community Care  
  101 Wood Ave. South, Eighth Floor  
  Iselin, NJ 08830

- A member can get help with a grievance by calling the State’s health benefits coordinator at 1-800-701-0710 (TTY 1-800-701-0720).
| **Case/Care Managers** | • Our case/care managers are available during normal business hours from 8 a.m. to 5 p.m. Eastern time.  
• For urgent issues, assistance is available after normal business hours, on weekends and on holidays through Provider Services. |
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<tr>
<td><strong>Network Management Representatives</strong></td>
<td>Representatives are assigned to service areas based on New Jersey counties. For more information, contact Provider Services at 1-800-454-3730.</td>
</tr>
</tbody>
</table>
| **Report Fraud, Waste and Abuse Concerns** | • Visit our website, [www.myamerigroup.com](http://www.myamerigroup.com) and select the link for [Reporting Waste, Fraud and Abuse](#)  
• Call our Special Investigations Unit (SIU) fraud hotline at 1-866-847-8247  
• Send an email to our Medicaid Special Investigation Unit at medicaidfraudinvestigations@anthem.com |
4 PRIMARY CARE PROVIDERS

A Primary Care Provider (PCP) is a licensed Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) or certain other licensed medical practitioner who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is responsible for providing all required primary care services to enrollees, including periodic examinations, preventive health care and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, and initiation of referrals to specialty providers described in the NJ Medicaid/NJ FamilyCare contract and the benefits package, and for maintaining continuity of patient care. A PCP shall include general/family practitioners, pediatricians, internists, and may include specialist physicians, physician assistants, CNMs or CNPs/CNS’s, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with these contract provisions and licensure requirements. Providers must assure the use of the most current diagnosis and treatment protocols and standards established by the DHSS and medical community.

4.1 PCP Role

The PCP is a network provider who has the responsibility for the complete care of his or her patient, our member. The PCP serves as the entry point into the health care system for the member. The PCP is responsible for the complete care of his or her patient, including providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services, and maintaining the continuity of care. The PCP responsibilities shall include at a minimum:

- Managing the medical and health care needs of members to ensure all medically necessary services are made available in a timely manner
- Monitoring and follow-up on care provided by other medical service providers for diagnosis and treatment, to include services available under Medicaid Fee-For-Service (FFS)
- Maintaining a medical record of all services rendered by the PCP and other referral providers
- Advising and performing recommended preventive care screenings and routine well-care services
- Notifying health plan of inability to provide service for clients of the Division of Developmental Disabilities (DDD) and/or the Aged, Blind and Disabled (ABD) population by completing the DDD and ABD survey in the Appendix.

A PCP must be a physician or network provider/subcontractor who provides or arranges for the delivery of medical services, including case/care management, to ensure all services found to be medically necessary are made available in a timely manner. The PCP may practice in a solo or group setting or may practice in a clinic (e.g., a Federally Qualified Health Center [FQHC] or Rural Health Center [RHC]) or outpatient clinic.

We encourage enrollees to select a PCP who provides preventive and primary medical care as well as authorization and coordination of all medically necessary specialty services. Members are encouraged to make an appointment with their PCP within 90 calendar days of their effective date of enrollment.

FQHCs and RHCs may function as a PCP.
PCPs must adhere to the following availability guidelines:

- A PCP is available 24 hours a day, 7 days a week in person or by an on-call physician.
- Providers must answer emergency telephone calls from members within 15 minutes.
- Each PCP must provide a minimum of 20 office hours per week of personal availability as a PCP within each county in which they have a practice.

The New Jersey Division of Medical Assistance and Health Services (DMAHS) administers the NJ FamilyCare program. This includes Medicaid recipients, NJ FamilyCare members (including Managed Long Term Services and Supports or MLTSS), Supplemental Security Income (SSI) members and clients of the DDD in New Jersey. See Section 5 — Amerigroup Health Care Benefits and Copayments — for a detailed list of covered services for each specific category.

You can help identify members who may qualify for coverage. If you know of or identify potential eligibles who may be entitled to NJ FamilyCare coverage, ask them to call a State of New Jersey health benefits coordinator at 1-800-701-0710 (TTY 1-800-701-0720) or Amerigroup at 1-877-453-4080 (TTY 711).

4.2 Provider Specialties

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

- Family practitioner
- General practitioner
- General pediatrician
- General internist
- Nurse practitioners certified as specialists in family practice or pediatrics
- Physician assistants

4.3 PCP Onsite Availability

We’re dedicated to ensuring access to care for our members, and this depends upon the accessibility of network providers. Our network providers are required to abide by these standards:

- PCPs are required to provide members with access to covered services 24 hours a day/7 days a week. Access includes regular office hours on weekdays and availability of a provider or designated agent by telephone after regular office hours, on weekends and on holidays.
- A 24-hour telephone service may be used. The service may be answered by a designee such as an on-call physician or nurse practitioner with physician backup, an answering service or a pager system; however, this must be a confidential line for member information and/or questions. An answering machine is not acceptable. If an answering service or pager system is used, the call must be returned within 15 minutes if of an emergent nature.
- The PCP or another physician/nurse practitioner must be available to provide medically necessary services.
- Covering physicians are required to follow the precertification guidelines.
- It is not acceptable to automatically direct the member to the emergency room when his or her PCP is not available.
- We encourage our PCPs to offer after-hours office care in the evenings and on weekends.
4.4 Provider Enrollment and Disenrollment Process

Enrollment
1. Providers who are interested in enrolling in the Amerigroup network of providers may access the website at www.amerigroup.com to submit an application request.

Select Providers > Join Our Network > Get Started and then New Jersey to submit an Application Request.

You may also call Provider Services at: 1-800-454-3730 Monday through Friday from 8 a.m. to 8 p.m.

2. To view the Amerigroup network of participating PCPs and Specialists, select Amerigroup Provider Network.

3. To submit an application for network consideration, please send to the following:

Medical, HCBS and Other:
Amerigroup, ATTN: Credentialing Department, 101 Wood South, Iselin, NJ 08830

Dental:
Healthplex
333 Earle Ovington Blvd., Suite 300, Uniondale, NY 11553 or call 1-888-468-2183.

4. For questions regarding the status of an application, please send an email to nj1credentialing@amerigroup.com.

5. The time frame for an application to be reviewed is 60-90 days.

You may cease participating with Amerigroup for either mandatory or voluntary reasons.

Mandatory disenrollment occurs when a provider becomes unavailable due to immediate, unforeseen reasons. Examples of this include but are not limited to death and loss of license. Members are auto assigned to another PCP to ensure continuous access to Amerigroup covered services, as appropriate. We will notify members of any termination for PCPs or other providers from whom they receive ongoing care.

We will provide notice to affected members if you disenroll for voluntary reasons, such as retirement. You must provide written notice to us within the time frames specified in your participating provider agreement with us. Members who are linked to a PCP that has disenrolled for voluntary reasons will be notified to self-select a new PCP.
4.5 Member Enrollment

We and our network providers shall accept assignment of a member and will not discriminate against eligible enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, gender or physical or mental handicap.

Nondiscrimination and Accessibility Requirements Update
On May 13, 2016, the Department of Health and Human Services Office of Civil Rights (DHHS OCR) released the Nondiscrimination in Health Programs and Activities Final Rule (The Final Rule) to improve health equity under the Affordable Care Act (The ACA). Section 1557 of The ACA prohibits discrimination on the basis of race, color, national origin, sex, age or disability in health programs and activities that a) receive financial assistance from the federal government, and b) are administered by any entity established under Title I of the ACA.

Amerigroup complies with all applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, sex, age or disability in its health programs and activities. Amerigroup provides free aids and services to people with disabilities to communicate effectively with us. Amerigroup also provides free language services to people whose primary languages are not English (e.g., qualified interpreters and information written in other languages).

We notified your Amerigroup patients these services can be obtained by calling the Member Services phone number on their member ID card.

If you or your Amerigroup 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, sex, you can file a grievance with our Grievance/Appeals Representative via:

- Mail: Amerigroup Community Care
  101 Wood Ave. S., Suite 800
  Iselin, NJ 08830
- Phone: 1-732-452-6000 (TTY/TDD: 711)
- Fax: 1-877-271-2409

If you or your Amerigroup patient needs help filing a grievance, the Amerigroup Grievance/Appeals Representative is available to help. You or your patient can also file a civil rights complaint with the DHHS OCR:

- Online at the OCR complaint website: 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: 1-800-868-1019 (TTY/TTD: 1-800-537-7697)

Complaint forms are available at www.hhs.gov/ocr/filing-with-ocr/index.html. For additional details about Section 1557 and The Final Rule, visit:

- The DHHS OCR information page: www.hhs.gov/civil-rights/for-individuals/section-1557/index.html
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.

Member Enrollment
A member may request a new PCP, and we will accommodate his or her request immediately. This means PCPs may receive new members on any day of the month rather than just on the first of the month. Please note the member must initiate the request for a PCP change. PCPs will be reimbursed for services according to their contract. If PCPs are capitated, their reimbursement will be adjusted on a pro rata basis for those members who select or leave their PCP on any day other than the first of the month.

Newborn care is covered only if the mother was enrolled with us at the time of the baby’s birth and is subject to the following guidelines:

- Coverage of newborn infants will be our responsibility from the date of birth and for a minimum of 60 days after the birth through the period ending at the end of the month in which the 60th day falls, unless the baby is determined eligible beyond that point. Any baby hospitalized during the first 60 days of life will remain our responsibility until discharge. This includes hospital readmissions within 48 hours of discharge for the same diagnosis (other than live born infant). We will notify DMAHS when a newborn who has been hospitalized has not been added to our enrollment roster after 12 weeks from the date of birth. DMAHS will take action with the appropriate County Welfare Agency (CWA) to have the infant added to the eligibility file and subsequently the enrollment roster, following this notification. The mother’s Managed Care Organization (MCO) is responsible for the hospital stay for the newborn following delivery and for subsequent services based on enrollment.

- A newborn whose mother is covered under SSI and does not apply or is not eligible for Aid to Families with Dependent Children (AFDC)/Temporary Assistance for Needy Families (TANF) will remain our responsibility from the date of birth and for a minimum of 60 days after the birth, and for any readmits for the same diagnosis for 48 hours through the period ending at the end of the month in which the 60th day falls, unless the newborn is determined eligible beyond that point. Any newborn who is hospitalized during the first 60 days of life will remain our responsibility until discharge, as well as for hospital readmissions within 48 hours of discharge for the same diagnosis (other than live born infant). We will notify DMAHS when a newborn has been hospitalized and not added to our enrollment roster after 12 weeks from the date of birth.
• A newborn placed in the Division of Child Protection and Permanency (DCP&P) will remain our responsibility from the date of birth for medically necessary newborn care. Once the child is medically stable and awaiting placement in a DCP&P-approved home, the newborn is covered under Medicaid FFS.

• A newborn whose mother is enrolled in NJ FamilyCare B, C or D is our responsibility from the date of birth through the end of the month in which the 60th day of coverage occurs unless the newborn is determined to be eligible beyond this period.

If a member relocates outside the Amerigroup service area and is otherwise still eligible for benefits, we will continue to provide or arrange care to the member until DMAHS can disenroll him or her.

### 4.6 Members Eligibility Listing

The PCP will receive a list of his or her panel of assigned members monthly. If a member calls to change his or her PCP, the change will be effective the next business day. The PCP should verify that each Amerigroup member receiving treatment in his or her office is on his or her membership list. If a PCP does not receive the lists in a timely manner, he or she should contact a Provider Services representative. For questions regarding a member’s eligibility, you can visit our provider website or call the automated Provider Inquiry Line at 1-800-454-3730.

### 4.7 Member Identification Cards

Each of our members will be provided an identification card, which identifies the member as a participant in the Amerigroup program, within 10 calendar days of notification of enrollment into Amerigroup or prior to the member’s enrollment effective date. To ensure immediate access to services, you can verify enrollment with New Jersey's fiscal agent, MOLINA, or contact us at 1-800-454-3730 to verify eligibility and benefits. The holder of the member ID card issued by Amerigroup is a member or guardian of the member.

Every Amerigroup member ID card lists the following:

- Effective date of Amerigroup membership
- Date of birth of member
- Member number
- Carrier and group number (RXGRP #) for injectables
- Amerigroup logo
- Health plan name — Amerigroup Community Care
- PCP name
- PCP telephone number
- Vision telephone number
- Amerigroup Member Services telephone number

Presentation of an Amerigroup member ID card does not guarantee eligibility. No matter which type of card a member presents, remember to verify eligibility at every visit through our provider self-service site or by calling Provider Services.
Amerigroup member ID card sample:

SSI member under DDD

SSI member not under DDD

For members who are under DDD or MLTSS, behavioral health is billed to Amerigroup. For members who are not under DDD or MLTSS, behavioral health is billed to the Medicaid FFS program.

NJ FamilyCare ID Cards

The NJ FamilyCare (A, B, C, D or ABP) is listed in the upper left-hand corner of the member’s ID card.
For NJ FamilyCare D, members who are referred to an emergency room by their PCP for services normally rendered in the PCP’s office or are admitted, the emergency room copayment is waived. If the PCP refers the member to the emergency room for services normally rendered in the PCP’s office, the PCP must notify Amerigroup. This ensures appropriate adjudication of the claim.

MLTSS FamilyCare A ID Cards
For those NJ FamilyCare members who are not responsible for copayments or who are responsible for copayments and have met their copayment maximum, the member ID card will list $0 copayment.

4.8 Americans with Disabilities Act Requirements

Our policies and procedures are designed to promote compliance with the Americans with Disabilities Act of 1990. Providers are required to take actions to remove an existing barrier and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes:

- Street-level access
- Elevator or accessible ramp into facilities
- Access to lavatory that accommodates a wheelchair
- Access to examination room that accommodates a wheelchair
- Clearly marked handicap parking, unless there is street-side parking

4.9 Communication Access

Our policy is designed to ensure meaningful access to health care services for members with Limited English Proficiency (LEP). Our policy supports members with LEP to overcome language barriers and fully use services and benefits. Language assistance options are available at no cost to the member or provider.

Upon request, written member materials are available in Braille, in large print, on tape and in languages other than English. Member materials are written at the appropriate reading level.
Oral interpretive services are available either in-office or by phone. If you are serving one of our members and you are having trouble communicating, call our Member Services department at 1-800-600-4441 to access an interpreter. For immediate needs, we have Spanish language interpreters available without delay and can provide access to interpreters of other languages within minutes. To arrange for in-office interpretive services, call Member Services at 1-800-600-4441.

For members who are deaf or hard of hearing, we can also help you telephonically communicate with them via a translation device. Call TTY 711. Also, in-office sign language assistance is available. Call Member Services at 1-800-600-4441 to arrange for the service.

Providers are required to offer interpretive services to members who may require services, document the offer and the member’s response, and advise members that interpretive services are available at no cost to the member.

Below are a few guidelines that may result in better communication when using an interpreter:

- Keep your sentences short and concise. The longer and more complex your sentences, the less accurate the interpretation.
- Avoid use of medical terminology when possible, which is unlikely to translate well.
- Ask key questions in several different ways; this increases the chance you’ll get a response to exactly what you need to know.
- 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. This is an effective review of how well the member has understood what you told them.

Family members, especially minor children, should not be used as interpreters in assessments, therapy or other medical situations in which impartiality and confidentiality are critical, unless specifically requested by the member. The provider should help the member to use a nonfamilial interpreter and should help the member understand his or her concerns regarding the use of minor children as interpreters, even at the member’s request.

4.10 Medically Necessary Services or Supplies

Covered services or supplies must meet the New Jersey managed care contract definition of medically necessary. Medically necessary health services or supplies are those that:

- Prevent, evaluate, diagnose, correct, prevent the worsening of, alleviate, ameliorate or cure a physical or mental illness or condition
- Maintain health
- Prevent the onset of an illness, condition or disability
- Prevent or treat a condition that endangers life or causes suffering or pain, or results in illness or infirmity
- Prevent the deterioration of a condition
- Promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities appropriate for individuals of the same age
• Prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical
deformity or malfunction and there is no other equally effective, more conservative or substantially
less costly course of treatment available or suitable for the member

The services provided, as well as the type of provider and setting must be:
• Reflective of the level of services that can be safely provided
• Consistent with the diagnosis of the condition
• Appropriate to the specific medical needs of the member and not solely for the convenience of the
member or provider of service in accordance with standards of good medical practice and generally
recognized by the medical scientific community as effective

**Course of treatment** may include mere observation or, where appropriate, no treatment at all.
Experimental services or services generally regarded by the medical profession as unacceptable
treatment are not medically necessary. Medically necessary services provided must be based on peer-
reviewed publications, expert pediatric, psychiatric and medical opinion, and medical and/or pediatric
community acceptance.

For **pediatric members**, medically necessary also means services that:
• Are needed by a member as a result of a comprehensive screening visit or an interperiodic
  encounter, whether or not they are ordinarily covered services for all other Medicaid members
• Are appropriate for the age and health status of the member
• Will aid in the overall physical and mental growth and development of the member
• Will assist in achieving or maintaining functional capacity

**Dental vs. medical**: Network specialty providers (physician specialist, maxillofacial oral surgeon or
prosthodontist) are required to submit a completed precertification request for surgical cases with
appropriate diagnostic and medical and/or dental necessity rationales.

For procedures that may be considered either medical or dental, such as surgical procedures for a
fractured jaw or removal of tumors, cysts and neoplasms, we have written policies and procedures that
clearly and definitively indicate whether a physician specialist or oral surgeon may perform the
procedure and when, where and how authorization shall be promptly obtained if needed. Such policies
and procedures can be found on our website at [https://medicalpolicies.amerigroup.com](https://medicalpolicies.amerigroup.com) and are
available in hard copy upon request.

Amerigroup has a dental director on staff. The dental director oversees the provision of the
Amerigroup dental program as managed by Healthplex. The Amerigroup dental director:
• Reviews surgical cases.
• Develops, reviews and administers dental policies.
• Reviews dental provider applications.
• Directs dental provider orientation to the Amerigroup dental network.
• Directs dental quality activities.
• Works with the State through the Dental Advisory Counsel of the DMAHS.

**Note**: We only cover the use of experimental procedures or experimental medications under certain
circumstances (e.g., clinical trials); precertification must be obtained before rendering these services.
5.1 Amerigroup Covered Services

The following are the health care services and benefits we cover for NJ FamilyCare members.

5.2 Cost-Sharing Information

For NJ Medicaid members or NJ FamilyCare A, B, ABP, and MLTSS members, no copayment or deductible is required or may be collected for medically necessary covered services. In certain instances, MLTSS members receiving nursing facility or assisted living services have patient pay liability (PPL). The member’s cost share will be determined by the county welfare agency, which will subsequently enter the cost share amount in the New Jersey Medicaid Management Information System (NJMMIS) and send notification to the NF or AL provider. In addition, the notification will be sent to the member and/or the member’s designee. Further details can be found on page 26 of the FAQ at www.nj.gov/humanservices/dmahs/home/MLTSS_Provider_FAQs.pdf.

For NJ FamilyCare D members, a monthly premium may be required and is collected by the State. In addition, NJ FamilyCare C and D members may be responsible for a copayment or Personal Contribution to Care (PCC) for services dependent upon their State-assigned program status code. Native American Indians and Eskimos under age 19 in NJ FamilyCare C and D are not responsible for copays. Review the member ID card for copayment information.

The boxes below show the covered services and copay amounts for services that have copays. Copays listed are for NJ FamilyCare C and D members who have copays.

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>MEDICAID/NJ FAMILYCARE A AND ABP</th>
<th>NJ FAMILYCARE B</th>
<th>NJ FAMILYCARE C</th>
<th>NJ FAMILYCARE D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Audiology Services</strong>&lt;br&gt;Include:&lt;br&gt;• Diagnostic services&lt;br&gt;• Screening services&lt;br&gt;• Preventive services&lt;br&gt;• Corrective services&lt;br&gt;• Needed supplies and equipment &lt;br&gt;Requires referral from physician or other licensed medical practitioner</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
<td>• Covered for age 15 and younger&lt;br&gt;• Limited to $1,000 per ear every 24 months</td>
</tr>
<tr>
<td><strong>Chiropractor Services</strong>&lt;br&gt;Limited to treatment by means of manual manipulation of the spine</td>
<td>No copay</td>
<td>No copay</td>
<td>$5 per visit</td>
<td>Not covered</td>
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</tbody>
</table>
Dental Services
All NJFC Members: Plans A, B, C, D, ABP, MLTSS and Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP dual eligible Medicare/Medicaid) have comprehensive dental benefits, which include diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral surgical and other services. Some procedures require prior authorization. Orthodontic services are age-restricted and only approved with adequate documentation of medical necessity. Diagnostic and preventive dental services include exams, cleanings, space maintainers, sealants and fluoride treatments:
- Dental visit at one year of age or soon after the eruption of the first primary tooth and twice a year through age 20 years.
- Topical fluoride treatments are covered twice yearly for all members including age 21 and over.

Sealants:
- Sealants and sealant repairs are covered for bicusps and permanent molars once every three years for members under age 17.

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<tr>
<th>COVERED SERVICES</th>
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<th>NJ FAMILYCARE C</th>
<th>NJ FAMILYCARE D</th>
</tr>
</thead>
<tbody>
<tr>
<td>NJ FamilyCare A, ABP, MLTSS and FIDE SNP:</td>
<td>No copay</td>
<td>$5 per visit (no copay for diagnostic or preventive services)</td>
<td>$5 per visit (no copay for diagnostic or preventive services)</td>
<td>Limited to children under the age of 19</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>MEDICAID/NJ FAMILYCARE A AND ABP</td>
<td>NJ FAMILYCARE B</td>
<td>NJ FAMILYCARE C</td>
<td>NJ FAMILYCARE D</td>
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<td>• Covered for those age 17 or older with documentation of medical necessity.</td>
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<td>Restorative (fillings and crowns):</td>
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<td>• As medically appropriate to restore natural tooth</td>
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<tr>
<td>• Prior authorization needed for crowns.</td>
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<tr>
<td>Endodontic (root canal, etc.): Requires prior authorization.</td>
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<tr>
<td>Prosthodontic (removable dentures): Requires prior authorization. Fixed bridgework and implants require prior authorization with documentation of medical necessity.</td>
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<tr>
<td>Oral and Maxillofacial Surgery (extractions and oral surgery): For oral surgery, prior authorization is required for inpatient and outpatient facilities.</td>
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<tr>
<td>Medical or Dental Procedures: For procedures that may be considered either medical or dental such as maxillofacial prosthetics, surgical procedures for fractured jaw or removal of cysts, the contractor shall establish written policies and procedures clearly and definitively delineated for all</td>
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</table>

- 26 -
<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
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<th>NJ FAMILYCARE C</th>
<th>NJ FAMILYCARE D</th>
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<tbody>
<tr>
<td>providers and administrative staff, indicating that either a physician specialist, maxillofacial oral surgeon or prosthodontist may perform the procedure and when, where and how authorization, if needed shall be promptly obtained.</td>
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</tr>
</tbody>
</table>

Orthodontic: Limited to children when medically necessary based on State guidelines.

Periodontics (supporting structures, gums); prior authorization is required

Continuity of care to case completion will apply with continued NJ FamilyCare/Medicaid eligibility in the event of change of Contractor enrollment or NJ FamilyCare program plan. If a member loses eligibility, the contractor shall be responsible for continuity of care and reimbursement for the following dental services approved and started during a period of enrollment:

a. Endodontic, crown and prosthetic (both fixed and removable) services – the contractor shall continue to provide coverage to completion of these services and any
<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
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<th>NJ FAMILYCARE D</th>
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<tbody>
<tr>
<td>other associated services required for their successful completion after loss of eligibility when such endodontic, crown or prosthetic service(s) are approved and initiated under the contractor’s plan for 90 days following the loss of eligibility.</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
<td>Limited coverage</td>
</tr>
<tr>
<td>b. With loss of eligibility where endodontic treatment and associated restorative services have been approved and endodontic treatment was started, all other services required to restore the tooth to form and function shall be covered for completion.</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
<td>Limited coverage</td>
</tr>
<tr>
<td>c. Limited and interceptive orthodontics and treatment with habit appliances are reimbursed at the time of insertion and shall be covered for completion. This does not apply to comprehensive orthodontic treatment.</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
<td>Limited coverage</td>
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<tr>
<td><strong>Durable Medical Equipment (DME) &amp; Supplies</strong></td>
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<tr>
<td>Includes: Assistive technology devices, artificial aids, surgical implants, wheelchairs</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
<td>Limited coverage</td>
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<tr>
<td>COVERED SERVICES</td>
<td>MEDICAID/NJ FAMILYCARE A AND ABP</td>
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<td>NJ FAMILYCARE C</td>
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<tr>
<td>Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services</td>
<td>No copay</td>
<td>No copay</td>
<td>Coverage limited to screening and diagnosis</td>
<td>No copay</td>
</tr>
<tr>
<td>Includes:</td>
<td>Private duty nursing included only if approved by Amerigroup</td>
<td>Treatment services limited to those:</td>
<td>Coverage limited to screening and diagnosis</td>
<td>Coverage limited to well-child visits including immunizations, lead screening and treatments only</td>
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<tr>
<td>Medical exams</td>
<td></td>
<td>• Included in Amerigroup benefits or</td>
<td>• Included in Amerigroup benefits or</td>
<td>Private duty nursing included only if approved by Amerigroup</td>
</tr>
<tr>
<td>Dental services</td>
<td></td>
<td>• Specified through FFS Medicaid</td>
<td>• Specified through FFS Medicaid</td>
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<tr>
<td>Vision services</td>
<td></td>
<td>Private duty nursing included only if approved by Amerigroup</td>
<td>Private duty nursing included only if approved by Amerigroup</td>
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<td>Hearing services</td>
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<td>Lead screening</td>
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<tr>
<td>Health care and treatment to correct or help improve any defects or conditions found in screenings</td>
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<tr>
<td>Includes the following when indicated as a result of an EPSDT screening:</td>
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<td>Nonlegend drugs</td>
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<td>Ventilator services in the home</td>
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<tr>
<td>Private duty nursing (provided by a registered nurse or licensed practical nurse under the guidance of the member’s physician in the member’s home or in a hospital)</td>
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<tr>
<td>Screening services are provided periodically:</td>
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<tr>
<td>Neonatal exam</td>
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<td>Under 6 weeks</td>
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<td>2 months</td>
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<td>4 months</td>
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<td>6 months</td>
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<td>9 months</td>
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<td>12 months</td>
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<td>15 months</td>
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<td>18 months</td>
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<td>24 months</td>
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<td>Annually through age 20</td>
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<tr>
<td>Emergency Medical Care</td>
<td>No copay</td>
<td>No copay</td>
<td>$10 per visit</td>
<td>$35 (no copay required if member)</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>MEDICAID/NJ FAMILYCARE A AND ABP</td>
<td>NJ FAMILYCARE B</td>
<td>NJ FAMILYCARE C</td>
<td>NJ FAMILYCARE D</td>
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<tr>
<td>24 hours a day, 7 days a week</td>
<td>No copay</td>
<td>No copay</td>
<td>$5 per visit (no copay for Pap smears or preventive care services)</td>
<td>$5 per visit (no copay for preventive care services)</td>
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<td><strong>Family Planning Services</strong> Include:</td>
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<tr>
<td>• Services needed to delay or prevent pregnancy</td>
<td>May use Amerigroup network providers or Medicaid approved family planning providers</td>
<td>May use Amerigroup network providers or Medicaid approved family planning providers</td>
<td>May use Amerigroup network providers or Medicaid approved family planning providers</td>
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<tr>
<td>• Pregnancy testing</td>
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<td>• Genetic testing and counseling</td>
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<td>• Contraceptives (including oral contraceptives)</td>
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<td>• Follow-up care for complications linked with contraceptive methods issued by the family planning provider</td>
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<tr>
<td>• Sterilizations</td>
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<td>Elective, induced abortions (and related services) are covered under the FFS Medicaid program, including certain related office, laboratory, drugs, radiological and diagnostic services and surgical procedures.</td>
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<td>Infertility and sterilization reversals are not covered.</td>
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<tr>
<td><strong>Hearing Aid Services</strong> Include:</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
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<tr>
<td>• Hearing aids and accessories</td>
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<tr>
<td>• Ear mold impressions</td>
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<tr>
<td>• Routine follow-up and adjustments</td>
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<tr>
<td>• Repairs</td>
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- 30 -
<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>MEDICAID/NJ FAMILYCARE A AND ABP</th>
<th>NJ FAMILYCARE B</th>
<th>NJ FAMILYCARE C</th>
<th>NJ FAMILYCARE D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires hearing screening, resulting in prescription for hearing aid services</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
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<tr>
<td><strong>Home Health Agency Services</strong></td>
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<tr>
<td>Include:</td>
<td></td>
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<td></td>
<td>Coverage provided by Amerigroup limited to skilled nursing provided or supervised by a registered nurse, home health aides for skilled care and medical social services that are medically necessary</td>
</tr>
<tr>
<td>Services given at member’s home (excludes a hospital, nursing facility or intermediate care facility)</td>
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<tr>
<td>Nursing services by a registered nurse or licensed practical nurse</td>
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<tr>
<td>Home health aide services</td>
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<tr>
<td>Medical supplies and equipment</td>
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<tr>
<td>Appliances</td>
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<tr>
<td>Audiology services</td>
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<tr>
<td>Services must be ordered by member’s physician.</td>
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<tr>
<td><strong>Hospice Agency Services</strong></td>
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<tr>
<td>Hospice services covered in community and institutional settings</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
</tr>
<tr>
<td>Room and board services covered only when services are delivered in an institutional (nonprivate residence) setting.</td>
<td>Palliative and curative care covered for children under age 21</td>
<td>Palliative and curative care covered for children under age 21</td>
<td>Palliative and curative care covered for children under age 21</td>
<td>Palliative and curative care covered for children under age 19</td>
</tr>
<tr>
<td><strong>Inpatient Hospital</strong> (includes Rehabilitation Hospitals and special hospitals)</td>
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<tr>
<td>Includes services normally given in a hospital that are under the guidance of a physician</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
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<tr>
<td>COVERED SERVICES</td>
<td>MEDICAID/NJ FAMILYCARE A AND ABP</td>
<td>NJ FAMILYCARE B</td>
<td>NJ FAMILYCARE C</td>
<td>NJ FAMILYCARE D</td>
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<tr>
<td>Except for a DDD or MLTSS member for an acute psychiatric hospital admission, coverage provided by traditional Medicaid for members when primary diagnosis is mental health/substance abuse-related</td>
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<tr>
<td>Requires prior authorization for nonemergency care and care following stabilization of an emergency condition Not covered:</td>
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<tr>
<td>• Cosmetic surgery</td>
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<tr>
<td>• Rest cures</td>
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<tr>
<td>• Personal comfort and convenience items</td>
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<tr>
<td>• Services and supplies not directly related to the care of the patient</td>
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<tr>
<td>• Telephone charges</td>
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<tr>
<td>• Take-home supplies</td>
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<tr>
<td>Laboratory Services</td>
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<tr>
<td>Must be ordered by a physician or other licensed practitioner</td>
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<tr>
<td>Members will be notified of results within 24 hours for urgent and emergent cases and within 10 business days for routine cases.</td>
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<tr>
<td>Managed Long Term Services and Supports</td>
<td>No copay</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
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<tr>
<td>• Adult Family Care</td>
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<tr>
<td>• Assisted Living Services</td>
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<tr>
<td>• Assisted Living Program</td>
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<tr>
<td>• TBI Behavioral Management</td>
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<tr>
<td>• Chore Services</td>
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<tr>
<td>Patient pay liability may be required to nursing facilities and assisted living in certain cases.</td>
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<tr>
<td>COVERED SERVICES</td>
<td>MEDICAID/NJ FAMILYCARE A AND ABP</td>
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<tr>
<td>• TBI Therapies</td>
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<tr>
<td>• TBI Community Residential Services</td>
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<td>• Community Transition Services</td>
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<tr>
<td>• Home Based Supportive Care</td>
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<td>• Home-Delivered Meals</td>
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<tr>
<td>• Non-Medical Transportation</td>
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<tr>
<td>• Nursing Facility Services (Custodial)</td>
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<tr>
<td>• Personal Emergency Response System</td>
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<td>• Private Duty Nursing (Adult)</td>
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<td>• Residential and Vehicle Modifications</td>
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<tr>
<td>• Respite Care</td>
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<tr>
<td>• Social Day Care</td>
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<tr>
<td>• Structured Day Program</td>
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<tr>
<td>• Supported Day Program</td>
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<tr>
<td><strong>Note:</strong> Please consult MLTSS Service Dictionary on NJ State website for most current covered procedure codes.</td>
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</tbody>
</table>

| Maternity and Related Newborn Care                   | No Copay                         | No copay        | No copay for prenatal care visits | $5 copay for first prenatal visit |
|                                                    |                                  |                 |                               | No copay for preventive services or newborns covered under FFS Medicaid |
|                                                    |                                  |                 |                               | $10 copay for services rendered during nonoffice hours and for home visits |

| Medical Day Care Services                            | No copay                         | Not covered     | Not covered                   | Not covered                   |

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<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>MEDICAID/NJ FAMILYCARE A AND ABP</th>
<th>NJ FAMILYCARE B</th>
<th>NJ FAMILYCARE C</th>
<th>NJ FAMILYCARE D</th>
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</thead>
<tbody>
<tr>
<td><strong>Medical Supplies</strong>&lt;br&gt;Includes diagnosis-specific disposable medical supplies</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
</tr>
<tr>
<td><strong>Mental Health/Substance Abuse Services</strong>&lt;br&gt;Include:&lt;br&gt;• Intake evaluation&lt;br&gt;• Off-site crisis intervention&lt;br&gt;• Family therapy&lt;br&gt;• Family meetings&lt;br&gt;• Psychological testing&lt;br&gt;• Medication management&lt;br&gt;Services for conditions that alter mental states that are of an organic nature covered by Amerigroup.&lt;br&gt;Partial hospitalization and partial care covered under the FFS Medicaid program except for MLTSS members.</td>
<td>No copay&lt;br&gt;Covered by Amerigroup for members who are clients of the Division of Developmental Disabilities (DDD &amp; DDD/CCW) as well as members enrolled in the managed Long Term Services and Supports (MLTSS) program.&lt;br&gt;Mental health day care programs at Adult Partial Care Centers covered by FFS Medicaid for all members except MLTSS.&lt;br&gt;Covered by FFS Medicaid for all other members (see Services Provided under Fee-for-Service for NJ FamilyCare Members for more info, limits and exclusions)</td>
<td>Covered by FFS Medicaid (see Services Provided under Fee-For-Service for NJ FamilyCare Members for more info, limits and exclusions)</td>
<td>No copay&lt;br&gt;Covered by FFS Medicaid (see Services Provided under Fee-For-Service for NJ FamilyCare Members for more info, limits and exclusions)</td>
<td>$25 per visit&lt;br&gt;$5 per visit for CHIP beneficiaries under age 19&lt;br&gt;Covered by FFS Medicaid (see Services Provided under Fee-For-Service for NJ FamilyCare Members for more info, limits and exclusions)</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>MEDICAID/NJ FAMILYCARE A AND ABP</td>
<td>NJ FAMILYCARE B</td>
<td>NJ FAMILYCARE C</td>
<td>NJ FAMILYCARE D</td>
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<td>------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Nursing Facility Services</strong></td>
<td>Nursing facility services covered by Amerigroup for all Medicaid/NJ FamilyCare A members and any NJ FamilyCare ABP members from the date of admission to the date of discharge.</td>
<td>Not covered Inpatient Rehabilitation service or inpatient hospice benefit for NJ FamilyCare B members may be provided in this setting, when appropriate.</td>
<td>Not covered Inpatient Rehabilitation service or inpatient hospice benefit for NJ FamilyCare C members may be provided in this setting, when appropriate.</td>
<td>Not covered Inpatient Rehabilitation service or inpatient hospice benefit for NJ FamilyCare D members may be provided in this setting, when appropriate except for Rehabilitative Services for Substance Abuse (not covered)</td>
</tr>
<tr>
<td><strong>Optical Appliances</strong> (artificial eyes, eyeglasses, contact lenses and other visual aids prescribed)</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
</tr>
<tr>
<td>Optical appliances must be prescribed by a participating ophthalmologist or optometrist</td>
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</tr>
<tr>
<td><strong>For members age 0-18 and age 60 or older:</strong> Members can get one pair of frames and eyeglass lenses chosen from Medicaid-approved materials once every year, or sooner in some cases, when meeting Medicaid-approved criteria for changes in prescription.</td>
<td></td>
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</tr>
<tr>
<td><strong>For members age 19-59:</strong> Members can get one pair of frames and eyeglass lenses chosen from Medicaid-approved materials once every two years, or sooner in some</td>
<td></td>
<td></td>
<td></td>
<td>Limited to one pair of glasses (or contact lenses) per 24-month period or as medically necessary</td>
</tr>
</tbody>
</table>
Cases, when meeting Medicaid-approved criteria for changes in prescription.

Members should talk to their vision providers to see if a new eyeglass prescription is needed. Members have a choice of covered frames.

Contact lenses may be covered for:
• Members with certain ocular pathological conditions
• Members whose vision cannot be improved to at least 20/70 with regular lenses but can be improved to 20/70 or better with contact lenses

Contact lenses may be replaced once every two years, or more often, if there is a significant change in a member’s prescription.

If members do not meet any of the above medical necessity criteria, but choose contact lenses anyway, up to a $100 credit may be given toward the cost of the contact lenses.

