Provider Quick Reference Guide

Precertification/notification requirements
Important phone numbers  ■  Revenue codes

New Jersey

https://providers.amerigroup.com/NJ
Ongoing provider communications: To keep you up-to-date with the 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 provider website at https://providers.amerigroup.com/NJ under News and Announcements.

Easy access to **precertification/notification requirements** and other important information for Medicaid-only products

For more information about requirements, benefits and services, visit our provider website to get the most recent, full version of our provider manual.

If you have questions about this quick reference guide (QRG) or recommendations on how to improve it, call your local Provider Relations representative. We want to hear from you and improve our service so you can focus on serving your patients!

**Precertification/notification instructions and definitions**

**Request precertifications and give us notifications:**
- **Online:** https://providers.amerigroup.com/NJ
- **By phone:** 1-800-454-3730
- **By fax:** 1-800-964-3627

**Behavioral health requests should be faxed to 1-800-505-1193.**

**Managed long-term services and supports (MLTSS) requests should be faxed to 1-888-826-9762.**

**Precertification/prior authorization** – the act of authorizing specific services or activities before they are rendered or occur (also known as prior authorization [PA])

**Notification** – telephonic, fax or electronic communication received from a provider to inform us of the intent to render covered medical services to a member
- Give us notification prior to rendering services outlined in this document.
- For emergency or urgent services, give us notification within 24 hours or the next business day.
- Member eligibility and provider status (network and non-network) are verified.

If you submitted a prior authorization request for nonemergency services (home care, home infusion, durable medical equipment [DME], out-of-network outpatient) and you have not received a response from Amerigroup Community Care, please contact the Healthcare Management Services Precertification Team at 732-452-6050.

For all other prior authorization requests for nonemergency services, contact Provider Services at 1-800-454-3730.

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

Requirements listed are for network providers. In most cases, out-of-network providers may be required to request precertification for services when network providers do not.
Behavioral Health/Substance Abuse
- Self-referral — No precertification is required.
- Behavioral/mental health services and substance abuse services (e.g., diagnosis, treatment and detoxification) and costs for methadone and its administration are managed by the state for all Medicaid and NJ FamilyCare enrollees. Amerigroup retains responsibility for covering detoxification in a medical acute care inpatient setting.
- Exception: For Medicaid enrollees who are clients of the Division of Developmental Disabilities (DDD), Amerigroup retains responsibility for covering mental health/substance abuse services excluding partial care, partial hospitalization, and the cost of methadone and its administration.
- Exception: For MLTSS members, Amerigroup retains responsibility for covering mental health/substance abuse services including partial care, partial hospitalization services and the cost of methadone.
- Mental health services include but are not limited to comprehensive intake evaluation, off-site crisis intervention, family therapy, family conference, psychological testing and medication management. See the Medicaid provider manual for a detailed service list.
- Services available to NJ FamilyCare D enrollees (i.e., CHIP beneficiaries under the age of 19 pursuant to the Mental Health Parity and Addiction Equity Act of 2008) under fee-for-service include:
  - Inpatient hospital services for mental health, including psychiatric hospitals
  - Outpatient benefits for short-term, outpatient evaluative and crisis intervention, or home health mental health services
  - Inpatient and outpatient services for substance abuse
- Behavioral health services available to members in the Alternative Benefit Plan (ABP) and NJ FamilyCare A, but remaining in fee-for-service for non-MLTSS and non-DD populations:
  - Psychiatric emergency rehabilitation services (PERS)/affiliated emergency services
  - Substance abuse partial day treatment
  - Substance abuse outpatient
  - Substance abuse intensive outpatient
  - Substance abuse/short-term residential
  - Nonacute detoxification
  - Targeted case management (ICMS)
  - Program of Assertive Community Treatment (PACT)
  - Community supports services (CSS)
  - Behavioral health homes (BHH)
  - Mental health outpatient
  - Adult mental health rehabilitation (group homes)
  - Opioid treatment services
  - Mental health partial care and partial hospitalization

Cardiac
- Precertification is required.
- Contact AIM at 1-800-714-0400, Monday-Friday from 8 a.m.-8 p.m. Eastern time.