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Medicaid/NJ FamilyCare A and ABP</th>
<th>NJ FamilyCare B</th>
<th>NJ FamilyCare C</th>
<th>NJ FamilyCare D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optometrist Services</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
<td>$5 per visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>One routine eye exam covered every 12 months</td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
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<tr>
<td>COVERED SERVICES</td>
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<tr>
<td>Includes liver, lung, heart, heart-lung, pancreas, kidney, cornea, intestine and bone marrow, including autologous bone marrow transplants</td>
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<tr>
<td>Donor and recipient costs covered by Amerigroup.</td>
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<tr>
<td>Experimental organ transplants excluded.</td>
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<thead>
<tr>
<th>Outpatient Hospital Services</th>
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<tbody>
<tr>
<td>Include:</td>
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<tr>
<td>• Preventive services</td>
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<tr>
<td>• Diagnostic services</td>
</tr>
<tr>
<td>• Therapeutic services</td>
</tr>
<tr>
<td>• Palliative services</td>
</tr>
<tr>
<td>May require prior authorization for nonemergency care and physician referral</td>
</tr>
<tr>
<td>Mental health visits covered by FFS Medicaid with the exception of the DDD and MLTSS populations (see section Services Provided under Fee-For-Service for NJ Medicaid/NJ FamilyCare Members for details)</td>
</tr>
</tbody>
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<thead>
<tr>
<th></th>
<th>MEDICAID/NJ FAMILYCARE A AND ABP</th>
<th>NJ FAMILYCARE B</th>
<th>NJ FAMILYCARE C</th>
<th>NJ FAMILYCARE D</th>
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</thead>
<tbody>
<tr>
<td>Outpatient Rehabilitation</td>
<td>Covered</td>
<td>Therapy limited to 60 visits per incident per therapy per calendar year</td>
<td>$5 copay Therapy limited to 60 visits per incident per therapy per calendar year</td>
<td>$5 copay Therapy for nonchronic conditions, acute illnesses and injuries limited to 60 visits per incident per therapy per calendar year</td>
</tr>
</tbody>
</table>
## Covered Services

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Medicaid/NJ FamilyCare A and ABP</th>
<th>NJ FamilyCare B</th>
<th>NJ FamilyCare C</th>
<th>NJ FamilyCare D</th>
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</thead>
<tbody>
<tr>
<td>Speech Pathology Services for treatment of speech development delays are not covered unless the delays are a result of disease, injury or congenital defects.</td>
<td></td>
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</tr>
<tr>
<td>Personal Care Assistant Services</td>
<td>No copay</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Personal Preference Program services are covered for Medicaid/NJ FamilyCare A and ABP members only.</td>
<td>Limited according to state regulations</td>
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</tr>
<tr>
<td>Podiatrist Services</td>
<td>No copay</td>
<td>No copay</td>
<td>$5 per visit</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Excludes routine hygienic care of the feet, such as treatment of corns, calluses, nail trimming, foot soaking or other services, in the absence of a pathological condition</td>
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<tr>
<td>COVERED SERVICES</td>
<td>MEDICAID/NJ FAMILYCARE A AND ABP</td>
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<td>NJ FAMILYCARE C</td>
<td>NJ FAMILYCARE D</td>
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<tr>
<td><strong>Prescription Drugs</strong></td>
<td>No copay</td>
<td>No copay</td>
<td>$1 copay for generic, $5 copay for brand-name drugs</td>
<td>$5 copay — if greater than 34-day supply, then $10 copay</td>
</tr>
<tr>
<td>May require prior authorization for selected drugs</td>
<td>Over-The-Counter (OTC) drugs covered for children under the age of 21 and limited to $15 per quarter for members 21 and older (see Extra Amerigroup Benefits for NJ Medicaid/NJ FamilyCare Members for more info on OTC drugs)</td>
<td>OTC drugs covered for children under the age of 21 and limited to $15 per quarter for members 21 and older (see Extra Amerigroup Benefits for NJ Medicaid/NJ FamilyCare Members for more info on OTC drugs)</td>
<td>OTC drugs covered for children under the age of 21 and limited to $15 per quarter for members 21 and older (see Extra Amerigroup Benefits for NJ Medicaid/NJ FamilyCare Members for more info on OTC drugs)</td>
<td>OTC drugs are not covered</td>
</tr>
<tr>
<td>Amerigroup uses a formulary: a list of drugs your doctor can choose from to treat your illnesses; prior authorization is required for consideration of drugs outside the formulary when medically necessary except in the case of certain prescriptions or pharmacy services ordered by Mental Health/Substance Abuse (MH/SA) providers for Mental Health/Substance Abuse related conditions (see page 49 for more information)</td>
<td><strong>Legend (prescription)</strong> drugs and nonlegend drugs approved by the Medicaid program are covered</td>
<td><strong>Preventive Health Care, Counseling and Health Promotion</strong> Includes referrals to WIC programs</td>
<td><strong>For all female members:</strong> If your PCP is not a women’s health specialist, covered services include direct access to an Amerigroup network woman’s health specialist for covered care that is needed to provide women’s routine and preventive health care</td>
<td><strong>No copay</strong></td>
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<table>
<thead>
<tr>
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<tr>
<td>services, such as annual gynecological exams, mammograms.</td>
<td>No copay</td>
<td>No copay</td>
<td>$5 per visit</td>
<td>$5 per visit during normal office hours</td>
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<td></td>
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<td></td>
<td>No copay for wellness visits, lead screenings and treatments, age-appropriate immunizations, prenatal care and Pap smears, when needed</td>
<td>$10 per visit for non-office hours and home visits</td>
</tr>
<tr>
<td><strong>Primary Care and Physician Services (24 hours a day, 7 days a week)</strong></td>
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<td>$5 for first prenatal care visit only — no copay thereafter</td>
</tr>
<tr>
<td>Include:</td>
<td></td>
<td></td>
<td></td>
<td>No copay for preventive wellness visits, lead screenings and treatments, age-appropriate immunizations, and Pap smears, when appropriate</td>
</tr>
<tr>
<td>• Primary and specialty care</td>
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<tr>
<td>• Certified nurse midwives</td>
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<tr>
<td>• Certified nurse practitioners</td>
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<tr>
<td>• Clinical nurse specialists</td>
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<tr>
<td>• Physician assistant services</td>
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<tr>
<td>• Independent clinic services (includes preventive, diagnostic, therapeutic, rehabilitative or palliative services)</td>
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<tr>
<td>Services provided by nonparticipating providers are not covered, unless:</td>
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<tr>
<td>• Referred by a participating provider</td>
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<tr>
<td>• Referred in error by a participating provider</td>
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<tr>
<td><strong>Prosthetic and Orthotic Devices</strong> (includes certified shoe provider)</td>
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<tr>
<td>Prosthetic devices include corrective or supportive devices that:</td>
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<tr>
<td>• Replace a missing part of the body</td>
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<tr>
<td>• Prevent or correct physical deformity or malfunction</td>
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<tr>
<td></td>
<td>No copay</td>
<td>No copay</td>
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<td>Limited to the initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease, injury or congenital defect</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>MEDICAID/NJ FAMILYCARE A AND ABP</td>
<td>NJ FAMILYCARE B</td>
<td>NJ FAMILYCARE C</td>
<td>NJ FAMILYCARE D</td>
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<tr>
<td>Support a weak or deformed part of the body</td>
<td>Orthotic devices include devices or braces that provide support, more function and help to overcome physical impairment or defects; prosthetic and orthotic devices must be prescribed by a physician or other licensed practitioner</td>
<td>Replacement or repair covered when due to natural growth. Orthotic devices are not covered</td>
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</tbody>
</table>

**Radiology Services (X-rays)**
Diagnostic and therapeutic services mean professional and technical radiology services

Members will be notified of results within 24 hours for urgent and emergent cases and within 10 business days for routine cases

| No copay | No copay | No copay |

**Medical Transportation Services – Ground Transportation**
Covered for emergencies only

MLTSS members do have coverage for certain community transportation needs.

| No copay | No copay | No copay | No copay |

### 5.3 Services Provided Under Medicaid Fee-for-Service for NJ FamilyCare Members

The following services are covered by New Jersey Medicaid FFS, not Amerigroup. These services may require medical orders by the member’s PCP. Providers should contact NJ FamilyCare at 1-800-701-0710.
<table>
<thead>
<tr>
<th>FEE-FOR-SERVICE</th>
<th>MEDICAID/NJ FAMILYCARE A AND ABP</th>
<th>NJ FAMILYCARE B</th>
<th>NJ FAMILYCARE C</th>
<th>NJ FAMILYCARE D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Services</td>
<td>Covered through Medicaid Fee-for-Service for NJ FamilyCare ABP and NJ FamilyCare A only unless the member has qualified for MLTSS or is DDD.</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>1. Psychiatric Emergency Rehabilitation Services</td>
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<tr>
<td>2. Substance Abuse Partial Day Treatment</td>
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<td>3. Substance Abuse Outpatient</td>
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<tr>
<td>4. Substance Abuse Intensive Outpatient</td>
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<td>5. Substance Abuse/Short Term Residential</td>
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<td>6. Non-acute Detoxification</td>
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<td>7. Targeted Case Management (ICMS)</td>
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<tr>
<td>8. Program of Assertive Community Treatment (PACT)</td>
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<td>9. Community Supports Services (CSS)</td>
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<tr>
<td>10. Behavioral Health Homes (BHH)</td>
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<tr>
<td>11. Mental Health Outpatient</td>
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<tr>
<td>12. Adult Mental Health Rehabilitation (Group Homes)</td>
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<td>13. Opioid Treatment Services</td>
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<tr>
<td>14. Mental Health Partial Care and Partial Hospitalization</td>
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<tr>
<td>DCP&amp;P Residential Treatment Center Care</td>
<td>Covered</td>
<td>Covered through fee-for-service</td>
<td>Covered through fee-for-service</td>
<td>Not covered</td>
</tr>
<tr>
<td>Treatment centers to provide medical and social services to ensure the safety and well-being of children who may be abused or neglected;</td>
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<tr>
<td>FEE-FOR-SERVICE</td>
<td>MEDICAID/NJ FAMILYCARE A AND ABP</td>
<td>NJ FAMILYCARE B</td>
<td>NJ FAMILYCARE C</td>
<td>NJ FAMILYCARE D</td>
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<tr>
<td>INCLUDES CRITICAL DIAGNOSTIC AND TREATMENT SERVICES, AND TIMELY AND NEEDED ACCESS TO ALL COVERED BENEFITS</td>
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<tr>
<td>ELECTIVE, INDUCED ABORTIONS AND RELATED SERVICES</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>FAMILY PLANNING SERVICES</td>
<td>Can be covered through any Amerigroup provider or any state-approved Medicaid provider</td>
<td>Can be covered through any Amerigroup provider or any state-approved Medicaid provider</td>
<td>Can be covered through any Amerigroup provider or any state-approved Medicaid provider</td>
<td>For certain NJ FamilyCare D members: Can be covered through any Amerigroup provider or any state-approved Medicaid provider; call Member Services to learn more</td>
</tr>
<tr>
<td>INPATIENT AND OUTPATIENT MENTAL HEALTH SERVICES</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>INPATIENT PSYCHIATRIC HOSPITAL SERVICES</td>
<td>Covered for members under 21 or 65 and over</td>
<td>Covered for members under 21 or 65 and over</td>
<td>Covered for members under 21 or 65 and over</td>
<td>Covered for members under age 21 or age 65 and over</td>
</tr>
<tr>
<td>INTERMEDIATE CARE FACILITIES/INTELLECTUAL DISABILITY</td>
<td>Covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>MENTAL HEALTH/SUBSTANCE ABUSE SERVICES</td>
<td>Covered except for DDD and MLTSS members</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>SEX ABUSE EXAMS AND RELATED DIAGNOSTIC TESTING (at DYFS-contracted Child Abuse Regional Diagnostic Centers or by DYFS-contracted physicians)</td>
<td>Covered by Medicaid Program with case management</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>SUBSTANCE ABUSE SERVICES</td>
<td>Covered except for DDD and MLTSS members</td>
<td>Covered</td>
<td>Covered</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>FEE-FOR-SERVICE</td>
<td>MEDICAID/NJ FAMILYCARE A AND ABP</td>
<td>NJ FAMILYCARE B</td>
<td>NJ FAMILYCARE C</td>
<td>NJ FAMILYCARE D</td>
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<tr>
<td>Diagnosis, treatment and detoxification services</td>
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<tr>
<td>Methadone and its administration</td>
<td>Amerigroup will retain responsibility for furnishing mental health/substance abuse services, excluding partial care and partial hospitalization services and the cost of methadone maintenance, to Medicaid enrollees who are clients of the Division of Developmental Disabilities in accordance with Article 4.1.2. Amerigroup will retain responsibility for furnishing mental health/opioid treatment services, including partial care and partial hospitalization services and the cost of the drugs for opioid treatment and its administration to MLTSS Members in accordance with Article 9.9.</td>
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<tr>
<td>FEE-FOR-SERVICE</td>
<td>MEDICAID/NJ FAMILYCARE A AND ABP</td>
<td>NJ FAMILYCARE B</td>
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<tr>
<td>Americigroup will retain responsibility for furnishing medically necessary detoxification in a medical acute care inpatient setting.</td>
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<tr>
<td>Transportation Services – Nonemergency ambulance, Mobile Intensive Care Units (MICUs) and invalid coach services</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Transportation Services – Livery</td>
<td>Livery (taxi, bus, train, car service, and reimbursement for mileage, etc.) transportation for travel to nonhospital providers</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
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</tbody>
</table>

5.4 Services Not Covered by Amerigroup or Medicaid Fee-For-Service for NJ FamilyCare Members

There are other services that are not part of our member’s Amerigroup benefits. These services are not covered by Medicaid FFS either. These services are listed below:

- All services Amerigroup says are not medically necessary
- Cosmetic surgery, except when medically necessary and with prior approval
- Experimental organ transplants and investigational services
- Infertility diagnosis and treatment services including sterilization reversals and related office services (medical or clinical), drugs, lab work, radiological and diagnostic services, and surgical procedures
- Rest cures, personal comfort and convenience items, services, and supplies not directly related to the care of the patient including guest meals and lodging, telephone charges, travel expenses, take-home supplies, and similar costs
- Respite care except for MLTSS members
- Services that involve the use of equipment in facilities when the purchase, rental or construction of the equipment has not been approved by New Jersey law
- All claims that come directly from services provided by or in federal institutions
- Services provided to members under 65 and over 21 years old in an inpatient psychiatric institution that is not an acute-care hospital
- Free services — free services provided by public programs or voluntary agencies should be used when possible
- Services or items furnished for any sickness or injury that occurs while the covered member is on active duty in the military
- Payments to providers outside of the United States and in territories pursuant to N.J.S.A. 52:34-13.2 and section 6505 of the Affordable Care Act of 2010, which amends section 1902(a) of the Social Security Act
- Services or items furnished for any condition or accidental injury that arises out of and during employment where benefits are available (worker’s compensation law, temporary disability benefits law, occupational disease law or similar laws); this applies whether or not the member claims or receives benefits and whether or not a third party gets a recovery for resulting damages
- Any benefit covered or payable under any health, accident or other insurance policy
- Any services or items furnished that the provider normally provides for free
- Services furnished by an immediate relative or member of the Medicaid beneficiary’s household
- Services billed when the health care records do not correctly reflect the provider’s procedure code
- Services or items reimbursed based on a cost study or other evidence acceptable to the state of New Jersey

For NJ FamilyCare D members, these additional services are not included:
- Intermediate care facility/intellectual disability services
- Private duty nursing, unless authorized by Amerigroup
- Personal care assistant services
- Medical day care services
- Chiropractic services
- Orthotic devices
- Residential treatment center psychiatric programs
- Care and services provided by religious nonmedical institutions
- EPSDT (except for well-child care, including immunizations and lead screening and treatments)
- Transportation services, including nonemergency ambulance, invalid coach and lower-mode transportation such as taxi or bus Hearing aid services, except for children up to age 16
- Blood and blood plasma (exception: administration of blood, processing of blood, processing fees and fees related to autologous blood donations are covered)
- Cosmetic surgery (except when medically necessary and with prior approval)
- Custodial care
- Special remedial and educational services
- Experimental and investigational services
- Rehabilitative services for substance abuse
- Weight reduction programs or dietary supplements (except surgical operations, procedures or treatment of obesity when approved by the contractor)
- Acupuncture and acupuncture therapy (except when performed as a form of anesthesia in connection with covered surgery)
- Recreational therapy
• Sleep therapy
• Court-ordered services
• Thermograms and thermography
• Biofeedback
• Radial keratotomy
• Nursing facility services
• Audiology services, except for children up to age 16
• Managed long term services and supports not otherwise listed above

5.5 Orthodontia

Limited, interceptive and comprehensive orthodontia are covered for children in the NJ Medicaid/NJ FamilyCare programs in cases of medical necessity, which include:

• Severe functional difficulties
• Developmental anomalies of facial bones and/or oral structures
• Facial trauma resulting in severe functional difficulties
• Demonstration that long-term psychological health requires orthodontic correction

A consultation to visually assess a member’s needs is recommended and does not require precertification. A pre-orthodontic treatment visit to complete the Handicapped Labiolingual Deviation (HLD) assessment is required for consideration of interceptive and comprehensive treatment and does not require precertification. The HLD assessment form can be found at https://www.njmmis.com/downloadDocuments/22-14.pdf. All orthodontic treatment requires precertification.

HealthPlex administers orthodontia benefits for our members.

5.6 Vision Services

Our members have enhanced vision service benefits. Facilities and providers are listed in the Provider Referral Directory. If a member needs assistance in obtaining care, the member should contact Superior Vision at the telephone number listed on his or her member ID card. Contact Superior Vision provider services support at 1-800-428-8789 for routine vision services. Contact us at 1-800-454-3730 regarding medical vision services.

Under NJ Medicaid/NJ FamilyCare A, B, C, and ABP the following services are covered:

• One exam is covered once every 12 months for members up to age 18. One pair of eyeglasses, including frame and lenses selected from Medicaid-allowable materials, is covered once every 12 months or more frequently as medically necessary.
• One exam is covered once every 12 months for members ages 19 through 59. One pair of eyeglasses, including frame and lenses selected from Medicaid-allowable materials, is covered once every 24 months or more frequently as medically necessary.
• One exam is covered once every 12 months for members age 60 or older. One pair of eyeglasses, including frame and lenses selected from Medicaid-allowable materials, is covered once every 12 months or more frequently as medically necessary.
Under NJ FamilyCare D, one exam is covered once every 12 months for members. One pair of eyeglasses, including frame and lenses selected from Medicaid-allowable materials, is covered once every 24 months or more frequently as medically necessary.

Under NJ FamilyCare C and D, the vision exam requires a $5 copayment. No copayment is required for Native Americans and Eskimos under age 19 enrolled in NJ FamilyCare C and D.

Frames and eyeglass lenses are covered in full if the member chooses from Medicaid-allowable materials. There is no allowance if the member does not choose from the selected Medicaid-allowable materials. Repairs and replacements are covered with precertification if they are within the New Jersey Medicaid guidelines for repairs and/or replacements.

Contact lenses are covered as medically necessary:
- Specific ocular pathological conditions (e.g., keratoconus, monocular surgical aphakia to effect binocular vision, anisometropia of 3.0 diopters or more)
- Members whose vision cannot be improved to at least 20/70 with regular lenses but can be improved to 20/70 or better with contact lenses
- Replacement of contact lenses within two years only if there has been a significant change in basic lens parameters (e.g., design or prescription); precertification is required

In addition, Superior Vision will provide the following Amerigroup value-added benefit to the extent the medical necessity criteria for contact lenses are not met and the member elects to receive contact lenses. Superior Vision will allow an amount equal to the lesser of the member PCP’s billed charges, usual and customary or $100 for the cost of contact lenses, whichever is less.

5.7 Prenatal Care

We provide a comprehensive package of maternity care and educational outreach services, which addresses the areas of a woman’s life likely to affect pregnancy outcomes and the health of her infant. Taking Care of Baby and Me® is the educational and incentive gift component provided to all pregnant members. Each member is automatically enrolled in this program through the maternal notification process.

Maternal and child case/care managers are available to:
- Improve pregnancy outcomes by establishing care plans for high-risk members
- Coordinate services such as transportation, WIC, home-visitor programs, breast-feeding support and counseling
- Provide outreach to members

We believe preventive and early prenatal care will reduce infant morbidity and mortality rates. Early prenatal care can help reduce the care required by low birth weight, which would otherwise be compromised in low-birth-weight infants.
For parents with infants admitted to the NICU, we offer the You and Your Baby in the NICU program. Parents receive counseling and support to be involved in the care of their babies, visit the NICU, interact with hospital-care providers and prepare for discharge. Parents are provided with an education resource outlining successful strategies they may deploy to collaborate with the care team.

5.8 Early and Periodic Screening, Diagnostic and Treatment Services

Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) is a federally mandated comprehensive child health program for Medicaid recipients from birth through age 20. It is designed to identify physical and mental defects and provide treatment (or referral when indicated) to correct or ameliorate defects and chronic conditions.

EPSDT screening must include:

- A comprehensive health and developmental history, including assessment of both physical and mental health development and provision of all diagnostic and treatment services that are medically necessary to correct or ameliorate a physical or mental condition identified during a screening visit
- A comprehensive, unclothed physical examination, including:
  - Vision and hearing screening
  - Dental inspection
  - Nutritional assessment
- Age-appropriate immunizations, health history and the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines; Amerigroup and network providers will adjust for periodic changes in recommended types and schedule of vaccines; immunizations must be reviewed at each screening examination as well as during acute-care visits, and necessary immunizations must be administered when not contraindicated; deferral of administration of a vaccine for any reason must be documented
- Appropriate laboratory tests; the following list of screening tests is not all-inclusive:
  - Hemoglobin/hematocrit/EP
  - Urinalysis
  - Tuberculin test — intradermal, administered annually and when medically indicated
  - Lead screening using blood lead-level determinations must be performed for every Medicaid-eligible and NJ Medicaid/NJ FamilyCare child:
    - Between 9–18 months, preferably at 12 months of age
    - Between 18–26 months, preferably at 24 months of age
    - Between 27–72 months of age for any child not previously tested
  Additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and will be obtained as necessary.
- Health education and/or anticipatory guidance
- Referral for further diagnosis and treatment or follow-up of all abnormalities which are treatable/correctable or require maintenance therapy, uncovered or suspected (referral may be to the provider conducting the screening examination or to another provider as appropriate)
EPSDT screening services should reflect the age of the child and are provided periodically according to the following schedule:

- Neonatal exam
- Under 6 weeks of age
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- Annually through age 20

Vision services, at a minimum, include diagnosis and treatment for defects in vision and the provision of eyeglasses when medically necessary. Vision screening in an infant means, at a minimum, eye examination and observation of responses to visual stimuli. Screening for distant visual acuity and ocular alignment will be done for each child beginning at age 3.

Dental services may not be limited to emergency services. Dental screening in this context means, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries, or oral infection. A referral to a dentist at one year of age or soon after the eruption of the first primary tooth is mandatory. Thereafter there must be, at a minimum, a dental visit twice a year with confirmation by the PCP during well child visits to ensure that all needed dental preventive and treatment services are provided, through the age of twenty (20) years.

**NJ Smiles Program**

The contractor shall provide a program to allow nondental providers to provide dental risk assessment, fluoride varnish application and dental referral for children through the age of 6.

- Fluoride varnish may be applied by nondental providers who have proof of training for this service. Primary care physicians (pediatricians or physicians seeing pediatric enrollees), physician assistants and nurse practitioners can receive this training.
- Fluoride varnish application will be combined with risk assessment and referral to a dentist that treats children under the age of 6 and will be linked to well child visits for children through the age of 6.
- These three services will be reimbursed as an all-inclusive service billed using a CPT code and can be provided up to four times a year. This frequency does not affect the frequency of this service by the dentist.
- Contractor must provide training to all PCPs on the requirement of referral to a dentist for a dental visit by 12 months of age.
- The contractor must notify PCPs and PCD on their referral process and required communications between these provider groups.
- Contractor must provide training to all PCD and PCPs on prescribing fluoride supplements (based on access and use to fluoridated public water) and their responsibility in counseling parents and guardians of young children on oral health and age appropriate oral habits and safety to include what dental emergencies are and use of the emergency room for dental services.
- The caries risk assessment service shall also be allowed by the PCD and is billed using a CDT procedure code. The reimbursement will be the same regardless of the determined risk level. The risk assessment must be provided at least once per year in conjunction with an oral evaluation service by a PCD and is linked to the provider not the member. It may be provided a second time with prior authorization and documentation of medical necessity.
Hearing services, at a minimum, include diagnosis and treatment for defects in hearing, including hearing aids. For infants identified as at-risk for hearing loss through the New Jersey Newborn Hearing Screening Program, hearing screening should be conducted prior to three months of age using professionally recognized audiological assessment techniques. For all other children, hearing screening means, at a minimum, observation of an infant’s response to auditory stimuli and audiogram for a child age three and older. Speech and hearing assessments will be part of each preventive visit for an older child.

MH/SA care includes an assessment documenting pertinent findings. When there is an indication of a possible MH/SA issue, the Well-Being Screening Tool or a DHS-approved equivalent will be used to evaluate the member. Such other necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects, and physical and mental/substance abuse illnesses and conditions discovered by the screening services.

For NJ FamilyCare B and C members, coverage includes all preventive screening and diagnostic services, medical examinations, immunizations, dental, vision, lead screening, and hearing services. It includes only those treatment services identified through the examination that are included under our covered benefits or specified services through the FFS program.

For NJ FamilyCare D members, coverage is limited. For coverage information, please refer to Section 5 — Amerigroup Health Care Benefits and Copayments.

For all EPSDT visits, use the *HMO EPSDT Worksheet* located in Appendix A – Forms.

Since Medicaid members may be less likely to seek preventive care than other populations, it is important for us and our network physicians to arrange for a high level of EPSDT and immunization services for members. We encourage our members to receive EPSDT visits through the member handbook, new member welcome calls, a yearly member newsletter and written notices to all members who have missed an EPSDT appointment.

We require participating PCPs to encourage child members to receive EPSDT and adult members to receive an annual physical. If members miss an EPSDT appointment, the providers must document the missed appointments in the medical records and try to reach the members to reschedule. We will send each PCP a list of his or her Amerigroup members who have missed an EPSDT visit or failed to have an encounter. The physician’s office staff must contact the members on this list to set up an appointment for a well visit. The provider must document efforts to contact members in the medical record. Although the EPSDT worksheet is not submitted with the claim for payment, the EPSDT worksheet must be submitted to us upon request to confirm EPSDT has been performed.

### 5.9 EPSDT Reminder Program

A list of our members who, based on our claims data, may not have received EPSDT services according to the periodicity schedule is sent to their PCP each month. Additionally, we mail information to these members encouraging them to contact their PCP’s office to set up appointments for needed services.
Please note:

- The specific services needed for each member are listed on the report. Reports are based only on services received during the time the member has been enrolled with us.
- Services must be rendered within due date span in accordance with federal EPSDT guidelines, the State Department of Health guidelines and the Centers for Disease Control and Prevention (CDC) Childhood and Adolescent Immunization Guide. In accordance with these guidelines, services received prior to the specified periodicity date do not fulfill EPSDT requirements.
- The list is based on Amerigroup claims data received prior to the date printed on the list. In some instances, the appropriate services may have been provided after the report run date.
- To ensure accuracy in tracking preventive services, please submit a completed claim form for those dates of service to:
  
  Amerigroup Community Care  
  P.O. Box 61010  
  Virginia Beach, VA 23466-1010

5.10 Immunizations

Immunizations must be given to our members in accordance with the most current recommendations for vaccines and periodicity schedule of the Advisory Committee on Immunization Practices (ACIP) and any revisions formally recommended by ACIP, whether or not they are included as contract amendments.

We will keep you up-to-date on the latest recommendations from the ACIP regarding new vaccines, scheduling and/or methods of administration, and we will adjust your payments appropriately if necessary. We have also built in provisions for appropriate reimbursement for catch-up immunizations for pediatric members who have missed age-appropriate vaccines.

To the extent you are able, we ask that you participate in the statewide immunization registry database. For more information, please visit https://njiis.nj.gov/njiis.

Vaccines for Children Program

The State of New Jersey requires all providers who see NJ Medicaid/NJ FamilyCare A members and administer vaccines to children to enroll with the Department of Health (DOH) Vaccines For Children (VFC) Program. Additionally, providers must use the free vaccines for NJ Medicaid/NJ FamilyCare A patients if the vaccine is covered by VFC. DOH does not reimburse providers for the cost of VFC-covered vaccines, but we reimburse providers an $11.50 administration fee for such vaccines. We will reimburse providers for the administration and the cost of non-VFC vaccines.

Effective for claims with service dates on or after July 1, 2014, Amerigroup will be responsible for providing coverage and reimbursement for vaccine costs and related administration fees as vaccines are no longer available through the NJ-VFC program when provided to NJ FamilyCare Plans B, C and D eligible children. Providers will be required to obtain required vaccines from traditional market sources.

Please note: Many vaccines involve more than one component or antigen (e.g., MMR, DTaP and DTaP/IPV). In the VFC program, vaccine administration cap rates are determined per vaccine, not per
component or per antigen. Under current CMS policy, the cap rates will continue to be determined per vaccine. VFC-enrolled providers may not charge VFC-entitled children a vaccine administration fee exceeding the regional administration fee cap per dose of vaccine. CMS is carefully looking at the fee cap in light of underlying changes in the cost of administering vaccines and anticipates an update to the fee cap in the near future.

To properly code multicomponent vaccines, please use 90460 for the first vaccine/toxoid component and 90461 for each additional vaccine/toxoid component. These codes replace 90465, 90466, 90467 and 90468. If code 90461 is used for a vaccine with multiple antigens or components, it should be given a $0 value for a child covered under the VFC program. This applies to both Medicaid/SCHIP-enrolled VFC-entitled children as well as VFC-entitled children not in Medicaid/SCHIP (e.g., uninsured, underinsured, and American Indian or Alaska Native children not enrolled in Medicaid/SCHIP).

5.11 Blood Lead Screening

Providers will furnish a screening program for the presence of lead toxicity in children that consists of two components: verbal risk assessment and blood lead testing.

During every well-child visit for children between the ages of 6 months and 6 years old, the PCP will screen each child for lead poisoning. A blood test will be performed at 12 months and 24 months of age to determine lead exposure and toxicity. In addition, children over the age of 24 months and up to 72 months should receive blood lead screenings if there is no past record of a test. Please see blood lead-risk forms located in Appendix A – Forms.

Providers will perform a verbal risk assessment for lead toxicity at every periodic visit between the ages of 6 months and 72 months (6 years). For further information, see the Verbal Blood Lead-Risk Assessment form located in Appendix A – Forms. Generally, a child’s level of risk for exposure to lead depends upon the answers to the Verbal Blood Lead-Risk Assessment form. If the answers to all questions are negative, a child is considered at a low risk for high doses of lead exposure. If the answers to any question are affirmative or I don’t know, a child is considered at a high risk for high doses of lead exposure. Regardless of risk, each child must be tested between 9 months and 18 months (preferably at 12 months) and between 18 months and 26 months (preferably at 24 months). Further, any child between 27 months and 72 months who has not previously been tested should be tested. A child’s risk category can change with each administration of the verbal risk assessment. For children determined to be at a high risk for high doses of lead exposure, a blood lead-level screening must be performed at the time a child is determined to be high risk or beginning at 6 months of age if there is pertinent information or evidence that the child may be at risk at a younger age.

The blood lead-level screening must be performed by a laboratory licensed by the New Jersey Department of Health. All screenings must be performed through a blood lead-level determination. We have policies and procedures in place to identify and treat high-risk children for lead exposure and toxicity. The procedures include blood lead-level screening, diagnostic evaluation and treatment with follow-up care of children whose blood lead levels are elevated. The erythrocyte protoporphyrin test is no longer acceptable as a screening test for lead poisoning; however, it is still valid as a screening test for iron deficiency anemia. Blood lead-level screening may be performed by a capillary sample (i.e., finger stick), venous sample or the use of a filter-paper method. However, all elevated blood lead-
levels (e.g., equal to or greater than 5 micrograms per one deciliter) obtained through a capillary sample and filter paper must be confirmed by a venous sample.

We will send letters to our network PCPs who have lead screening rates less than 80 percent for two consecutive six-month periods. The letter will educate the PCPs on their need and responsibility to provide lead-screening services. PCPs who do not meet the 80-percent screening rate will be placed on corrective action plans. We will monitor these PCPs to document improvement.

We encourage use of the filter paper lead-screening method. A finger stick collection can be readily performed in the office with minimal clinical expertise required, and MEDTOX supplies are provided at no charge. In-office lead screening will serve to remove one of the patient’s largest barriers to obtaining the service — locating and securing an appointment at a lab. Contact your Provider Relations representative for more information on how to get started.

We have policies and procedures in place regarding a Lead Case/Care Management (LCM) program. Children with blood lead levels \( \geq 5 \mu g/dL \) and members of the same household who are between 6 months and 6 years of age are enrolled in the Amerigroup LCM program. The LCM program consists of the following:

- If the child is found to have a blood lead level equal to or greater than five micrograms per deciliter, providers should use their professional judgment, in accordance with the CDC guidelines regarding patient management and treatment, as well as follow-up blood testing.
- If the child is found to have a blood lead level equal to or greater than five micrograms per deciliter, the provider should recommend a follow-up venous blood screening for the child and blood lead testing for the other children and pregnant women living in the household.
- When a child is found to have one confirmed blood lead level between 5-9 \( \mu g/dl \), Amerigroup must ensure its PCPs cooperate with the local health department in whose jurisdiction the child resides to facilitate the preliminary environmental evaluation.
- When a child is found to have a confirmed blood lead level equal to or greater than 10 \( \mu g/dl \), or two confirmed consecutive tests one to four months apart with results between 5-9 \( \mu g/dl \), the PCP should cooperate with the local health department in whose jurisdiction the child resides to facilitate an environmental intervention to determine and remediate the source of lead. This cooperation shall include sharing of information regarding the child’s care, including the scheduling and results of follow-up blood lead tests.
- When laboratory results are received, Amerigroup requires PCPs to report all children with blood lead levels > 5 \( \mu g/dl \). Conversely, when a provider other than the PCP has reported the lead screening test to Amerigroup, Amerigroup will ensure that this information is transmitted to the PCP.
- Education for the family regarding all aspects of lead hazard and toxicity, including materials that explain the sources of lead exposure; the consequences of elevated blood lead levels; preventive measures, including housekeeping, personal hygiene and appropriate nutrition; and an explanation of why following a prescribed medical regimen is necessary.
- Communication to all interested parties is necessary.
- Development of a written case/care management plan with the PCP, the child’s family and other interested parties; the case/care management plan will be reviewed and updated on a regular basis.
• Coordination of the various aspects of the affected child’s care (e.g., Women, Infants and Children [WIC] Program, support groups, and community resources).
• Pursuit of noncompliant members for follow-up tests/appointments and documentation of these activities in the LCM program.


5.12 Obstetrical and Gynecological Services

Well-Woman Exam – Direct Access
Members may self-refer to an Amerigroup network OB/GYN provider for routine and preventive women’s health care services when their PCP is not a women’s health specialist. Routine and preventive health care services will not require a referral from the PCP under this type of circumstance. A well-woman examination includes:
- Pelvic exam
- Pap smear
- STD screen
- Blood work and/or lab
- Pregnancy test if medically indicated
- Breast exam
- Mammogram; we follow the recommendations of the U.S. Preventive Services Task Force guidelines, which are supported by the U.S. Office of Disease Prevention and Health Promotion; however, we will cover the cost of mammograms ordered by network providers for members of any age, and the physician may send the member to any of our network imaging facilities for the mammogram.

Noninterference
We will not prohibit or restrict a provider from engaging in medical communication with the provider’s patient, either explicitly or implied. In addition, our provider manual, newsletters, directives, letters, oral instructions or any other forms of communication will not prohibit medical communication between you and your patients. You are free to communicate with your patients about their health status, medical care or treatment options, including any alternative treatment that may be self-administered, and the risks, benefits and consequences of treatment or nontreatment regardless of whether we provide benefits for that care or treatment, if you’re acting within the lawful scope of practice. You’re free to practice your respective profession in providing the most appropriate treatment required by your patients and will provide informed consent within the guidelines of the law, including possible positive and negative outcomes of the various treatment modalities.

Obstetrical Care
At the member’s first obstetrical (OB) visit, the obstetrician must notify us at 1-800-454-3730. This is the maternal notification process. The provider must complete the Maternity OB Notification form and submit it to us so we can facilitate appropriate case/care management. We offer a wide variety of educational classes for our members.
After notification, the obstetrician may act as the member’s PCP throughout the entire pregnancy, including six weeks postpartum. Additional medically necessary, covered test procedures may be ordered without precertification from the member’s general PCP. The obstetrician may also refer the member to other network physicians, as necessary, to provide nonobstetrical care. To ensure continuity of care, any referral for nonobstetrical-related care should first be discussed with the member’s general PCP.

Obstetrical care includes the following:
- All office visits during pregnancy including additional office visits for treatment of non-OB related issues such as urinary tract infections
- Routine office hemoglobin and urinalysis tests, unless the tests are being performed for non-OB related conditions
- Initial serology for syphilis
- Ultrasounds, prenatal lab tests, other lab tests such as alpha-fetoprotein, RFP, Rhogam and nonstress tests
- Member care for delivery, including induction of labor by pitocin, episiotomy and delivery with or without forceps
- Physician’s services during normal hospital stay for uncomplicated cesarean section or vaginal deliveries
- Prenatal Pap smears
- Postpartum services during the six-week period following delivery including all office visits and postpartum Pap smear

After delivery, the member may remain in the hospital for a period of no less than 48 hours for a vaginal birth and no less than 96 hours for a C-section birth.

The Amerigroup Comprehensive Maternity Services Program
The Amerigroup Comprehensive Maternity Services program provides a package of care which addresses all areas that affect pregnancy outcomes and the health of infants. Coordination and continuity of care over time are part of the program requirements and guidelines. Coordination includes care coordination; comprehensive initial, periodic and postpartum assessment; development and implementation of a written plan of care and an initial orientation for all members concerning the process and content of prenatal care; and their rights and responsibilities. Care coordination refers to activities designed to provide the member with care that is continuous, well integrated and tailored to the member’s individual needs. This includes active follow-up activities designed to ensure the plan of care is being followed and revised as needed.

The Amerigroup Comprehensive Maternity Services program contains two major components: medical and health support services. The medical component includes obstetrical prenatal, intrapartum and postpartum care services. The health support services include care coordination, health education, nutrition, social and/or psychological services, and home visits.

Prenatal care notification must be provided to Amerigroup. Delivery precertification will be obtained at the time of notification of pregnancy. We require providers to submit the Amerigroup Maternity Notification form found in Appendix A. This form may be faxed to us at 1-800-964-3627.
The following is a summary of information required:

- Outreach (notify us if assistance with outreach is needed)
- Prenatal care (provided at the time of notification)
  - OB high-risk conditions
  - Prior pregnancy
  - Current pregnancy
  - Psychological risk factors
- Fetal risk factors in current pregnancy
- Delivery services (obtained by our case/care managers during concurrent review)
- Postpartum services

5.13 Infertility Services

Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical or clinic), drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered by Amerigroup or the FFS Medicaid Program.

5.14 Hysterectomy and Sterilization

Federal law requires providers to provide hysterectomies and sterilizations to Medicaid members in ways designed to ensure those members consider their options and make informed choices. We cover sterilizations only under the following conditions:

- The individual is at least 21 years old at the time of consent to be sterilized
- The individual is mentally competent
- The individual has voluntarily given informed consent
- At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery; informed consent must have been given at least 30 days before the expected date of delivery and at least 72 hours before emergency abdominal surgery

To meet informed-consent requirements, the person who obtained consent must have offered to answer all questions and provided the following information:

- Advice that the individual is free to withhold or withdraw consent to the procedure at any time before sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled
- A description of available alternative methods of family planning and birth control
- Advice that the sterilization procedures are considered irreversible
- A thorough explanation of the specific sterilization procedure to be performed
- A full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used
- A full description of the benefits or advantages that may be expected as a result of the sterilization
- Advice that the sterilization will not be performed for at least 30 days, except under certain circumstances described above

The above information must be effectively communicated to all individuals, including persons who are blind, deaf or otherwise handicapped. An interpreter must be provided if the individual does not
understand the language on the consent form or the language used by the person who is obtaining consent. The individual must be permitted to have a witness of his or her choice when consent is given. The Medicaid consent form must be completed and signed.

The Hysterectomy Receipt of Information form and Sterilization Consent form – 7473 MED are located in Appendix A – Forms. The forms take the provider through the entire consent process. A copy of the consent form must be placed in the member’s medical record. Another copy must be attached to the claim for the hysterectomy or sterilization procedure in order for the claim to be adjudicated. Both Amerigroup and the State’s External Quality Review Organization (EQRO) review such forms during medical chart audits.

5.15 HIV Testing and Voluntary Counseling

We collaborate with community-based agencies that educate, test and treat pregnant women with HIV/AIDS to reduce perinatal transmission of HIV from the mother to the infant. All pregnant women will receive HIV education and counseling and HIV testing with their consent as part of their regular prenatal care. A refusal of testing must be documented in the member’s medical record. Additionally, counseling and education regarding perinatal transmission of HIV and available treatment options (e.g., the use of Zidovudine or the most current treatment accepted by the medical community for treating the disease) for the mother and newborn infant will be made available during the pregnancy and/or to the infant within the first months of life. We arrange for treatment for HIV-positive pregnant women in collaboration with the member’s obstetrician in accordance with the CDC and NJ State Department of Human Services, Division of Epidemiology and AIDS Program. The following forms are located in Appendix A – Forms: Counsel for HIV Antibody Blood Test, Consent for HIV Antibody Blood Test and Results of HIV Antibody Blood Test.

5.16 Outpatient Laboratory and Radiology Services

We allow laboratory testing in the office. PCPs and specialists will be reimbursed according to their provider agreement.

For those offices with limited or no office laboratory facilities, laboratory tests should be referred to a network reference laboratory, preferably Bio-Reference Labs, which functions as an Amerigroup participating lab vendor. Please refer to the provider referral directory for a complete listing of participating laboratory vendors. In addition, we allow members to access network hospital outpatient departments for blood drawing and/or specimen collection only when a convenient alternative is not available. Request forms for laboratory services should be obtained from the network laboratory, completed appropriately and forwarded with the specimen to the laboratory chosen.

All laboratory services furnished by nonparticipating providers require precertification by Amerigroup, except for hospital laboratory services in the event of an emergency medical condition.

For offices with limited or no office laboratory facilities, lab tests should be referred to one of our preferred lab vendors.

Preadmission laboratory tests must be ordered and completed within 72 hours of admission.
Below are tests that will not be recognized as stat (i.e., immediate) tests:

- Fecal occult blood
- Dip-stick or tablet reagent urinalysis for the following: bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity and urobilinogen
- Ovulation tests
- Erythrocyte sedimentation rate, nonautomated
- Hemoglobin, copper sulfate, nonautomated
- Blood glucose by glucose-monitoring device cleared by the U.S. Food and Drug Administration (FDA) specifically for home use
- Spun hematocrit
- Hemoglobin by single analyte instruments with self-contained features to perform specimens’ reagents interaction, providing direct measurement and readout (e.g., Hemocue)

**Clinical Laboratory Improvement Amendment Reporting**

The federal Clinical Laboratory Improvement Amendment (CLIA) requires that all laboratories servicing Medicaid recipients must have a certificate of waiver or a certificate of registration.

The laboratories with a certificate of waiver may only provide the following nine tests:

1. Fecal occult blood
2. Dip-stick or tablet reagent urinalysis for the following: bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity and urobilinogen
3. Ovulation tests
4. Erythrocyte sedimentation rate, nonautomated
5. Hemoglobin, copper sulfate, nonautomated
6. Blood glucose by glucose-monitoring device cleared by the U.S. Food and Drug Administration (FDA) specifically for home use
7. Spun hematocrit
8. Hemoglobin by single analyte instruments with self-contained features to perform specimens’ reagents interaction, providing direct measurement and readout (e.g., Hemocue)

### 5.17 Radiology Services

Physicians will use AIM Specialty Health (AIM) for the management of certain diagnostic imaging studies. AIM will perform precertification services for Magnetic Resonance Imaging (MRI)/Magnetic Resonance Angiogram (MRA), Positron Emission Tomography (PET) scan, Computed Tomography (CT) and nuclear cardiology performed in an outpatient setting. Physicians who order any of the tests listed above must obtain precertification by contacting AIM at 1-800-714-0400, Monday through Friday from 8 a.m. to 8 p.m. Eastern time. In addition to reviewing clinical appropriateness and issuing precertifications for these studies, AIM will locate a preferred imaging facility from our network of radiology service providers. Any of these tests performed in conjunction with an inpatient stay are not subject to precertification by AIM.
5.18 Reading of X-Rays or Lab Results

When both a PCP and a radiologist read an X-ray, only the radiologist will be reimbursed for reading the film. If the PCP feels there is a concern with the reading diagnosis, he or she should contact the radiological facility to discuss the concern.

Urgent/emergent results: You’re required to notify enrollees of laboratory and radiology results within 24 hours of receipt of results in urgent or emergent cases. You may arrange an appointment to discuss laboratory/radiology results within 24 hours of receipt of results when it is deemed face-to-face discussion with the enrollee/authorized person may be necessary. Urgent/emergency appointment standards must be followed. Rapid strep test results must be available to the enrollee within 24 hours of the test.

Routine results: Providers are required to establish a mechanism to notify Amerigroup members of nonurgent or nonemergent laboratory and radiology results within 10 business days of receipt of the results.

5.19 Therapy Services

Physical Therapy (PT), Occupational Therapy (OT) or Speech-language Pathology Therapy (SPT) services are available as an integral part of a comprehensive medical program. Such rehabilitative services are for the purpose of attaining maximum reduction of physical or mental disability and restoration of the individual to his or her best functional level.

Cognitive Rehabilitative Therapy (CRT) services are available for our NJ FamilyCare A, B, C, D and ABP members with nontraumatic brain injuries.

Outpatient therapy care (including PT, OT and SPT services) are arranged through the Therapy Network New Jersey (TNNJ). Each person in a family can choose a different therapist. Therapy providers should call TNNJ at 1-855-825-7818 for more information regarding prior approvals for outpatient therapy services.

5.20 Medical Day Care

Adult Day Health Services (ADHS) are available to provide medically necessary services in an ambulatory care setting for individuals who don’t live in a facility but require such services to support their community living due to physical and/or cognitive impairment.

Pediatric Medical Day Care (PMDC) is available to provide medically necessary services in an ambulatory care setting for children who reside in the community and require continuous care because their needs cannot be met in a regular day care or preschool program for the handicapped.

Not all members are eligible for Medical Day Care services.
5.21 Personal Care Assistants

Personal Care Assistant (PCA) services, including personal care, household duties and health-related tasks, are available from a home health agency or homemaker agency to accommodate long-term chronic or maintenance health care. This also includes services for members with mental illnesses. Not all members are eligible for PCA services.