Chemotherapy
- Precertification is required for coverage of inpatient chemotherapy services.
- Precertification is not required for coverage of chemotherapy procedures when performed in outpatient settings by a participating facility, provider office, outpatient hospital or ambulatory surgery center.

For information on oncology, ancillary medications and chemotherapy drugs, please see the “Pharmacy” section of this QRG.

Chiropractic Services
- Chiropractic services are limited to treatment by means of manual manipulation of the spine.
- For NJ FamilyCare D, services performed by a chiropractor are not covered.

Cognitive Rehabilitative Therapy (CRT)
- Precertification is required.
- CRT is covered only for members with nontraumatic brain injuries.
- Habilitative CRT services outside of a waiver are not covered.

Dental Services
- Members may self-refer to participating dentists and dental specialists — No precertification is required.
- Members are required to visit their primary care dentist for dental services.
- NJ Smiles is a program to allow trained PCP office staff to provide dental risk assessment, fluoride varnish application and dental referral for children through the age of 6. Children should have their first dental visit around the time of their first tooth eruption and no later than age 1. The NJ Smiles Directory lists dental specialists and general dentists who provide dental treatment to children ages 0-6. This directory is listed on our provider website at https://providers.amerigroup.com/NJ. Use it to locate dentists treating children, including those less than 6 years old.
- For temporomandibular joint services, see the “Oral Maxillofacial” section of this QRG.
- NJ Medicaid/NJ FamilyCare A, B, C, D, FIDE-SNP (dual eligible Medicare-Medicaid), MLTSS and ABP: Dental services are covered. Services include diagnostic and preventive services (e.g., exams, cleaning, sealants and fluoride) every six months for all members. Sealants are covered once every three years for members under age 17. Restorative, endodontic, periodontic, prosthodontic, oral and maxillofacial surgery, and adjunctive services are covered. Some services require prior authorization.


Orthodontic services are to be provided to children through the age of 20 or upon loss of eligibility through NJ FamilyCare. Orthodontic treatment will refer to limited, interceptive, habit correction or comprehensive orthodontic treatment, as well as all other ancillary orthodontic services considered only when medical criteria for exemption, as noted above, have been met.

Continuity of care through case completion will apply when a member with an orthodontic case in progress changes managed care organizations.

Reimbursement for orthodontic services will not be continued upon loss of eligibility from an NJ FamilyCare/Medicaid program.

Members may call Healthplex at 1-800-720-5352, Monday-Friday from 8 a.m.-6 p.m. Eastern time for additional information on dental benefits.

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 QRG. 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 electroencephalogram. Any other nuclear radiology procedure requires precertification.
- Precertification through AIM is required for coverage of MRA, MRI, CAT scans, PET scans and nuclear cardiac scans. Contact AIM at 1-800-714-0040, and AIM will locate an in-network imaging facility.
- 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.

Durable Medical Equipment

- 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.

Precertification may be requested by completing a Certificate of Medical Necessity (CMN) — available on our website — or by submitting a physician order and Amerigroup Referral and Precertification 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 HCPCS and/or other codes for billing covered services. All custom wheelchair precertifications require an Amerigroup medical director’s review.

No precertification is required for network providers for coverage of glucometers, nebulizers, dialysis/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.

NJ FamilyCare D: See the provider manual for items covered.

See the “Medical Supplies” section of this QRG for guidelines related to disposable medical supplies.

Early and Periodic Screening, Diagnosis and Treatment Visit

- Self-referral — No precertification is required.
- Use the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) schedule and document visits/encounters on a CMS-1500 form to receive incentive payments. Copays do not apply to EPSDT services.
- NJ FamilyCare D: Members receive limited coverage for EPSDT services.

Educational Consultation

No notification or precertification is required. There is no coverage for smoking cessation.

Emergency Room

- No precertification or 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.

For observation precertification requirements, see the “Observation” section of this QRG.
Ear, Nose and Throat Services (Otolaryngology)
- No precertification is required for E&M, testing and most procedures.
- Precertification is required for:
  - Tonsillectomy and/or adenoidectomy.
  - Nasal/sinus surgery.
  - Cochlear implant surgery and services.
Visit our website to view specific service codes for precertification/notification requirements. See also the “Diagnostic Testing” section of this QRG.

Family Planning/Sexually Transmitted Disease Care
- Self-referral — No precertification is required.
- 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).
- No coverage is available outside the participating network.
- No precertification or notification is required for coverage of primary sterilization procedures; member must be age 21 or older.
- A Sterilization Consent Form is required for claims submission of primary sterilization procedures.

Gastroenterology Services
- No precertification is required for network provider E&M, testing and most procedures.
- Precertification is required for upper endoscopy and bariatric surgery, including insertion, removal and/or replacement of adjustable gastric-restrictive devices and subcutaneous port components.
Visit our website to view specific service codes for precertification/notification requirements. See also the “Diagnostic Testing” section of this QRG.

Gynecology
Self-referral — No precertification is required for E&M, testing and procedures.

Hearing Aids
- Precertification is required for digital hearing aids.
- NJ Medicaid/NJ FamilyCare A, B, C and ABP: Precertification is required for coverage.
- NJ FamilyCare D: 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.

Hearing Screening
- No precertification or notification is required for coverage of diagnostic and screening tests, hearing aid evaluations or counseling.
- NJ FamilyCare D: 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.

Home Health Care
- Precertification is required.
- NJ Medicaid/NJ FamilyCare A, B, C and ABP: Covered services are limited to skilled nursing, home health aide and medical social services that require precertification for coverage.
- NJ FamilyCare D: When the purpose of treatment is skilled care, and social services are required for the treatment of the member’s medical condition, covered services are limited to a skilled-nursing homebound beneficiary who is supervised by a registered nurse and home health aide.
- Private-duty nursing is covered by the plan for all members until their 21st birthday.

Hospice Care
- Precertification is required for coverage of inpatient hospice services.
- Notification is required for coverage of outpatient hospice services.

Hospital Admission
- Elective and nonemergency admissions require precertification for coverage. Precertification should be requested as early as possible, but no later than 24 hours prior to admission.
- Emergency admissions require notification within 24 hours of admission or the next business day.
- For preadmission lab testing, see the provider referral directory for a complete list of participating vendors.
- Same-day admission is required for surgery.

Laboratory Services (Outpatient)
- All laboratory services furnished by non-network providers require precertification by Amerigroup except for hospital laboratory services provided for an emergency medical condition.
- For offices with limited or no office laboratory facilities, lab tests may be referred to an Amerigroup lab vendor.
- See your provider referral directory for a complete listing of participating lab vendors.
- Reference labs also include AccuReferral Lab and Bio-Reference Lab.

Medical Supplies
- No precertification is required for coverage of disposable medical supplies.
- For NJ FamilyCare D, coverage 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 vacuum-assisted closure (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.

**Neurology**
- No precertification is required for network providers for E&M and testing.
- 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 also the “Diagnostic Testing” section of this QRG.

**Observation**
- No precertification or notification is required for in-network observation.
- If observation results in admission, notification to Amerigroup is required within 24 hours or the next business day.

**Obstetrical Care**
- No precertification is required for coverage of obstetrical (OB) services when performed by a participating provider.
- Notification to Amerigroup is required at the first prenatal visit.
- Notification is required for coverage of emergency and obstetric admissions within 24 hours or the next business day. See the “Diagnostic Testing” section of this QRG.
- Two ultrasounds for normal pregnancy diagnosis are covered.

**Ophthalmology**
- No precertification is required for E&M, testing and most procedures.

Visit our provider website to view specific service codes for precertification/notification requirements. See also the “Plastic/Cosmetic/Reconstructive Surgery” section of this QRG.

**Oral Maxillofacial**
- No precertification is required for coverage of evaluation and management (E&M)-level office visits.
- Precertification is required for coverage of all other services.
- Precertification is required for coverage of trauma to the teeth and oral maxillofacial medical and surgical conditions, including TMJ.