5.22 Pharmacy Services

Our 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.

Our pharmaceutical management procedures, provided below, are updated and provided at least annually and when changes are made.

Monthly Limits
All prescriptions are limited to a 34-day supply per fill.

Covered Drugs
Our Pharmacy program uses a Preferred Drug List (PDL). This is a list of the preferred drugs within the most commonly prescribed therapeutic categories. The PDL comprises drug products reviewed and approved by the Amerigroup Pharmacy and Therapeutics (P&T) Committee. The P&T Committee comprises network physicians, pharmacists and other health care professionals who evaluate safety, efficacy, adverse effects, outcomes and total pharmacoeconomic value for each drug product reviewed. The PDL also includes several Over-The-Counter (OTC) products recommended as first-line treatment where medically appropriate. To prescribe medications that do not appear on the PDL, please contact Pharmacy Services at 1-800-454-3730. Please refer to the PDL on our website at https://providers.amerigroup.com/AGP%20Documents/NJNJ_CAID_PDL.pdf.

The following are examples of covered items:

- Formulary legend drugs
- Insulin
- Disposable insulin needles and syringes
- Disposable blood, urine glucose and acetone testing agents (e.g., Chemstrips, Clinitest tablets, Diastix Strips, Tes-Tape)
- Lancets and lancet devices
- Compounded medication of which at least one ingredient is a legend drug and is listed on the Amerigroup Medication Formulary
- Any other drug, which under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber and is listed on the Amerigroup Medication Formulary
- Formulary legend contraceptives (Exception: Injectable contraceptives may be dispensed up to a 90-day supply.)
Under the New Jersey Medicaid program (P.L. 1996, c42, the State Fiscal Year 1997 Appropriations Act), unless the provider writes in ink in his own handwriting at the bottom of the prescription Brand Medically Necessary, the prescription will be filled with a generic substitution in every case. When a prescriber writes Brand Medically Necessary, these prescriptions will require prior authorization.

Prior Authorization Drugs
We strongly encourage you to write prescriptions for preferred products as listed on the PDL. If for medical reasons a member cannot use a preferred product, you’re required to contact Amerigroup Pharmacy Services to obtain prior authorization. Prior authorization may be requested:
- Online at [https://providers.amerigroup.com/Help/Pages/login.aspx](https://providers.amerigroup.com/Help/Pages/login.aspx).
- By fax to 1-844-509-9863 for Retail Pharmacy or 1-844-509-9865 for Medical Injectable.
- By phone at 1-800-454-3730 (24 hours per day, 7 days per week).

Be prepared to provide relevant clinical information regarding the member’s need for a nonpreferred product or a medication requiring prior authorization. Decisions are based on medical necessity and are determined according to certain established medical criteria. Prior authorization determinations shall be made within 24 to 72 hours of receipt of all necessary information.

Our Pharmacy Prior Authorization Form can be found on our website at: [https://providers.amerigroup.com/Public%20Documents/Pharmacy_Prior_Auth_Form.pdf](https://providers.amerigroup.com/Public%20Documents/Pharmacy_Prior_Auth_Form.pdf).

Amerigroup only restricts or requires a prior authorization for prescriptions or pharmacy services prescribed by MH/SA providers if one of the following exceptions is demonstrated:
1. The drug prescribed is not related to the treatment of substance abuse, dependency, addiction or mental illness or to any side effects of the psychopharmacological agents. These drugs are to be prescribed by our PCPs or specialists in our network.
2. The prescribed drug does not conform to standard rules of our pharmacy plan.
3. Amerigroup may require a prior authorization (PA) process if the number of prescriptions written by the MH/SA provider for MH/SA-related conditions exceeded four per month per member. For drugs that require weekly prescriptions, these prescriptions shall be counted as one per month and not as four separate prescriptions.

Prior authorization (PA) Drugs for Mental Health/Substance Abuse (MH/SA)-related conditions:
1. All pharmacy services are covered by Amerigroup. (Methadone and its administration when prescribed for substance abuse treatment will adjudicate under the member’s medical benefit.)
   a. This includes drugs prescribed by MH/SA providers.
2. Atypical antipsychotic and anticonvulsant drugs ordered by a nonparticipating or participating Amerigroup provider will always be covered regardless of the treatment plan established by Amerigroup.
   a. The Amerigroup medication formulary and prior authorization requirements will apply only when the initial medication treatment plan is changed.
3. Prior authorization is not needed for MH/SA drugs written by MH/SA providers, regardless of whether they are/are not on the Amerigroup formulary.

For drugs that require weekly prescriptions, these prescriptions are counted as one per month and not as four separate prescriptions.
Over The Counter (OTC) Drugs Pertaining Only to Medicaid Members

We have an enhanced OTC benefit for our members. Our members may obtain a prescription for OTC or nonlegend drugs.

- For members of all categories age 21 and older, the benefit limit is $15 per quarter per member.
- For members of all categories under age 21 (except NJ FamilyCare D), there is no benefit limit.
- For NJ FamilyCare D members, OTC drugs are not a covered benefit.

Our complete formulary and PDL includes coverage of several OTC drugs when accompanied by a prescription. The following are examples of OTC medication classes covered:

- Analgesics and Antipyretics
- Antacids
- Antibacterials, topical
- Antidiarrheals
- Antiemetics
- Antifungals, topical
- Antifungals, vaginal
- Anti-inflammatories, topical
- Antihistamines
- Contraceptives
- Cough and cold preparations
- Decongestants
- Laxatives
- Pediculocides
- Respiratory agents (including spacing devices)

Excluded Drugs

The following drugs are examples of medications that are excluded from the pharmacy benefit:

- Anti-wrinkle agents (e.g., Renova)
- Agents used for cosmetic reasons or hair growth
- Drugs used for experimental or investigational indication
- Erectile dysfunction drugs for individuals who are registered on New Jersey’s sex offender registry
- Experimental or investigational drugs
- Immunizing agents
- Implantable drugs and devices (Norplant, Mirena IUD)
- Infertility medications
- Weight-control products (except Meridia and Alli which require prior authorization)

5.23 Specialty Drug Program

We contract with Accredo to be our preferred Specialty Pharmacy Vendor for high-cost, specialty and injectable drugs that treat a number of chronic or rare conditions, including:

- Anemia
- Crohn’s disease
- Cystic fibrosis
- Gaucher disease
- Immunologic disorders
- Multiple sclerosis
- Neutropenia
- Primary pulmonary hypertension
• Growth hormone deficiency
• Hemophilia
• Hepatitis C
• Respiratory Syncytial Virus (RSV) disease
• Rheumatoid arthritis

Please call Accredo at 1-844-433-4878 or visit http://www.accredo.com/healthcare-professionals/referral-forms to request a specific medication.

Certain medications require prior authorization:

• **Under the pharmacy benefit:**
  o To determine whether the medication you are prescribing under the pharmacy benefit requires prior authorization, please refer to the Amerigroup Medication Formulary located at [https://providers.amerigroup.com/AGP%20Documents/NJNJ_CAID_Formulary.pdf](https://providers.amerigroup.com/AGP%20Documents/NJNJ_CAID_Formulary.pdf) or to the Preferred Drug List (PDL) located at [https://providers.amerigroup.com/AGP%20Documents/NJNJ_CAID_PDL.pdf](https://providers.amerigroup.com/AGP%20Documents/NJNJ_CAID_PDL.pdf)
  o Please note that the PDL guide does not contain a complete list of drugs (as does the Amerigroup Medication Formulary); rather it lists the preferred drugs within the most commonly prescribed therapeutic categories

• **Under the medical benefit:**
  o To determine whether the medication you are prescribing under the medical benefit requires prior authorization, please refer to the Precertification Lookup Tool found at: [https://providers.amerigroup.com/QuickTools/Pages/PrecertificationLookup.aspx](https://providers.amerigroup.com/QuickTools/Pages/PrecertificationLookup.aspx)

If it is determined that the medication you are seeking to prescribe requires prior authorization, please contact the Pharmacy Department at 1-800-454-3730.

When prescribing a specialty drug, please fax your request to Accredo at 1-800-824-2642 or call Accredo at 1-844-433-4878, and they will coordinate shipment to your office or to the member’s home. You should not provide these drugs from your office stock without first obtaining precertification from us.

### 5.24 Behavioral Health Services

Behavioral health services are covered for members who are clients of the Division of Developmental Disabilities (DDD) and the Managed Long Term Services and Supports (MLTSS) program. Non-DDD and non-MLTSS members are covered under the Medicaid FFS program for behavioral health services. Behavioral health services are available for DDD and MLTSS members as follows:

- PCPs can call the toll-free number on the member’s identification card. A behavioral health care manager will be available for consultation and/or to furnish the name of an appropriate provider.
- Our members can call the toll-free number on their identification card to access services.
- Behavioral health providers can call the toll-free number on the member’s identification card and request precertification for an Amerigroup member who has requested services from the provider directly.

In addition, for all categories of members, we will cover certain diagnoses of diseases of organic origin categorized as altering the mental status of a member. These include the diagnoses in the following International Classification of Diseases, 10th Revision, and Clinical Modification (ICD-10-CM) series:
<table>
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<th>ICD-10 Description</th>
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<th>ICD-10 Description</th>
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<tbody>
<tr>
<td>290.0</td>
<td>Senile dementia, uncomplicated</td>
<td>F0390</td>
<td>Unspecified dementia without behavioral disturbance</td>
</tr>
<tr>
<td>290.1</td>
<td>Presenile dementia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>290.10</td>
<td>Presenile dementia, uncomplicated</td>
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</tr>
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<td>Presenile dementia with delusional features</td>
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Amerigroup recommends that PCPs and other providers use the Well-Being Screening Tool, which is located in Appendix A – Forms, or other industry screening tools such as the PHQ-9, SBIRT, CAGE, etc., for all members.

In the case of an admission, members should receive an outpatient follow-up encounter within seven days of hospital discharge. We will contact members who have been discharged within the same seven-day period to monitor and facilitate access to follow-up care.

The goals of the precertification process are to avoid unreasonably restricted access to medications and to ensure that the prescribed drug is related to the treatment of a behavioral health condition or to any side effect of the psychopharmacological medication. Precertification for medications will occur in very limited circumstances whether for DDD members, MLTSS members, or non-DDD/MLTSS members. Precertification is required where the prescribed drug does not conform to the standard rules of our pharmacy plan as described in the Amerigroup Drug Utilization Review program description and in this manual.

We will only restrict or require precertification for prescriptions or pharmacy services prescribed by MH/SA providers if one of the following exceptions is demonstrated:

- The drug prescribed is not related to the treatment of substance abuse, dependency, addiction or mental illness or to any side effects of the psychopharmacological agents. These drugs are to be prescribed by the members’ PCPs or specialists in our network.
- The prescribed drug does not conform to standard rules of our pharmacy plan.
- At our option, we may require a precertification process if the number of prescriptions written by the MH/SA provider for MH/SA-related conditions exceed four per month per member. For drugs that require weekly prescriptions, these prescriptions will be counted as one per month and not as four separate prescriptions. Our prior authorization process for the purposes of this section will require review and prior approval by DMAHS.

**5.25 Behavioral Health Precertification**

We require precertification for all elective behavioral health inpatient admissions and certain outpatient services. We use the Amerigroup Behavioral Health Medical Policies and Clinical UM Guidelines, as well as the American Society of Addiction Medicine’s Patient Placement Criteria. The following all-inclusive list of services must be precertified:

- Inpatient admission
- Outpatient BH services
- Partial hospital programs
- Electroconvulsive therapy
- Psychological and neuropsychological testing
5.26 Coordination of Physical and Behavioral Care

We’ve designed systems to ensure the coordination of physical and behavioral care for DDD members, MLTSS members, and non-DDD/MLTSS members who are currently receiving services.

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 by following our specialty referral procedures for DDD members. For non-DDD members, the physical health provider needs only to facilitate a referral to a behavioral health service.

DDD members with behavioral health benefits — Amerigroup does not require a paper referral process. If a PCP or provider feels a DDD member needs a referral to a behavioral health (BH) specialist, he or she can refer the member to any participating BH specialist. If the PCP/provider cannot find a participating specialist or wants a member to go to a nonparticipating BH specialist, he or she must request an out-of-network (OON) authorization from Amerigroup, documenting medical necessity and the reason for the OON request. For assistance with finding a specialist, providers can
call Provider Services and members can call Member Services. In addition, all DDD members are open to care management, and the care manager can assist the member or provider with finding specialists.

Providers can refer members without Amerigroup BH benefits to any participating Medicaid provider or to Rutgers University Behavioral Health Care 24 hours a day, 7 days a week at 1-844-276-2777. Members eligible for care management will be assisted by the care manager.

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 DDD, MLTSS and non-DDD/MLTSS 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 admittance to a BH unit. 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.

For members who are not DDD or MLTSS enrolled, 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).
5.27 Out-of-Area Coverage

We will provide or arrange for out-of-area coverage of covered benefits in emergency situations and nonemergency situations when travel back to the service area is not possible or practical or when medically necessary services can only be provided elsewhere.

- We’re not responsible for out-of-state coverage for routine care if the member resides out of the state for more than 30 days.
- For full-time students attending school and residing out of the country, we’re not responsible for health care benefits while the member is in school.
- We’re not responsible for services provided outside of the United States or its territories.

5.28 Domestic Violence Services

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

State law requires reporting of child abuse. Such reporting can be done anonymously. Report any injuries from firearms and other weapons to the police. Report suspected child abuse or neglect immediately to the DCP&P at 1-800-792-8610. They receive calls at this number 24 hours a day, 7 days a week. To report abuse that occurred in an institution, call the DCP&P at 1-800-215-6853.

State law encourages individuals to report suspected cases of elder or partner abuse, neglect or exploitation that occurs in the community. Report suspected elder or partner abuse immediately to the State’s Division of Aging and Community Services at 1-800-792-8820 or to the particular county Adult Protective Services office. An individual can access the National Domestic Violence Hotline number by calling 1-800-799-7233; or for text telephone assistance, call 1-800-787-3224.

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

5.29 Domestic Violence Screening Tools

Domestic Violence — Framing Statements

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

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

Domestic Violence — New Member

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

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

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

5.30 Sexual Abuse

It is required that each provider contact DCP&P at 1-800-792-8610 when sex abuse is suspected. Referrals should be made to the DCP&P-designated sex abuse specialty centers. If a suspected abuse case arises and a referral is required, the provider or member may call a specialty center directly or may call Amerigroup Member Services at 1-800-600-4441 for a list of the specialty centers near them.
5.31 Amerigroup in the Community

We’re a community-focused managed health care company that works to improve the lives of uninsured and low-income parents, children and persons with disabilities. Through our NJ FamilyCare managed care programs, we ensure access to quality health care for those who otherwise might go without medical coverage. We work with respected, community-based organizations to sponsor outreach events across the service area including:

- Sponsoring summer technology camps for youth
- Holding free Summer Family Fun Nights to help strengthen family bonds
- Providing free hats and mittens to keep children warm in the winter
- Offering a free, safe, violence-free and fun environment for local teens to learn life skills, job training, and alcohol and drug prevention
- Supporting the health of elderly community members
- Curtailing the effects diabetes and asthma have on our community’s people through education and support

We also provide health education workshops in the community on a variety of topics to children, parents and staff members.

We strive to contribute to the community’s overall quality of life for substantial and long-lasting impact by forming networks in which community organizations, health care professionals and community members work together.

5.32 Head Start Program

Head Start is a national program that provides comprehensive developmental services for preschool children ages 3-5 years from low-income families and under the Early Head Start program for infants, toddlers and pregnant women. We collaborate with the community Head Start programs to provide timely and age-appropriate health screening and referrals for routine health services.

- We assign each member a community-based PCP.
- Head Start staff encourages members to see their PCPs for screenings and health services.
- We support timely and complete immunization of all children.
- We support routine dental, vision and hearing exams for members.
- Physical exams are encouraged according to the EPSDT periodicity schedule.
- We support personal hygiene as part of the child’s daily routine through age-appropriate educational programs.
- Our Member Services staff, nurse case/care managers and Health Promotion staff coordinate the delivery of services for the children and work with their caretakers to eliminate barriers to timely health care.
- Our Health Educators provide staff education programs and parent workshops focused on disease prevention and the importance of childhood screenings.

5.33 School-Based Youth Services Programs and Local Health Departments

We work collaboratively with School-based Youth Service Programs and Local Health Departments.

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New Jersey School-based Youth Services Program
The School-based Youth Services Program (SBYSP), developed by the New Jersey Department of Human Services, provides adolescents and children with the opportunity to complete their education, to obtain skills that lead to employment or additional education, and to lead a mentally and physically healthy life.

SBYSP sites primarily serve adolescents between ages 13-19 years, many of whom are at risk of dropping out of school, becoming pregnant, using drugs, developing mental illness or being unemployed. SBYSP sites also serve those most at risk of being dependent for long periods on state-assistance programs.

Each site offers a comprehensive range of services including:
- Crisis intervention
- Individual and family counseling
- Primary and preventive health services
- Drug and alcohol abuse counseling
- Employment counseling, training and placement
- Summer and part-time job development
- Referrals to health and social services
- Recreation

Some sites offer day care, teen parenting, training, special vocational programs, family planning, transportation and hotlines. Parental consent is required for all SBYSP services.

We provide health education workshops to SBYSP participants on a variety of topics including:
- Adolescent health
- Nutrition
- Conflict resolution
- Personal hygiene
- Healthy relationships

For an updated list of SBYSP and program directors, please visit www.state.nj.us/dcf/prevention/school.

Local Health Departments
For an updated list of Local Health Departments in New Jersey, please visit www.state.nj.us/health/lh/lhdirectory.pdf.

Early Intervention Services
The first three years of life are important, formative years in maximizing a child's future potential. If you suspect that your infant or toddler may be experiencing developmental delays, contact Early Intervention Services at 1-888-653-4463. The call is toll-free for New Jersey residents.

Early intervention services are designed to address a problem or delay in development as early as possible. The services are available for infants and toddlers up to age three. Contracted agencies serve as the Early Intervention Program providers (EIPs) and arrange for early intervention practitioners to address the needs of eligible children and their families. Following the evaluation and assessment, an
Individualized Family Service Plan (IFSP) is developed to describe the services that are needed by the child and family and how they will be implemented. Services are provided by qualified practitioners in natural environments, settings in which children without special needs ordinarily participate and that are most comfortable and convenient for the family, such as the home, a community agency, or a child care facility.

5.34 New Technology Assessments

We continue to keep pace with change and to ensure that members have access to safe and effective care. We have a formal process to evaluate and address new developments in medical technology, including medical therapies and procedures, drugs, and equipment.

5.35 Coordination of Benefits

If a member is covered by more than one health care plan, we’ll administer Coordination of Benefits (COB). Under COB, the primary payer of benefits is identified in order to eliminate duplication of reimbursement. COB claims must be submitted within 60 days from the date of the primary insurer’s Explanation of Benefits (EOB) or 180 days from the dates of service, whichever is later.

If Amerigroup is identified as the primary payer of benefits, Amerigroup will reimburse the provider up to the contracted rate or the nonparticipating rate currently in effect, as applicable. If Amerigroup is identified as the secondary payer of benefits, Amerigroup will coordinate reimbursement to the provider with the primary payer’s reimbursement to avoid duplication of benefits.

In addition, all providers and members must abide by all our policies and procedures, including notification or precertification of services.

We will notify the state within 30 days after we learn a member has health insurance coverage not reflected in the state’s file or casualty insurance coverage or if there is a change in a member’s health insurance coverage. In addition, we require our providers to notify us of this information.

Any questions or inquiries regarding paid, denied or pended claims should be directed to Provider Services at 1-800-454-3730.

For additional information, please refer to the New Jersey Quick Reference Card (Guide) found on our website. Go to https://providers.amerigroup.com/NJ, select Manuals & QRCs, then New Jersey Quick Reference Card (Guide), then Coordination of Benefits.

5.36 Third-Party Liability

You must use and report any other public or private third party sources of payment for services rendered to members.

If you’re aware of third-party coverage, you must submit a claim first to the appropriate third party before submitting a claim to us.
In the following situations, you may bill us first and then coordinate with the liable third party, unless we have received prior approval from the state to take other action:

- The coverage is derived from a parent whose obligation to pay support is being enforced by the Department of Human Services.
- The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the Medicaid program.
- The claim is for labor, delivery and postpartum care and does not involve hospital costs associated with the inpatient hospital stay.
- The claim is for a child who is in a DCP&P support out-of-home placement. Third-party liability recovery may not be pursued for these enrollees for safety reasons.
- The claim involves coverage or services mentioned above in combination with another service.

If you know the third party will neither pay for nor provide the covered service and the service is medically necessary, you may bill us without having received a written denial from the third party.

**Sharing of Third-Party Liability Information by a Provider**

You must notify us within 30 days after you learn a member has health insurance coverage not reflected in the health insurance provided by Amerigroup or casualty insurance coverage or of any change in a member’s health insurance coverage.

When you become aware that a member has retained counsel who either may institute or has instituted a legal cause of action for damages against a third party, you must notify us in writing, including the member’s name and Medicaid identification number, date of accident and/or incident, nature of injury, name and address of the member’s legal representative, copies of pleadings, and any other documents related to the action in the provider’s possession or control. This will include but not be limited to (for each service date on or subsequent to the date of the accident and/or incident) the member’s diagnosis and the nature of the service provided to the member.

You must notify us with seven days when you become aware of a member’s death, utilizing the *Combined Notification of Death and Estate Referral* form located on our website at https://providers.amerigroup.com/NJ.

You must notify us of the incarceration of a member within 30 days of the date you become aware of the incarceration. Incarcerated individuals are not eligible for managed Medicaid coverage pursuant to N.J.A.C. 10:71-3.14. When you notify us of an incarcerated member, we will promptly notify DMAHS of possible member incarcerations (involuntary physical restraint of a person who has been arrested for, or convicted of a crime), upon verification of each incarceration, as directed by the state, we will recover capitation payments made for the period of incarceration on a prorated basis after the beginning date of incarceration.

If an incarcerated member receives inpatient services, the fee for service (FFS) Medicaid Program will pay for the enrollee’s inpatient claim only. MCOs do not pay any claims while the enrollee is incarcerated. MCO coverage resumes after the enrollee is released from incarceration, upon notification from DMAHS.
You must agree to cooperate with ours and the State’s efforts to maximize the collection of third-party payments by providing us updates to the information required by this section.

5.37 Self-Referral Services

Self-referral services do not require a referral from a PCP. Members may self-refer for a limited number of services:

- A service provided by the member’s assigned PCP or an approved Amerigroup provider for special needs care
- Specialty care services provided by a network specialist
- Emergency room care provided in a medical emergency
- Annual well-woman exam, routine and preventive women’s health care services when the PCP is not a women’s health specialist; services can be received from a network obstetrician/gynecologist, certified nurse midwife or PCP
- Care provided by the provider’s nurse or physician assistant
- Dental care provided by a network family dentist
- Family planning (FP) services provided by a network or non-network Medicaid-approved FP provider
- Medicaid services that are not covered by Amerigroup
- Prenatal care provided by a network obstetrician or certified nurse midwife
- Members with HIV and other chronic conditions may select a specialist who has been approved by Amerigroup; the provider may provide specialty services and primary care to the member without precertification
- Routine vision care provided by a Superior Vision provider

The member handbook details the self-referral process, and members can call Member Services for explanation of the self-referral process.

5.38 Managed Long Term Services and Supports (MLTSS)

Managed Long Term Services and Supports (MLTSS) is a program for managing long-term care services. Long-term care includes help doing everyday tasks that members may no longer be able to do for themselves as they grow older or if they have a disability. These include bathing, dressing, getting around the home, preparing meals or doing household chores. Long-term care also includes care in a member’s own home or in the community that may keep members from having to go to a nursing home for as long as possible. These are called home and community-based services, or HCBS.

Long-term care services also include care in a nursing home.

An existing Amerigroup member can qualify for Managed Long Term Services and Supports (MLTSS) by meeting these established Medicaid requirements:

- **Financial Requirements:** These include monthly income, as well as total liquid assets. For more detailed information on Medicaid financial eligibility, go to [http://www.state.nj.us/humanservices/dmahs/clients/medicaid/abd](http://www.state.nj.us/humanservices/dmahs/clients/medicaid/abd).
- **Clinical Eligibility:** A person meets the qualifications for nursing home level of care, which means that he/she requires limited assistance with a minimum of three activities of daily living (ADL) such as bathing, toileting and mobility or the consumer has cognitive deficits and ADL needs of supervision in greater than three ADL areas.
• **Age and/or Disability Requirements:** These involve age requirements whereby one must be 65 years or older; and/or disability requirements whereby one must be under 65 years of age and determined to be blind or disabled by the Social Security Administration or the State of New Jersey.

Members utilizing 15 or more hours of personal care assistance (PCA) a week or attending as an Adult Medical Day Care program are potentially MLTSS eligible.

A list of MLTSS services requiring precertification and can be found below, as well as on our provider website. To ensure person-centered planning, requests for MLTSS services must be communicated to the member’s Care Manager. Providers should fax MLTSS service requests to 1-888-826-9762.

**Process to Enroll in MLTSS**
- Amerigroup case managers are able to screen and refer members who may need the additional services provided under the Managed Long-Term Services and Supports program. The State of New Jersey ultimately determines eligibility for the MLTSS program.
- If the member is a Nursing Facility resident, providers can both receive an authorization and refer the member for enrollment in MLTSS by providing notification of admission by phone to 732-452-6050 or fax to 1-877-244-1720.
- Other providers wishing to refer members for the MLTSS program should speak with the member’s acute case manager or call the MLTSS Department at 1-855-661-1996.
- Members self-referring can also call the MLTSS Department at 1-855-661-1996 and state that they are interested in enrolling in the MLTSS program. Members requiring Telephone Typewriter/Teletypewriter (TTY) Services can call 711.

The individual will then be contacted by a staff member of our Enrollment Team to schedule a visit.

**Standard Credentialing Requirements**
**Requirements for providers:**
- Updated CAQH (within the year)
- DOO (Disclosure of Ownership)
- ADA (American Disability Act)
- ABD (Aged Blinded and Disabled)
- Current Malpractice Insurance

**Requirements for facilities:**
- Updated CAQH (within the year)
- DOO (Disclosure of Ownership)
- ADA (American Disability Act)
- ABD (Aged Blinded and Disabled)
- Current Malpractice Insurance

**MLTSS Services**
- Adult Day Health Services
- Adult Family Care
- Assisted Living Services – Assisted Living Residence & Comprehensive Personal Care Home
• Assisted Living Program
• Behavior Management (TBI) (Group & Individual)
• Caregiver/Participant Training
• Chore Service
• Cognitive Therapy (Group & Individual)
• Community Residential Services
• Community Transition Services
• Home Based Supportive Care
• Home Delivered Meals
• Medical Day Services – above the state plan limit
• Medication Dispensing Device
• MLTSS PCA – above the state plan limit
• Non-Medical Transportation
• Nursing Facility Services (Custodial)
• Occupational Therapy (Group & Individual)
• Personal Emergency Response System
• Private Duty Nursing (for individuals over the age of 21)
• Residential Modifications
• Respite
• Social Adult Day Care
• Speech, Language and Hearing Therapy (Group & Individual)
• Structured Day Program
• Supportive Day Services
• Physical Therapy (Group & Individual)
• Vehicle Modifications

At Amerigroup, we are committed to treating our members in a manner that affirms their rights and responsibilities.

**We have a written policy that complies with federal and state laws affecting the rights of enrollees.**

**As a member, Amerigroup members have a right to:**

• Be treated with respect, dignity, and need for privacy
• Be provided with information about the organization, its services, the practitioners providing care, and member rights and responsibilities and to be able to communicate and be understood with the assistance of a translator if needed
• Be able to choose primary care practitioners, within the limits of the plan network, including the right to refuse care from specific practitioners
• Participate in decision-making regarding their health care, to be fully informed by the primary care practitioner, other health care provider or Care Manager of health and functional status, and to participate in the development and implementation of a plan of care designed to promote functional ability to the optimal level and to encourage independence
• Voice grievances about the organization or care provided and recommend changes in policies and services to plan staff, providers and outside representatives of the enrollee's choice, free of restraint, interference, coercion, discrimination or reprisal by the plan or its providers
• Formulate advance directives
• Have access to his/her medical records in accordance with applicable Federal and State laws
• Be free from harm, including unnecessary physical restraints or isolation, excessive medication, physical or mental abuse or neglect
• Be free of hazardous procedures
• Receive information on available treatment options or alternative courses of care
• Refuse treatment and be informed of the consequences of such refusal
• Have services provided that promote a meaningful quality of life and autonomy for members, independent living in members’ homes and other community settings as long as medically and socially feasible, and preservation and support of members’ natural support systems

We also have a written policy that recognizes the rights below. As our MLTSS member, our members also have the right to:
• Request and receive information on choice of services available
• Have access to and choice of qualified service providers
• Be informed of their rights prior to receiving chosen and approved services
• Receive services without regard to race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, marital status or disability
• Have access to appropriate services that support health and welfare
• Assume risk after being fully informed and able to understand the risks and consequences of the decisions made
• Make decisions concerning care needs
• Participate in the development of and changes to the Plan of Care
• Request changes in services at any time, including adding, increasing, decreasing or stopping services
• Request and receive from a Care Manager a list of names and duties of any person(s) assigned to provide services under the Plan of Care
• Receive support and direction from a Care Manager to resolve concerns about care needs and/or complaints about services or providers
• Be informed of and receive in writing facility specific resident rights upon admission to an Institutional or residential setting
• Be informed of all the covered/required services entitled to, required by and/or offered by the Institutional or residential setting, and any charges not covered by the managed care plan while in the facility
• Not be transferred or discharged out of a facility except for medical necessity; to protect physical welfare and safety or the welfare and safety of other residents; or because of failure, after reasonable and appropriate notice of nonpayment to the facility from available income as reported on the statement of available income for Medicaid payment
• Have health plan protection and promotion of the member’s ability to exercise all rights identified in this document
• Have all rights and responsibilities outlined here forwarded to an authorized representative or court appointed legal guardian

Amerigroup has a written policy that addresses our MLTSS members’ responsibility for working with those providing health care services. It is our MLTSS members’ responsibility to:
• Provide all health and treatment related information, including but not limited to, medication, circumstances, living arrangements, informal and formal supports to the health plan’s Care Manager in order to identify care needs and develop a plan of care
• Understand their health care needs and work with their Care Manager to develop or change goals and services
• Work with their Care Manager to develop and/or revise the Plan of Care to facilitate timely authorization and implementation of services
• Ask questions when additional understanding is needed
• Understand the risks associated with decisions about care
• Report any significant changes on their health condition, medication, circumstances, living arrangements, informal and formal supports to the Care Manager
• Notify their Care Manager should any problem occur or if they are dissatisfied with the services being provided
• Follow health plan rules and/or those rules of Institutional or residential settings (including any applicable cost share)

MLTSS Patient Pay Liability
The Division of Medical Assistance and Health Services (DMAHS), through the County Welfare Agency (CWA), is in charge of making decisions about patient pay liability. DMAHS will tell Amerigroup about any patient pay liability amounts owed. Except for cost-sharing and patient pay liability, Amerigroup will make sure members don’t pay for services they are not responsible for.

Collection of Patient Pay Liability
If members have pay liability amounts that they owe, here is how it will be collected:
• For members who live in nursing facilities (NFs), special care nursing facilities (SCNFs) or community-based residential alternatives, Amerigroup will have the providers in these facilities collect patient pay liability.
• Amerigroup will pay these facilities the balance of the amount that applies.
• The patient pay liability amount applied to the claim will be shown on your Explanation of Payment.

Nonpayment of Patient Pay Liability
Upon notice from the nursing facility/community-based residential provider that the patient pay liability has not been paid, the Care Manager will help by:
• Looking at the efforts made by nursing facility/community-based residential provider to collect the patient pay liability and documenting this in a member’s electronic medical record
• Stressing the importance of paying the patient pay liability and what happens if the member does not, including letting the Office of Community Choice Options know if the provider wants to pursue an Involuntary Transfer and documenting this in a member’s case file

Upon notice from the nursing facility/community-based residential provider that the facility/provider is thinking about an Involuntary Discharge (per NJAC 8:85) due to nonpayment, the Care Manager will work to find an another nursing facility/residential provider for. These efforts will be documented in the member’s case file.

If a member is in a NF or SCNF and the Care Manager can’t find another NF/SCNF for, the Care Manager
will:
- Determine if needs can safely and cost-effectively be met in the community by doing a transition assessment
- Find out if the provider is willing to continue serving a member who has failed to pay his or her patient pay liability

If a member lives in Assisted Living or Adult Family Care and the Care Manager can’t find an alternate community-based residential provider that will serve the member, Amerigroup will submit a request to DMAHS for guidance.

**MLTSS Care Management**

Our MLTSS Care Management model promotes cross-functional collaboration in the development of a member’s Plan of Care. Members enrolled in MLTSS receive service coordination and are provided individualized services to support their behavioral, social, environmental, and functional and health needs. MLTSS nurses and Care Managers accomplish this by screening, assessing, and developing targeted and tailored member interventions while working collaboratively with the member, practitioner, provider, caregiver and natural supports.

Since many Amerigroup members have complex needs that require services from multiple providers and systems, gaps may occur in the delivery system serving these members. These gaps can create barriers to members receiving optimal care. Our service coordination model helps reduce these barriers by identifying the unmet needs of members and assisting them to find solutions to those needs. This may involve coordination of care, assisting members in accessing community-based resources, providing disease-specific education, or any of a broad range of interventions designed to improve the quality of life and functionality of members and to make efficient use of available healthcare and community-based resources.

The scope of the MLTSS Care Management Model includes but is not limited to:
- Initial and ongoing assessment identifying the needs of member populations and relevant sub-populations
- Annual reassessments to identify any change in member’s status and potential modifications to the Plan of Care. Problem-based, comprehensive service planning to include measurable prioritized goals and interventions tailored to the complexity level of the member as determined by the initial and reassessments
- Coordination of care with PCPs and specialty providers
- A service coordination approach that is “member-centric” and provide support, access, and education along the continuum of care
- A Plan of Care that is personalized to meet a member’s specific needs and identifies:
  - Prioritized goals
  - Time frames for re-evaluation
  - Resources to be utilized including the appropriate level of care
  - Planning for continuity of care and family participation
- Obtaining member/family/caregiver input and level of participation in the creation of a Plan of Care which includes the development of self-management strategies to increase the likelihood of improved health and outcomes.
Discharge to the Community
Amerigroup assists with discharge planning, either to the community or through a transfer to another facility, if the member or responsible party so requests. If the member or responsible party requests a discharge to the community, the MLTSS Care Manager will:

- Collaborate with the facility Social Worker to convene a planning conference with the nursing facility/special care nursing facility staff to identify all potential needs in the community
- Facilitate a home visit to the residence where the member intends to move to assess environment, durable medical equipment (DME) and other needs upon discharge
- Convene a discharge planning meeting with the member and family, using the data complied through discussion with the nursing facility/special care nursing facility staff as well as home visit, to identify member preferences and goals
- Involve and collaborate with community originations such as Centers for Independent Living (CILs) or Area Agencies on Aging (AAAs) in this process to assist members as they transition to the community

Finalize and initiate execution of the transition plan. Although our member-centric approach is driven by the member, the transition implementation is a joint effort between the nursing facility/special care nursing facility and the Amerigroup MLTSS Care Manager.

Money Follows the Person
The Money Follows the Person (MFP) demonstration program not only allows residents to receive Home and Community Based Services (HCBS) in the community but also enhanced services that allow for payment of rent and utility deposits and reasonable expenses to re-establish a residence in lieu of continued institutional care. Additional information about the program can be found on the New Jersey Department of Human Services website at http://www.state.nj.us/humanservices/ddd/programs/olmstead/mfp.html.

MFP funding is available to members who meet the functional criteria for one of the following HCBS waivers:
- Frail Elderly
- Physically Disabled
- Traumatic Brain Injury

To be eligible for this program, a member must meet the following criteria:
- Be a current resident of a nursing facility (NF) with a 90-day continuous stay (the 90 days cannot include Medicare skilled rehabilitation days).
- Be Medicaid-eligible 30 days prior to receiving MFP services.
- Meet the clinical level of care eligibility for the MLTSS program.
- Have an interest in transitioning back into the community.

All MFP services require prior authorization (PA) through the Plan of Care (POC) process.
Some Services Offered Under the MFP Demonstration
In addition to the above services, the MFP demonstration has additional services and funding available to address barriers to successful transition of individuals to community based settings rather than institutional settings (not a complete list):
• Transition services
• Transition Coordination Service
• Therapeutic Support (TBI only)
• Options Counseling for Community Transitions

Claim Submission and Adjudication Procedures
You have the option of submitting claims electronically or by mail. Providers must submit claims within 180 days from the date of discharge for inpatient services or from the date of service for outpatient services.

Electronic Submission
We encourage you to submit claims electronically, as you will be able to:
• Submit claims either through a clearinghouse or directly to us
• Receive payments quickly
• Eliminate paper
• Save money

Clearinghouse Submission
You can submit electronic claims through Electronic Data Interchange (EDI). You must submit claims within 180 calendar days from the date of discharge for inpatient services or from the date of service for outpatient services. You can submit claims through:
• Emdeon (formerly WebMD) – Claim Payer ID 27514
• Capario (formerly MedAvant) – Claim Payer ID 28804
• Availity (formerly THIN) – Claim Payer ID 26375

An EDI claims submission guide is located at https://providers.amerigroup.com.

Website Submission (Participating Providers Only)
Submit claims on our website by:
• Entering claims on a preformatted CMS-1500 and CMS-1450 claim template
• Uploading a HIPAA-compliant ANSI 837 5010 claim transaction

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

Paper Claims Submission
You must submit a properly completed CMS-1450 or CMS-1500 (08-05) claim form:
• On the original red claim forms (not black and white or photocopied forms)
• Laser printed or typed (not handwritten)
• In a large, dark font
Paper claims must be submitted within 180 days of the last date of service of the course of treatment to the following address:

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

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

- Cases of coordination of benefits (COB). COB claims must be submitted within 60 days from the date of the primary insurer’s Explanation of Benefits (EOB) or 180 days from the dates of service, whichever is later.
- Cases where a member has retroactive eligibility. In situations of enrollment in Amerigroup with a retroactive eligibility date, the time frames for filing a claim will begin on the date that Amerigroup receives notification from the enrollment broker of the member’s eligibility/enrollment.

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

- Patient’s ID number
- Patient’s name
- Patient’s date of birth
- ICD-10 diagnosis code/revenue codes
- Date of service
- Patient’s date of birth
- Place of service
- Procedures, services or supplies rendered CPT-4 codes/HCPCS codes/DRGs
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- Billing provider information
- NPI of billing and rendering provider when applicable
- COB/other insurance information
- Precertification number or copy of precertification
- Name of referring physician
- NPI/API
- NDC, unit of measure and quantity for medical injectables
- Any other state-required data

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

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

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

You must submit encounter data up to one year from date of service:

- EDI submission methods
- CMS-1500 (08-05) claim form
- Other arrangements that are approved by Amerigroup

Include the following:

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

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

- Training
- Follow-up audits
- Even termination

**Claims Adjudication**

We are dedicated to providing timely adjudication of claims. We process all claims according to generally accepted claims coding and payment guidelines defined by the CPT-4 and ICD-10 Manuals, or successor versions.

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

We reserve the right to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure.

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

- Submit claims within 180 days from the last date the service is rendered in a course of treatment or for inpatient claims filed by a hospital within 180 days from the date of discharge.
- Submit the claim within 180 days of receiving a response from the third-party payer in cases of other insurance.
• Submit claims for members whose eligibility has not been added to the state’s eligibility system within 180 days from the date the eligibility is added and we are notified of the eligibility/enrollment.
• Submitted claims after the 180-day filing deadline will be denied.

After filing a claim with us, review the weekly Explanation Of Payment (EOP). If the claim does not appear on an EOP within 30 business days as adjudicated or you have no other written indication that the claim has been received, check the status of your claim on our provider website or by calling Provider Services at 1-800-454-3730. If the claim is not on file with us, resubmit your claim within 180 days from the date of service. If filing electronically, check the confirmation reports for acceptance of the claim that you receive from your EDI or practice management vendor.

We adjudicate claims in accordance with the New Jersey regulatory requirements.

Clean Claims Payment
A clean claim is a request for payment for a service rendered by a provider that:
• Is submitted on time
• Is accurate
• Is submitted on a HIPAA-compliant standard claim form (CMS-1500 or CMS-1450 or successor forms)
• Requires no further information, adjustment or alteration to be processed and paid
• Is not under review for medical necessity
• Note: Claims from providers under investigation for fraud or abuse are not subject to prompt pay timelines.

If we do not pay the claim within that time frame, we will pay all applicable interest as required by law.

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

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

We will adjudicate and pay clean claims appropriately from practitioners, either in individual or group practice or who practice in shared health facilities, in accordance with state requirements. Days are calculated from receipt date to date of payment. The date of receipt is the date we receive the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

Claims Status
You can check claims statuses by going to our website or by calling our Provider Inquiry Line at 1-800-454-3730. You can also use the claims status information for accepted and rejected claims that were submitted through a clearinghouse.
If we do not have the claim on file, resubmit your claim within the timely filing requirements. If filing electronically, check the confirmation reports for acceptance of the claim that you receive from your EDI or practice management vendor.

**Provider Reimbursement**

**Electronic Funds Transfer and Electronic Remittance Advice**

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

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

Some of the benefits providers may experience include:

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

To register for ERA/EFT, please visit our provider website.

**PCP Reimbursement**

We reimburse PCPs according to their contractual arrangement.

**Specialist Reimbursement**

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

Specialty care providers will obtain PCP and Amerigroup approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized by the PCP’s referral or beyond the scope of self-referral permitted under this program.

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

**Overpayment Process**

Refund notifications may be identified by two entities, Amerigroup and its contracted vendors or the Providers. Amerigroup researches and notifies the provider of an overpayment requesting a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.
Once an overpayment has been identified by Amerigroup, Amerigroup will notify the provider of the overpayment. The overpayment notification will include instructions on how to refund the overpayment.

If a provider identifies an overpayment and submits a refund, a completed Refund Notification Form specifying the reason for the return must be included. This form can be found on the provider website at https://providers.amerigroup.com. The submission of the Refund Notification Form will allow Cost Containment to process and reconcile the overpayment in a timely manner. For questions regarding the refund notification procedure, please call Provider Services at 1-800-454-3730 and select the appropriate prompt.

In instances where we are required to adjust previously paid claims to adhere to a new published rate, we will initiate a reconciliation of the affected claims. As such, we will determine the cumulative adjusted reimbursement amount based on the new rates. In the event the outcome of this reconciliation results in a net amount owed to us, we will commence recovery of such amounts through an offset against future claims payments. Such recoveries are not considered part of the overpayment recovery process described above or in the provider agreement.

Changes addressing the topic of overpayments have taken place with the passage of the Patient Protection and Affordable Care Act (PPACA), commonly known as the Healthcare Reform Act or Affordable Care Act.

The provision directly links the retention of overpayments to false claim liability. The language of 42 U.S.C.A. § 1320a-7k makes explicit that overpayments must now be reported and returned to states or respective MCOs within 60 days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the False Claims Act, including treble damages. In order to avoid such liability, health care providers and other entities receiving reimbursement under Medicare or Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the PPACA.

The provision entitled “Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments,” codified at 42 U.S.C.A. § 1320a-7k, clarifies the uncertainty left by the 2009 Fraud Enforcement and Recovery Act. This provision of the HealthCare Reform Act applies to providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations and Medicare Prescription Drug Program sponsors. It does not apply to beneficiaries.

Provider Payment Disputes
For information related to provider payment disputes, refer to Section 13.9 of this Provider Manual.

Critical Incident Reporting and Management
We have a critical incident reporting and management system for incidents that occur in a home and community-based long term care services and supports delivery setting.

We will identify and track critical incidents and shall review and analyze critical incidents to identify and address potential and actual quality of care and/or health and safety issues. We will regularly:
- Review the number and types of incidents (including, for example, the number and type of incidents across settings, providers and provider types)
- Review the findings from investigations (including findings from APS and CPS if available)
- Identify trends and patterns
- Identify opportunities for improvement
- Develop and implement strategies to reduce the occurrence of incidents and improve the quality of HCBS

Critical incidents include the following incidents when they occur in a home and community based setting:
1. Unexpected death of a member
2. Media Involvement or the potential for media involvement
3. Physical abuse (including seclusion and restraints both physical and chemical)
4. Psychological/verbal abuse
5. Sexual abuse and/or suspected sexual abuse
6. Fall resulting in the need for medical treatment
7. Medical emergency resulting in need for medical treatment
8. Medication error resulting in serious consequences
9. Psychiatric emergency resulting in the need for medical treatment
10. Severe injury resulting in the need from medical treatment
11. Suicide attempt resulting in need for medical attention
12. Neglect Mistreatment, caregiver (paid or unpaid)
13. Neglect/Mistreatment, self
14. Neglect mistreatment, other
15. Exploitation, financial
16. Exploitation, theft
17. Exploitation, destruction of property
18. Exploitation, other
19. Theft with law enforcement involvement
20. Failure of member’s back-up plan
21. Elopement/wandering from home or facility
22. Inaccessible for initial/on-site meeting
23. Unable to contact
24. Inappropriate or unprofessional conduct by a provider involving member
25. Cancellation of utilities
26. Eviction/loss of home
27. Facility closure, with direct impact to member’s health and welfare
28. Natural disaster, with direct impact to member’s health and welfare
29. Operational breakdown
30. Other

Providers must report critical incidents to Amerigroup in accordance with applicable requirements. The maximum time frame for reporting an incident to Amerigroup is 24 hours. The initial report of an incident within 24 hours may be submitted orally, in which case the person/agency/entity making the initial report will submit a follow-up written report within 48 hours.
Suspected abuse, neglect and exploitation of members who are adults must be immediately reported to the appropriate state, county or local authorities. Suspected brutality, abuse or neglect of members who are children must also be immediately reported to the appropriate state, county or local authorities.

Providers must immediately (i.e., within 24 hours) take steps to prevent further harm to any and all members and respond to any emergency needs of members.

MLTSS providers with a critical incident must conduct an internal critical incident investigation and must submit a report on the investigation. The time frame for submitting the report on the investigation:

- Must be as soon as possible
- May be based on the severity of the incident
- Will be no more than 30 days after the date of the incident except under extenuating circumstances

Amerigroup will review the provider’s report and follow-up with the provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable time frames.

Providers must cooperate with any investigation conducted by Amerigroup or outside agencies (e.g., Department of Human Services, Adult Protective Services, Child Protective Services and law enforcement).

For members participating in self-directed services, we will:

- Review all of the Fiscal Intermediary’s (FI) reports regarding investigations of critical incidents and follow-up with the FI as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable time frames.
- Provide appropriate training and take corrective action as needed to ensure staff, contract HCBS providers, the FI-EA and workers comply with critical incident requirements.
- Conduct oversight, including oversight of staff, contract HCBS providers and the FI-EA to ensure the Amerigroup policies and procedures are being followed and necessary follow-up is being conducted in a timely manner.

**Unable to Contact**

Amerigroup requires that all MLTSS providers develop and implement a policy and process for addressing situations where the provider and its staff are unable to contact a member. “Unable to contact” shall be defined as an MLTSS member who is absent, without notification, from any program or service offered under MLTSS and Amerigroup, its staff members, including Care Managers, or its contracted MLTSS providers are unable to identify the location of the Member using contact information available in the member’s Care Management record. If an MLTSS member is unable to be contacted for 30 days or more, that member will then be disenrolled from the MLTSS program.
**Elder Abuse**
Older adults and those adults with disabilities want to live independently. They need to be safe and as independent as possible. Many cannot depend upon or trust those nearest to them. Those they love the most may abuse them.

It is not only your moral and ethical obligation to report elder abuse but also your legal obligation.

The types of adult abuse include:
- **Neglect** occurs when the basic needs of a dependent adult are not met by a caregiver. Neglect may be unintentional, resulting from the caregiver’s lack of ability to provide or arrange for the care or services the adult requires. Neglect also may be due to the intentional failure of the caregiver to meet the adult's needs.
- **Self-neglect** occurs when a dependent adult is unable to care for him/her or to obtain needed care. The impairments result in significant danger to the adult, and in some situations, deterioration can occur to the point that the adult’s life may be at risk.
- **Abuse (physical, sexual and emotional)** generally involves more extreme forms of harm to the adult, including the infliction of pain, injury, mental anguish, unreasonable confinement or other cruel treatment.
- **Financial exploitation** occurs when a caregiver improperly uses funds intended for the care or use of the adult. These are funds paid to the adult or to the caregiver by a governmental agency.

In order to report abuse, please contact the New Jersey Department of Human Services, Adult Protective Services which serves adults age 18 or older who are abused, neglected or financially exploited and unable to protect themselves due to mental or physical disabilities or advanced age.

**Claims Payments**
If a provider has more than one location, payments are made only to the location they indicated as their primary location.
6 MEMBER RIGHTS AND RESPONSIBILITIES

6.1 Member Rights

Members have rights and responsibilities when participating with a managed care organization (MCO). Our Member Services representatives serve as advocates for our members. The following lists the rights and responsibilities of members:

Members have the right to:
• Receive a current directory of doctors and other providers within the Amerigroup network that includes addresses, telephone numbers and a list of providers that accept members who speak languages other than English
• Choose any of our Amerigroup network specialists; members need to get a referral from their primary care provider (PCP) first; the referral is based on whether the specialist can take new patients; some services do not need a referral
• Be referred by their PCP to get care from a specialist who has treated chronic disabilities
• Be able to get in touch with their PCP or a backup PCP 24 hours a day, 365 days a year for urgent care; this information is on the member ID card
• Call 911 without getting an OK from Amerigroup if they have an emergency medical condition; this information is on the member ID card
• Talk with their doctors about all medical treatments they can have, even if they are not covered; they may also get information on treatment they can have or other care options; this includes anything listed in the clinical guidelines
• File a complaint or appeal with Amerigroup or the state
• Be treated with respect and dignity
• Have information about Amerigroup, our services, policies and procedures, network providers, member rights and responsibilities, and any changes made
• Refuse treatment to the extent of the law and be aware of the results; this includes the right to refuse to be part of research.
• Have an advance directive in effect
• Expect their records and communications will be kept confidential; they will not be given to anyone unless they allow it
• Choose their own PCP in the Amerigroup network, choose a new network PCP and have privacy when seeing their providers
• Have a choice of specialists and receive information on how to obtain referral to a specialist or other provider, like an eye doctor
• Have their medical information given to a person they choose, or have it given to a person who is legally authorized, when concern for their health makes it inadvisable to give such information to them
• Get help from someone who speaks their language or through a TTY line
• Be free from being billed by providers for covered services that are medically necessary and were authorized by Amerigroup, unless there is a copayment
• Offer suggestions for changes in the way Amerigroup does business
• Be free of hazardous procedures
• Be fully informed by their PCP, care/case manager or other Amerigroup network providers and help make decisions about their health care
• Take part in developing and implementing a plan of care that promotes the best results for them and encourages independence
• Have services that promote quality of life and independence; Amerigroup wants to help keep and encourage their natural support systems
• Have a doctor be the one to decide if their coverage is to be denied or limited
• Voice complaints about Amerigroup or the care provided and recommend changes to policies and services to Amerigroup staff, providers and outside representatives of their choice free of limits, interference, force, discrimination or attack by Amerigroup or our providers
• Right to refuse care from specific providers free of restraint, interference, coercion, discrimination or reprisal by the plan or its providers
• Have access to their medical records in accordance with federal and state laws
• Be free from harm, including unnecessary physical restraints or isolation, excessive medication, physical or mental abuse, or neglect
• Make recommendations regarding the member rights and responsibilities policy
• Receive a second opinion if wanted

Amerigroup and its providers shall not discriminate against an enrollee or attempt to disenroll a member for filing a complaint or grievance/appeal against the HMO.

**Members have the right to receive the following information each year:**
• Member rights and responsibilities
• Amerigroup benefits and services and how to get these benefits and services
• Provisions for after-hours and emergency coverage
• Charges to members, if charges apply, including:
  o How to pay charges
  o Copayments and fees
  o What to do if they get a bill for services
• Termination of or changes in benefits, services, health care facilities or providers
• How to appeal decisions that affect their coverage, benefits or relationship with Amerigroup
• How to change PCPs
• How to disenroll from Amerigroup
• How to file a grievance and how to recommend changes they think Amerigroup should make
• The percentage of Amerigroup network providers who are board-certified
• A description of:
  o How to get services, including authorization requirements
  o Any special benefit rules that may apply to services they get outside of the Amerigroup network
  o How to get services covered by fee-for-service Medicaid
  o How to get out-of-area coverage
  o Policies on referrals for specialty and ancillary care
6.2 Member Responsibilities

Amerigroup members have the responsibility to:

- Let their family doctor know as soon as possible after they get emergency treatment
- Treat their doctors and their staffs and Amerigroup employees with respect and dignity
- Get information and consider treatments before they are done
- Discuss any problems about following their doctor’s directions
- Know what refusing treatment recommended by a doctor can mean
- Help their family doctor get their medical records from the doctor they had before; they should help their doctor fill out their new record as well
- Get permission from their family doctor or the doctor’s associates before seeing a consultant or specialist; they should also get permission from their doctor before going to the emergency room unless they have an emergency
- Call Amerigroup and change their doctor before seeing a new doctor
- Keep following Amerigroup policies and procedures until they are disenrolled
- Make and keep appointments and be on time; always call if they need to cancel an appointment or if they will be late
- State their complaints, concerns and opinions in an appropriate and courteous way
- Learn and follow the policies and procedures outlined in their member handbook
- Tell their doctor who they want to be told about their health
- Become involved in their health care; they should work with their doctor about recommended treatment; they must then follow the plans and instructions for care that they have agreed upon with their provider
- Carry their Medicaid and Amerigroup ID card at all times; they should report any lost or stolen cards to Amerigroup as soon as they can; also, contact Amerigroup if information on their card is wrong or if they have changes in name or address
- Provide, to the extent possible, information needed by Amerigroup, their doctor and professional staff in caring for them, including the names of any doctors they are currently seeing

6.3 Member Grievance Procedure

The member (or provider acting on behalf of a member, with the member’s written consent) has a right to voice dissatisfaction of any aspect of the Amerigroup or a provider’s operations. Providers cannot file a grievance on behalf of a member unless the member has granted the provider written permission to act as his or her personal representative.

A grievance may be filed for any cause other than adverse medical management action or interpretation of medically necessary benefits to deny, reduce, terminate, delay or suspend a covered service, as well as any other acts or omissions of Amerigroup which impair the quality, timeliness or availability of such benefits.

A member will not be penalized for filing a grievance. At no time will Amerigroup cease care pending a grievance investigation.
Member Grievance Resolution
The member (or provider acting on behalf of a member, with the member’s written consent) may file a grievance by fax, mail, in-person or by telephone to Member Services at 1-800-600-4441 (TTY 711). The mailing address is:

Quality Management Department
Amerigroup Community Care
101 Wood Ave. South, Eighth Floor
Iselin, NJ 08830

Member grievances are kept confidential to the extent permissible under federal or state laws, regulations and/or contractual requirements.

A member may receive assistance from the State with a grievance by writing to the following address:
NJ Medicaid/NJ FamilyCare
P.O. Box 712
Trenton, NJ 08625-0712

For dental grievances and appeals:
A member, or provider with the member’s written consent, may call Healthplex Member Services at 1-888-468-2183 or write to the following address:

Grievances and Appeals
Healthplex of New Jersey, Inc.
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553

Level I Grievance Review
Upon receipt of a Level I grievance, supporting documentation may be requested by Amerigroup. This may include consultation with the member and/or providers, review of medical records, or other relevant documents and discussions with other persons having knowledge of the issue. A Level I grievance acknowledgement letter will be sent to the member within five business days of the initiation of the grievance. A resolution letter will be sent to the member and provider if the provider requests the grievance on the member’s behalf within 30 calendar days from the time of the initiation of the grievance. Also, the member will be notified in writing of his or her right to a Level II grievance review.

Level II Grievance Review
If the member (or provider acting on behalf of a member, with the member’s written consent) expresses dissatisfaction with the Level I grievance resolution, he or she can request a Level II grievance review within 60 days of the date of the Level I grievance resolution letter.

A Grievance Acknowledgement Letter will be sent to the member within five business days of the initiation of the Level II grievance. The Quality Management associate will consult with pertinent department heads (QM, Provider Services, and Medical Director) and members of senior staff that were not involved in the review or decision of the original grievance as necessary to address the member's concern.
A Level II grievance resolution letter will be sent to the member and provider, if the provider requests the grievance on the member’s behalf, within 30 calendar days from receipt of the Level II grievance.

6.4 Member Appeal Procedure

Amerigroup has established and maintains a procedure approved by DMAHS for the resolution of appeals initiated by the member (or provider acting on behalf of a member, with the member’s written consent) with respect to utilization management determinations resulting in a denial, termination or limitation of health care (to include dental) services. No member who exercises the right to file an appeal will be subject to disenrollment or otherwise penalized due to such an appeal.

Members have the right to two levels of appeal — one internal and one external. Notwithstanding any contract provisions contained in the Provider Agreement that state otherwise, the guidance provided herein is the medical appeal process that is effective July 1, 2017.

Internal Appeal Procedure

The member (or provider acting on behalf of a member, with the member’s written consent) may request an appeal in writing within 60 days from the date of the initial adverse benefit determination. A member may request an appeal verbally or in writing. If an appeal is requested verbally, it must be followed up by a written, signed appeal (with the exception of expedited appeals, which do not require written follow-up). If a member initiates an appeal without clinical information, Amerigroup will assist the member by requesting pertinent medical records. Written appeals are to be mailed to:

Quality Management Department
Amerigroup Community Care
101 Wood Avenue South, 8th Floor
Iselin, NJ 08830

Internal appeals will be resolved within 30 calendar days or less in accordance with the medical exigencies of the case (including all situations in which the member is confined as an inpatient).

The expedited appeal is a request to change an adverse determination for urgent care. An urgent care request is any request for medical care or treatment with respect to which the application of the time period for making an appeal determination could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function or would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. Expedited internal appeals are resolved as soon as possible in accordance with the medical exigencies of the case, which under no circumstances shall exceed 72 hours in the case of appeals from determinations regarding urgent or emergent care, an admission, availability of care, continued stay, health care services for which the member received emergency services but has not been discharged from a facility. The resolution time frame may be extended if requested by the member (or provider acting on behalf of a member, with the member’s written consent), or by Amerigroup if justified that additional information is needed and this is in the member’s best interest and the member voluntarily agrees to the extension. We will orally deliver initial notice of the decision to the member and provider followed by written notice of the decision.
A physician with appropriate clinical experience in treating the member’s condition or disease and/or a physician peer reviewer who was not involved in the initial determination and is not a subordinate of the original reviewer shall make the final determination in all adverse determinations. Additionally, any provider acting on behalf of a member with the member’s written consent will have the opportunity to speak with the medical director and/or health care professional that rendered the decision. Upon request, the member (or provider acting on behalf of a member, with the member’s written consent), will be provided with the clinical criteria relied upon to make the determination and may also obtain a copy of the medical records relating to the appeal free of charge.

If the internal appeal is denied, Amerigroup will communicate this in writing to the member (or provider acting on behalf of a member, with the member’s written consent), and will advise of the right to proceed to an external appeal, and will include the Independent Health Care Appeals Program (IHCAP) filing form, and the right for NJ FamilyCare A and NJ FamilyCare ABP members to request a Fair Hearing.

The external appeal process is limited to determinations regarding medical services and does not apply to: personal care services (PCA); adult family care; assisted living program; assisted living services (when the denial is not based on medical necessity); caregiver/participant training; chore services; community transition services; home based supportive care; home delivered meals; respite care; social day care; structured day program (when the denial is not based on medical necessity); and supported day services (when the denial is not based on the diagnosis of traumatic brain injury [TBI]). Amerigroup will notify the member (or provider acting on behalf of a member, with the member’s written consent) in writing of the right to proceed to a Fair Hearing as the next level of appeal.

**External Appeal Procedure**

The member (or provider acting on behalf of a member, with the member’s written consent) must comply with the internal appeal process before submitting an external appeal to the Independent Health Care Appeals Program (IHCAP), which will be conducted by an Independent Utilization Review Organization (IURO) and administered by the New Jersey Department of Banking and Insurance (DOBI).

An appeal to the IHCAP must be submitted in writing and made within 60 days following the date of receipt of the internal appeal determination from Amerigroup. IHCAP submissions must include the following information:

- A copy of the internal appeal final written decision from Amerigroup
- A copy of the summary health coverage from the member handbook
- Copies of all pertinent medical records and correspondence to be reviewed by the IURO
- The filing fee for providers filing on behalf of a New Jersey Medicaid/NJ FamilyCare member is $25.00 and is payable to the New Jersey DOBI (Amerigroup will assume any additional costs related to the IURO review.)
- Providers that file on behalf of the member must attach a copy of the signed and dated member consent
- The appeal must be submitted using the IHCAP filing form included with the internal appeal denial response or available on the New Jersey DOBI website: [www.state.nj.us/dobi/managed.htm](http://www.state.nj.us/dobi/managed.htm) to:
  
  New Jersey Department of Banking and Insurance  
  Office of Managed Care  
  P.O. Box 329  
  Trenton, NJ 08625-0329

Amerigroup will submit copies of all pertinent medical records along with the medical record release signed by the member and correspondence for review by the IURO.

The IURO will complete its review within 45 calendar days of receipt of all documentation necessary for the review and issue its decision as soon as possible in accordance with the medical exigencies of the case. The IURO may extend its review for a reasonable period of time due to circumstances beyond its control. If this is necessary, the IURO will notify the member (or provider acting on behalf of a member, with the member’s written consent) DOBI and Amerigroup in writing prior to the conclusion of the review, specifying the reasons for the delay.

For appeals involving care for an urgent case, the IURO shall complete its review within no more than 48 hours following its receipt of the appeal.

The IURO’s determination is binding and will convey its decision to both the member and Amerigroup. Amerigroup will promptly provide coverage for the health care services found by the IURO to be medically necessary and will notify the IURO, member (or provider acting on behalf of a member, with the member’s written consent) and DOBI, acceptance of the decision within 72 hours.

**Fair Hearing**

NJ FamilyCare A and NJ FamilyCare ABP members have the right to a Fair Hearing. The internal appeal process must be completed prior to the initiation of the Fair Hearing process. Neither NJ FamilyCare B, C or D members nor providers have the right to request a Fair Hearing.

The Fair Hearing must be requested within 120 days from the date of the notice of decision. The member has the right to represent himself or herself or to be represented by legal counsel, friend or other spokesperson. The department’s Fair Hearing decision is binding on Amerigroup. Fair Hearing requests are to be submitted in writing to:

State of New Jersey  
Division of Medical Assistance and Health Services  
Fair Hearing Unit  
P.O. Box 712  
Trenton, NJ 0865-0712

**6.5 Grievance Tracking and Reporting**

Grievances will be tracked and trended by the Quality Management department. Records will include, but information is not limited to:

- The date the grievance was filed
- The dates and outcomes of all actions and findings
• The date and decision of any grievance proceeding
• The dates and proceedings of any litigation
• All letters and documentation submitted regarding the grievance

The Quality Management department will maintain grievance records and keep them readily available for state inspection.

6.6 Continuation of Benefits

Amerigroup will automatically continue provision of services while the internal or external appeal or Fair Hearing is being reviewed when all of the following are met:
• The appeal involves the termination, suspension or reduction of a previously authorized course of treatment
• The services were ordered by an Amerigroup network provider
• The appeal is received timely on or before the final day of the previously approved authorization or within 10 calendar days from the date of the adverse benefit determination, whichever is later

For those eligible members who have requested a Fair Hearing, continuation of benefits must be requested in writing within 10 calendar days from the date of the denial letter or prior to the intended effective date of the HMO proposed action, whichever is later. Provision of services will be discontinued if the member withdraws the appeal or Fair Hearing request.

If determination of the medical appeal is in the member’s favor, we will authorize coverage and arrange for services promptly and as expeditiously as the member’s health condition requires and will pay for previously denied services. If the determination is not in the member’s favor, the member may be liable for the cost of the services.

6.7 First Line of Defense Against Fraud, Waste and Abuse

We are committed to protecting the integrity of our health care program and the effectiveness 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.

As the recipient of funds from federal and state-sponsored health care programs, we have a duty to help prevent, detect and deter fraud, waste and abuse. We have outlined our commitment to this in our Corporate Compliance Program.
False Claims Act
We are committed to complying with all applicable federal and state laws, including the federal False Claims Act (FCA). The FCA is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for 3 times the damages or loss to the government, plus civil penalties of $5,500 to $11,000 per false claim. The FCA also contains Qui Tam or “whistleblower” provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government, or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.

Employee Education about the False Claims Act
As a requirement of the Deficit Reduction Act of 2005, contracted providers who receive Medicaid payments of at least 5 million dollars (cumulative from all sources), must comply with the following:

• Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).

• Include as part of such written policies detailed provisions regarding policies and procedures for detecting and preventing fraud, waste, and abuse.

• Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, waste, and abuse.

As part of the requirements of the Federal Deficit Reduction Act of 2005, you are required to adopt our policies on this. You can find our policies and our Code of Business Conduct and Ethics at https://providers.amerigroup.com.

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

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

Provider Fraud, Waste and Abuse
• Billing for services not rendered
• Billing for services that were not medically necessary
• Double billing
• Unbundling
• Upcoding

To help prevent fraud, waste and abuse, make sure your services are:
• Medically necessary
• Documented accurately
• Billed according to guidelines
Member Fraud, Waste and Abuse
• Benefit sharing
• Collusion
• Drug trafficking
• Forgery
• Illicit drug seeking
• Impersonation fraud
• Misinformation/misrepresentation
• Subrogation/third-party liability fraud
• Transportation fraud

To help prevent member fraud, waste and abuse:
• Educate members
• Be observant
• Spend time with members and review their prescription record
• Review their Amerigroup member ID card
• Make sure the cardholder is the person named on the card
• Encourage members to protect their cards, like credit cards, or cash
• Encourage them to report any lost or stolen card to us immediately

We have several ways for you, your staff and our members to report any suspected fraud, waste and abuse by:
• Visiting our website, www.myamerigroup.com, and selecting the link for Reporting Waste, Fraud and Abuse.
• Calling our national customer service line at 1-800-600-4441 (TTY 711).
• Calling our Special Investigations Unit (SIU) fraud hotline at 1-866-847-8247.
• Sending an email directly to the Amerigroup Special Investigation Unit at medicaidfraudinvestigations@anthem.com. This email address is checked every business day.

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

There are other additional New Jersey State requirements related to fraud, waste and abuse. For additional details on these requirements, please see information located at the following Department of Human Services website: www.state.nj.us/humanservices/ddd/documents/ddd%20web%20current/CIRCULARS/DC54.pdf.

You can also make a report directly to the State of New Jersey. If you suspect Medicaid fraud, waste or abuse, call the New Jersey Medicaid Fraud Division’s hotline at 1-888-937-2835 toll free.

6.8 HIPAA

The Health Insurance Portability and Accountability Act (HIPAA):
• Improves the portability and continuity of health benefits
• Provides greater patient rights to access and privacy
• Ensures greater accountability in health care fraud
• Simplifies the administration of health insurance

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

We only request the minimum member information necessary to accomplish our purpose. Likewise, you should only request the minimum member information necessary for your purpose. However, regulations do allow the transfer or sharing of member information to:
• Conduct business and make decisions about care
• Make an authorization determination
• Resolve a payment appeal

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

You should maintain fax machines used for transmitting and receiving medically sensitive information in a restricted area. When faxing information to us, please:
• Verify the receiving fax number
• Notify us you are faxing information
• Verify that we received your fax

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

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

When contacting us, be prepared to verify your:
• Name
• Address
• NPI number
• TIN
• Amerigroup provider number

The following language must be included at the bottom of all communications containing member PHI:

Important Note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or have enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.
7.1 Welcome Call

We give new members a welcome call to:
- Educate them about our services
- Help them schedule initial checkups
- Identify any health issues (e.g., pregnancy or previously diagnosed diseases)

7.2 Appointment Scheduling

Through our participating providers, we ensure members have access to primary care services for routine, urgent and emergency services and to specialty care services for chronic and complex care. Providers will respond to our member’s needs and requests in a timely manner. The PCP should make every effort to schedule our members for appointments using the guidelines outlined in Section 7 – PCP Access and Availability.

7.3 Nurse HelpLine

Our Nurse HelpLine is a service designed to support the provider by offering information and education about medical conditions, health care and prevention to members after normal physician practice hours. The Nurse HelpLine provides triage and crisis management services and helps direct members to appropriate levels of care. The Nurse HelpLine telephone number is 1-800-600-4441 (TTY 711). This information is listed on the member’s ID card to ensure members have an additional avenue of access to health care information when needed. Features of the Nurse HelpLine include:
- Availability 24 hours a day, 7 days a week
- Information provided is based upon nationally recognized and accepted guidelines
- Free translation services for 170 different languages and for members with difficulty hearing
- Education for members about appropriate alternatives for handling nonemergent medical conditions
- A nurse faxes the member’s assessment report to the provider’s office within 24 hours of receipt of the call

7.4 Interpreter Services

Interpreter services are available if needed. Over-the-telephone interpreter services are available 24 hours a day, 7 days a week. For in-office interpreter services, call our Provider Services line at 1-800-454-3730 to arrange for the service.

7.5 Health Promotion

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

We manage projects that offer our members education and information regarding their health. Ongoing projects include:

- Our annual member newsletter
- Creation and distribution of Ameritips, our health education tools used to inform members of health promotion issues and topics
- Health Tips on Hold (educational telephone messages while the member is on hold)
- A monthly calendar of health education programs offered to members
- Development of health education curricula and procurement of other health education tools (e.g., breast self-exam cards)
- Relationship development with community-based organizations, faith-based organizations, schools, local businesses, special needs organizations and health centers to enhance opportunities for members

7.6 Care Management

We have a comprehensive program to meet our members’ needs when they are pregnant or have conditions or diagnoses that require ongoing care and treatment. We also encourage you to refer members to us who may potentially be appropriate for comprehensive care management by calling 1-800-454-3730. Once we have identified a member’s needs, our nurse will work with that member and the member’s PCP to identify the:

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

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

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

Member Assessment
Our care manager conducts a comprehensive assessment to determine a member’s needs, evaluating that person’s:

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

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

**Plan of Care**
After the assessment, our care manager:
• Determines the level of care management services
• Guides, develops and implements an individualized plan of care
• Works with the member, the member’s representative and his or her family and provider

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

In addition, care managers consider our members’ needs for:
• Social services
• Educational services
• Therapeutic services
• Other nonmedical support services (personal care, WIC, transportation)

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

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

**7.7 Disease Management Centralized Care Unit**

Disease Management Centralized Care Unit (DMCCU) programs are based on a system of coordinated care management interventions and communications designed to assist physicians and others in managing members with chronic conditions. The programs include a holistic, member-centric care management approach that allows care managers to focus on multiple needs of members. Disease Management (DM) Programs:
• Behavioral health
  o Bipolar disorder
  o Schizophrenia
• Cardiac
  o Coronary artery disease
  o Congestive heart failure
• Diabetes
• HIV/AIDS
• Pulmonary
o Asthma
o Chronic obstructive pulmonary disease

Additional DM programs may be available for members in your area. (Please call the number provided to learn if these programs apply to your members.)

- Hypertension
- Bipolar disorder
- Obesity

**Program Features**

- Proactive population identification processes
- Evidence-based national practice guidelines
- Collaborative practice models to include physician and support-service providers in treatment planning for members
- Continuous patient self-management education, including primary prevention, behavior modification programs and compliance/surveillance, as well as home visits and case/care management for high-risk members
- Ongoing process and outcomes measurement, evaluation and management
- Ongoing communication with providers regarding patient status

Our Disease Management programs are based on nationally approved clinical practice guidelines located on our website. Simply access the New Jersey page and log in to the secure site by entering your login name and password. On the Online Inquiries page, scroll down to Resources, click on the Clinical Practice Guidelines link and select New Jersey. 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 printed copy.

**Who is eligible?**

All Amerigroup members with the above diagnoses are eligible for DMCCU services. Members are identified through continuous case finding efforts to include early case finding welcome calls, claims mining and referrals. As a valued provider, you can also refer patients to the Disease Management Program who can benefit from additional education and care management support by calling 1-800-454-3730.

Members identified for participation in any of the programs are assessed and risk stratified, based on the severity of their disease. Once enrolled in a program, 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 updates regarding patient status and progress.

**Disease Management Provider Rights and Responsibilities:**

As a participating provider with members enrolled in the disease management program, you have additional rights and responsibilities. You have the right to:

- Obtain information about Amerigroup, including programs and services, our staff, their qualifications and any contractual relationships
- Decline to participate in or work with the Amerigroup programs and services for our members, if contractually possible
- Be informed of how the organization coordinates our disease management-related interventions with treatment plans for individual patients
- Know how to contact the person responsible for managing and communicating with your patients
- Be supported by Amerigroup to make decisions interactively with patients regarding their health care
- Receive courteous and respectful treatment from Amerigroup staff
- Communicate complaints to Amerigroup regarding disease management as outlined in the Amerigroup Provider Complaint and Grievance Procedure

**Hours of Operation**
Our care managers are licensed nurses/social workers and are available from 8:30 a.m. to 5:30 p.m. Eastern time, Monday through Friday. Confidential voice mail is available 24 hours a day. The Nurse HelpLine is available 24 hours a day, 7 days a week for our members.

**Contact Information**
Please call 1-888-830-4300 to reach one of our care managers. Additional information about disease management can be found on our website. Select New Jersey, scroll down to Patient Support and click on the link titled Disease Management Centralized Care Unit (DMCCU). Members can get more information about our DMCCU program by visiting [www.myamerigroup.com](http://www.myamerigroup.com) or calling 1-888-830-4300.

### 7.8 Health Education Advisory Committee

The Health Education Advisory Committee develops outreach programs and provides advice to our members regarding health education. The committee strives to ensure materials and programs meet cultural competency requirements, are understandable to the member and address the member’s health education needs.

The Health Education Advisory Committee’s responsibilities are to:
- Identify health education needs of the membership based on review of demographic and epidemiologic data
- Identify cultural values and beliefs that must be considered in developing a culturally competent health education program
- Assist in the review, development, implementation and evaluation of the member health education tools for the outreach program
- Review the health education plan and make recommendations on health education strategies
- Identify barriers to obtaining appropriate health care services and develop ways to address those barriers

### 7.9 WIC Program

Under New Jersey state law, Medicaid recipients eligible for WIC benefits include the following classifications:
- Pregnant women
- Women who are breast feeding their infant up to one year postpartum
- Women who are not breastfeeding up to six months postpartum
- Infants under age one
- Children under age five

Please use the New Jersey WIC form located in Appendix A – Forms of this manual if any of your Amerigroup members meet these criteria.

The referral includes information needed by WIC programs to provide appropriate services. The referral must be completed with the current (within 60 days) height, weight, hemoglobin or hematocrit, and any identified medical/nutritional problems for the initial WIC referral and for all subsequent certifications.

Members may apply for WIC services at their local WIC agency service. Please call Provider Services at 1-800-454-3730 for the agency nearest to the member.

Network providers are expected to coordinate with the WIC Program. Coordination includes the referral of potentially eligible women, infants and children and the reporting of appropriate medical information to the WIC Program.
8 PROVIDER RESPONSIBILITIES

8.1 Medical Home

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

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

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

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

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

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

The PCP is a licensed Medical Doctor (MD) or Doctor of Osteopathy (DO) or certain other licensed medical practitioner who, within the scope of practice and in accordance with state certification/licensure requirements, standards and practices, is responsible for providing all required primary care services to enrollees, including periodic examinations, preventive health care and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, and maintaining continuity of patient care. A PCP shall include general/family practitioners, pediatricians and internists and may include specialist physicians, Physician Assistants (PAs), certified nurse midwives or certified nurse practitioners, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with these contract provisions and licensure requirements. Providers who practice in FQHCs and RHCs may be included as PCPs. Below are highlights of the PCP’s responsibilities.

The PCP shall:

- Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers, including FFS; provide coordination necessary for referrals to specialists and FFS providers (both in and out-of-network); and maintain a medical record of all services rendered by the PCP and other providers.
- Provide 24-hour-a-day, 7-day-a-week coverage; regular hours of operation should be clearly defined and communicated to members.
- Provide services ethically and legally, provide all services in a culturally competent manner and meet the unique needs of members with special health care needs.
- Participate in any system established by Amerigroup to facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements.
- Make provisions to communicate in the language or fashion primarily used by his or her membership.
- Participate and cooperate with Amerigroup in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by Amerigroup. This includes providing information or documentation as needed to administer health care operations or to verify compliance with mandatory screenings/participating standards as determined by the New Jersey Medicaid program.
- Participate in and cooperate with the Amerigroup complaint and grievance procedures. Amerigroup will notify the PCP of any member grievance.
- Not balance-bill members; however, the PCP is entitled to collect applicable copayments for certain services from certain members.
- Continue care in progress during and after termination of his or her contract for up to four months until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records.
- Develop and have an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens.
- Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act.
- Support, cooperate and comply with our Quality Improvement Program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner.
• Inform us if a member objects to provision of any counseling, treatments or referral services for religious reasons
• Treat all members with respect and dignity; provide members with appropriate privacy and treat member disclosures and records confidentially, giving the members the opportunity to approve or refuse their release
• Provide to members complete information concerning their diagnosis, evaluation, treatment and prognosis and give members the opportunity to participate in decisions involving their health care, except when contraindicated for medical reasons
• Advise members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program; and advise members on treatments which may be self-administered
• When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings
• Have a policy and procedure to ensure proper identification, handling, transport, treatment, and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
• Agree to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide quality patient care
• Agree that any notation in a patient’s clinical record indicating diagnostic or therapeutic intervention as part of the clinical research shall be clearly contrasted with entries regarding the provision of nonresearch related care
• Transfer patients’ medical records to other providers when required; requests must be fulfilled within 10 days and at no charge

**Note:** We do not cover the use of any experimental procedures or experimental medications except under certain circumstances with prior authorization in place.

### 8.3 Access and Availability

All providers are expected to meet the federal and state accessibility standards and those defined in the Americans with Disabilities Act of 1990. Health care services provided through Amerigroup must be accessible to all members.

We are dedicated to arranging access to care for our members. We are able to provide quality access dependent upon the accessibility of network providers. Providers are required to adhere to the following access standards:

• Emergency services are to be provided immediately upon presentation at a service delivery site.
• Urgent care is to be made available within 24 hours.
• Symptomatic acute care is to be made available within 72 hours.
• Routine care is to be made available within 28 days.
• Specialist referrals is to be made available within four weeks or shorter as medically indicated.
• Urgent specialty care is to be made available within 24 hours as required by the member’s medical condition as determined by the member’s PCP.
• Initial pediatric care is to be made available within three months of enrollment.
- Baseline physicals are to be made within 180 days of initial enrollment or in accordance with EPSDT guidelines.
- Baseline physicals for DDD clients are to be made available within 90 days of initial enrollment or in accordance with EPSDT guidelines.
- Prenatal care is to be made within three weeks of a positive pregnancy test (home or laboratory), within three days of identification of high risk, within seven days of request in first and second trimester, or within three days of request in third trimester.
- Routine physicals are to be made available within four weeks as needed for school, camp, work or similar setting.
- Lab and radiology are to be provided within three weeks for routine services and within 48 hours for urgent services.
- Waiting time in the office must not exceed 45 minutes.
- Intermediate/limited encounters must not exceed four per hour behavioral health/substance abuse care appointments must be made available within six hours for non-life threatening emergency, within 24 hours for urgent care, within 10 days for initial routine care, and within 30 days for follow-up routine care.
- PCPs are required to provide members with access to covered services 24 hours a day/7 days a week. When unavailable, providers must arrange for on-call coverage by another participating provider. Answering services must either connect the caller directly to the provider; contact the PCP on behalf of the caller, and the provider returns the call; or provide a telephone number to reach the PCP/covering provider. Answering machines must provide a telephone number to contact the PCP/covering provider. Crisis situations must be responded to within 15 minutes. Emergency dental treatment no later than 48 hours or earlier as the condition warrants, urgent dental care appointments within three days of referral and routine nonsymptomatic dental care appointments within 30 days of referral; if the member does not have dental benefits, we will not pay for emergency dental services unless a doctor other than a dentist gives medical treatment, and the doctor also needs to perform emergency dental work during treatment; if the member does have dental benefits and is in need of emergency care, he/she must contact his/her dentist right away. If the dentist’s office is closed, the member should leave a message with his/her name and telephone number and will receive a call back within one hour for instruction; if the dentist is not able to see the member, the member should call Healthplex at 1-800-720-5352. (TTY 1-800-662-1220) for help in scheduling an appointment or finding another dentist; if the member is out of town and in need of emergency dental care, he/she can go to any dentist for treatment to address an emergency only, or call Healthplex for help to find a dentist.

We will ensure each new member (for SSI and New Jersey Care — ABD elderly and disabled members) or authorized person is contacted to offer an initial visit to the member’s PCP within 45 days of enrollment or according to the needs of the member. Those members identified with special needs will be contacted within 10 days of enrollment and offered an expedited appointment.

We routinely monitor providers’ adherence to the access to care standards.
8.4 Member Missed Appointments

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

Our members who frequently cancel or fail to show up for an appointment without rescheduling the appointment may need additional education in appropriate methods of accessing care. In these cases, please call Provider Services at our National Customer Care Department at 1-800-454-3730 to address the situation. Our staff will contact the member and provide more extensive education and/or case/care management as appropriate. Our goal is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCP.

8.5 Noncompliant Members

We recognize providers may need help in managing noncompliant members. If you have an issue with a member regarding behavior, treatment cooperation and/or completion, and/or making or appearing for appointments, please contact Provider Services at 1-800-454-3730.

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

We must first approve any reassignments of a member from a provider’s panel. We require documentation of the reasons for the request for reassignment before the provider notifies the member that he or she is being removed from the provider’s panel.

To remove a member from your panel, you must send a certified letter to the member or head of household and indicate that the member must select a new PCP within 30 days of the notice. A copy of the letter must be sent to:

Amerigroup Community Care
101 Wood Ave. South, Eighth Floor
Iselin, NJ 08830

You must continue to provide care until the effective date for assignment to the new PCP.

In extreme situations in which a member consistently refuses to cooperate with Amerigroup and/or network providers, we may request DMAHS to disenroll the member. In no event may a member be disenrolled due to health status, need for health services or a change in health status.
Members may be disenrolled in any of the following circumstances:

- We determine the willful actions of the member are inconsistent with membership in our plan, and we have made and provided DMAHS with documentation of at least three attempts to reconcile the situation. Examples of inconsistent actions include persistent refusal to cooperate with any participating provider regarding procedures for consultations or obtaining appointments (this does not preclude a member’s right to refuse treatment), intentional misconduct, willful refusal to receive prior approval for nonemergency care, willful refusal to comply with reasonable administrative policies of Amerigroup, fraud, or making a material misrepresentation to Amerigroup. In no way can this provision be applied to individuals on the basis of their physical condition, utilization of services, age, socioeconomic status, mental disability, or uncooperative or disruptive behavior resulting from his/her special needs.
- We become aware the member has become ineligible for enrollment or has moved to a residence outside of the covered enrollment area.
- We learn the member is residing outside the state of New Jersey for more than 30 days. This does not apply to situations when the member is receiving out-of-state care provided and/or authorized by Amerigroup. This does not apply to full-time students.

Prior to recommending disenrollment of a member, we will make a reasonable effort to identify for the member those actions that have interfered with effective provision of covered medical care and services and to explain what actions or procedures are acceptable. We must allow the member sufficient opportunity to comply with acceptable procedures prior to recommending disenrollment. We will provide at least one oral and at least one written warning to the member regarding the implications of his or her actions. An authorized person may be able to act on behalf of a member in the above situations.

If the member fails to comply with acceptable procedures, we will give at least 30 days’ prior written notice to the member of its intent to recommend disenrollment. The notice will include a written explanation of the reason we intend to request disenrollment and will advise the member of his or her right to file a disenrollment grievance. We will give DMAHS a copy of the notice and advise DMAHS immediately if the member files a disenrollment grievance. An authorized person may be able to act on behalf of a member in the above situations.

In addition, an eligible member may initiate a Fair Hearing at any time during the grievance process but is limited to 120 days after the notice. NJ Medicaid/NJ FamilyCare A and ABP members have the right to a Fair Hearing. NJ FamilyCare B, C and D members are not eligible for Fair Hearings.

We and our network providers will not request a member’s disenrollment based on an adverse change in the member’s health status or utilization of services which are medically necessary for treatment of a member’s condition.

Retroactive Enrollment

There shall be no retroactive enrollment in Managed Care. Services for those beneficiaries during any retroactive period will remain fee-for-service, except for individuals eligible under NJ FamilyCare B, C, and D who are not eligible until enrolled in an MCO. Coverage shall continue indefinitely unless this contract expires or is terminated, or the enrollee is no longer eligible or is deleted from the contractor’s list of eligible enrollees.
Exceptions and Clarifications

- Deceased enrollees. If an enrollee is deceased and appears on the recipient file as active, the contractor shall promptly notify DMAHS on no less than a weekly basis, utilizing the “Combined Notification of Death and Estate Referral Form” form located in subsection B.5.1 of the Appendix. DMAHS shall recover capitation payments made on a prorated basis after the date of death. The contractor shall require its providers to report to the contractor enrollee deaths and dates of deaths on no less than a weekly basis.

8.6 Members with Special Needs

Adults with special needs include those members with complex/chronic medical conditions requiring specialized health care services, including persons with physical, mental, substance abuse and/or developmental disabilities, including such persons who are homeless and persons who are eligible for the MLTSS program. Children with special health care needs are those members who have or are at an increased risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required generally by children. This group also includes all children who are MLTSS members and members who are at risk for nursing home placement or who may require other long-term services and supports.

We have developed methods for:
- Well-child care
  - Well-child care includes recommendations around weight assessment, nutrition counseling, physical activity, Pharyngitis testing, immunizations, vaccinations, lead screening, dental visits and doctor visit frequency for children under 15 months old, 3 to 6 years old and adolescents.
- Health promotion and disease prevention
  - Health promotion is centered on ensuring that members and their families get the health care they need. We accomplish this by managing health benefits such as primary care services, hospital care, specialist referrals, prescriptions, immunizations and wellness checkups. Additional services and programs are also offered such as Taking Care of Baby and Me, a 23-hour nurse helpline and health education classes. Disease prevention is based on a system of coordinated care management interventions and communications assigned to assist physicians and others in managing members with chronic conditions. This includes a holistic, member-centric approach to Disease management, motivational interviewing techniques used in conjunction with member self-empowerment and programs focused on Behavioral Health conditions, substance abuse disorders, heart conditions, diabetes, HIV/AIDS, pulmonary conditions and obesity.
- Specialty care for those who require such care
  - Specialty care for those who require such care – for a member requiring special care from a doctor, such as a surgeon, OB-GYN or podiatrist, to focus on a certain illness or part of the body).
- Diagnostic and intervention strategies
- Home therapies
- Ongoing ancillary services
- Long-term management of ongoing medical complications
- Care management systems for assuring children with serious, chronic and rare disorders receive appropriate diagnostic work ups on a timely basis
- Access to specialty centers inside and outside of New Jersey for diagnosis and treatment of rare disorders
- Referral for eligibility for Managed Long Term Services and Supports
  - Amerigroup care managers are able to screen and refer members who may need the additional services provided under the Managed Long Term Services and Supports program. The State of New Jersey ultimately determines eligibility for the MLTSS program.
  - If the member is a Nursing Facility resident, providers can both receive an authorization and refer the member for enrollment in MLTSS by providing notification of admission by phone to 732-452-6050 or fax to 1-877-244-1720.
  - Other providers wishing to refer members for the MLTSS program should speak with the member’s acute case manager or call the MLTSS Department at 1-855-661-1996.
  - Members self-referring can also call the MLTSS Department at 1-855-661-1996 and state that they are interested in enrolling in the MLTSS program. Members requiring Telephone Typewriter/Teletypewriter (TTY) Services can call 711.

If an MLTSS member with special needs requires assistance for a crisis situation after hours, they can call the toll free number at 1-855-661-1996 and select the option to speak with an associate. The call is then answered by a live representative who will screen the call to determine if it is a crisis situation and if so, the call is warm transferred to manager on duty.

We allow for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member. To ensure members have access to needed providers, Amerigroup will procure a Single Case Agreement (SCA) with the out of network provider after receiving the prior authorization from medical management.

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

We work to ensure a new member with complex/chronic conditions receives immediate transition planning. The planning will be completed within a time frame appropriate to the member’s condition, but in no case later than 10 business days from the effective date of enrollment when indicated on the Plan Selection form or within 30 days after special conditions are identified by a provider. The transition plan will include the following:
- Review of existing care plans
- Preparation of a transition plan that ensures continual care during the transfer to the plan
- Coordination and follow-through to ensure the member receives the necessary DME if it was ordered prior to the member’s enrollment with us and it was not received by the date of enrollment with us
Outreach and enrollment staff is trained to work with members with special needs, to be knowledgeable about their care needs and concerns, to be able to converse in the different languages common among the members, and to be able to converse using different means of communication common among the members, including TTY service for the hearing impaired and American Sign Language, if necessary.

If a new member upon enrollment or a member upon diagnosis requires very complex, highly specialized health care services, the member may receive care from a participating specialist or a participating specialty care center with expertise in treating the life-threatening disease or specialized condition. The specialist or specialty care center will be responsible for providing and coordinating the member’s primary and specialty care. The specialist or specialty care center, acting as both primary and specialty care provider, will be permitted to treat the member without a referral from the member’s PCP and may authorize such referrals, procedures, tests and other medical services. If approval is obtained to receive services from a non-network provider, the care will be provided at no additional cost to the member.

We will arrange for the provision of dental services to members with special needs. At a minimum, these will include the following:

- Providing consultations and assistance to the member’s caregivers
- A referral to a dental specialist or dentist that provides dental treatment to patients with special needs shall be allowed when a PCD requires a consultation for services by that specialty provider
- Providing adequate time for members with developmental disabilities; initial and follow-up dental visits may require up to 60 minutes on average to allow for a comprehensive dental examination and other services; standards allow for up to four visits annually without prior authorization
- Additional diagnostic, preventive and periodontal services are available beyond the frequency limitations of every six months and are allowed every three months to enrollees with special needs when medical necessity for these services is documented and submitted for consideration; documentation must include the expected prognosis and improvement in the oral condition associated with the increased frequency for the requested service
- Providing home visits when medically necessary and where available
- Providing adequate support staff to meet the needs of the members
- Providing for the use and replacement of fixed, as well as removable prosthetic devices as medically necessary and appropriate
- Providing a reimbursement system for the cost of preoperative and postoperative evaluations associated with dental surgery
- Providing a dental management plan
- Coordinating authorizations for dental required hospitalizations by consulting with our dental and medical consultants in an efficient and time-sensitive manner

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

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

In order to maintain continuity of care, we encourage our members to remain with their PCP. However, members may request to change their PCP for any reason by contacting our Member Services department at 1-800-600-4441. The member’s name will be provided to the PCP on the membership roster.

Members can call to request a PCP change any day of the month. PCP change requests will be processed generally on the same day or by the next business day. Members will receive a new ID card within 10 days.

8.8 Covering Physicians

During your absence or unavailability, you must arrange for coverage for our members in your care. Please either: (i) make arrangements with one or more network providers to provide care for your members, or (ii) make arrangements with another similarly licensed and qualified provider who has appropriate medical staff privileges at the same network hospital or medical group, as applicable, to provide care to the members in question. Upon your request, Amerigroup is responsible for coordinating referrals with a non-network provider when medically necessary covered services cannot be provided by a network provider. In addition, Amerigroup will coordinate with the non-network provider with respect to payment.

8.9 Specialist as a PCP

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

- The need for multiple hospitalizations exists
- The majority of care needs to be given by a specialist
- The administrative requirements arranging for care exceed the capacity of the nonspecialist 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 our Case/Care Management department and complete a Specialist as PCP Request Form. One of our case/care managers will review the request and submit it to our medical director. We will notify the member and the provider of its determination in writing within 30 days of receiving the request. Should we deny the request, we will provide written notification to the member and provider outlining the reasons for the denial of the request within one day of the decision. Specialists serving as PCPs will continue to be paid FFS while serving as the member’s PCP. The designation cannot be retroactive. For further information, see the Specialist as PCP Request Form located in the Appendix A – Forms section of the manual.
8.10 Reporting Changes in Address and/or Practice Status

Any status changes are to be reported to:

Amerigroup Community Care
101 Wood Ave. South, Eighth Floor
Iselin, NJ 08830

8.11 Specialty Referrals

In order to reduce the administrative burden on your office staff, we have established procedures designed to permit a member with a condition requiring ongoing care from a specialist physician or other health care provider to request extended authorization when required.

You can request extended authorization by contacting us. You must supply the necessary clinical information for us to review.

On a case-by-case basis, we will approve extended authorization. In the event of termination of a contract with the treating provider, the continuity of care provisions in the provider’s contract with us will apply. The provider may renew the authorization by submitting a new request to us. Additionally, we require the specialist physician or other health care provider to provide regular updates to the member’s PCP (unless acting also as the designated PCP for the member).

If the specialist or other health care provider needed to provide ongoing care for a specific condition is not available in our network, the referring physician shall request authorization from Amerigroup for services outside the network. Access will be approved to a qualified non-network health care provider within a reasonable distance and travel time at no additional cost if medical necessity is met.

If a provider’s application for an extended authorization is denied, the member (or the provider on behalf of the member) may appeal the decision through our medical appeals process.

Dental Referrals and Second Opinions

We will not impose an arbitrary number of attempted dental treatment visits by a PCD or PCP as a condition prior to the PCD or PCP initiating any specialty referral requests. Also, we will not obligate the referring dentist to supply diagnostic documentation similar to that required for a prior authorization request for treatment services as part of a referral request, nor obligate the dentist receiving the referral to prepare and submit diagnostic materials in order to approve or reimburse for a referral. We have a second opinion program that can be utilized at the enrollee’s option for diagnosis and treatment of dental conditions that are treated within a dental specialty. In addition, the member may receive the second opinion within the contractor’s network or the contractor may arrange for the member to obtain a second opinion outside the network at no cost to the member. We shall authorize any reasonable referral request from a PCP/PCD without imposing any financial penalties to the same PCP/PCD. For a listing of our participating dental providers, go to https://www.healthplex.com/our_dentists.
8.12 Non-network Specialist Referrals

Precertification is required for all admissions made by PCPs and specialists. Failure to obtain precertification for a procedure or admission requiring such precertification may result in denial of benefit payment. The medical director will review any appeal of such a denial.

If the member has a medical need that cannot be met by a network provider, a case/care manager will arrange access to needed services by a non-network provider within the service area, including coordination of transportation. We will provide for review by a specialist of the same or similar specialty as the type of PCP or provider to whom a referral is requested before denying any request for non-network care. We reimburse non-network providers at rates comparable to those of our network providers; an amount negotiated between the non-network provider and Amerigroup or the Medicaid FFS amount.

8.13 Second Opinions

A member, parent and/or legally appointed representative or the member’s PCP, PCD and/or specialist has the opportunity to obtain a second opinion for diagnosis or treatment of medical or dental conditions and/or elective surgical procedures. The second opinion shall be provided at no cost to the member. For dental conditions, these are conditions treated within a dental specialty. The second opinion must be obtained from a network provider (see Provider Referral Directory) or a non-network provider if there is not a network provider with the expertise required for the condition. Once approved, the PCP or specialist will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The PCP or specialist will notify the member of the outcome of the second opinion.

We may also request a second opinion at our own discretion. This may occur under the following circumstances:

• Whenever there is a concern about care expressed by the member or the provider
• Whenever we discover potential risks or outcomes of recommended or requested care during our regular course of business
• Before initiating a denial of coverage of service
• When denied coverage is appealed
• When an experimental or investigational service is requested

When we request a second opinion, we will make the necessary arrangements for the appointment, payment and reporting. We will inform the member and the PCP of the results of the second opinion and the consulting provider’s conclusion and recommendations regarding further action.

8.14 Specialty Care Providers

To participate in the Medicaid managed care model, the provider must be a licensed provider by the state before signing a contract with Amerigroup.

We contract with a network of provider specialty types to meet the medical specialty needs of members and provide all medically necessary covered services. The specialty care provider is a network
physician who has the responsibility for providing the specialized care for members (see Role and Responsibility of the Specialty Care Providers). In addition to sharing many of the same responsibilities to members as the PCP (See Responsibilities of the PCP), the specialty care provider provides services that include:

- Allergy and immunology services
- Burn services
- Community behavioral health (e.g., mental health and substance abuse) services
- Cardiology services
- Clinical nurse specialists, psychologists, clinical social workers – behavioral health
- Critical care medical services
- Dermatology services
- Endocrinology services
- Gastroenterology services
- General surgery
- Hematology/oncology services
- HIV/AIDS services
- Neonatal services
- Nephrology services
- Neurology services
- Neurosurgery services
- Ophthalmology services
- Orthopedic surgery services
- Otolaryngology services
- Pediatric services
- Perinatal services
- Psychiatry (adult) assessment services
- Psychiatry (child and adolescent) assessment services
- Trauma services
- Urology services

8.15 Role and Responsibility of the Specialty Care Providers

Specialist providers will treat members and will render covered services only to the extent and duration that is medically necessary. Examples of obligations of the specialists include the following:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program
- Accepting all members referred to them
- Submitting required claims information including source of referral to Amerigroup
- Arranging for coverage with network providers while off-duty or on vacation
- Verifying member eligibility and precertification of services (if 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 the member’s PCP when scheduling a hospital admission or scheduling any procedure requiring the PCP’s approval
• Coordinating care, as appropriate, with other providers involved in providing care for members, especially in cases where there are medical and behavioral health comorbidities or co-occurring mental health and substance abuse disorders

The specialist shall:
• Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers, including those engaged on a FFS basis; provide coordination necessary to refer to other specialists and FFS providers (both in- and out-of-network); and maintain a medical record of all services rendered by the specialist and other providers.
• Provide 24-hour-a-day, 7-day-a-week coverage and maintain regular hours of operation that are clearly defined and communicated to members.
• Provide services ethically and legally and in a culturally competent manner and meet the unique needs of members with special health care requirements.
• Participate in the systems established by Amerigroup that facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements.
• Participate and cooperate with Amerigroup in any reasonable internal or external quality assurance, utilization review, continuing education or other similar programs established by Amerigroup. This includes providing information or documentation as needed to administer health care operations or to verify compliance with mandatory screenings/participating standards as determined by the New Jersey Medicaid program.
• Make reasonable efforts to communicate, coordinate and collaborate with other specialty care providers, including behavioral health providers, involved in delivering care and services to consumers.
• Participate in and cooperate with the Amerigroup complaint and grievance processes and procedures. Amerigroup will notify the specialist of any member grievance brought against the specialist.
• Not balance bill members. However, the specialist is entitled to collect applicable copayments for certain services from certain members as specified on the member’s Amerigroup identification card.
• Continue care in progress during and after termination of his or her contract. Please see Section 9 – Continuity of Care for more information.
• Comply with all applicable federal and state laws regarding the confidentiality of patient records
• Develop and have an exposure control plan regarding blood-borne pathogens in compliance with OSHA standards.
• Make best efforts to fulfill the obligations under the Americans with Disabilities Act applicable to his or her practice location.
• Support, cooperate and comply with the Amerigroup Quality Improvement Program initiatives and any related policies and procedures designed to provide quality care in a cost-effective and reasonable manner.
• Inform Amerigroup if a member objects for religious reasons to the provision of any counseling, treatment or referral services.
• Treat all members with respect and dignity; provide members with appropriate privacy; and treat member disclosures and records confidentially, giving the members the opportunity to approve or refuse their release as allowed under applicable laws and regulations.
• Provide to members complete information concerning their diagnosis, evaluation, treatment and prognosis and give members the opportunity to participate in decisions involving their health care, except when contraindicated for medical reasons.
• Advise members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program and advise members on treatments that may be self-administered.
• When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.
• Have a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
• Agree to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide quality patient care.
• Agree that any notation in a patient’s clinical record indicating diagnostic or therapeutic intervention that is part of a clinical research study is clearly distinguished from entries pertaining to nonresearch related care.
• Transfer patients’ medical records to other providers when required; requests must be fulfilled within 10 days and at no charge.

Note: We do not cover the use of any experimental procedures or experimental medications except under certain preauthorized circumstances.

8.16 Specialty Care Providers Access and Availability

We will maintain a specialty network to ensure access and availability to specialists for all members. A provider is considered a specialist if he or she has a provider agreement with us to provide specialty services to members. Specialists must adhere to the following access guidelines:

<table>
<thead>
<tr>
<th>Service</th>
<th>Access Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent, nonemergency visits</td>
<td>Within 24 hours of referral</td>
</tr>
<tr>
<td>Routine visits</td>
<td>Within four weeks</td>
</tr>
<tr>
<td>Prenatal care</td>
<td>Members will be seen within the following time frames:</td>
</tr>
<tr>
<td></td>
<td>• Within three weeks of a positive pregnancy test (home or lab)</td>
</tr>
<tr>
<td></td>
<td>• Within three days of identification as high-risk</td>
</tr>
<tr>
<td></td>
<td>• Within seven days of request if in first or second trimester</td>
</tr>
<tr>
<td></td>
<td>• Within three days of first request if in third trimester</td>
</tr>
</tbody>
</table>

8.17 Cultural Competency

With the increasing diversity of the American population, it is important for us to work effectively in cross-cultural situations. Your ability to communicate with your patients has a profound impact on the effectiveness of the health care you provide. Your patients must be able to communicate symptoms and needs clearly and understand your recommended treatments and advice.

Our cultural competency program helps you and your patients to:
• Acknowledge the importance of culture and language
• Embrace cultural strengths with people and communities
• Assess cross-cultural relations
• Understand cultural and linguistic differences
• Strive to expand your cultural knowledge

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

Cultural barriers can affect your relationship with your patient, including:
• Our member’s comfort level and his or her fear of what you might find in an examination
• Different levels of understanding among diverse consumers
• A fear of rejection of personal health beliefs
• A member’s expectation of what you do and how you treat him or her

To help overcome these barriers, you need the following:

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

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

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

8.18 Member Records

Using nationally recognized standards of care, we work with providers to develop clinical policies and guidelines of care for our members. The Medical Advisory Committee (MAC) oversees and directs us in formalizing, adopting and monitoring guidelines. We require medical records to be maintained in a manner that is current, detailed and organized and permits effective and confidential patient care and quality review. In addition, the New Jersey Department of Human Services/Division of Medical Assistance and Health Services has contracts with an External Quality Review Organization (EQRO) to perform federally required outside medical record audits. We understand the problems providers encounter with the multitude of entities that currently perform medical record audits, and we will try to schedule reviews as conveniently as possible.

We use the New Jersey Medical Record Review Audit tool. In addition, our audits include Amerigroup-specific tools designed to collect information to support quality improvement focus studies and HEDIS® reporting. We will report the findings to our network providers.

Providers are required to maintain medical records that conform to good professional medical practice and appropriate health management. A permanent medical record will 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 the following Amerigroup and state standards.

Medical Record Standards
The records reflect all aspects of patient care, including ancillary services.

These standards will, at a minimum, meet the following medical record requirements. Documentation of each visit must include:
1. **Patient identification information.** Each page or electronic file in the record must contain the patient’s name or patient ID number.

2. **Personal/biographical data.** The record must include the patient’s age, sex, address, employer, home and work telephone numbers, and marital status.

3. **Entry date and provider identification.** All entries must be dated and author identified.

4. **Legibility.** Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.

5. **Allergies.** Medication allergies and adverse reactions must be prominently noted on the record. In the absence of allergies, No Known Allergies (NKA) must be noted in an easily recognizable location.

6. **Past medical history** (for patients seen three or more times). Past medical history must be easily identified, including serious accidents, operations and illnesses. For children, past medical history related to prenatal care and birth.

7. **Immunizations.** For pediatric records of patients age 12 and under, a completed immunization record or a notation of prior immunization must be recorded and include vaccines and their dates of administration when possible.

8. **Diagnostic information.**

9. **Medication information.**

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

11. **Functional or cognitive deficits.** For adult members age 66 or older, documentation must include an assessment of member’s ability to perform ADL and IADL.

12. **Smoking/alcohol/substance abuse.** A notation concerning cigarettes, tobacco products, alcohol use and substance abuse must be stated if present for patients age 12 and older. Abbreviations and symbols may be appropriate.

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

14. **Emergency care.** Copies of emergency treatment documentation such as ER summary sheet.

15. **Hospital discharge summaries.** Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the patient is enrolled and for prior admissions, as appropriate.

16. **Advance directive.** For medical records of adult patients, the medical record must document whether or not the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney that directs health care decision making for individuals who are incapacitated.

17. **History and physical examination.** The medical record must have history and physical examination.

18. **Plan of treatment.** Plan of treatment is appropriate to findings and member is not at risk by diagnostic or therapeutic problem.

19. **Diagnostic tests.**

20. **Therapies and other prescribed regimens.** Documentation of therapies and other prescribed regimens such as (PT, OT, E-Stim, etc.) must be noted.

21. **Follow-up.** Notations about follow-up care, calls or visits, specific time of return noted in days, weeks or months documented in the medical record.

22. **Timely record transfer (when applicable).**
23. **Unresolved problems.** Documentation that unresolved problems from previous visits are addressed in subsequent visits.

24. **Security.** Providers are required to maintain a written policy to ensure that medical records are safeguarded against loss, destruction or unauthorized use.

25. **Release of information.** Written procedures are required for the release of information and obtaining consent for treatment.

26. **Documentation.** Documentation is required setting forth the results of medical, preventive and behavioral health screening and of all treatment provided and results of such treatment.

27. **Multidisciplinary teams.** Documentation is required of the team members involved in the multidisciplinary team of a patient needing specialty care.

28. **Integration of clinical care.** Documentation of the integration of clinical care in both the physical and behavioral health records is required. Such documentation must include:
   - Screening for behavioral health conditions (including those which may be affecting physical health care and vice versa) and referral to behavioral health providers when indicated
   - Screening and referral by behavioral health providers to PCPs when appropriate

### 8.19 Medical Record Management and Confidentiality

We will release medical records of the member and/or facilitate the release of medical records in the possession of network providers. Release of medical records will be consistent with the provisions of confidentiality.

We will maintain and require network providers to maintain appropriate records relating to performance under this agreement, including records related to services provided to members. The medical records will include separate comprehensive medical records for each member as are necessary to record all clinical information pertaining to members, including notations of personal contacts, primary care visits and diagnostic studies. Each member’s medical records will be kept in detail consistent with federal and state requirements and good medical and professional practice, based on the services required and provided. Medical records must be available at each encounter with a medical professional. Records will also include appropriate financial records to document fiscal activities and expenditures, including records relating to the sources and applications of funds determination of amounts payable under the contract and the capacity of the members or network providers, if relevant, to bear the risk of potential financial losses. Financial records will be consistent with applicable state and federal regulations.

We require that duly authorized representatives be granted access to all records relating to our subcontractors’ performance under their agreements for the purposes of examinations, audit, investigation and copying of such records. The provider will give access to such records upon prior written notice during normal business hours, unless otherwise provided or permitted by applicable laws, rules or regulations.

We require network providers to maintain an appropriate record keeping system for services to Amerigroup members. Such system will collect all pertinent information relating to the medical management of each member and make that information readily available to appropriate health professionals and agencies. Records, including member medical records, must be retained for the latter of 10 years from the date of service or after the final payment is made under the contract or subcontract and all pending matters are closed.
Medical records of members will be sufficiently complete as to permit subsequent peer review, medical audit or investigation. All required records, either originals or reproductions thereof, will be maintained in legible form and be readily available to appropriate state professional or investigative staff upon request for review and evaluation by professional medical, nursing and investigative staff.

If our members disenroll from Amerigroup, network providers are required to release medical records of members as may be directed by the member, Amerigroup and/or authorized representatives of the appropriate agencies of the state and federal government. Release of records will be consistent with confidentiality provisions expressed in this manual and at no cost to members. All records will be retained in accordance with the confidentiality requirements cited in this manual.

Medical records and management information data concerning members enrolled in Amerigroup are confidential and will be disclosed to other persons within Amerigroup only as necessary to provide medical care and quality, peer or grievance review of medical care and other necessary administrative duties.

Amerigroup and its participating network providers agree and understand that all information, records, data and data elements collected and maintained for the operation of Amerigroup insurance programs and pertaining to members must be protected from unauthorized disclosure. Access to such information, records, data and data elements will be limited to those who perform their duties in accordance with provisions of this contract and in accordance with applicable law.

8.20 Minor Members

Our policy on treatment of minors is designed to comply with federal, state and NCQA requirements and guidelines. We communicate the policy to staff, members and providers.

No minor member will need to have parental permission for services such as family planning, prenatal care or substance abuse counseling. Only the minor member, not the member’s parents or any other individual, may consent to the provision of services. However, counseling should be offered to adolescents to encourage them to discuss their needs with a parent, an adult family member or other trusted adult. Minor members may also be treated for life-threatening conditions without parental permission.

8.21 Patient Visit Data

Documentation of individual encounters must provide adequate evidence of at a minimum:
1. A history and physical exam that includes appropriate subjective and objective information obtained for the presenting complaints
2. For patients receiving behavioral health treatment, documentation that includes at-risk factors (danger to self/others, ability to care for self, affect, perceptual disorders, cognitive functioning and significant social health)
3. An admission or initial assessment that must include current support systems or lack of support systems
4. For patients receiving behavioral health treatment, a documented assessment that is done with each visit relating to client status/symptoms to the treatment process and that may indicate initial
symptoms of the behavioral health condition as decreased, increased or unchanged during the treatment period
5. A plan of treatment that includes activities/therapies and goals to be carried out
6. Diagnostic tests
7. Documented therapies and other prescribed regimens for patients who receive behavioral health treatment and that include evidence of family involvement as applicable and include evidence that the family was included in therapy sessions, when appropriate
8. Regarding follow-up care encounter forms or notes with a notation indicating follow-up care, a call or a visit that must note in weeks, months or as needed (PRN) the specific time to return with unresolved problems from any previous visits being addressed in subsequent visits
9. Results including all other aspects of patient care, such as ancillary services

We will systematically review medical records to ensure compliance with the standards. We will institute actions for improvement when standards are not met.

We maintain an appropriate record keeping system for services to members. This system will collect all pertinent information relating to the medical management of each member and make that information readily available to appropriate health professionals and appropriate state agencies.

8.22 Clinical Practice Guidelines

Using nationally recognized standards of care, we work with providers to develop clinical policies and guidelines for the care of its membership. The PAC oversees and directs us in formulating, adopting and monitoring guidelines.

We select at least four evidence-based clinical practice guidelines that are relevant to the member population. We will measure performance against at least two important aspects of each of the four clinical practice guidelines annually. The guidelines must be reviewed and revised at least every two years or whenever the guidelines change.

Clinical Practice Guidelines are located on our provider website. Simply access the New Jersey page and log in to the secure site by entering your login name and password. On the Online Inquiries page, scroll down to Resources, click on the Clinical Practice Guidelines link and select New Jersey. A copy of the guidelines can be printed from the website, or you can contact Provider Services at 1-800-454-3730 to request a printed copy.

8.23 Advance Directives

We adhere to the Patient Self-Determination Act and recognize and support the following advance directives:
• Durable power of attorney
• Living will

A durable power of attorney lets a member name a patient advocate to act on his or her behalf. A living will lets a member state his or her wishes on medical treatment in writing. A Living Will and Durable Power of Attorney are located in Appendix A – Forms.
We encourage members age 18 and over to ask you for an *Advance Directive* form and education at their first appointment. Please document their forms in your medical records.

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

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

9.1  Medical Review Criteria

Anthem, Inc. has its own nationally recognized medical policy process for all of its subsidiary entities including Amerigroup Community Care.

Effective May 1, 2013, medical policies, which are publicly accessible at Amerigroup Medical Policy and Clinical Utilization Management (UM) Guideline subsidiary website, became the primary benefit plan policies for determining whether services are considered to be a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive for Amerigroup subsidiaries.

Effective March 1, 2014, McKesson InterQual criteria is used only for medical necessity review for medical inpatient concurrent review, inpatient site of service appropriateness, home health and outpatient rehabilitation. Amerigroup Behavioral Health Medical Policies and Clinical UM Guidelines is used for all behavioral health reviews. In the absence of licensed McKesson Interqual criteria, Amerigroup subsidiaries may use Amerigroup Clinical Utilization Management (UM) Guidelines. A list of the specific Amerigroup Clinical UM Guidelines used will be posted and maintained on the Amerigroup subsidiary websites and can be obtained in hard copy by written request. The policies described above will support precertification requirements, clinical-appropriateness claims edits and retrospective review.

Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. As such, in some cases, state Medicaid contracts or Centers for Medicare & Medicaid Services (CMS) requirements will supersede both McKesson InterQual and Amerigroup medical policy criteria. Medical technology is constantly evolving, and we reserve the right to review and periodically update medical policy and utilization management criteria.

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

Utilization Management Decision Making

Amerigroup as a corporation and individual persons involved in UM decisions are governed by the following statements:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- We do 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.
All final decisions regarding denials of referrals, PAs, treatment and treatment plans for nonemergency services shall be made by a physician and/or peer physician specialist or by a licensed New Jersey dentist/dental specialist in the case of dental services, or by a licensed mental health and/or behavioral health specialist in the case of behavioral health services. Prior authorization decisions for nonemergency services shall be made within fourteen (14) calendar days or sooner as required by the needs of the enrollee.

If the documentation provided supports the provision of a different service(s) than the one(s) requested for approval, the clinical peer who reviewed the service(s) may approve the service(s) which are supported by the submitted documentation.

9.2 Precertification/Notification Process

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

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

For dental services, in considering prior authorization of services we may consider the overall general health, patient compliance and dental history, condition of the oral cavity and complete treatment plan that is both judicious in the use of program funds and provides a clinically acceptable treatment outcome. In situations where a complex treatment plan is being considered, the provider may sequentially submit several prior authorization requests, one for each of the various stages of the treatment.

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

We will authorize provision of a drug not on the formulary and requested by the PCP or referral provider on behalf of the member if the approved prescriber certifies medical necessity for the drug for a determination. If the formulary includes generic equivalents, we will provide for a brand-name exception process for prescribers to use when medically necessary.

Amerigroup will notify providers of approved prior authorization determinations for nonurgent services by telephone or in writing. Prior authorization denials and limitations will be provided in writing in accordance with the Health Claims Authorization Processing and Payment Act, P.L. 2005, c.352. A medical necessity reviewer is available at 1-800-454-3730 to discuss any denial decision with the practitioner.
In the case of an Amerigroup member who was receiving a service (from Amerigroup or another managed care organization, or the Medicaid fee-for-service program) prior to the determination, Amerigroup will continue to provide the same level of service while the determination is in appeal. However, Amerigroup may require the member to receive the service from within the Amerigroup provider network, if equivalent care can be provided within network.
We require precertification of all inpatient elective admissions. The referring primary care or specialist physician is responsible for precertification.

The referring physician identifies the need to schedule a hospital admission and must submit the request to our Medical Management department.

Requests for precertification with all supporting documentation must be submitted at a minimum of 72 hours prior to the scheduled 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.

This will allow us to verify benefits and process the precertification request. For services that require precertification, we make case-by-case determinations that consider the individual’s health care needs and medical history in conjunction with InterQual Criteria.

The hospital can confirm that an authorization is on file by calling our automated Provider Inquiry Line at 1-800-454-3730. If coverage of an admission has not been approved, the facility should call us at 1-800-454-3730. We will contact the referring physician directly to resolve the issue.

Amerigroup has appropriate staff available to accept precertification requests. When a request is received from the physician via telephone or fax for medical services, the Care Specialist will verify eligibility and benefits. This information will be forwarded to the precertification nurse.

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

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with InterQual Criteria, an Amerigroup reference number will be issued to the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member’s needs and medical history.
If medical necessity criteria for the admission are not met on the initial review, the medical director will contact the requesting physician to discuss the case.

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

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

10.1 Emergent Admission Notification Requirements

Network hospitals must notify us of emergent admissions within one business day. Our Medical Management staff will verify eligibility and determine benefit coverage.

We are available 24 hours a day, 7 days a week to accept emergent admission notification at our Provider Inquiry line at 1-800-454-3730.

Coverage of emergent admissions is authorized based on review by a concurrent review nurse. When the clinical information received meets InterQual Criteria, an Amerigroup reference number will be issued to the hospital.

If the notification documentation provided is incomplete or inadequate, we will notify the hospital to submit the additional necessary documentation.

If the medical director denies coverage of the request, the appropriate denial letter will be mailed to the hospital, member’s PCP and member.

10.2 Nonemergent Outpatient and Ancillary Services – Precertification and Notification Requirements

We require precertification for coverage of selected nonemergent outpatient and ancillary services (see chart) when performed by a participating provider. All nonemergent outpatient and ancillary services referred to a nonparticipating provider require precertification by the referring provider. The prior authorization requirement time frame to state prior authorization decisions for non-emergency services shall be made within fourteen (14) calendar days or sooner as required by the needs of the enrollee.

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.
• **Make inquiries** on 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, including email notifications if requested using a valid email address.
• **Real-time results** for some common procedures, with immediate decisions.
• **Access ICR** under *Authorizations and Referrals* via the Availity Web Portal.


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.)

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

For prior authorizations requiring additional time for review, please call 1-800-452-7101, Monday through Friday from 8 a.m. to 5 p.m.

To ensure timeliness of the authorization, the expectation of the facility and/or provider is that the following must be provided:
• Member name and ID
• Name, telephone number and fax number of physician performing the elective service
• Name of the facility and telephone number where the service is to be performed
• Date of service
• Member diagnosis
• Name of elective procedure to be performed with CPT-4 code
• Medical information to support requested services (medical information includes current signs/symptoms, past and current treatment plans, response to treatment plans, and medications)

The table below contains precertification and notification requirement guidelines:

| Amerigroup Community Care Precertification/Notification Coverage Guidelines |
|-----------------------------|-----------------------------|
| **Service** | **Requirement** | **Comments** |
| Behavioral Health/Substance Abuse | Self-referral | Behavioral/mental health services, substance abuse services (e.g., diagnosis, treatment and detoxification) and costs for methadone and its administration are managed by the state for non-Division of Developmental Disabilities (DDD) and non-MLTSS enrollees, including NJ FamilyCare enrollees. |
### Amerigroup Community Care Precertification/Notification Coverage Guidelines

<table>
<thead>
<tr>
<th>Service</th>
<th>Requirement</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• Amerigroup will retain responsibility for furnishing mental health/substance abuse services, excluding partial care and partial hospitalization services and the cost of the drugs listed below, to Medicaid enrollees who are clients of the Division of Developmental Disabilities in accordance with Article 4.1.2 of the state Medicaid contract.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Amerigroup will retain responsibility for furnishing mental health/opioid treatment services including partial care and partial hospitalization services and the cost of the drugs for opioid treatment and its administration to MLTSS Members in accordance with Article 9.9.</td>
</tr>
<tr>
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<td>• Amerigroup will retain responsibility for furnishing medically necessary detoxification in a medical acute care inpatient setting.</td>
</tr>
<tr>
<td>FamilyCare D</td>
<td></td>
<td>• Excludes mental health visits in outpatient hospital settings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inpatient hospital services for mental health, including psychiatric hospitals; there is no limit to the number of days for Children’s Health Insurance Program (CHIP) beneficiaries under 19 years of age, pursuant to the Mental Health Parity and Addition Act (MHPAEA) of 2008</td>
</tr>
<tr>
<td></td>
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<td>Outpatient benefits for short-term, outpatient evaluative and crisis intervention or home health/mental health; There is no limit to the number of visits for CHIP beneficiaries under 19 years of age pursuant to the MHPAEA of 2008.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inpatient and outpatient services for substance abuse; there is no service limit for CHIP beneficiaries under 19 years of age, pursuant to the MHPAEA of 2008.</td>
</tr>
<tr>
<td>Cardiac</td>
<td>Precertification</td>
<td>Precertification is required. Contact AIM at 1-800-714-0400, Monday through Friday from 8 a.m. to 8 p.m. Eastern time.</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>Precertification</td>
<td>Precertification is not required.</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Inpatient</td>
<td>• Precertification is required for coverage of inpatient chemotherapy services.</td>
</tr>
<tr>
<td></td>
<td>Precertification</td>
<td>• Precertification is not required for coverage of chemotherapy procedures when performed in outpatient settings.</td>
</tr>
<tr>
<td></td>
<td>Outpatient</td>
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<tr>
<td>Service</td>
<td>Requirement</td>
<td>Comments</td>
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</tr>
<tr>
<td>Oncology and Ancillary Medications</td>
<td>No precertification</td>
<td>outpatient settings by a participating facility, provider office, outpatient hospital or ambulatory surgery center.</td>
</tr>
<tr>
<td></td>
<td>Oncology and Ancillary Medications: See the Pharmacy section of this manual.</td>
<td>- For information on coverage of and precertification requirements for chemotherapy drugs, see the Pharmacy section of this manual.</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Precertification</td>
<td>• Chiropractic services are limited to treatment by means of manual manipulation of the spine.</td>
</tr>
<tr>
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<td></td>
<td>• <strong>NJ FamilyCare D:</strong> Services performed by a chiropractor are not covered.</td>
</tr>
<tr>
<td>Cognitive Rehabilitation Therapy</td>
<td>Precertification</td>
<td>• Precertification is required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>See the <strong>Rehabilitation Therapy</strong> section of this grid.</td>
</tr>
<tr>
<td>Dental Services</td>
<td>Self-referral; orthodontia requires precertification</td>
<td><strong>New Jersey Medicaid/NJ FamilyCare A, ABP, B, C, D, MLTSS, and FIDE SNP:</strong></td>
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<tr>
<td></td>
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<td>• Members are required to visit their primary care dentist for dental services.</td>
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<td></td>
<td></td>
<td>• Dental services are covered, including diagnostic and preventive dental services, which include exams, cleanings, space maintainers, sealants and fluoride treatments every six months for all members regardless of age.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sealants and sealant repairs are covered once every three years for members under age 17 or with documentation of medical necessity.</td>
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<tr>
<td></td>
<td></td>
<td>• Orthodontia and restorative (fillings and crowns) as medically appropriate to restore natural tooth is covered.</td>
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<td></td>
<td><strong>Precertification:</strong></td>
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<td>• Required for treatment, including crowns; root canals; extractions; implants; TMJ treatment; periodontic, prosthodontic and endodontic services; oral and maxillofacial surgical procedures; and orthodontia.</td>
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<tr>
<td></td>
<td></td>
<td><strong>Orthodontia:</strong></td>
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<tr>
<td></td>
<td></td>
<td>• We will provide orthodontic services for limited, interceptive, habit correction or comprehensive</td>
</tr>
</tbody>
</table>
treatment in children when medically necessary based on state guidelines.

- Initial consultations and visits to conduct the HLD assessment do not require precertification.
- Medically necessary comprehensive services shall be provided for children demonstrating one or more of the following pathologies:
  - Severe functional difficulties
  - Developmental anomalies of facial bones and/or oral structures
  - Facial trauma resulting in severe functional difficulties
  - Demonstration that long term psychological health requires orthodontic correction
- Orthodontic treatment will refer to limited, interceptive and comprehensive orthodontic treatment, as well as all other ancillary orthodontic services considered only when medical criteria for exemption, as noted above, have been met.
- We will coordinate with the dental provider and enrollee on compliance and to ensure the anticipated treatment completion date will occur prior to the loss of benefit eligibility due to age. The dental office must provide an Informed Consent Form, which must be signed after the patient and parent or guardian are advised of the following:
  - The age limit for orthodontic coverage
  - Length of treatment
  - Consequences of excessive breakage of appliance(s) and/or other behavior that is not conducive to completing treatment in a timely manner
  - The enrollee’s responsibility for payment should coverage be lost for any reason
- We will provide a case rate for reimbursement of comprehensive orthodontic services with reimbursement paid out over the time of active treatment. The total comprehensive case rate is paid for a completed case regardless of the number of months needed for active treatment and retention.
- Prerertification for orthodontic services that is submitted during a member’s period of eligibility will be reviewed, and the member will be informed of any anticipated date of loss of eligibility if known and/or loss of the orthodontic benefit based on age.
<table>
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<tr>
<th>Service</th>
<th>Requirement</th>
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<tbody>
<tr>
<td>• Amerigroup will provide guidance for network providers on submission of prior authorization for initial, continuation and retention phase of treatment and have available the following documents for provider use:</td>
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<td>o Informed consent</td>
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<td>o Letter of attestation on completed dental services for the PCD</td>
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<td>o Release from treatment</td>
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<tr>
<td>• Children in comprehensive orthodontic care will be monitored by Amerigroup to facilitate compliance and completion of treatment, and Amerigroup will initiate outreach to the family when notified by the dentist of an orthodontic case in which behavior is not conducive to treatment completion. Case management will be provided to encourage behavioral changes that will allow completion of the case or facilitate preventive and needed dental treatment.</td>
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<tr>
<td>• Continuity of care through case completion will apply with continued eligibility.</td>
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<td>• Payment for orthodontic services will not be continued upon termination from a New Jersey Medicaid/NJ FamilyCare program.</td>
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<tr>
<td>• Orthognathic Surgical Cases with Comprehensive Orthodontic Treatment</td>
<td></td>
<td>o The surgical consult, treatment plan and approval for surgical case must be included with the request for prior authorization of the orthodontic services.</td>
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<td></td>
<td>o Prior authorization and documentation requirements are the same as those for comprehensive treatment and shall come from the treating orthodontist.</td>
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<tr>
<td></td>
<td></td>
<td>o The parent/guardian and patient should understand that loss of eligibility at any time during treatment will result in the loss of all benefits and payment by the NJFC/Medicaid program.</td>
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<tr>
<td>• Documentation of Completion of Comprehensive Cases – Final Records</td>
<td></td>
<td>o Attestation of case completion must be submitted on the provider’s letterhead to document that active treatment had a favorable outcome and that the case is ready for retention. Procedure code D8680, orthodontic retention shall be submitted on the visit to remove the bands and place the case in retention.</td>
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<tr>
<td>Service</td>
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<td></td>
<td><strong>Members may call Healthplex at 1-800-720-5352, Monday through Friday, 8 a.m. to 6 p.m. Eastern time for assistance with finding dental providers (TTY 711).</strong></td>
</tr>
</tbody>
</table>
| Dermatology Services  | Network providers require no precertification for Evaluation and Management (E&M), testing and most procedures. | **Services considered cosmetic in nature are not covered.**  
**See the Diagnostic Testing section in this manual.**  
**Visit our website to view specific service codes for precertification/notification requirements.** |
| Diagnostic Testing    |                                                                              | **No precertification is required for routine diagnostic testing.**  
**Precertification is required for coverage of MRA, MRI, CAT scans, PET scans, nuclear cardiac scans and video electroencephalograms. Any other nuclear radiology procedure requires precertification.**  
**Precertification through AIM is required for coverage of MRA, MRI, CAT scans, and nuclear cardiac and PET scans. Contact AIM at 1-800-714-0400 Monday through Friday from 8 a.m. to 8 p.m. Eastern time. AIM will locate an imaging facility from the Amerigroup network of radiology service providers.**  
**No precertification is required for tests performed in conjunction with a precertified or emergent inpatient stay.**  
**Outpatient radiology services excluded from the precertification requirement (which may be provided at a hospital without precertification) include radiation oncology services, services provided in association with an emergency room visit, observation stays and services associated with and on the same day as a precertified outpatient surgery performed at a hospital.**  
**NJ FamilyCare D: There is no coverage for thermography and thermograms.** |
| Dialysis              |                                                                              | **No precertification is required for coverage of dialysis procedures performed at a participating provider.**  
**Precertification is required for medications related to dialysis treatment.**                                                                 |
## Amerigroup Community Care Precertification/Notification Coverage Guidelines

<table>
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<tr>
<th>Service</th>
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</table>
| Durable Medical Equipment         | Precertification and Certificate of Medical Necessity (CMN) | - No precertification is required for coverage of glucometers and nebulizers, dialysis and end-stage renal disease equipment, gradient pressure aids, infant photo/light therapy, sphygmomanometers, walkers and orthotics for arch support, heels, lifts, shoe inserts and wedges by network providers.  
- **All Durable Medical Equipment (DME) billed with an RR modifier (rental) requires precertification.**  
- Precertification is required for coverage of certain prosthetics, orthotics and DME. For code-specific precertification requirements for DME, prosthetics and orthotics ordered by a network provider or network facility, please use the Precertification Lookup tool on our provider website.  
- See the Medical Supplies section of this manual for guidelines related to disposable medical supplies.  
- Precertification may be requested by completing a CMN — available on our website — or by submitting a physician order and Amerigroup Referral and P 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 devices, enteral nutrition devices and oxygen. Amerigroup and the provider must agree on Health Care Common Procedural Coding System (HCPCS) and/or other codes for billing covered services. All custom wheelchair precertifications require an Amerigroup medical director’s review.  
- **NJ FamilyCare D** members receive limited coverage for DME. |
| Early and Periodic Screening, Diagnostic and Treatment Visit | Self-referral                                      | - Use Early and Periodic Screening, Diagnostic and Treatment (EPSDT) schedule and document visits/encounters on a Centers for Medicare and Medicaid Services (CMS) 1500 claim form to receive incentive payments. Copays do not apply to EPSDT services.  
- **NJ FamilyCare D** members receive limited coverage for EPSDT services. |
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<th>Service</th>
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<tr>
<td>Educational Consultation</td>
<td></td>
<td>No notification or precertification is required.</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>Self-referral</td>
<td>• No notification is required for emergency care provided in the emergency room. If emergency care results in admission, notification to Amerigroup is required within 24 hours or the next business day.</td>
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<tr>
<td></td>
<td></td>
<td>• For observation precertification requirements, see the Observation section of this manual.</td>
</tr>
<tr>
<td>Enteral Formulas and Nutritional Supplements</td>
<td>Precertification</td>
<td>• Enteral formula and nutritional supplements are covered under DME benefit and must be obtained through a DME provider rather than though a pharmacy under the pharmacy benefit.</td>
</tr>
<tr>
<td>Ear, Nose and Throat Services (Otolaryngology)</td>
<td></td>
<td>• Precertification is required for:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Tonsillectomy and/or adenoidectomy</td>
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<td>• Nasal/sinus surgery</td>
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<tr>
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<td>• Cochlear implant surgery and services</td>
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<tr>
<td></td>
<td></td>
<td>Visit our website to view specific service codes for precertification/notification requirements. See the Diagnostic Testing section of this manual.</td>
</tr>
<tr>
<td>Family Planning/Sexually Transmitted Disease</td>
<td>Self-referral</td>
<td>• Infertility treatment is not covered. Covered services include pelvic and breast exams, lab work, drugs and biological devices and supplies related to family planning (e.g., intrauterine device).</td>
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<td>• No coverage is available outside the participating network for NJ FamilyCare D members.</td>
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<td>• No precertification or notification is required for coverage of primary sterilization procedures; member must be age 21 or older.</td>
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<tr>
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<td>• <strong>A Sterilization Consent Form is required for claims submission of primary sterilization procedures.</strong></td>
</tr>
<tr>
<td>Gastroenterology Services</td>
<td></td>
<td>Precertification is required for upper endoscopy, bariatric surgery, including insertion, removal and/or replacement of adjustable gastric-restrictive devices and subcutaneous port components.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Visit our website to view specific service codes for precertification/notification requirements. See the Diagnostic Testing section of this manual.</td>
</tr>
<tr>
<td>Gynecology</td>
<td>Self-referral</td>
<td>• No precertification is required for E&amp;M, testing and outpatient procedures.</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Precertification</td>
<td>• Precertification is required for digital hearing aids.</td>
</tr>
<tr>
<td>Service</td>
<td>Requirement</td>
<td>Comments</td>
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<td><strong>New Jersey Medicaid/NJ FamilyCare A, ABP, B and C:</strong> Precertification is required for coverage.</td>
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<td></td>
<td><strong>NJ FamilyCare D:</strong> Hearing aid and audiology services are covered for NJ FamilyCare D members age 15 and younger but are limited to $1,000 per ear every 24 months under Grace’s Law.</td>
</tr>
<tr>
<td>Hearing Screening</td>
<td></td>
<td>No notification or precertification is required for coverage of diagnostic and screening tests, hearing aid evaluations or counseling.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>NJ FamilyCare D:</strong> Hearing aid and audiology services are covered for NJ FamilyCare D members age 15 and younger but are limited to $1,000 per ear every 24 months under Grace’s Law.</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Precertification</td>
<td><strong>New Jersey Medicaid/NJ FamilyCare A, ABP, B and C:</strong> Covered services are limited to skilled nursing, home health aide and medical social services that require precertification for coverage.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>NJ FamilyCare D:</strong> Covered services are limited to skilled-nursing that is supervised by a registered nurse and home health aide when the purpose of treatment is skilled care and social services required for treatment of the member’s medical condition.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Private-duty nursing is covered by the plan for Medicaid and A, B, C, D and ABP members until their 21st birthday.</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Precertification /Notification</td>
<td>Precertification is required for coverage of inpatient hospice services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Notification is required for coverage of outpatient hospice services.</td>
</tr>
<tr>
<td>Hospital Admission</td>
<td>Precertification</td>
<td>Elective admissions require precertification for coverage.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emergency admissions require notification within 24 hours or the next business day.</td>
</tr>
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<td>For preadmission lab testing, see the provider referral directory for a complete list of participating vendors.</td>
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<td>Same-day admission is required for surgery.</td>
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<tr>
<td>Laboratory Services (Outpatient)</td>
<td></td>
<td>All laboratory services furnished by non-network providers require precertification by Amerigroup, except for hospital laboratory services provided for an emergency medical condition.</td>
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<td></td>
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<td>For offices with limited or no office laboratory facilities, lab tests may be referred to an Amerigroup lab vendor.</td>
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<td>See your provider referral directory for a complete listing of participating lab vendors.</td>
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</table>
## Amerigroup Community Care Precertification/Notification Coverage Guidelines

<table>
<thead>
<tr>
<th>Service</th>
<th>Requirement</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Medical Supplies</td>
<td></td>
<td>• No precertification is required for coverage of disposable medical supplies. <strong>NJ FamilyCare D:</strong> Coverage for NJ FamilyCare D members is limited to the following: apnea monitors; bathroom equipment (permanently affixed equipment is not covered); catheterization and related supplies; commodes; DME repairs; enteral nutrition and related services/supplies; hospital beds (manual, semi-electric and full electric) and related equipment; insulin pumps and related supplies; manual wheelchairs (motorized wheelchairs are not covered); nebulizers and related supplies; ostomy/ileostomy/jejunostomy supplies; oxygen and related equipment/supplies; pacemaker monitors; parenteral therapy and related services/supplies; patient lifts and related equipment; pressure mattresses/pads (low air-loss and air-fluidized beds are not covered); respiratory-assist devices and related supplies; suction machines and related supplies; Total Parenteral Nutrition (TPN) equipment and related supplies; tracheostomy supplies; traction/trapeze apparatus; wheelchair accessories; wound care supplies; and wound VAC and related supplies.  • Hearing aid supplies are covered for NJ FamilyCare D members age 15 and younger but are limited to $1,000 per ear every 24 months under Grace’s Law.</td>
</tr>
<tr>
<td>Neurology</td>
<td>No precertification is required for network provider for E&amp;M and testing.</td>
<td>• Precertification is required for neurosurgery, spinal fusion and artificial intervertebral disc surgery. Visit our provider website to view specific service codes for precertification/notification requirements.  • See the Diagnostic Testing section of this manual.</td>
</tr>
<tr>
<td>Observation</td>
<td></td>
<td>• No precertification or notification is required for in-network observation.</td>
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<tr>
<td>Service</td>
<td>Requirement</td>
<td>Comments</td>
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<tr>
<td>Amerigroup Community Care</td>
<td></td>
<td>• If observation results in admission, notification to Amerigroup is required within 24 hours or the next business day.</td>
</tr>
<tr>
<td>Obstetrical Care</td>
<td></td>
<td>• No precertification is required for coverage of obstetrical services when performed by a participating provider.</td>
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<tr>
<td></td>
<td></td>
<td>• Notification to Amerigroup is required at the first prenatal visit.</td>
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<tr>
<td></td>
<td></td>
<td>• Notification is required for coverage of emergency and obstetric admissions within 24 hours or the next business day. See the Diagnostic Testing section of this manual.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Two ultrasounds for normal pregnancy diagnosis are covered.</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>No precertification is required for E&amp;M, testing and most procedures.</td>
<td>See the Plastic/Cosmetic/Reconstructive Surgery section of this manual. Visit our provider website to view specific service codes for precertification/notification requirements.</td>
</tr>
<tr>
<td>Oral Maxillofacial</td>
<td></td>
<td>• No precertification is required for coverage of E&amp;M-level office visits.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Precertification is required for coverage of all other services, including coverage of trauma to the teeth and oral maxillofacial medical and surgical conditions (including TMJ treatment).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• See the Plastic/Cosmetic/Reconstructive Surgery section of this manual.</td>
</tr>
<tr>
<td>Otolaryngology Services</td>
<td></td>
<td>See the Ear, Nose and Throat Services (Otolaryngology) section of this manual.</td>
</tr>
<tr>
<td>Out-of-Area/Out-of-Plan Care</td>
<td>Precertification</td>
<td>Precertification is required except for the coverage of emergency care (including self-referral) and OB delivery. See related services for precertification. Emergency admission to an out-of-area/out-of-network facility requires notification within one business day.</td>
</tr>
<tr>
<td>Outpatient/Ambulatory Surgery</td>
<td>Precertification</td>
<td>Precertification is required based on the procedure performed. See the Precertification Lookup tool on our website.</td>
</tr>
<tr>
<td>Pain Management</td>
<td>Precertification</td>
<td>Non-E&amp;M-level testing and procedures require precertification for coverage.</td>
</tr>
<tr>
<td>Perinatology</td>
<td></td>
<td>See Diagnostic Testing and Laboratory Services.</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Prior Authorization/Precertification</td>
<td>• The pharmacy benefit covers medically necessary prescription and over-the-counter medications prescribed by a licensed provider. Exceptions and</td>
</tr>
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<table>
<thead>
<tr>
<th>Service</th>
<th>Requirement</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Physiatry</td>
<td>Precertification is required for coverage of all non-E&amp;M services and procedures related to pain management.</td>
<td></td>
</tr>
<tr>
<td>Physical Medicine and Rehabilitation</td>
<td>• Outpatient Physical Therapy (OPT), Occupational Therapy (OT) and Speech Therapy (ST) are covered. Facility based therapy services require precertification. See Rehabilitation Therapy (Outpatient: Occupational, Physical and Speech Therapies and Cognitive Rehabilitation Therapy).</td>
<td></td>
</tr>
<tr>
<td>Plastic/Cosmetic/Reconstructive</td>
<td>• No precertification is required for coverage of E&amp;M codes. All other services require precertification.</td>
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<tr>
<td>Service</td>
<td>Requirement</td>
<td>Comments</td>
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<tr>
<td>Surgery (including Oral Maxillofacial Services)</td>
<td></td>
<td>• Services considered cosmetic in nature are not covered. Services related to a previous cosmetic procedure are not covered.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Reduction mammoplasty requires an Amerigroup medical director’s review.</td>
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<tr>
<td></td>
<td></td>
<td>• No precertification is required for coverage of oral maxillofacial E&amp;M services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Precertification is required for coverage of trauma to the teeth, and oral maxillofacial medical and surgical conditions including TMJ. Visit our provider website to view specific service codes for precertification/notification requirements.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• See the Oral Maxillofacial and Diagnostic Testing sections of this manual.</td>
</tr>
<tr>
<td>Podiatry</td>
<td></td>
<td>• No precertification is required for coverage of E&amp;M testing and most procedures when provided by a participating podiatrist.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Visit our provider website to look up specific service codes for precertification/notification requirements.</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td></td>
<td>• No precertification is required for coverage of radiation therapy procedures when performed in the following outpatient settings by a participating facility or provider: office, outpatient hospital and ambulatory surgery center.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Precertification is required for coverage of services rendered in an inpatient setting.</td>
</tr>
<tr>
<td>Radiology</td>
<td></td>
<td>See Diagnostic Testing.</td>
</tr>
<tr>
<td>Rehabilitation Therapy (Outpatient: Occupational, Physical and Speech Therapies and Cognitive Rehabilitation Therapy)</td>
<td></td>
<td>• <strong>New Jersey Medicaid/NJ FamilyCare A and ABP:</strong> Outpatient therapy services are covered. Facility based therapy services require precertification.</td>
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<tr>
<td></td>
<td></td>
<td>• <strong>NJ FamilyCare B and C:</strong> Outpatient therapy services are covered for 60 visits per incident per therapy per calendar year. Facility based therapy services require precertification.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>NJ FamilyCare D:</strong> Outpatient physical therapy, occupational therapy and speech therapy services for nonchronic conditions, acute illness and injuries are covered. Facility based therapy services require precertification.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Outpatient therapy care (including PT, OT and SP evaluation and therapy services) are arranged through TNNJ. Therapy</td>
</tr>
<tr>
<td>Service</td>
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</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Precertification</td>
<td>• Precertification is required for coverage of all care and services provided in a skilled nursing facility.</td>
</tr>
<tr>
<td>Sleep Medicine/Study</td>
<td>Precertification</td>
<td>• Precertification is required through AIM at 1-800-714-0040.</td>
</tr>
<tr>
<td>Sterilization</td>
<td></td>
<td>• Sterilization is a covered benefit for members age 21 and older.</td>
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<tr>
<td></td>
<td></td>
<td>• No precertification or notification is required for sterilization procedures, including tubal ligation and vasectomy.</td>
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<tr>
<td></td>
<td></td>
<td>• The sterilization consent form is required for claims submission for primary sterilization procedures.</td>
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<td></td>
<td></td>
<td>• Reversal of sterilization is not a covered benefit.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sterilization services from a nonparticipating provider are not covered.</td>
</tr>
<tr>
<td>Termination of Pregnancy</td>
<td></td>
<td>Elective, induced abortion and related services are covered by the New Jersey Medicaid FFS program. For benefit questions, members may call the New Jersey Medicaid Hotline at 1-800-356-1561. For New Jersey Medicaid FFS claims information, providers should call Molina at 1-800-776-6334.</td>
</tr>
<tr>
<td>Nonemergency Transportation except for MLTSS Non-Medical Transportation – MLTSS members call their Care Managers</td>
<td></td>
<td>• For all cities and counties, members should call LogistiCare at 1-866-527-9933.</td>
</tr>
<tr>
<td>Vision Care (Medical)</td>
<td>No precertification is required for testing and procedures.</td>
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<td></td>
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<td>• Precertification is required for repair of eyelid defects.</td>
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<td></td>
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<td>• Services considered cosmetic in nature are not covered.</td>
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<tr>
<td></td>
<td></td>
<td>• See the Diagnostic Testing section of this manual.</td>
</tr>
<tr>
<td>Service</td>
<td>Requirement</td>
<td>Comments</td>
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</table>
| Vision Care (Routine)   | Self-referral | • **New Jersey Medicaid/NJ FamilyCare A, ABP, B and C:** Coverage is limited to one routine eye exam per year. Members may contact Superior Vision at 1-800-428-8789.  
• **New Jersey Medicaid/NJ FamilyCare A, ABP, B and C:** Coverage is provided for one pair of eyeglass lenses once every 12 months for members under age 19 and age 60 and older.  
• **New Jersey Medicaid/NJ FamilyCare A, ABP, B and C:** Coverage is provided for one pair of eyeglass lenses once every 24 months for members age 19 through 59 as medically necessary.  
• **NJ FamilyCare D:** Members are eligible for a new pair of eyeglass lenses every 24 months or as medically necessary.  
• Coverage is provided for contact lenses once every 24 months for specific pathological conditions and vision correction that cannot be improved to at least 20/70 or better with regular lenses. Members not meeting the medical necessity benefit can opt for contact lenses as a value-added benefit. Amerigroup will reimburse the lesser of usual and customary charges or $100. |
| Well-Woman Exam         | Self-referral | • Well-woman exams are covered once per calendar year when performed by a PCP or in-network gynecologist.  
• Exam includes routine lab work, sexually transmitted disease screening, Pap smear and mammogram (age 35 or older). |
| Revenue Codes           | To the extent the following services are covered benefits, precertification or notification is required for all services billed with the following revenue codes:  
• All inpatient and behavioral health accommodations  
• 0023 — Home health prospective payment system  
• 0240 through 0249 — All-inclusive ancillary psychiatric  
• 0632 — Pharmacy multiple source  
• 3101 through 3109 — Adult day care and foster care |

For services that require precertification, we use McKesson InterQual Criteria.

We are staffed with clinical professionals who coordinate services provided to members and are available 24 hours a day, 7 days a week to accept precertification requests. When a request for medical services is received from the physician via fax, the precertification assistant will verify eligibility and benefits and will forward the request to the nurse reviewer.
The nurse will review the request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. When appropriate, the nurse will assist the physician in identifying alternatives for health care delivery as supported by the medical director. All determinations to deny or limit an admission, service procedure or extension of stay shall be rendered by a physician.

When the clinical information received meets medical necessity criteria, an Amerigroup reference number will be issued to the referring physician.

If the request is a stat/urgent request (expedited service authorizations), the decision will be made within 24 hours of receipt of the necessary information but no later than three business days after receipt of the request for services.

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

If the medical director denies the request for coverage, the appropriate Notice of Action will be mailed to the requesting provider, the member’s PCP, the facility and the member.

10.3 Inpatient Reviews

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

Inpatient Concurrent Review
Each network hospital will have an assigned UM clinician. Each UM clinician will conduct a concurrent review of the hospital medical record by telephone to determine the authorization of coverage for a continued stay.

The UM clinician will conduct continued stay reviews daily and review discharge plans, unless the patient’s condition is such that it is unlikely to change within the upcoming 24 hours and discharge planning needs cannot be determined.

When the clinical information received meets medical necessity criteria, approved days and bed-level coverage will be communicated to the hospital for the continued stay.

If the discharge is approved, our UM clinician will help coordinate discharge planning needs with the hospital utilization review staff and attending physician. The attending physician is expected to coordinate with the member’s PCP regarding follow-up care after discharge. The PCP is responsible for contacting the member to schedule all necessary follow-up care. In the case of a behavioral health
discharge, the attending physician is responsible for ensuring that the member has secured an appointment for a follow-up visit with a behavioral health provider to occur within seven calendar days of discharge.

We will authorize the covered length of stay one day at a time based on the clinical information that supports the continued stay. Exceptions to the one-day length of stay authorization are made for confinements when the severity of the illness and subsequent course of treatment are likely to be several days or are predetermined by state law. Examples of confinement and/or treatment include the following: ICU, CCU, behavioral health rehabilitation and C-section or vaginal deliveries. Exceptions are made by the medical director.

If, based upon appropriate criteria and after attempts to speak to the attending physician, the medical director denies coverage for an inpatient stay request, the appropriate notice of action will be mailed to the hospital, member’s PCP and member.

**Inpatient Retrospective Review**

Inpatient admissions that were not notified or authorized (as applicable) will be reviewed retrospectively, if appropriate utilization management protocols have been followed. Please note that we require notification within one business day following an emergent or urgent admission. Elective admissions need to be authorized 72 hours prior to admission.

Medical records requested for the purpose of quality improvement audits are also reviewed retrospectively. Providers’ Medical Records departments will be contacted to determine the procedure for securing access to medical records. Our authorized coordinator reviews the charts, obtaining copies of pertinent records for review by the medical director. If quality improvement criteria are not met, the case is referred to the medical director, who evaluates the case and renders a decision for hospitalization.

**10.4 Discharge Planning**

Discharge planning is designed to assist the provider in the coordination of the member discharge when acute care (hospitalization) is no longer necessary.

When long-term care is necessary, we work with the provider to plan the member’s discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital facility, such as:

- Hospice facility
- Convalescent facility
- Home health care program (e.g., home intravenous antibiotics)

When the provider identifies medically necessary and appropriate services for the member, we will assist the provider and the discharge planner in providing a timely and effective transfer to the next appropriate level of care.
Discharge plan authorizations follow InterQual Criteria. Authorizations include and are not limited to transportation, home health, DME, pharmacy, follow-up visits to practitioners and outpatient procedures.

10.5 Continuity of Care

If a member’s physician is terminated from the network for any reason, he or she may, under certain circumstances, continue to provide medically necessary services to the member for four months or longer for certain types of treatment. A member will continue care with the treating physician under the following conditions:

- A pregnancy that requires the treating physician to continue the postpartum evaluation of the member for up to six weeks after delivery
- Postoperative care that requires the treating physician to continue care for a period up to six months
- Oncology treatment that requires the treating physician to continue care for a period up to one year
- Psychiatric treatment that requires the treating physician to continue care for a period up to one year

10.6 Confidentiality of Information

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

10.7 Emergency Services

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

We do not discourage members from using the 911 emergency systems or deny access to emergency services. Emergency services are provided to members without requiring precertification. Emergency services coverage includes services that are needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

Emergency medical condition: A physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:
• Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
• Serious impairment to bodily functions
• Serious dysfunction of any bodily organ or part

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

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

Emergency services will include an examination at an emergency room for suspected physical/child abuse and/or neglect. A medical examination at an emergency room is required by N.J.A.C. 10:122D-2.5(b) when a foster home placement of a child occurs after business hours.

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

For NJ FamilyCare D members, no copayment is required if the member was referred to the emergency room by his or her PCP for services that should have been rendered in the PCP’s office or if the member is admitted into the hospital. The PCP should notify us to ensure appropriate adjudication of the claim.

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

10.8 Urgent Care

We require our members to contact their PCPs in situations where urgent, unscheduled care is necessary. Precertification with Amerigroup is not required for a member to access a participating urgent care center.
11 QUALITY MANAGEMENT

11.1 Quality Management Program

Overview
Our Quality Management (QM) program is committed to excellence in the quality of service and care our members receive and the satisfaction of our network providers, and we are constantly looking for ways to refine our program.

Our comprehensive QM program:
- Adheres to the New Jersey-modified Quality Assessment and Performance Improvement program standards
- Objectively monitors and evaluates the care and services provided to members
- Plans studies across the continuum of care and service to ensure ongoing, proactive evaluation and refinement of the program
- Reflects the demographic and epidemiological needs of the population served
- Encourages both members and providers to weigh in with recommendations for improvement
- Identifies areas where we can promote and improve patient safety

The initial program development was based on a review of the needs of the population served. Systematic re-evaluation of the needs of the Amerigroup-specific population occurs on an annual basis. This includes not only age/sex distribution, but also a review of utilization data — inpatient, emergent/urgent care and office visits by type, cost and volume. This information is used to define high-volume and problem-prone areas.

We adhere to the New Jersey-modified Quality Assessment and Performance Improvement (QAPI) program. The QAPI objectively and systematically monitors and evaluates the quality and appropriateness of care and service to members through quality-of-care studies and related activities and pursues opportunities for improvement on an ongoing basis. Opportunities to promote and improve patient safety are inherent in the Quality Management Program. Practitioners and providers must allow Amerigroup to use performance data in cooperation with our quality improvement program and activities.

The Quality Management Committee structure is overseen by the Amerigroup governing body and includes:
- A Quality Management Committee
- A Provider Advisory Committee
- A Credentialing Committee
- A Health Education Community Advisory Committee

Quality of Care
All physicians, advanced registered nurse practitioners and Physician Assistants (PAs) are evaluated for compliance with pre-established standards as described in our credentialing program.
Review standards are based on medical community standards, external regulatory and accrediting agencies requirements and contractual compliance.

Reviews are accomplished by Quality Management (QM) coordinators and associate professionals who strive to develop relationships with providers and hospitals that will positively impact the quality of care and services provided to our members.

Results are submitted to our QM department and incorporated into a profile.

Our quality program includes review of quality of care issues identified for all care settings. QM staff uses member complaints, reported adverse events and other information to evaluate the quality of service and care provided to our members.

### 11.2 Quality Management Committee

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

The QMC’s responsibilities are to:

- Establish strategic direction and monitor and support implementation of the quality management program
- Establish processes and structure that ensure NCQA compliance
- Review planning, implementation, measurement and outcomes of clinical/service quality improvement studies
- Coordinate communication of quality management activities throughout Amerigroup
- Review HEDIS data and action plans for improvement
- Review and approve the annual quality management program description
- Review and approve the annual work plans for each service delivery area
- Provide oversight and review of delegated services
- Provide oversight and review of subordinate committees
- Receive and review reports on utilization review decisions and take action when appropriate
- Analyze member and provider satisfaction survey responses
- Monitor Amerigroup operational indicators through Amerigroup senior staff

Throughout the year, we evaluate data trends related to how our members receive health care and preventive care services and compare our findings to national practice guidelines. Clinical performance and service satisfaction are based upon results from:

- **Medicaid Healthcare Effectiveness Data and Information Set (HEDIS)** — A program developed by the National Committee for Quality Assurance (NCQA) to measure how effectively health plans and providers deliver preventive care

- **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** — Surveys evaluating member satisfaction with care and services received over the past six months; a random sample of New Jersey plan members answered questions about their doctors and the health plan
To review the complete Quality Improvement Program evaluation, call Provider Services at 1-800-454-3730 — we’ll be glad to send you a copy.

11.3 Provider Advisory Committee

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

The PAC’s responsibilities are to:

- Use an ongoing peer review system to monitor practice patterns, to identify appropriateness of care and to improve risk prevention activities
- Approve clinical protocols and guidelines which help ensure the delivery of quality care and appropriate resource utilization
- Review clinical study design and results
- Develop action plans and recommendations regarding clinical quality improvement studies
- Consider and act in response to provider sanctions
- Provide oversight of Credentialing Committee decisions to credential and recredential providers for participation in our network
- Approve credentialing and recredentialing policies and procedures
- Oversee members’ access to care
- Review and provide feedback regarding new technologies
- Approve recommendations from subordinate committees

11.4 Credentialing

Our credentialing policies and procedures incorporate the current NCQA Standards and Guidelines for the Accreditation of Health Plans as well as the New Jersey Division of Medical Assistance and Health Services (DMAHS) requirements for the credentialing and recredentialing of licensed independent providers and organizational providers with whom it contracts.

Each provider agrees to submit for verification all requested information necessary to credential or recredential physicians providing services in accordance with the standards we have established. Each provider will cooperate with us as necessary to conduct credentialing and recredentialing pursuant to our policies, procedures and rules.
Credentialing Requirements
Each provider, applicable ancillary, facility and hospital will remain in full compliance with all our credentialing criteria as set forth in its Credentialing Policies and Procedures and all applicable laws and regulations. Each provider, applicable ancillary, facility and hospital will complete an Amerigroup application form upon our request. Individual physicians may use the Council for Affordable Quality Healthcare Application, New Jersey Universal Physician Application and the New Jersey Physician Recredentialing Application in lieu of our applications if they so choose. Each provider will comply with such other credentialing criteria as may be established by Amerigroup.

We adhere to the QAPI provisions regarding credentialing and recredentialing.

Recredentialing is generally performed every three years.

Credentialing Procedures
We are committed to operating an effective, quality credentialing program. We credential the following provider types: Medical Doctors (MDs), Doctors of Osteopathy (DOs), doctors of dental surgery, doctors of dental medicine, doctors of podiatric medicine, doctors of chiropractic, physician assistants, optometrists, nurse practitioners, certified nurse midwives, licensed professional counselors/social workers, psychologists, speech/language therapists and other applicable or appropriate mid-level providers as well as hospitals and allied services (ancillary) providers.

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

We will establish a Credentialing Committee and a Provider Advisory Committee for the formal determination of recommendations regarding credentialing decisions. The Credentialing Committee will make decisions regarding participation of initial applicants and their continued participation at the time of recredentialing. The oversight rests with the Provider Advisory Committee.

Our credentialing policy is revised periodically based on input from several sources, including the credentialing committees, our medical director, our chief medical officer, and state and federal requirements. The policy will be reviewed and approved as needed but at a minimum 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. We are responsible for externally verifying specific items attested to on the application. Any discrepancies between information included in the application and information we obtain 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 documents compliance with our managed care policies and procedures and state requirements.

Each provider has the right to inquire about the status of his or her application. He or she may do so by the following methods: (1) telephone; (2) facsimile; (3) contact through his or her Provider Relations representative; or (4) in writing.
As an applicant for participation in our network, each provider has the right to review information obtained from primary verification sources during the credentialing process. Upon notification from us, the provider has the right to explain information obtained that may vary substantially from that provided and to provide 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.

Currently, the following verifications are completed as applicable prior to final submission of a practitioner file to the Amerigroup medical director or Credentialing Committee. To the extent allowed under applicable law or state agency requirements, per NCQA Standards and Guidelines, the medical director has authority to approve clean files without input from the Credentialing Committee. All files not designated as a clean file will be presented to the Credentialing Committee for review and decision regarding participation.

In addition to the submission of an application and the execution of a Participating Provider Agreement, the following must be reviewed and approved by the Credentialing Committee or the medical director.

1. **Board certification.** Verification by referencing the American Medical Association (AMA) Provider Profile, American Osteopathic Association, the American Board of Medical Specialties, American Board of Podiatric Surgery and/or American Board of Podiatric Orthopedics and Primary Podiatric Medicine. All dental specialists have met the NJ Board requirements for that specialty and have a current specialty permit.

2. **Verification of education and training.** Verification by referencing board certification or the appropriate state-licensing agency.

3. **Verification of work history.** The practitioner must submit a curriculum vitae documenting work history for the past five years. Any gaps in work history greater than six months must be explained in writing and brought to the attention of the medical director and Credentialing Committee, as applicable.

4. **Hospital affiliations and privileges.** To the extent allowed under applicable law or state agency requirements, verification of clinical privileges in good standing at an Amerigroup network hospital may be accomplished by the use of an attestation signed by the provider. If an attestation is not acceptable, hospital admitting privileges in good standing are verified for the practitioner. This information is obtained in the form of a written letter from the hospital, roster format (multiple practitioners), Internet access or by telephone contact. The date and name of the person spoken to at the hospital are documented.

5. **State licensure or certification.** Verification of state license information to ensure that the practitioner maintains a current legal license or certification to practice in the state. This information can be verified by referencing data provided to Amerigroup by the state via roster, telephone or the Internet.

6. **DEA number.** Verification of the Drug Enforcement Administration (DEA) number to ensure the practitioner is currently 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 (NTIS) data. If the practitioner is not required to possess a DEA certificate but does hold a state controlled substance certificate, the Controlled Dangerous Substance (CDS) certificate is verified to
ensure the practitioner is currently eligible to prescribe controlled substances. This information is verified by obtaining a copy of the CDS certificate or by referencing CDS online or Internet data if applicable.

All dentists must have, or have confirmations of application submission, of valid DEA and CDS certificates.

7. **Professional liability coverage.** To the extent allowed under applicable law or state agency requirements, verification of malpractice coverage may be accomplished by the use of an attestation signed by the provider, indicating the name of the carrier, policy number, coverage limits and the effective and expiration dates of such malpractice coverage. If attestation is not acceptable, the practitioner’s malpractice insurance information is verified by obtaining a copy of the professional liability insurance face sheet from the practitioner or from the malpractice insurance carrier. Practitioners are required to maintain professional liability insurance in specified amounts.

8. **Professional liability claims history.** Verification of an applicant’s history of professional liability claims, if any, reviewed by our 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, total number and frequency of claims in the past five years, and the amounts of settlements and/or judgments.

9. **CMS sanctions.** Verification that the practitioner’s record is clear of any sanctions by Medicare/Medicaid. This information is verified by accessing the NPDB. The Excluded Parties Listing Service (EPLS) website is also reviewed to further ensure there are no sanctions that would prevent the provider from participating in any federal program.

10. **Disclosures – attestation and release of information.** Our provider application will require responses to the following:
    - Physical or mental health reasons for the inability to perform the essential functions of the position with or without accommodation
    - Any history or current problems with chemical dependency, alcohol or substance abuse
    - History of license revocations, suspension, voluntary relinquishment, probationary status, or other licensure conditions or limitations
    - History of conviction of any criminal offense other than minor traffic violations
    - History of loss or limitation of hospital privileges or disciplinary activity, including denial, suspension, limitation, termination or nonrenewal of professional privileges
    - History of complaints or adverse action reports filed with a local, state, or national professional society or licensing board
    - History of refusal or cancellation of professional liability insurance
    - History of suspension or revocation of a DEA or CDS certificate
    - History of any Medicare/Medicaid sanctions
    - Attestation by the applicant of the correctness and completeness of the application
    Any issue identified must be explained in writing. These explanations are presented with the provider’s application to the Credentialing Committee.

11. **NPDB Reporting.** The NPDB is queried against applicants and our contracted providers. The NPDB will provide a report for every practitioner queried. These reports are shared with the medical director and the Credentialing Committee for review and action as appropriate. The Federation of
State Medical Boards for MDs, DOs and PAs is queried to verify any restrictions and/or sanctions made against the practitioner’s license. The appropriate state-licensing agency is queried for all other providers. All sanctions are investigated and documented, including Amerigroup decision to accept or deny the applicant’s participation in the network.

12. **Americans with Disabilities Act (ADA) Provider Survey Form.** Your office must be ADA compliant and you must complete and return the ADA Provider Survey Form in order to be credentialed with us.

13. **Recredentialing.** At the time of recredentialing (every three years), information for from quality improvement activities, performance indicators, utilization management, member complaints, member satisfaction surveys and reverification of work history, hospital privileges, and current licensure is also presented for the Credentialing Committee’s review.

14. **Criminal Background Checks.** Attestation of compliance with all State required completion of the New Jersey Criminal Background Check Attestation.

The provider will be notified by telephone or in writing if any information obtained in support of the assessment or reassessment process varies substantially from the information submitted by the providers. 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 or deny initial participation will be communicated in writing within 60 days of the Credentialing Committee’s decision. To the extent allowed under applicable law or state agency requirements per NCQA Standards and Guidelines, the medical director may render a decision regarding the approval of clean files without benefit of input from the Credentialing Committee. In the event the provider’s continued participation is denied, the provider will be notified by certified mail. If continued participation is denied, the provider will be allowed 30 days to appeal the decision.

**Credentialing Organizational Providers**

The provider application contains the provider’s actual signature that 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 mental health or substance abuse services in an inpatient, residential or ambulatory setting.

Currently, the following steps are completed in addition to the application and Network Provider Agreement before approval for participation of a hospital or organizational provider.

State licensure is verified by obtaining a current copy of the state license from the organization or by contacting the state-licensing agency. Primary source verification is not required. Any restrictions to a license are investigated and documented, including the decision to accept or deny the organization’s participation in the network.

We contract with facilities that meet the requirements of an unbiased and recognized authority. Hospitals (e.g., acute, transitional or rehabilitation) should be accredited by the Joint Commission on
Accreditation of Healthcare Organizations (JCAHO), 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 JCAHO or the Community Health Accreditation Program. Nursing homes should be accredited by JCAHO. JCAHO or the Accreditation Association for Ambulatory Health Care should accredit ambulatory surgical centers. If facilities, ancillaries or hospitals are not accredited, we will accept a copy of a recent state or CMS review in lieu of performing an onsite review. If accreditation or copy of a 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 our policy.
- We will track a facility’s or ancillary’s reassessment date and reassess every 36 months as applicable. Requirements for recredentialing of organizational providers are the same for reassessment as they are for the initial assessment.
- Medicare and Medicaid sanctions are reviewed by accessing the Office of the Inspector General website.
- The EPLS website and other state required databases are reviewed to further ensure there are no sanctions that would prevent the provider from participating in any federal or state program.

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

Organizations have the right to review the information submitted in support of the assessment 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 terminate an organization’s participation will be communicated in writing via certified mail.

**Delegated Credentialing**

We will ensure the quality of our credentialing program through direct verification and through delegation of credentialing functions to qualified provider organizations with state approval. Where a provider group is believed to have a strong credentialing program, we may evaluate a delegation of credentialing and recredentialing. A provider group must have a minimum of 150 participating providers.

The Credentialing department will review the written credentialing policy of the provider group for adequacy. Steps, if any, are identified where the provider group’s credentialing policy does not meet our standards. We will perform or arrange for the provider group to perform our credentialing steps not addressed by the provider group.

We will perform a predelegation audit of the provider group’s credentialing practices. A passing score is considered to be an overall average of 90 percent compliance. The provider group is expected to submit an acceptable corrective action plan within 30 days of receipt of the audit results. If there are
serious deficiencies, we will deny the delegation or will restrict the level of delegation. We may waive the need for the predelegation onsite audit if the delegated entity’s credentialing program is NCQA-certified to include all credentialing and recredentialing elements. We are responsible for oversight of any delegated credentialing arrangement and schedules appropriate reviews. The reviews are held at least annually.

Peer Review
The peer review process provides a systematic approach for monitoring the quality and appropriateness of care.

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

Should investigation of a member grievance result in concern regarding a physician’s compliance with community standards of care or service, all elements of peer review will be followed.

Dissatisfaction severity codes and levels of severity are applied to quality issues. The medical director assigns a level of severity to the grievance. Peer review includes investigation of physician actions by or at the discretion of the medical director. The medical director takes action based on the quality issue and the level of severity, invites the cooperation of the physician and consults and informs the Provider Advisory Committee and Peer Review Committee. The medical director informs the physician of the Committee’s decision, recommendations, follow-up actions and/or disciplinary actions to be taken. Outcomes are reported to the appropriate internal and external entities which include the Quality Management Committee.

The peer review process is a major component of the Provider Advisory Committee monthly agenda.

The peer review policy is available upon request.
Network and non-network providers have a right to express dissatisfaction with any aspect of Amerigroup operations with respect to administrative issues and nonpayment related matters.

Providers have the right to file a written grievance or may ask questions and resolve problems by contacting Provider Services at 1-800-454-3730. When we receive an inquiry via the telephone, our representatives will attempt to immediately resolve the matter to the provider’s satisfaction. If you are dissatisfied with the inquiry resolution, you can proceed with filing a grievance.

12.1 Provider Grievance Procedure

Provider grievances will be resolved fairly, consistent with our policies and covered benefits. All provider grievances will be kept confidential to the extent allowed under state and federal rules, regulations and laws. You won’t be penalized for filing a grievance. Provider grievances must be submitted in writing and accompanied by supporting documentation. Our mailing address is:

Amerigroup Community Care
Director of Provider Solutions
101 Wood Ave. S., 8th Floor
Iselin, NJ 08830

Level I Grievance Review
The director of Provider Solutions oversees and coordinates the provider grievance process. Upon receipt of a Level I grievance review, we immediately inform the appropriate Amerigroup department head and/or medical director. Grievances of an emergent nature will be resolved immediately. Grievances of an urgent nature will be resolved within 48 hours from the time of receipt. All other provider grievances will be resolved and responded to in writing within 60 days from the receipt of the grievance by Amerigroup or by the date specified in the regulatory agency notice.

Level II Grievance Review
If you are dissatisfied with the Level I grievance resolution, you can either send a letter by mail or fax or call Provider Services at 1-800-454-3730, to request a Level II grievance review.

A Level II grievance review consists of a committee review. A committee meets as necessary to investigate and resolve grievances unresolved to a provider’s satisfaction during the Level I Grievance Review. The committee is comprised of the director of Quality Management, director of Provider Solutions, medical director and any additional members of senior staff, network providers and/or consultants of the same or similar specialty as your concern who were not involved with the original grievance decision.

You may choose to attend a grievance meeting or participate in meetings through another means of technology (e.g., telephone conference). The meeting will be set up at a reasonable time and location for you. Emergent grievances will be resolved immediately. Urgent grievances will be resolved within...
48 hours of initiation. A Level II Grievance Resolution Letter will be sent to you within 30 days of receipt of the request.

12.2 Provider Appeal Procedure

Amerigroup has established and maintains a procedure approved by DMAHS for the resolution of appeals initiated by providers with respect to denial of payment for services determined to be not medically necessary or appropriate or the denial for payment of a requested service or confinement for an administrative reason such as late notification of an admission, failure to precertify a service that requires pre-certification or ineligibility on date of service. Clinical guidelines are available on our provider website or you can request a hard copy. Appeals must be submitted in writing to:

Quality Management Department
Amerigroup Community Care
101 Wood Avenue South, 8th Floor
Iselin, NJ 08830

Appeals will be resolved within 30 calendar days or less in accordance with the medical exigencies of the case (including all situations in which the member is confined as an inpatient).

Utilization management determinations will be made by an appropriate practitioner. The reviewer may be the health plan Medical Director, a board-certified consultant, medical, behavioral health, pharmaceutical, dental, chiropractic or vision practitioner as appropriate who was not involved in the initial determination and is not a subordinate of the original reviewer. Additionally, the provider will have the opportunity to speak with an appropriate health plan medical director (or appropriate practitioner). Upon request, the provider will be provided with the clinical criteria relied upon to make the determination.

The provider grievance and appeal procedures detailed above should not be used to address provider contracting issues. If you have concerns related to the terms, conditions or termination of your Amerigroup provider contract, please contact the dedicated Network Management representative assigned to your service area or call Provider Services at 1-800-454-3730 for further assistance.
13 CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

You have the option of submitting claims electronically or by mail. Providers must submit claims within 180 days from the date of discharge for inpatient services or from the date of service for outpatient services.

13.1 Electronic Submission

We encourage you to submit claims electronically, as you will be able to:
- Submit claims either through a clearinghouse or directly to us
- Receive payments quickly
- Eliminate paper
- Save money

Clearinghouse Submission
You can submit electronic claims through Electronic Data Interchange (EDI). You must submit claims within 180 calendar days from the date of discharge for inpatient services or from the date of service for outpatient services. You can submit claims through:
- Emdeon (formerly WebMD) – Claim Payer ID 27514
- Capario (formerly MedAvant) – Claim Payer ID 28804
- Availity (formerly THIN) – Claim Payer ID 26375

An EDI claims submission guide is located at providers.amerigroup.com.

Website Submission (Participating Providers Only)
Submit claims on our website by:
- Entering claims on a preformatted CMS-1500 and CMS-1450 claim template
- Uploading a HIPAA-compliant ANSI 837 5010 claim transaction

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

13.2 Paper Claims Submission

You must submit a properly completed CMS-1450 or CMS-1500 (08-05) claim form:
- On the original red claim forms (not black and white or photocopied forms)
- Laser printed or typed (not handwritten)
- In a large, dark font

Paper claims must be submitted within 180 days of the last date of service of the course of treatment to the following address:

New Jersey Claims
Amerigroup Community Care
P.O. Box 61010
Virginia Beach, VA 23466-1010
There are exceptions to the timely filing requirements. They include:

- Cases of coordination of benefits/subrogation. Coordination of benefits claims must be submitted within 60 days from the date of primary insurer’s Explanation of Benefits (EOB) or 180 days from the dates of service, whichever is later. Cases where a member has retroactive eligibility. In situations of enrollment in Amerigroup with a retroactive eligibility date, the time frames for filing a claim will begin on the date that Amerigroup receives notification from the enrollment broker of the member’s eligibility/enrollment.

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

- Patient’s ID number
- Patient’s name
- Patient’s date of birth
- ICD-10 diagnosis code/revenue codes
- Date of service
- Place of service
- Procedures, services or supplies rendered CPT-4 codes/HCPCS codes/DRGs
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- Billing provider information
- NPI of billing and rendering provider when applicable
- COB/other insurance information
- Precertification number or copy of precertification
- Name of referring physician
- NPI/API
- NDC, unit of measure and quantity for medical injectables
- Any other state-required data

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


**Clean Claims Payment**

For MLTSS services, we will adjudicate clean claims to a paid or denied status within 15 days of receipt for electronic claims and 30 days of receipt for paper claims. For standard claims, we will adjudicate clean claims to be paid or denied status within 30 days for electronic claims and 40 days for paper claims.
Corrected Claims
Timely filing is within 365 days from the date of service.
• Paper corrected claims must be clearly marked “Corrected Claim.”
• Electronic submissions must have the applicable frequency code.

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

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with HIPAA requirements, and in accordance with the rule issued by the U.S. Department of Health and Human Services (HHS).

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 healthcare settings.

Although we often use the term ICD-10 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.

13.4 Encounter Data

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

You must submit encounter data no later than 90 days from the date of service through:
• EDI submission methods
• CMS-1500 (08-05) claim form
• Other arrangements that are approved by Amerigroup

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

Our Utilization and Quality Improvement staff monitors compliance, coordinates it with the medical director and then reports findings to the QMC on a quarterly basis. Lack of compliance will result in:
• Training
• Follow-up audits
• Even termination

13.5 Claims Adjudication

We are dedicated to providing timely adjudication of claims. We process all claims according to generally accepted claims coding and payment guidelines defined by the CPT-4 and ICD-10 Manuals.

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

We reserve the right to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure.

For claims payment to be considered, providers must adhere to the following time limits:
• Submit claims within 180 days from the last date the service is rendered in a course of treatment or for inpatient claims filed by a hospital within 180 days from the date of discharge.
• Submit the claim within 60 days of receiving a response from the third-party payer in cases of other insurance.
• Submit claims for members whose eligibility has not been added to the State’s eligibility system within 180 days from the date the eligibility is added and we are notified of the eligibility/enrollment.
• Submitted claims after the 180-day filing deadline will be denied.

After filing a claim with us, review the weekly Explanation Of Payment (EOP). If the claim does not appear on an EOP within 30 days for electronic claims and 40 days for paper claims, as adjudicated, or you have no other written indication that the claim has been received, check the status of your claim on our provider website or by calling Provider Services at 1-800-454-3730. If the claim is not on file with us, resubmit your claim within 180 days from the last date of service in a course of treatment. If filing electronically, check the confirmation reports for acceptance of the claim that you receive from your EDI or practice management vendor.

We adjudicate claims in accordance with the New Jersey regulatory requirements.

13.6 Clean Claims Payment

A clean claim is a request for payment for a service rendered by a provider that:
• Is submitted on time
• Is accurate
• Is submitted on a HIPAA-compliant standard claim form (CMS-1500 or CMS-1450 or successor forms)
• Requires no further information, adjustment or alteration to be processed and paid
• Is not under review for medical necessity
• Note: claims from providers under investigation for fraud or abuse are not subject to prompt pay timelines.

We will adjudicate clean claims to a paid or denied status within 30 days of receipt for electronic claims and 40 days of receipt for paper claims. We may request additional information to process a claim; upon receipt of the requested information from the provider, we must complete processing of the clean claim within 30 days of receipt for electronic claims and 40 days of receipt for paper claims. If we do not pay the claim within that the required time frames, we will pay all applicable interest as required by law.

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

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

We will adjudicate and pay clean claims appropriately from practitioners, either in individual or group practice or who practice in shared health facilities, in accordance with state requirements. Days are calculated from receipt date to date of payment. The date of receipt is the date we receive the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

13.7 Claims Status

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

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

13.8 Provider Reimbursement

Electronic Funds Transfer and Electronic Remittance Advice
We offer Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) with online viewing capability. Providers can elect to receive Amerigroup payments electronically through direct deposit to their bank account. In addition, providers can select from a variety of remittance information options, including:
• ERA presented online and printed in your location
• HIPAA-compliant data file for download directly to your practice management or patient accounting system
• Paper remittance printed and mailed by Amerigroup

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

To register for ERA/EFT, please visit our provider website.

**PCP Reimbursement**
We reimburse PCPs according to their contractual arrangement.

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

Specialty care providers will obtain PCP and Amerigroup approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized by the PCP’s referral or beyond the scope of self-referral permitted under this program.

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

**Overpayment Process**
Refund notifications may be identified one of two ways, by our Cost Containment Unit (CCU) or by providers. The CCU researches and notifies the provider of an overpayment requesting a refund check. Providers may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified by Amerigroup, the CCU will notify the provider of the overpayment. The provider will submit a Refund Notification Form along with the refund check. If a provider identified the overpayment and returns our check, please include a completed Refund Notification Form specifying the reason for the return. This form can be found on our provider website. The submission of the Refund Notification Form will allow the CCU to process and reconcile the overpayment in a timely manner. Once the CCU has reviewed the overpayment, you will receive a confirmation letter explaining the details of the reconciliation. For questions regarding the Refund Notification procedure, please call Provider Services at 1-800-454-3730 and select the appropriate prompt.
13.9 Provider Payment Disputes

You may access a timely payment dispute process. A payment dispute is any dispute between a health care provider and Amerigroup for reasons including: lost or incomplete claim forms or electronic submissions, requests for additional explanation as to services or treatment rendered by a health care provider, inappropriate or unapproved referrals initiated by the providers, billing disputes, timely filing, notification/precertification issues, and service already provided where the provider does not agree with the results of our claim adjudication.

You won’t be penalized for filing a payment dispute. No action is required by the member.

Stage 1 and Stage 2 disputes must be submitted in writing to our Payment Dispute Unit within 60 days of a claims determination. The Payment Dispute Unit will receive, distribute and coordinate all payment disputes. A separate address has been established for this purpose:

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

The dispute letter must detail the reason for the dispute and be accompanied by supporting documentation such as the EOP or medical records.

Examples of appropriate documentation to support provider payment disputes:

- Letter stating the reasons why the provider believes the claim reimbursement is incorrect
- Copy of the original claim
- Copy of the Amerigroup EOP
- EOP or EOB from another carrier
- Evidence of eligibility verification (e.g., copy of ID card, panel report, call log record with date of the name of the person you spoke with at Amerigroup when you verified eligibility)
- Medical records
- Approved referral and authorization forms from Amerigroup indicating the authorization number
- Contract rate sheets indicating evidence of payment rates
- Evidence of previous dispute submission or timely filing:
  - Certified mail receipt with claim/dispute log if more than one claim/dispute was submitted
  - Overnight mail receipt with claim/dispute log if more than one claim/dispute was submitted
  - EDI claim transmission reports indicating that the claim was accepted; rejection reports are not accepted as proof of timely filing
- A statement specifying the line items the provider is disputing
- Information we previously requested that the provider has not yet submitted if available
- Itemization of the contract provisions the provider believes we are not complying with if any
- Pertinent correspondence between the provider and Amerigroup on this matter
- A description of pertinent communications between the provider and Amerigroup on this matter that were not in writing
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- Relevant sections of the National Correct Coding Initiative or other coding support the provider relied on if the dispute concerns the disposition of billing codes
- Other documents the provider may believe supports the provider’s position in this dispute

The New Jersey Department of Banking and Insurance has developed the Health Care Provider Application to Appeal a Claim Determination Form for use by providers in submitting Payment Disputes to HMOs. This form is available from DOBI at: http://www.state.nj.us/dobi/chap352/352implementnotice.html.

An internal review shall be conducted and its results communicated in a written decision to you within 30 calendar days of the receipt of the dispute. If additional information is requested, the provider must submit the additional information within 30 calendar days. If the information is not received within 30 calendar days, the dispute will be denied and closed due to incomplete information with no further recourse on behalf of the provider.

Stage 1 Payment Dispute

You must submit a written dispute to us with all applicable documentation supporting your position regarding the adjudication of the claim. The Stage 1 written dispute must be received within 90 calendar days of the provider’s EOP.

Our Payment Dispute Unit will render a written determination within 30 calendar days of the receipt of the dispute.

Independent Arbitration

If you’re dissatisfied with the result of the Stage 1 dispute resolution, you may file for independent arbitration pursuant to New Jersey P.L. 2005, c.35. In order to file for independent arbitration, certain conditions must be met including:

- The claims amount in dispute must be $1,000 or more. Claims that are aggregated to meet the $1,000 threshold must fulfill the aggregation criteria as specified by the New Jersey Department of Banking and Insurance, which includes the following:
  - All disputed claim amounts aggregated for arbitration must be from claims that have been submitted to the internal Stage 2 dispute process and the dispute process has been exhausted
  - All claims in the aggregation of disputed claims must be timely; untimely claims will be removed from the aggregation, and if the remaining claims do not meet the threshold amount, none of the claims will be considered for arbitration at that time.
  - Disputed claim amounts should be aggregated by carrier and by covered person or CPT code.
- You must complete the state-developed Health Care Provider Application to Dispute a Claims Determination form. Copies of the form are available on our provider website or through the New Jersey Department of Banking and Insurance website.
- Although not required by law, you should strongly consider obtaining a completed Consent to Authorization of Release of Medical Records for Arbitration of Claims form from the member for whom the services were provided. In the absence of this authorization, no personal health information can be shared with the arbiter. Copies of the form are available on our website at www.amerigroup.com or through the New Jersey Department of Banking and Insurance website at www.state.nj.us/dobi/chap352/352implementnotice.html.
- The claim must not be eligible for dispute under the IHCAP.
• The provider must include the fee for arbitration as required by the Department of Banking and Insurance. Please check with the Department of Banking and Insurance for the most current information as to the appropriate fee.
• The request for arbitration must be made within 90 days of the most recent adverse determination regarding the claim.

**Stage 2 Dispute**
If your Stage 1 dispute resolution is not favorable and you do not chose arbitration or qualify for arbitration, you can file an optional Stage 2 dispute. You must submit a written dispute to us with any additional documentation or information supporting your position regarding the dispute determination. The Stage 2 dispute must be received within 30 calendar days of the determination of the Stage 1 dispute.

Our Payment Dispute Unit will render a written determination within 10 business days of the receipt of the dispute.

If additional information is requested, you must submit the additional information within 30 calendar days. If the information is not received within 30 calendar days, the dispute will be denied and closed with no further recourse on your behalf.

Questions regarding our provider payment dispute process should be directed to your Provider Relations representative or to Provider Services at 1-800-454-3730.

**13.10 Coordination of Benefits**
If a member is covered by more than one health care plan, we will administer Coordination Of Benefits (COB). Under COB, the primary payer of benefits is identified in order to eliminate duplication of reimbursement. COB claims must be submitted within 60 days from the date of the primary insurer’s Explanation of Benefits (EOB) or 180 days from the dates of service, whichever is later.

If Amerigroup is identified as the primary payer of benefits, Amerigroup will reimburse the provider up to the contracted rate or the non-participating rate currently in effect, as applicable. If Amerigroup is identified as the secondary payer of benefits, Amerigroup will coordinate reimbursement to the provider with the primary payer’s reimbursement to avoid duplication of benefits.

In addition, all providers and members must abide by all our policies and procedures, including notification or precertification of services.

We will notify the state within 30 days after we learn that a member has health insurance coverage not reflected in the state’s file or casualty insurance coverage or if there is a change in a member’s health insurance coverage. In addition, we require our providers to notify us of this information.

Any questions or inquiries regarding paid, denied or pended claims should be directed to Provider Services at 1-800-454-3730.
13.11 Billing Members

Overview
Before rendering services, providers should always inform members that the cost of services we do not cover can be charged to the member in certain circumstances.

If you choose to provide services **we do not cover**:
- Understand that we only reimburse for services that are medically necessary, including hospital admissions and other services
- Obtain the member’s signature on the Client Acknowledgment Statement specifying that the member will be held responsible for payment of non-covered services
- Understand that you may not bill for or take recourse against a member for denied or reduced claims for services that are within the amount, duration and scope of benefits of the Medicaid program

**Our members must not be balance-billed for the amount above what we paid for covered services.**

In addition, you may **not** bill a member if any of the following occurs:
- Failure to timely submit a claim, including claims we don’t receive
- Failure to submit a claim to Amerigroup for initial processing within 180 days of the last date of service in the course of treatment
- Failure to submit a corrected claim within the 365-calendar day filing resubmission period
- Failure to dispute a claim within the 90-day administrative dispute period
- Failure to dispute a utilization review determination within 30 days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made in claims preparation, claims submission or the dispute process

**Client Acknowledgment Statement**
You may bill one of our members for a service that has been denied as not medically necessary or not a covered benefit **only if** both of the following conditions are met:
- The member requests the specific service or item
- You obtain and keep a written acknowledgement statement signed by you and the member stating:
I understand that, in the opinion of (provider’s name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under Amerigroup as being not medically necessary for my care or that are not a covered benefit. I understand that Amerigroup has established the medical necessity standards for the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined to be inconsistent with the Amerigroup medically necessary standards for my care or not a covered benefit.

Signature: ________________________________________________

Date: ____________________________________________________
APPENDIX A – FORMS

Introduction

Note: Provider Relations has designated representatives assigned to service specific counties within New Jersey. To identify the representative for your county, please call Provider Services at 1-800-454-3730.

For approved lists of subcontractors for the following service areas, please reference the *New Jersey Quick Reference Guide*:
- Care management
- Dental
- DME
- Mental health
- Lab
- Pharmacy
- Radiology
- Vision

The following forms are included as sample reference materials.

*Referral and Claim Submission Forms – WIC Form*

*New Jersey State Department of Health*

*WIC/Maternity Services*
REFERRAL/NUTRITION ASSESSMENT FOR WOMEN

Please see instructions on last page

<table>
<thead>
<tr>
<th>NAME OF CLIENT</th>
<th>TELEPHONE NUMBER</th>
<th>DATE OF BIRTH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADDRESS OF CLIENT</th>
<th>CHECK ONE:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Pregnant</td>
</tr>
</tbody>
</table>

REFERRAL (To be completed by health professional, including second page)

ANTHROPOMETRIC AND LABORATORY DATE (One Blood Test is Required)

<table>
<thead>
<tr>
<th>First Prenatal</th>
<th># Weeks</th>
<th>Weight</th>
<th>Pre-Preg</th>
<th>Usual Wt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check-up:</td>
<td>Date: <strong>/</strong>/___ Gestation ______ (pounds) _______ (pounds) _______ (pounds) _______</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current</td>
<td># Weeks</td>
<td>Weight</td>
<td>Height</td>
<td></td>
</tr>
<tr>
<td>Check-up:</td>
<td>Date: <strong>/</strong>/___ Gestation ______ (pounds) _______ (inches) _______</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Test:</td>
<td>Date: <strong>/</strong>/___ Hb(mg/dL) ______ Hct ______ % EP(ug/dL) ______ Lead ______ Other ______</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MEDICAL HISTORY

Gravida ______ Para ______ Ab/Misc ______ Stillbirth _______ EDC _________ ADC ___________ □ Vag □ C-section

Past Med/Surg History ___________________________________________

Current Medical Problem(s) ______________________________________

Previous Preg Complications ______________________________________ Date Last Preg Ended __/__/____

Physician/Clinic ________________________________________________ Phone _________________________

Signature of Health Professional ________________________________________________ Date: _______/_______/_______

WIC APPOINTMENT: Date: __________/__________/__________ Time: ____________________

ASSESSMENT (To be completed by Client or Health Professional)

1) Are you taking any of the following?
   - Vitamins/Minerals □ Yes □ No Amount: __________ Type: _______________
   - Iron □ Yes □ No Amount: __________ Type: _______________
   - Over-the-counter Medicines □ Yes □ No Amount: __________ Type: _______________
   - Special Medicines □ Yes □ No Amount: __________ Type: _______________
   - Street Drugs □ Yes □ No Amount: __________ Type: _______________

2) How much did you smoke before you were pregnant? Amount: ____________________
   How much do you smoke now? Amount: ____________________

3) How much beer, wine cooler or liquor do you drink per week? Amount: ____________________

4) Are you on a special diet now? □ Yes □ No Prior to pregnancy? □ Yes □ No

5) Are you experiencing?
   - Nausea □ Yes □ No Heartburn □ Yes □ No
   - Frequent Vomiting □ Yes □ No Flatus (Gas) □ Yes □ No
   - Diarrhea □ Yes □ No Dental Problems □ Yes □ No
   - Constipation □ Yes □ No Bleeding Gums □ Yes □ No

6) Do you eat?
   - Paint Chips □ Yes □ No Dirt □ Yes □ No
   - Laundry Starch □ Yes □ No Clay □ Yes □ No
   - Corn Starch □ Yes □ No Plaster □ Yes □ No
   - Ice □ Yes □ No Other Cravings □ Yes □ No

7) Do you have a working?
   - Stove □ Yes □ No Sink with water supply □ Yes □ No
   - Refrigerator □ Yes □ No
8) Are you on any program?  
- WIC: □ Yes □ No  □ Yes □ No  
- Child Support Enf: □ Yes □ No  □ Yes □ No  
- Food Stamps: □ Yes □ No  □ Yes □ No  
- Maternity Services: □ Yes □ No  
- Presumptively Eligible: □ Yes □ No  
- AFDC/Medicaid: □ Yes □ No  
9) How do you plan to or presently feed your baby?  
- Breast milk: □ Yes □ No  □ Yes □ No  
- Undecided?: □ Yes □ No  
10) Do you do the following daily?  
- Work: □ Yes □ No  Type: _________________________  
- Care for Children: □ Yes □ No  How Many: ____________________  
- Exercise: □ Yes □ No  Type: _________________________  
11) If pregnant, how much weight (pounds) do you plan to gain? _____________________________  
12) Where do you plan to or presently take your child for medical care?
INSTRUCTIONS

--- AGENCY USE ONLY ---

**Referral Section (Complete by Health Professional)**
1) Fill in client’s name, address, phone number and date of birth; or use addressograph stamp.
2) Check status of woman being referred.
3) Fill in data on first prenatal check-up and current check-up, if applicable.
4) One blood test is required prior to submitting this form to WIC. Pregnant women need blood test that was done during pregnancy. Postpartum women (breastfeeding and non-breastfeeding) need blood test that was done after delivery.
5) Complete Gravida, Para, Abortions, Miscarriages.
6) Fill in EDC (Estimated Date of Confinement) for prenatal clients.
7) Fill in ADC (Actual Date of Confinement), vaginal or C-section delivery for postpartum clients.
8) Complete past medical/surgical history based on client’s record.
9) Fill in any pertinent current medical problems diagnosed.
Information in this section should NOT include most recent pregnancy for postpartum women.
10) Complete previous pregnancy complications, referring to list below:
    Write approximate letter or letters on space provided.
    a. Hx of low birth weight infant(s) <5.5 pounds
    b. Hx of premature infant(s) <37 weeks gestation
    c. Hx of infant(s) > 10 pounds at birth
    d. Hx of or planned C-section
    e. Multiple pregnancy or recent multiple birth
    f. Medical problems (e.g., diabetes, hypertension, pre-eclampsia, eclampsia)
    g. Disability that may compromise adequacy of diet
    h. Social or environmental condition that may compromise adequacy of diet
    i. Substance use (e.g., alcohol, drugs, cigarettes, pica)
    j. Vitamin/mineral supplement or medicine prescription
    k. Special formula prescription and medical reason for its necessity
    l. Other pertinent health/medical data
1) Fill in physician’s name or clinic and phone number.
2) Signature of referring health professional IS REQUIRED, with current date.

**Assessment Section/Food Frequency (Page 1 and 2)**
1) This section may be completed by the client or a health professional.
2) If completed by client, it must be reviewed by the health professional for accuracy and completeness. Check the appropriate answer for questions 1-18. Any responses that do NOT meet WIC standards demand further clarification.
3) The health professional should compare the food frequency with the recommended servings needed daily for pregnant/postpartum women and formulate a nutrition plan of care accordingly.
4) The Nutrition Assessment and Plan of Care must be written according to the hospital/ WIC State policy and procedure.
5) Upon completion of nutrition education, the health professional must circle the appropriate Nutrition Education Topics and record the date. (More topics below) If materials are provided, write the appropriate Topic Code in the space labeled Other.

<table>
<thead>
<tr>
<th>05 – Child Nutrition</th>
<th>11 – Mealtime Psychology</th>
<th>18 – Sugar in Diet</th>
</tr>
</thead>
<tbody>
<tr>
<td>06 – Dental Health</td>
<td>12 – Nutrients in WIC Foods</td>
<td>19 – Vitamin A in Diet</td>
</tr>
<tr>
<td>07 – Fat in Diet</td>
<td>15 – Salt in Diet</td>
<td>20 – Vitamin C in Diet</td>
</tr>
<tr>
<td>08 – Food Budget/Consumer Awareness/Meal Planning</td>
<td>16 – Smoking and Pregnancy</td>
<td>44 – No Show</td>
</tr>
<tr>
<td>09 – Fruit and Vegetables</td>
<td>17 – Snacking</td>
<td>45 – Client Refused</td>
</tr>
</tbody>
</table>

Name and Address of WIC Program, Physician or CLIC:  
Telephone Number
INSTRUCTIONS

Assessment Section/Food Frequency (Page 1 and 2)

1) This section may be completed by the client or a health professional.

2) If completed by the client, it must be reviewed by the health professional for accuracy and completeness. Check the appropriate answer for questions 1 through 18. Any responses that do NOT meet WIC standards demand further clarification.

3) The health professional should compare the food frequency with the recommended servings needed daily for pregnant/postpartum women and formulate a nutrition plan accordingly.

4) The Nutrition Assessment and Plan of Care must be written according to the hospital/ WIC State policy and procedure.

5) Upon completion of nutrition education, the health professional must circle the appropriate Nutrition Education Topic Code and write the date education was provided.

6) Listed below is continuation of nutrition Education Topics. If materials are provided, write the appropriate Topic Code in the space labeled Other.

   05 – Child Nutrition
   06 – Dental Health
   07 – Fat in the Diet
   08 – Food Budgeting/Consumer Awareness/Meal Planning
   09 – Fruit and Vegetables
   11 – Mealtime Psychology
   12 – Nutrients in WIC Foods
   15 – Salt in the Diet
   16 – Smoking and Pregnancy
   17 – Snacking
   18 – Sugar in Diet
   19 – Vitamin A in Diet
   20 – Vitamin C in Diet
   44 – No Show
   45 – Client Refused
**Specialist as PCP Request Form**

<table>
<thead>
<tr>
<th>Date:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Member’s name:</td>
<td></td>
</tr>
<tr>
<td>Member’s ID #:</td>
<td></td>
</tr>
<tr>
<td>PCP’s name (if applicable):</td>
<td></td>
</tr>
<tr>
<td>Specialist/specialty:</td>
<td></td>
</tr>
<tr>
<td>Member’s 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 for whom the specialist will function as this member’s PCP, including providing to the member access 24 hours a day, 7 days a week.

Specialist’s signature: _____________________________ Date: ____________

Medical director’s signature: ________________________ Date: ____________

Member’s signature: __________________________________ Date: ____________
In accordance with Chapter 174, P.L. 1995:

I acknowledge that ____________________________ has counseled
(Name of physician or other provider)

and provided me with:

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

I have consented to be tested for infection with HIV. □

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

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

_______________________________  ______________________________
Signature of Patient                Date

_______________________________
Signature of Witness
Consent for the HIV Antibody Blood Test

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

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

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

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

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

___________________________________  __________________
Date                                           Patient’s/Guardian’s Signature

___________________________________  __________________
Witness Signature                            Patient’s/Guardian’s Printed Name

____________________________________
Physician Signature

Amerigroup recognizes the need for strict confidentiality guidelines.
Results of the HIV Antibody Blood Test

A. EXPLANATION

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

B. AUTHORIZATION

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

C. USES

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

D. DURATION

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

E. RESTRICTIONS

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

F. ADDITIONAL COPY

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

Date: ______________, 20______ ____________________________

Signature

______________________________

Printed Name

Note: this form must be in at least eight-point type.
Blood Lead Risk Forms

Verbal Blood Lead Risk Assessment

Member’s name: ________________________________

Date: ________________________________

ID #: ________________________________

Person interviewed/relationship: ________________________________

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your child live in or regularly visit a house built before 1978? Does the house have chipping or peeling paint?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was your child’s day care center/preschool/babysitter’s home built before 1978? Does the house have chipping or peeling paint?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child live in or regularly visit a house built before 1978 with recent, ongoing or planned renovation or remodeling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have any of your children or their playmates had lead poisoning?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child frequently come in contact with an adult who works with lead? Examples include construction, welding or pottery, or other trades practiced in your community.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you give your child home or folk remedies that may contain lead?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Blood Lead Testing for High-Risk Children

### Member’s name: ____________________________________________

### Date: ____________________________________________________

### ID #: ____________________________________________________

### Person interviewed/relationship: ______________________________

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has your child’s blood been tested for lead?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When was your child last tested?</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>What was the result?</td>
<td>Result</td>
<td></td>
</tr>
<tr>
<td>Has the child seen the pediatrician since his or her last blood test?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>When?</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Was the child tested for lead poisoning?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

- If the PCP has not seen the child, encourage and help arrange a visit.
- If it has been over one year since the child’s last visit, encourage and help arrange a visit.
- If the child has been/is being treated for lead poisoning, apply risk assessment and encourage continuation of follow-up. Assist member through any barriers identified.
Perinatal Risk Assessment Form

Go to https://praspect.org/documentation/PRAEnrollmentForm_64807.pdf to complete the Perinatal Risk Assessment Form.

Perinatal Risk Assessment (PRA)

Practice Site Enrollment Form

- Please complete and fax this form to 856 409-5699 or on-line at www.praspect.org
- A separate enrollment form must be completed for each practice site
- If obstetric services are not provided at this site, please complete the first section and fax to 856 409-5699

PLEASE PRINT CLEARLY

Obstetric Services are provided at this practice? □ Yes □ No
If Yes, average # of new Obstetric patients enrolled at this site each month _________

Practice Name:___________________________________________________________

Street: _________________________________________________________________

City: ___________________________ State: ________ Zip: ____________

Primary Fax # (used on all PRA forms for this practice as provider identification) Phone #
( [__________] ) [_________] - [_________] ( [__________] ) [_________] - [_________]

NPI# ____________ ____________ ____________ ____________ ____________ ____________

Physician Names:________________________________________________________

Medicaid MCO Plans Accepted: select all that apply
□ UnitedHealthcare □ AmeriGroup □ Aetna Better Health □ Horizon NJ Health □ Wellcare

This practice site is interested in on-line submission of PRA data: __ Yes __ No Email address required for online submission
This practice site is currently capable of on-line submission of PRA data: __ Yes __ No

Primary PRA Contact at this site

- Coordinates PRA process at practice sites
- Receives communication from and provides feedback to FHI about PRA submission process

F Name __________________________ L Name __________________________

Phone _______ - _______ - _______

Best Time to Contact
Select all that apply
□ Morning □ Afternoon □ After 5

Specific Time [___]:[___] □ am □ pm

E-mail __________________________

*PRA Form Verification Contact

- Retrieves PRA Summaries and Follow-up Forms daily via the web (Will receive secure personal username and password to retrieve PRA follow-up forms upon enrollment)
- Verifies that information on PRA follow-up form is correct
- Must provide valid email address

*PRA User Contact (Screener)

- Completes PRA Forms
- Will be contacted by FHI when PRA form information is illegible or incomplete

* Please select all box(es) that apply to the descriptions above for each contact*

FName __________________________ LName __________________________

E-mail __________________________

Phone _______ - _______ - _______ □ Verifier □ User

FName __________________________ LName __________________________

E-mail __________________________

Phone _______ - _______ - _______ □ Verifier □ User

PLease Complete and Fax to 856-409-5699

Family Health Initiatives 2500 McClellan Ave, Ste 270 Pennsauken, NJ 08109 856-665-6000
# Diabetes Information Form

**Name:** ____________________________  **Date of birth:** ____________________________

**Allergies:** ____________________________  **Phone number:** ____________________________

<table>
<thead>
<tr>
<th>Examination/test</th>
<th>Schedule</th>
<th>Date of Onset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory</td>
<td></td>
<td>Date</td>
</tr>
<tr>
<td>Hgba1c &lt; 7.0% acceptable</td>
<td>Every 3-6 Months</td>
<td></td>
</tr>
<tr>
<td>Fasting lipid profile:</td>
<td></td>
<td>Result</td>
</tr>
<tr>
<td>HDL: 50 mg/dL (women)</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>40 mg/dL (men)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LDL: 100 mg/dL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Triglycerides: 175 mg/dL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urine microalbumin</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>Serum creatinine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History and physical</td>
<td></td>
<td>Date</td>
</tr>
<tr>
<td>examination</td>
<td></td>
<td>Comment</td>
</tr>
<tr>
<td>Interval history with</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>depression screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic retinal eye exam</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>Foot exam</td>
<td>Each Visit</td>
<td></td>
</tr>
<tr>
<td>Blood pressure: 130/80 mm</td>
<td>Each Visit</td>
<td></td>
</tr>
<tr>
<td>Hg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight/height</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ekg (≥ age 30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient education and</td>
<td></td>
<td>Date</td>
</tr>
<tr>
<td>therapy</td>
<td></td>
<td>Comment</td>
</tr>
<tr>
<td>Smoking cessation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diet/exercise</td>
<td></td>
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<tr>
<td>Medication adherence</td>
<td></td>
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<tr>
<td>Self-monitored blood glucose</td>
<td></td>
<td></td>
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<tr>
<td>Preconception/pregnancy</td>
<td></td>
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<tr>
<td>counseling</td>
<td></td>
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<tr>
<td>ACE inhibitors/ARB</td>
<td></td>
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<tr>
<td>Aspirin</td>
<td></td>
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<tr>
<td>Weight loss</td>
<td></td>
<td></td>
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<tr>
<td>Immunization</td>
<td></td>
<td>Date</td>
</tr>
<tr>
<td>Influenza vaccine</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal vaccine once;</td>
<td></td>
<td>Comment</td>
</tr>
<tr>
<td>repeat after five years for patients over age 65 who rec'd first dose at age &lt; 65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>Date</td>
</tr>
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<td></td>
<td></td>
<td>Comment</td>
</tr>
</tbody>
</table>

Living Will

You can make a living will by filling out this form. You can choose another form or use the one your doctor gives you, too. If you make a living will, give it to your PCP.

I, (Print your name here) ____________________________________________, am of sound mind. I want to have what I say here followed. I am writing this for when 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 (say what it is here)
_________________________________________________________________

TREATMENT I DO WANT. I want (put your initial by the services you do want):

_____ No medical services
_____ Pain relief
_____ All treatment to keep me alive as long as possible
_____ Other (say what it is here)
_________________________________________________________________

What I say 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 any time I wish. I just have to let my doctor know I want to change it or not have it at all.

Signature: ___________________________________________________________
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, too. If you name a durable power of attorney, give it to your PCP.

I, ________________________________, want ________________________________,

Name Name of person I want to carry out my wishes

______________________________________________________________

Person’s address

to make treatment decisions for me if I cannot. This person can make decisions when I am in a coma, not mentally able to or so sick I just cannot tell anyone. If the person I named is not able to do this for me, then I name another person to do it for me. This person is ________________________________,

Name of second person I want to carry out my wishes and 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 (say what it is here)

TREATMENT I DO WANT. I want (put your initial by the services you do want):

_____ No medical services
_____ Pain relief
_____ All treatment to keep me alive as long as possible
_____ Other (say what it is here)

What I say 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 any time 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: ________________________________________________
Hysterectomy and Sterilization Forms

Hysterectomy Receipt of Information Form

State of New Jersey
Department of Human Services
Division of Medical Assistance
and Health Services

A woman who has a hysterectomy can never again get pregnant. When you have a hysterectomy, the doctor removes your uterus (womb). You cannot have a baby after your uterus is removed, and you will not have menstrual periods anymore.

I received the above information orally and in writing from ________________________________

Name of clinic or physician
____________________________ before my operation was performed.

I talked to ________________________________ about a hysterectomy. ____________________
Name of responsible person(s) She/he/they
discussed it with me and gave me a chance to ask questions and answered them for me before the operation.

I have read all of this notice. I agree that it is a true description of what was explained to me by ________________________________ of ________________________________ and that

Name of staff member Clinic/hospital/physician
all my questions were answered to my satisfaction.

I, ________________________________, hereby consent or did consent of my own free will to have

Name of recipient
a hysterectomy done by ________________________________ and/or associates or assistants

Physician
of his or her choice.

I consent or did consent to any other medical treatment that the doctor thinks is (was) necessary to preserve my health.

I also consent to the release of this form and other medical records about the operation to the representatives of the United States Department of Health and Human Services or employees of programs or projects funded by that department, but only for purposes of determining if federal laws were observed.

____________________________________________________________________________
Recipient’s signature
Date: Month/Day/Year

FD-189 (REV 7/83) 7472 MED 7/83
Item-by-item Instructions for Completing the
Hysterectomy Receipt of Information Form FD-189 (Rev 3/91)

1) **Name of Clinic or Physician:** Enter the name of the clinic or physician who provided the information.

2) **Name of Responsible Persons:** Enter the name of the individual who discussed the procedure with the recipient.

3) **She/He/They:** Enter appropriate selection.

4) **Name of Staff Member:** Enter the name of the individual who explained the procedure to the recipient.

5) **Clinic/Hospital/Physician:** Enter the name of the clinic/hospital or physician’s office in which the individual who explained the procedure is affiliated.

6) **Recipient’s Name:** Copy the recipient’s name as printed on the Medicaid Eligibility Identification Card. First name must be entered first.

7) **Name of Physician:** Enter the physician’s name.

8) **Recipient’s Signature and Date:** Recipient must personally sign and date the completed form.
Sterilization Consent Form – 7473 M ED

Federally prescribed documentation regulations for sterilization procedures are extremely rigid. Specific Medicaid requirements must be met and documented on the Consent Form prior to the sterilization of an individual.

The Consent Form is a replica of the form contained in the Federal Regulations and must be used by providers when submitting claims for sterilization procedures. Any claim (hospital, operating physician, anesthesiologist, clinic, etc.) involved in a sterilization procedure must have a properly completed Consent Form attached when it is submitted for payment. Sterilization claims are hard copy restricted; electronic billing is not permitted.

 Providers may obtain additional copies of the Consent Form from the Fiscal Agent; however, photocopies of the Consent Form are acceptable.

A sample of the Consent Form and instructions for the form’s proper completion are provided for reference.

CONSENT FORM

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

- CONSENT TO STERILIZATION o
- STATEMENT OF PERSON OBTAINING CONSENT o

I have asked for and received information about sterilization from _______________________________.

- doctor or clinic

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

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

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

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

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

Before ___________________________ signed the consent form, I explained to him/her the nature of the sterilization operation _______________________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

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

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

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

Signature of person obtaining consent __________________________________________

Date

Facility __________________________________________

Address __________________________________________

Physician’s Statement

- PHYSICIAN’S STATEMENT o

Before ___________________________ signed the consent form, I explained to him/her the nature of the sterilization operation ______________________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

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

- date

- nature of the sterilization operation _______________________________

- specify type of operation

- doctor or clinic

- method called _______________________________. My consent expires 180 days from the date of my signature below.

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

**- date**
Representatives of the Department of Health, Education, and Welfare or Employees of programs or projects funded by that Department but only for determining if Federal Laws were observed.

_________________________ Date:________________________

 signature month/day/year

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)
___ American Indian or Alaska Native
___ Asian or Pacific Islander
___ Black (not Hispanic origin)
___ Hispanic
___ White (not of Hispanic origin)

o INTERPRETER'S STATEMENT o

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

_________________________ date

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

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

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

1) At least 30 days have passed between the date of the individual’s signature on this consent form and the date the sterilization was performed.

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

_____ Premature delivery
_____ Individual’s expected date of delivery
_____ Emergency abdominal surgery

(describe circumstances): __________________________ Date __________________________

_________________________ date

_________________________ Date

_________________________ month/day/year
Item-by-item Instructions for Completing the Sterilization Consent Form Section 1 Consent to Sterilization

1) **Doctor or Clinic:** Enter the name of the physician or clinic.

2) **Sterilization Procedure:** Enter the name of the sterilization procedure.

3) **Recipient’s Date of Birth:** Enter recipient’s date of birth in month, day and year sequence (mm/dd/yy).

4) **Recipient’s Name:** Copy the recipient’s name as printed on the Medicaid Eligibility Identification Card. First name must be entered first.

5) **Doctor:** Enter physician’s name who is performing the procedure.

6) **Type of Sterilization:** Enter the method of sterilization chosen.

7) **Recipient’s Signature and Date:** Recipient must personally sign and hand date form at least 30 days, but not more than 180 days prior to surgery.

Section II Race and Ethnicity Designation:

8) **Race and Ethnicity Designation:** Optional information requested by the federal government, but is NOT required.

Section III Interpreter’s Statement: To be used only when the recipient does not speak English

9) **Language Used:** Enter language used.

10) **Interpreter’s Signature:** Interpreter must sign and date form at least 30 days, but not more than 180 days prior to the sterilization procedure.

Section IV Statement of Person Obtaining Consent:

11) **Name of Individual:** Enter the name of the recipient as it appears in Section I, item 4.

12) **Sterilization/Operation:** Enter the name of the sterilization procedure.

13) **Signature of Person Obtaining Consent:** Signature and date of the person who explains the procedure to the recipient and obtains the recipient’s consent. Must be completed at least 30 days, but not more than 180 days prior to the sterilization procedure.

14) **Facility’s Name and Address:** Enter the name and address of the facility or physician’s office with which the person obtaining the consent is affiliated.

15) **Name of Individual to be Sterilized:** Enter the recipient’s name as it appears in Section I, item 4.

16) **Date of Sterilization:** Enter the date of the sterilization in month, day and year sequence (mm/dd/yy).

17) **Specify Type of Operation:** Enter the name of the sterilization procedure.

18) **Paragraphs 1) and 2):** The physician must indicate the paragraph that applies to recipient’s situation. Paragraph 1) states that at least 30 days have passed between the date of the individual’s signature on the consent form and the date the sterilization was performed. Paragraph 2) states that the sterilization was performed less than 30 days, but more than 72 hours after the date of the individual’s signature on the consent form. The circumstances are premature delivery (state the expected date of delivery) or emergency abdominal surgery (describe the emergency).

19) **Physician’s Signature and Date:** Physician must sign and date form after the surgery has been performed.
## Minimum Adult Preventive Health Guidelines

<table>
<thead>
<tr>
<th>Screening</th>
<th>Service</th>
<th>Age</th>
<th>Frequency</th>
<th>Recommendation By:</th>
<th>Date Recommendation Last Approved</th>
<th>Rating*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>BP Screen</td>
<td>≥21 years old</td>
<td>At least every two years Periodic screening at clinical discretion</td>
<td>U.S. Preventive Services Task Force (USPSTF)</td>
<td>5/04</td>
<td>A</td>
</tr>
<tr>
<td>Lipid Disorders</td>
<td>Total cholesterol and high-density lipoprotein cholesterol</td>
<td>Males 35–65 years old Females 45–65 years old Males 20–35 years old and females 20–45 years old with high risk for coronary heart disease</td>
<td>Every five years; shorter intervals for people who have lipid levels close to warranting therapy</td>
<td>USPSTF</td>
<td>5/04</td>
<td>A</td>
</tr>
<tr>
<td>Comprehensive Initial Evaluation</td>
<td>Medical history and physical</td>
<td>≥ 21 years old</td>
<td>Every new adult patient within 180 days of enrollment Developmentally delayed adults within 90 days of enrollment</td>
<td>Managed Care Contract</td>
<td>5/04</td>
<td>Yes</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>Fecal Blood Occult Flexible sigmoidoscopy Combination of fecal occult blood test and flexible sigmoidoscopy Colonoscopy Double-contrast barium enema</td>
<td>≥ 50 years old, earlier for high-risk patients</td>
<td>Every year Every five years Every 10 years Every five years</td>
<td>USPSTF</td>
<td>5/04</td>
<td>A</td>
</tr>
<tr>
<td>Adult Immunizations</td>
<td>Influenza Vaccine</td>
<td>≥ 65 years old</td>
<td>Every year for people ≥ 65 years old</td>
<td>USPSTF</td>
<td>5/04</td>
<td>Yes</td>
</tr>
<tr>
<td>Screening</td>
<td>Service</td>
<td>Age</td>
<td>Frequency</td>
<td>Recommendation By:</td>
<td>Date Recommendation Last Approved</td>
<td>Rating*</td>
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<tr>
<td>Pneumococcal Vaccine</td>
<td>&gt; 65 years old</td>
<td>Every year regardless of age for those who are residents of chronic care facilities or suffer from chronic cardiopulmonary disorders, metabolic diseases, hemoglobinopathies, immunosuppression, or renal dysfunction</td>
<td>Immunize once individuals who are immuno-compromised age &gt; 65 years old</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Td Booster</td>
<td>&gt; 12 years old</td>
<td>High-risk patients &gt; 50 years old who are institutionalized or who have chronic cardiac or pulmonary disease, diabetes mellitus or anatomic asplenia, or who live in special environments or social settings with an identified increased risk of pneumonia</td>
<td>Every 10 years</td>
<td></td>
<td></td>
<td>A</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>&gt; 21 years old</td>
<td>High-risk adults – persons living in or traveling to where the disease is endemic, men who have sex with men, military personnel, and hospital and laboratory workers</td>
<td>Every 10 years</td>
<td></td>
<td></td>
<td>B</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>Mammography</td>
<td>Baseline between 35–40 years old</td>
<td>Every 1–2 years</td>
<td>USPSTF Managed Care Contract</td>
<td>5/04</td>
<td>Yes</td>
</tr>
<tr>
<td>Screening</td>
<td></td>
<td>65–75 years old</td>
<td>Every year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening</td>
<td>Service</td>
<td>Age</td>
<td>Frequency</td>
<td>Recommendation By:</td>
<td>Date Recommendation Last Approved</td>
<td>Rating*</td>
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<tr>
<td>Cervical Cancer</td>
<td>Pap Smear</td>
<td>Within three years of onset of sexual activity or age 20 (whichever comes first) and has a cervix.</td>
<td>Every three years</td>
<td>USPSTF Managed Care Contract</td>
<td>5/04</td>
<td>A</td>
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<tr>
<td></td>
<td>Pelvic Exam</td>
<td>Annually</td>
<td></td>
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<tr>
<td>Prostate Cancer</td>
<td>PSA &amp; DRE</td>
<td>65–75 years old</td>
<td>Every two years</td>
<td>USPSTF Managed Care Contract</td>
<td>5/04</td>
<td>I</td>
</tr>
<tr>
<td>Screening</td>
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</table>


A = The USPSTF strongly recommends that clinicians routinely provide the service to eligible patients. There is good evidence that the service improves important health outcomes and concludes that benefits substantially outweigh harms.

B = The USPSTF recommends that clinicians routinely provide the service to eligible patients. There is at least fair evidence that the service improves important health outcomes and concludes that benefit outweigh harms.

I = The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing this service. Evidence that the service is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

Last updated 4/04
Approved by MAC – 5/17/04
Personal Care Assistant (CHHA) Referral Form

Please Complete All Areas of the Form - Type or Print Legibly

QUESTIONS? Call: 1-855-661-1996

- New
- Recertification
- Increase

*Submit 30 days prior to the authorization end date
*Include physician's prescription

- Insurance transfer

   (Include the former insurance carrier’s notice of eligibility with this form)

   Type or print the former insurance carrier’s Name

- Agency Transfer

   (Include the member’s transfer letter, stating the reason(s) for the request)

   Type or print the Agency Name

MEMBER INFORMATION

<table>
<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>Middle initial</th>
<th>Home/Cell phone</th>
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</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Member ID #</th>
<th>SS #</th>
<th>DOB</th>
<th>Gender</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Street address</th>
<th>Apt/Unit</th>
<th>City</th>
<th>County</th>
<th>Zip</th>
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<tbody>
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</tbody>
</table>

The member lives:
- Independently
- With Caregiver(s)
- Boarding Home
- Assisted Living
- Nursing Home
- Group Home
- RMC
- Other

If translation services are required, please specify the language:

Medicaid Waiver Program:
- GO
- CCW
- TBI
- CRPD
- MIII

Case Manager (Print First Name and Last Name): Phone #:

Diagnosis (worded and numeric 5 digits):

<table>
<thead>
<tr>
<th>Member’s Alternate Contact</th>
<th>Relationship</th>
<th>Home #</th>
<th>Cell #</th>
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</thead>
<tbody>
<tr>
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PHYSICIAN INFORMATION

<table>
<thead>
<tr>
<th>Name</th>
<th>NPI #</th>
<th>Fax#</th>
</tr>
</thead>
<tbody>
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</table>

Office Address:

<table>
<thead>
<tr>
<th>Agency Name</th>
<th>AGP Provider ID#</th>
<th>Phone#</th>
<th>Fax#</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Provider Information

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>County</th>
<th>Contact Person</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Attestation

I hereby attest that the aforementioned agency has received a physician certification indicating the member's need for PCA services. I understand that Amerigroup can request a copy of this certification 30 days after services are ordered.

Print: First Name and Last Name

Signature

Date

Fax this completed form and any supplemental documents to: 1-888-240-4716
# Adult Day Health Services Referral Form

**Please Complete All Areas of the Form - Type or Print Legibly**

**QUESTIONS? Call: 1-855-661-1996**

<table>
<thead>
<tr>
<th>New</th>
<th>Recertification</th>
<th>Increase</th>
<th>Insurance transfer</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
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</tbody>
</table>

*Submit 30 days prior to the authorization end date

*Include physician's prescription

Transfer from __________________________ (Include the member's transfer letter, stating the reason(s) for the request)

**MEMBER INFORMATION**

<table>
<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>Middle Initial</th>
<th>Home/Cell phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Member ID #</th>
<th>SS #</th>
<th>DOB</th>
<th>Gender</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Street address

<table>
<thead>
<tr>
<th>Api/Unit</th>
<th>City</th>
<th>County</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The member lives: ☐ Independently ☐ With Caregiver(s) ☐ Boarding Home ☐ Assisted Living ☐ Nursing Home ☐ Group Home ☐ HMO ☐ Other

If translation services are required, please specify the language:

<table>
<thead>
<tr>
<th>Medicaid Waiver Program:</th>
<th>☐ GO</th>
<th>☐ CCW</th>
<th>☐ TBI</th>
<th>☐ CRPD</th>
<th>☐ AIGAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this service included in the case manager's plan of care?</td>
<td>☐ No</td>
<td>☐ Yes (If Yes, attach the approval)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Manager (Print First Name and Last Name):</td>
<td>Phone #:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PROVIDER INFORMATION**

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>AGP Provider #</th>
<th>Phone #</th>
<th>Fax #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>County</th>
<th>Contact Person</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PHYSICIAN INFORMATION**

<table>
<thead>
<tr>
<th>Physician Name:</th>
<th>NPI #</th>
<th>Office #</th>
<th>Fax #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MEDICAL ELIGIBILITY SCREEN**

<table>
<thead>
<tr>
<th>Diagnosis (worded and numeric 5 digits):</th>
<th>Prescription is attached:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ YES ☐ NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current # of days (per week):</th>
<th>Requested # of days (per week):</th>
<th>Requested Authorization Dates:</th>
</tr>
</thead>
<tbody>
<tr>
<td>From ___ To ___</td>
<td>From ___ To ___</td>
<td>From ___ To ___</td>
</tr>
</tbody>
</table>

Does the member require assistance with completion of Activities of Daily Living (ADL)? ☐ NO ☐ YES (If Yes, complete below)

<table>
<thead>
<tr>
<th>AD</th>
<th>INDEPENDENT</th>
<th>SUPERVISION/CUEING</th>
<th>LIMITED ASSISTANCE OR GREATER</th>
<th>ADL PROVIDED ONSITE?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ YES ☐ NO</td>
<td>☐ YES ☐ NO</td>
<td>☐ YES ☐ NO</td>
<td>☐ YES ☐ NO</td>
</tr>
</tbody>
</table>

Does the member have deficits in his/her cognitive status? ☐ NO ☐ YES (If Yes, complete below)

<table>
<thead>
<tr>
<th>Cognitive Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-Term Memory</td>
</tr>
<tr>
<td>Procedural Memory</td>
</tr>
<tr>
<td>Decision Making</td>
</tr>
</tbody>
</table>

Does the member require a skilled nurse to be provided onsite at the ADHS facility daily? ☐ NO ☐ YES (If Yes, attach physician's order)

INCLUDE THE PROPOSED PLAN OF CARE WITH THIS FORM

<table>
<thead>
<tr>
<th>Director of Nursing (Print First Name and Last Name)</th>
<th>Signature</th>
<th>Date</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fax this completed form and any supplemental documents to: 1-888-240-4717
Pediatric Day Health Services Referral Form

Please Complete All Areas of the Form - Type or Print Legibly

QUESTIONS? Call: 1-855-661-1996

☐ New
☐ Recertification
*Submit 30 days prior to the authorization end date
☐ Increase
*Include physician’s prescription

☐ Insurance transfer
________________________________________
Type or print the former insurance carrier’s Name
(Including the former insurance carrier’s notice of eligibility with this form)

☐ Transfer from
________________________________________
Type or print the FACINS Name
(Including the member’s transfer letter, stating the reason(s) for the request)

MEMBER INFORMATION

<table>
<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>Middle initial</th>
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</tr>
<tr>
<td>Street address</td>
<td>Apt/Unit</td>
<td>City</td>
<td>County</td>
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PHYSICIAN INFORMATION

<table>
<thead>
<tr>
<th>Physician Name:</th>
<th>NPI #</th>
<th>Office Fax #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Address:</td>
<td>Office #</td>
<td></td>
</tr>
</tbody>
</table>

MEDICAL ELIGIBILITY SCREEN

Diagnosis (worded and numeric 5 digits):

Prescription is attached: □ YES □ NO

Current # of days (per week): Requested # of days (per week): Requested Authorization Dates

From ____________________ To ____________________

State reason for PDHS request (Include physician’s report describing the child’s special medical needs to support this request):

Director of Nursing (Print First Name and Last Name) Signature Date Phone Number

Fax this completed form and any supplemental documents to: 1-888-240-4717
Division of Developmental Disabilities and Aged, Blind and Disabled Form

The State of New Jersey will begin to transition Medicaid enrollees with developmental disabilities and certain mental health problems into the Medicaid Managed Care Program. We’re working to determine if the health care needs of these populations can be met by our current provider network. We ask you to please respond to the following questions.

Please include any experience with your aged, blind or deaf disabled patients. Qualifications can include years of providing care for these patients even if no formal training was undertaken in the past.

1. Do you feel qualified to handle patients (either children or adults) with developmental disabilities? (Circle) YES or NO

2. Do you feel qualified to handle patients with mental health/behavioral or substance abuse problems? (Circle) YES or NO

3. Do you feel qualified to handle patients with HIV and/or AIDS? (Circle) YES or NO

4. Do you feel qualified to handle the geriatric population (aged)? (Circle) YES or NO

If yes to the above questions, PLEASE BRIEFLY OUTLINE your qualifications including specialized training/certifications and experience.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Signature ___________________________ Date ___________________________
The following forms are also available on our website at https://providers.amerigroup.com/NJ. You may also download them for your use as needed.

**Behavioral Health Forms**
- Behavioral Health Outpatient Treatment Form
- Behavioral Health Outpatient Treatment Report Form C
- Well-Being Screening Tool
- Behavioral Health Neuropsychological Testing Form

**Blood Lead Risk Forms**
- Blood Lead Testing for High-Risk Children
- Verbal Blood Lead Risk Assessment

**Cost Containment Form**
- Refund Notification Form

**HIV Antibody Blood Forms**
- Consent for HIV Antibody Blood Test
- Counsel for HIV Antibody Blood Test
- Results of HIV Antibody Blood Test

**Hysterectomy and Sterilization Forms**
- Acknowledgement of Receipt of Hysterectomy Information
- Consent to Sterilization Forms

**Medical Record Forms**
- Clinical Information Form
- Adult Preventive Care Flow Sheet
- Adult Preventive/Diabetes Care Flow Sheet
- EPSDT Worksheet
- Vaccine Administration Form
- Patient Drug Profile
- Problem List 1
- Problem List 2
- Well-Care Form – Birth – 15 Months
- Well-Care Form – 18 Months – 12 Years
- Well-Care Form – 13 Years – 18 Years

**Medicare**
- CMS Waiver of Liability
- Medicare Advantage Health Risk Assessment

**Pharmacy Synagis Order Form**
- Accredo Enrollment Forms
Practitioner Evaluation and Audit Tools
- New Jersey Practitioner Clinical Medical Record Audit
- New Jersey Practitioner Office Site Evaluation

Provider Grievance and Appeals
- Provider Payment Dispute & Correspondence Submission
- Grievance Form

Referral and Claims Submission Forms
- Authorization Request Form
- Maternity Notification Form
- Specialist as PCP Request
- WIC
- CMS-1500 (08-05) Claim Form
- UB-04 Claim Form

Risk Assessment Forms
- PCD Caries Risk Assessment Form (Age 0-6)
- PCD Caries Risk Assessment Form (Age >6)
- PCP Oral Health Risk Assessment Tool (AAP)
**PCD Caries Risk Assessment Form (Age 0-6)**

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date:</td>
<td></td>
</tr>
<tr>
<td>Age:</td>
<td>Initials:</td>
</tr>
</tbody>
</table>

### Contributing Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoride Exposure (through drinking water, supplements, professional applications, toothpaste)</td>
<td>□ Yes</td>
<td>□ No</td>
<td></td>
</tr>
<tr>
<td>Sugary Foods or Drinks (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Eligible for Government Programs (WIC, Head Start, Medicaid or SCHIP)</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Caries Experience of Mother, Caregiver and/or other Siblings</td>
<td>□ Yes</td>
<td>□ No</td>
<td></td>
</tr>
<tr>
<td>Dental Home: established patient of record in a dental office</td>
<td>□ Yes</td>
<td>□ No</td>
<td></td>
</tr>
</tbody>
</table>

### General Health Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special Healthcare Needs (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
</tbody>
</table>

### Clinical Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual or Radiographically Evident Restorations/ Cavitied Carious Lesions</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Non-cavitated (incipient) Carious Lesions</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Teeth Missing Due to Caries</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Visible Plaque</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Dental/Orthodontic Appliances Present (fixed or removable)</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Salivary Flow</td>
<td></td>
<td></td>
<td>Visualy inadequate</td>
</tr>
</tbody>
</table>

### Overall assessment of dental caries risk:

- Low
- Moderate
- High

Instructions for Caregiver:

© American Dental Association, 2009, 2011. All rights reserved.
Caries Risk Assessment Form (Age 0-6)

Circle or check the boxes of the conditions that apply. Low Risk = only conditions in "Low Risk" column present; Moderate Risk = only conditions in "Low" and/or "Moderate Risk" columns present; High Risk = one or more conditions in the "High Risk" column present.

The clinical judgment of the dentist may justify a change of the patient's risk level (increased or decreased) based on review of this form and other pertinent information. For example, missing teeth may not be regarded as high risk for a follow up patient; or other risk factors not listed may be present.

The assessment cannot address every aspect of a patient's health, and should not be used as a replacement for the dentist's inquiry and judgment. Additional or more focused assessment may be appropriate for patients with specific health concerns. As with other forms, this assessment may be only a starting point for evaluating the patient's health status.

This is a tool provided for the use of ADA members. It is based on the opinion of experts who utilized the most up-to-date scientific information available. The ADA plans to periodically update this tool based on: 1) member feedback regarding its usefulness; and; 2) advances in science. ADA member-users are encouraged to share their opinions regarding this tool with the Council on Dental Practice.
# PCD Caries Risk Assessment Form (Age >6)

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date:</td>
<td></td>
</tr>
<tr>
<td>Age:</td>
<td>Initials:</td>
</tr>
</tbody>
</table>

## Contributing Conditions

<table>
<thead>
<tr>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Fluoride Exposure (through drinking water, supplements, professional applications, toothpaste)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>II. Sugary Foods or Drinks (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)</td>
<td>Primarily at mealtimes</td>
<td>Frequent or prolonged between meal exposures/day</td>
</tr>
<tr>
<td>III. Caries Experience of Mother, Caregiver and/or other Siblings (for patients ages 6–14)</td>
<td>No carious lesions in last 24 months</td>
<td>Carious lesions in last 7–23 months</td>
</tr>
<tr>
<td>IV. Dental Home: established patient of record, receiving regular dental care in a dental office</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

## General Health Conditions

<table>
<thead>
<tr>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Special Health Care Needs (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)</td>
<td>No</td>
<td>Yes (over age 14)</td>
</tr>
<tr>
<td>II. Chemo/Radiation Therapy</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>III. Eating Disorders</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>IV. Medications that Reduce Salivary Flow</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>V. Drug/Alcohol Abuse</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

## Clinical Conditions

<table>
<thead>
<tr>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Cavitated or Non-Cavitated (incipient) Carious Lesions or Restorations (visually or radiographically evident)</td>
<td>No new carious lesions or restorations in last 36 months</td>
<td>1 or 2 new carious lesions or restorations in last 36 months</td>
</tr>
<tr>
<td>II. Teeth Missing Due to Caries in past 36 months</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>III. Visible Plaque</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>IV. Unusual Tooth Morphology that compromises oral hygiene</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>V. Interproximal Restorations – 1 or more</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>VI. Exposed Root Surfaces Present</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>VII. Restorations with Overhangs and/or Open Margins; Open Contacts with Food Impaction</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>VIII. Dental/Orthodontic Appliances (fixed or removable)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>IX. Severe Dry Mouth (Xerostomia)</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

## Overall assessment of dental caries risk:

- Low
- Moderate
- High

Patient Instructions:
Caries Risk Assessment Form (Age >6)

Circle or check the boxes of the conditions that apply. Low Risk = only conditions in “Low Risk” column present; Moderate Risk = only conditions in “Low” and/or “Moderate Risk” columns present; High Risk = one or more conditions in the “High Risk” column present.

The clinical judgment of the dentist may justify a change of the patient’s risk level (increased or decreased) based on review of this form and other pertinent information. For example, missing teeth may not be regarded as high risk for a follow up patient; or other risk factors not listed may be present.

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PCP Oral Health Risk Assessment Tool (AAP)

Oral Health Risk Assessment Tool

The American Academy of Pediatrics (AAP) has developed this tool to aid in the implementation of oral health risk assessment during health supervision visits. This tool has been subsequently reviewed and endorsed by the National Interprofessional Initiative on Oral Health.

Instructions for Use

This tool is intended for documenting caries risk of the child, however, two risk factors are based on the mother or primary caregiver's oral health. All other factors and findings should be documented based on the child.

The child is at an absolute high risk for caries if any risk factors or clinical findings, marked with a ▲ sign, are documented yes. In the absence of ▲ risk factors or clinical findings, the clinician may determine the child is at high risk of caries based on one or more positive responses to other risk factors or clinical findings. Answering yes to protective factors should be taken into account with risk factors/clinical findings in determining low versus high risk.

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit:</td>
<td>Date:</td>
</tr>
<tr>
<td>6 month ☐</td>
<td>Date:</td>
</tr>
<tr>
<td>9 month ☐</td>
<td>Date:</td>
</tr>
<tr>
<td>12 month ☐</td>
<td>Date:</td>
</tr>
<tr>
<td>15 month ☐</td>
<td>Date:</td>
</tr>
<tr>
<td>18 month ☐</td>
<td>Date:</td>
</tr>
<tr>
<td>24 month ☐</td>
<td>Date:</td>
</tr>
<tr>
<td>30 month ☐</td>
<td>Date:</td>
</tr>
<tr>
<td>3 year ☐</td>
<td>Date:</td>
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<tr>
<td>4 year ☐</td>
<td>Other:</td>
</tr>
<tr>
<td>5 year ☐</td>
<td></td>
</tr>
<tr>
<td>6 year ☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RISK FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>▲ Mother or primary caregiver had active decay in the past 12 months &lt;br&gt;☑ Yes ☐ No</td>
</tr>
<tr>
<td>▲ Mother or primary caregiver does not have a dentist &lt;br&gt;☑ Yes ☐ No</td>
</tr>
<tr>
<td>▲ Continual bottle/sippy cup use with fluid other than water &lt;br&gt;☑ Yes ☐ No</td>
</tr>
<tr>
<td>• Frequent snacking &lt;br&gt;☑ Yes ☐ No</td>
</tr>
<tr>
<td>• Special health care needs &lt;br&gt;☑ Yes ☐ No</td>
</tr>
<tr>
<td>• Medicaid eligible &lt;br&gt;☑ Yes ☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROTECTIVE FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Existing dental home &lt;br&gt;☑ Yes ☐ No</td>
</tr>
<tr>
<td>• Drinks fluoridated water or takes fluoride supplements &lt;br&gt;☑ Yes ☐ No</td>
</tr>
<tr>
<td>• Fluoride varnish in the last 6 months &lt;br&gt;☑ Yes ☐ No</td>
</tr>
<tr>
<td>• Has teeth brushed twice daily &lt;br&gt;☑ Yes ☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CLINICAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>▲ White spots or visible decalcifications in the past 12 months &lt;br&gt;☑ Yes ☐ No</td>
</tr>
<tr>
<td>• Obvious decay &lt;br&gt;☑ Yes ☐ No</td>
</tr>
<tr>
<td>• Restorations (fillings) present &lt;br&gt;☑ Yes ☐ No</td>
</tr>
<tr>
<td>• Visible plaque accumulation &lt;br&gt;☑ Yes ☐ No</td>
</tr>
<tr>
<td>• Gingivitis (swollen/bleeding gums) &lt;br&gt;☑ Yes ☐ No</td>
</tr>
<tr>
<td>• Teeth present &lt;br&gt;☑ Yes ☐ No</td>
</tr>
<tr>
<td>• Healthy teeth &lt;br&gt;☑ Yes ☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ASSESSMENT/PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caries Risk: &lt;br&gt;☐ Low ☐ High</td>
</tr>
<tr>
<td>Completed: &lt;br&gt;☐ Anticipatory Guidance &lt;br&gt;☐ Fluoride Varnish &lt;br&gt;☐ Dental Referral</td>
</tr>
<tr>
<td>Self Management Goals: &lt;br&gt;☐ Regular dental visits &lt;br&gt;☐ Dental treatment for parents &lt;br&gt;☐ Brush twice daily &lt;br&gt;☐ Use fluoride toothpaste</td>
</tr>
<tr>
<td>• Wean off bottle &lt;br&gt;☐ Less/No juice &lt;br&gt;☐ Only water in sippy cup &lt;br&gt;☐ Drink tap water</td>
</tr>
<tr>
<td>• Healthy snacks &lt;br&gt;☐ Less/No junk food or candy &lt;br&gt;☐ No soda &lt;br&gt;☐ Xylitol</td>
</tr>
</tbody>
</table>

Treatment of High Risk Children

If appropriate, high-risk children should receive professionally applied fluoride varnish and have their teeth brushed twice daily with an age-appropriate amount of fluoridated toothpaste. Referral to a pediatric dentist or a dentist comfortable caring for children should be made with follow-up to ensure that the child is being cared for in the dental home.


The recommendations in this publication do not indicate an standard or standard level of care. Instead, they reflect interprofessional and multidisciplinary perspectives. Copyright © 2011 American Academy of Pediatrics. All rights reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and is not responsible for its content.
Oral Health Risk Assessment Tool Guidance

Timing of Risk Assessment
The Bright Futures/AAP “Recommendations for Preventive Pediatric Health Care,” (ie, Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. View the Bright Futures/AAP Periodicity Schedule—http://brightfutures.aap.org/clinical_practice.html.

Risk Factors

⚠️ Maternal Oral Health
Studies have shown that children with mothers or primary caregivers who have had active decay in the past 12 months are at greater risk to develop caries. This child is high risk.

Maternal Access to Dental Care
Studies have shown that children with mothers or primary caregivers who do not have a regular source of dental care are at a greater risk to develop caries. A follow-up question may be if the child has a dentist.

Continual Bottle/Sippy Cup Use
Children who drink juice, soda, and other liquids that are not water, from a bottle or sippy cup continually throughout the day or at night are at an increased risk of caries. The frequent intake of sugar does not allow for the acid it produces to be neutralized or washed away by saliva. Parents of children with this risk factor need to be counseled on how to reduce the frequency of sugar-containing beverages in the child’s diet.

Frequent Snacking
Children who snack frequently are at an increased risk of caries. The frequent intake of sugar/ refined carbohydrates does not allow for the acid it produces to be neutralized or washed away by saliva. Parents of children with this risk factor need to be counseled on how to reduce frequent snacking and choose healthy snacks such as cheese, vegetables, and fruit.

Special Health Care Needs
Children with special health care needs are at an increased risk for caries due to their diet, xerostomia (dryness of the mouth, sometimes due to asthma or allergy medication use), difficulty performing oral hygiene, seizures, gastroesophageal reflux disease and vomiting, attention deficit hyperactivity disorder, and gingival hyperplasia or overcrowding of teeth. Premature babies also may experience enamel hypoplasia.

Protective Factors

Dental Home
According to the American Academy of Pediatric Dentistry (AAPD), the dental home is oral health care for the child that is delivered in a comprehensive, continuously accessible, coordinated and family-centered way by a licensed dentist. The AAP and the AAPD recommend that a dental home be established by age 1. Communication between the dental and medical homes should be ongoing to appropriately coordinate care for the child. If a dental home is not available, the primary care clinician should continue to do oral health risk assessment at every well-child visit.

Fluoridated Water/Supplements
Drinking fluoridated water provides a child with systemic and topical fluoride exposure, a proven caries reduction intervention. Fluoride supplements may be prescribed by the primary care clinician or dentist if needed. View fluoride resources on the Oral Health Practice Tools Web Page http://aap.org/oralhealth/PracticeTools.html.

Fluoride Varnish in the Last 6 Months

Tooth Brushing and Oral Hygiene
Primary care clinicians can reinforce good oral hygiene by teaching parents and children simple practices. Infants should have their mouths cleaned after feedings with a wet soft washcloth. Once teeth erupt it is recommended that children have their teeth brushed twice a day. For children under the age of 3 (until 3rd birthday) it is appropriate to recommend brushing with a smear (1 grain of rice amount) of fluoridated toothpaste twice per day. Children 3 years of age and older should use a pea-sized amount of fluoridated toothpaste twice a day. View the AAP Clinical Report on the use of fluoride in the primary care setting for more information. http://pediatrics.aappublications.org/content/early/2014/08/19/peds.2014-1699.
Clinical Findings

- **White Spots/Decalifications**
  This child is high risk.
  White spot decalifications present—immediately place the child in the high-risk category.

- **Obvious Decay**
  This child is high risk.
  Obvious decay present—immediately place the child in the high-risk category.

- **Restorations (Fillings) Present**
  This child is high risk.
  Restorations (Fillings) present—immediately place the child in the high-risk category.

- **Visible Plaque Accumulation**
  Plaque is the soft and sticky substance that accumulates on the teeth from food debris and bacteria. Primary care clinicians can teach parents how to remove plaque from the child’s teeth by brushing and flossing.

- **Gingivitis**
  Gingivitis is the inflammation of the gums. Primary care clinicians can teach parents good oral hygiene skills to reduce the inflammation.

- **Healthy Tooth**
  Children with healthy teeth have no signs of early childhood caries and no other clinical findings. They are also experiencing normal tooth and mouth development and spacing.

For more information about the AAP’s oral health activities, email oralhealth@aap.org or visit www.aap.org/oralhealth.

The recommendations in this publication are intended to be a guide to assist in the management of oral health care. The views expressed in this publication may not reflect the views of all American Academy of Pediatrics Sections or imply endorsement by the American Academy of Pediatrics. This document is not intended as a substitute for the medical judgment of health care providers. The American Academy of Pediatrics recommends that parents consult their child’s health care provider on a regular basis and that the child’s health care provider knows that the child is taking this medication.
Instructions for Completing the New Jersey Orthodontic Evaluation HLD (NJ-Mod2) Index Form

The intent of the HLD (NJ-Mod2) Index is to measure the presence or absence and the degree of the handicap caused by the components to be scored with the index and NOT to diagnose "malocclusion". Presence of conditions 1 through 6A or a score total equal to or greater than 26 qualifies for medical necessity exception.

GENERAL INFORMATION:

- Only cases with permanent dentition will be considered (see comprehensive orthodontics for exception).
- A Boley Gauge or disposable ruler scaled in millimeters should be used;
- The patient’s teeth are positioned in centric occlusion;
- All measurements are recorded and rounded off to the nearest millimeter (mm);
- For sections 1 to 6A and 15 an X is placed if the condition exists and no further scoring is needed;
- For sections 6B to 14, indicate the measurement or if a condition is absent, a 0 is entered;
- The use of an assistant to record the findings is recommended;
- Diagnostic models are required with submission of prior authorization. Casts must be properly poured, adequately trimmed without voids or bubbles and marked for centric occlusion, or
- Diagnostic Digital models may be submitted to show right and left lateral, frontal and posterior and maxillary and mandibular occlusal views to include view with measuring tool;
- Diagnostic quality photographs to show facial, frontal and profile, intra-oral front, left and right side, maxillary and mandibular occlusal views (minimum of seven views).

INSTRUCTIONS FOR FORM COMPLETION:

1. Cleft Palate Deformity – acceptable documentation must include at least one of the following: intraoral photographs of the palate, written consultation report by a qualified specialist or craniofacial panel. Score an X if present.

2. Cranio-facial Anomaly – acceptable documentation must include written report by qualified specialist or craniofacial panel and photographs. Score an X if present.

3. Impacted Permanent Anterior Teeth – demonstrate that anterior tooth or teeth (incisors and cuspids) is or are impacted (soft or hard tissue); not indicated for extraction and treatment planned to be brought into occlusion. Arch space available for correction. Score an X if present.

4. Crossbite of Individual Anterior teeth – demonstrate that anterior teeth or tooth (incisors and cuspids) is or are in crossbite resulting in occlusal trauma with excessive

1/2017 Accepted
wear, significant mobility or soft tissue damage. Score X if present. If these conditions do not exist it is to be considered an extopic eruption.

5. **Severe Traumatic Deviation** – damage to skeletal and or soft tissue as a result of trauma or other gross pathology. Include written report and intraoral photographs. Score an X if present.

6A. **Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5** – Overjet is recorded with the patient's teeth in centric occlusion and is measured from the labial of the lower incisors to the labial of the corresponding upper central incisors. This measurement should record the greatest distance between any one upper central incisor and its corresponding lower central or lateral incisor. If the overjet is greater than 9mm or mandibular protrusion (reverse overjet) is greater than 3.5mm, score an X if present.

6B. **Overjet equal to or less than 9mm** – overjet is recorded as in condition in 6A. The measurement is rounded to the nearest millimeter and entered on the score form.

7. **Overbite** – A pencil mark on the tooth indicating the extent of the overlap facilitates the measurement. It is measured and rounded off the nearest millimeter and entered on the score form. “Reverse” overbite may exist and should be measured and entered on the score form.

8. **Mandibular protrusion (reverse overjet) equal to or less than 3.5mm** – Mandibular protrusion (reverse overjet) is recorded as a condition in 6A and rounded to the nearest millimeter. Enter the score on the form and multiply it by five (5).

9. **Open Bite in millimeters** – This condition is defined as the absence of occlusal contact in the anterior region. It is measured from the incisal edge of a maxillary central incisor to the incisal edge of a corresponding mandibular incisor, in millimeters. Enter the measurement on the score form and multiply by four (4). If case is such that measurement is not possible, measurement can usually be estimated.

10. **Ectopic Eruption** – Count each tooth, excluding third molars. Each qualifying tooth must be more than 50% blocked out of the arch. Enter the number of qualifying teeth on the score form and multiply by three (3). If anterior crowding (see condition #11) also exists in the same arch, score the condition that scores the most points. DO NOT COUNT BOTH CONDITIONS. However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.

11. **Deep Impinging Overbite** – destruction of soft tissue on palate is present. Submit intraoral photographs of tissue damage/impingement. The presence of deep impinging overbite is indicated by a score of three (3) on the score form.

12. **Anterior Crowding** – Arch length insufficiency must exceed 3.5mm. Mild rotations are not to be scored as crowded. Score one (1) for a crowded maxillary arch and/or one for a
crowded mandibular arch. Enter the total on the score form and multiply by five (5). If ectopic eruption exists in the anterior region of the same arch, count the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.

13. **Labio-Lingual Spread** – A Boley Gauge (or disposable ruler) is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded anterior tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for the labio-lingual spread, but only the most severe individual measurement should be entered on the score form.

14. **Posterior Unilateral Crossbite** – This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of four (4) on the score form. **NO ADDITIONAL SCORE FOR BI-LATERAL CROSSBITE.**

15. **Psychological factors affecting child’s development** – This condition requires detailed documentation by a mental health provider as described in the managed care contract that contains the psychological or psychiatric diagnosis, treatment history and prognosis. An attestation from the mental health provider must state and substantiate that orthodontic correction will result in a favorable prognosis of the mental/psychological condition.
NJ ORTHODONTIC ASSESSMENT TOOL - HLD (NJ-Mod2)

**All needed preventive and dental treatment must be completed - attach attestation**

Name: ____________________ Medicaid ID # ____________________
Age: _______ Sex: M / F Class/Type of Case: ____________________
Treatment: Comprehensive / Interceptive Name of General Dentist: ____________________
Name of orthodontist: ____________________ Billing Provider #: ____________________

Notes: Follow instructions for completing form found in newsletter. Conditions 1-6A are automatically qualifying conditions and need no further scoring. Indicate with an X when the conditions in 1-6A or 15 are present. Conditions 6B-14 must total 26 or more.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cleft palate deformity (attach description from credentialed specialist)</td>
<td></td>
</tr>
<tr>
<td>2. Cranio-facial Anomaly (attach description from credentialed specialist)</td>
<td></td>
</tr>
<tr>
<td>3. Impacted permanent anteriors where extraction is not indicated</td>
<td></td>
</tr>
<tr>
<td>Note the number of teeth</td>
<td></td>
</tr>
<tr>
<td>4. Crossbite of individual anterior teeth</td>
<td></td>
</tr>
<tr>
<td>5. Severe traumatic deviations</td>
<td></td>
</tr>
<tr>
<td>6A. Overjet greater than 9 mm with incompetent lips or reverse overjet</td>
<td></td>
</tr>
<tr>
<td>greater than 3.5 mm</td>
<td></td>
</tr>
<tr>
<td>6B. Overjet (mm)</td>
<td></td>
</tr>
<tr>
<td>7. Overbite (mm)</td>
<td></td>
</tr>
<tr>
<td>8. Mandibular protrusion (mm) x 5</td>
<td></td>
</tr>
<tr>
<td>9. Open bite (mm) x 4</td>
<td></td>
</tr>
<tr>
<td>10. Ectopic eruption (# of teeth x 3)</td>
<td></td>
</tr>
<tr>
<td>11. Deep impinging overbite (intra-oral photos that demonstrate palatal</td>
<td></td>
</tr>
<tr>
<td>soft tissue impingement/destruction are required) Score 3 points if</td>
<td></td>
</tr>
<tr>
<td>present</td>
<td></td>
</tr>
<tr>
<td>12. Anterior crowding MX____ MD____ Total____ x 5</td>
<td></td>
</tr>
<tr>
<td>(score 1 per arch)</td>
<td></td>
</tr>
<tr>
<td>13. Labiobuccal spread (mm)</td>
<td></td>
</tr>
<tr>
<td>14. Posterior unilateral crossbite (involving molar): Score 4 if present</td>
<td></td>
</tr>
<tr>
<td>15. Psychological factors affecting development (&quot;X&quot; requires detailed</td>
<td></td>
</tr>
<tr>
<td>documentation by mental health provider as described per contract of</td>
<td></td>
</tr>
<tr>
<td>psychological/psychiatric diagnosis, prognosis and that orthodontic</td>
<td></td>
</tr>
<tr>
<td>correction will improve mental/psychological condition.)</td>
<td></td>
</tr>
</tbody>
</table>

☐ Medical exceptions with score total less than 26 (check one)
   ____ Dental diagnosis  ____ Medical diagnosis  ____ Clinical significance or functional impairment

For consultant use only:
APPROVED ☐ EXCEPTION ☐ DENIED ☐

1/2017 Accepted
APPENDIX B – CLINICAL PRACTICE GUIDELINES

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), and American Academy of Family Practice (AAFP); and voluntary health organizations such 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 (SMHSHA) 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 our 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 preventive and nonpreventive clinical practice guidelines for acute and chronic medical and behavioral health conditions to all affected providers every two years and more frequently if an update has occurred. Preventive health guidelines will be distributed upon request to members and potential members. 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 our website at https://www.providers.amerigroup.com and log in to the secure site by entering your Login Name and Password. On the Online Inquiries page, scroll down to Resources, select the Clinical Practice Guidelines link and select the New Jersey link. 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.
**APPENDIX C – DEFINITIONS**

**Abuse** – Any practice inconsistent with sound fiscal, business or medical practices that results in an unnecessary cost to the Medicaid/ NJ FamilyCare program, including administrative costs from acts that adversely affect providers or members, or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes enrollee practices that result in unnecessary cost to the Medicaid/NJ FamilyCare program.

**Appeal** – A request for reconsideration of a health care management decision resulting in a denial, termination, or other limitation in the coverage of and access to health care services or reconsideration by an independent review organization administered by the DOBI.

**Children with Special Health Care Needs** – Members who have or are at an increased risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required generally by children. This group also includes all children who are MLTSS members and members who are at risk for nursing home placement or who may require other long-term services and supports.

**Consultation** – A referral between different provider types or referral from a PCP or PCD to a specialist or in the case of dentistry, to a dentist that provides dental services to special needs patients. A member cannot be denied access to the consultation or when needed to medically necessary services provided by that specialty provider.

**Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** – A Title XIX mandated program that covers screening and diagnostic services to determine physical and mental defects in enrollees under the age of 21, and health care, treatment and other measures to correct or ameliorate any defects and chronic conditions discovered, pursuant to federal regulations found in Title XIX of the Social Security Act.

**Enrollees with Special Needs** – Members with complex/chronic medical conditions requiring specialized health care services, including persons with physical, mental, substance abuse and/or developmental disabilities, including such persons who are homeless and persons who are eligible for the MLTSS program.

**Fraud** – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person.

**Grievance** – A written expression of concern or dissatisfaction with a nonclinical issue.

**Inquiry** – A request for information or action that can be immediately explained or resolved.

**Mobile Dental Practice** – Provider traveling to various locations and utilizes portable dental equipment to provide dental services to facilities, schools and residences. These providers are expected to provide on-site comprehensive dental care, necessary dental referrals to general dentist or specialists and emergency dental care in accordance with all State Board regulations and the NJ FamilyCare MCO Contract. The sites served by the Mobile Dental Practice must allow Member access to treatment and
allow for continuity of care. The MCO is responsible for assisting the member and facility in locating a dentist when referrals are issued. Patient records must be maintained at the facility when this is a long-term care facility or skilled nursing facility and duplicates may also be maintained in a central and secure area in accordance with State Board regulations. The MCO must maintain documentation for all locations that the mobile van will serve to include schedule with time and days.

**Mobile Dental Van** – is a vehicle specifically equipped with stationary dental equipment and is used to provide dental services within the van. A mobile dental van is not to be considered a dental practice. Providers using a mobile dental van to render dental services must also be associated with a dental practice that is located in a “brick and mortar” facility located in New Jersey, that serves as a dental home offering comprehensive care, emergency care and appropriate dental specialty referrals to the mobile dental van’s patients of record (members). Patient records are to be maintained in the brick and mortar location in accordance with State Board of Dentistry regulations. The distance between the dental practice and the sites and locations served by the mobile dental van must not be a deterrent to the member accessing treatment and allow for continuity of care by meeting the network standards for distance in miles as described in section 4.8.8 Provider Network Requirements. When a mobile dental van’s use is associated with health fairs or other one-time events, services will be limited to oral screenings, exams, fluoride varnish, prophylaxis and palliative care to treat an acute condition. State Board regulations must still be followed. The MCO must maintain documentation for all locations served to include schedule of time and days.

**Payment Dispute** – An administrative dispute between a health care provider and Amerigroup, for any reason such as lost or incomplete claim forms or electronic submissions, timely claim filing, notification/precertification, or requests for additional explanation regarding claim payment decisions. Payment disputes do not require any action by the member.

**Primary Care Dentist (PCD)** – A licensed dentist who is the health care provider responsible for supervising, coordinating and providing initial and primary dental care to patients; for initiating referrals for specialty care; and for maintaining the continuity of patient care.

**Primary Care Provider (PCP)** – A licensed medical doctor (MD) or doctor of osteopathy (DO) or certain other licensed medical practitioner who, within the scope of practice and in accordance with State certification/licensure requirements, standards and practices, is responsible for providing all required primary care services to enrollees, including periodic examinations, preventive health care and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, and initiation of referrals to specialty providers described in this contract and the benefits package, and for maintaining continuity of patient care. A PCP shall include general/family practitioners, pediatricians, internists and may include specialist physicians, physician assistants, CNMs or CNPs/CNSs, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with these contract provisions and licensure requirements.

**Waste** – Activities involving careless, poor or inefficient billing, or treatment methods causing unnecessary expenses and/or management of resources.