See the “Plastic/Cosmetic/Reconstructive Surgery” section of this QRG.

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**Otolaryngology Services**
See the “Ear, Nose and Throat Services (Otolaryngology)” section of this QRG.

**Out-of-Area/Out-of-Plan Care**
- Precertification is required except for the coverage of emergency care (including self-referral) and OB delivery.
- Emergency admission to an out-of-area/out-of-network facility requires notification within one business day.

See related services for precertification.

**Outpatient/Ambulatory Surgery**
- Precertification is required based on the procedure performed.
- See the Precertification Lookup tool on our website.

**Pain Management**
- Non-E&M-level testing and procedures require precertification for coverage.

**Perinatology**
- Notification is required.
- See the “Diagnostic Testing” and “Laboratory Services” sections of this QRG.

**Pharmacy**
- **Pharmacy benefit information:** The pharmacy benefit covers medically necessary prescription and over-the-counter medications prescribed by a licensed provider. Exceptions and restrictions exist as the benefit is provided under a closed formulary/Preferred Drug List (PDL). Please refer to the appropriate PDL and/or the Medicaid Medication Formulary on our website for the preferred products within therapeutic categories as well as requirements around generics, prior authorization (PA), step therapy, quantity edits and the PA process.
- **Medical-injectable drugs:** Many self-injectable medications, self-administered oral specialty medications and office-administered specialty medications are available through Accredo Specialty and require PA. To determine if a medical injectable requires prior authorization, please go to the Quick Tools section of our website and use the Precertification Lookup tool. For a complete list of covered injectables, visit the Pharmacy Tools section of our website. Call Accredo at 1-800-870-6419 to schedule delivery once you receive a PA approval.
- **Pharmacy prior authorization requests:** Submit your pharmacy PA requests:
  - 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.
- The pharmacy online prior authorization tool allows you to:
  - Verify member eligibility.
  - Attach clinical documentation.
  - Perform a drug lookup.
Enter multiple requests for multiple drugs at one time.
- Appeal denied requests.
- Upload supporting documents and review appeal status.
- Request medical injectables for those medications obtained by your office/facility for onsite infusion or administration.

**Physiatry**
- Precertification is required for coverage of all non-E&M services and procedures related to pain management.

**Physical Medicine and Rehabilitation**
- No precertification is required for coverage of E&M codes. All other services require precertification.
- Outpatient physical therapy (OPT), occupational therapy (OT) and speech therapy (ST) are covered and require precertification.

See the “Rehabilitation Therapy (Outpatient Occupational Therapy, Physical Therapy and Speech Therapy)” section of this QRG.

**Plastic/Cosmetic/Reconstructive Surgery**
- No precertification is required for coverage of E&M codes. All other services require precertification.
- Services considered cosmetic in nature are not covered. Services related to a previous cosmetic procedure are not covered.
- Reduction mammoplasty requires an Amerigroup medical director’s review.

Visit our provider website to view specific service codes for precertification/notification requirements. See also the “Oral Maxillofacial” and “Diagnostic Testing” sections of this QRG.

**Podiatry**
- Routine hygienic care of the feet, in the absence of a pathological condition, is excluded.
- No precertification is required for coverage of E&M testing and most procedures when provided by a participating podiatrist.

Visit our provider website to look up specific service codes for precertification/notification requirements.

**Radiation Therapy**
- 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 or ambulatory surgery center.
- Precertification is required for coverage of services rendered in an inpatient setting.

**Radiology**
See the “Diagnostic Testing” section of this QRG.

**Rehabilitation Therapy (Outpatient Occupational Therapy, Physical Therapy and Speech Therapy)**
- NJ Medicaid/NJ FamilyCare A and ABP: Outpatient therapy services are covered. Facility-based therapy services require precertification.
- NJ FamilyCare B and C: Each outpatient therapy service is covered for 60 days of therapy per incident, per calendar year. Facility-based therapy services require precertification.
- NJ FamilyCare D: OPT, OT and ST services for nonchronic conditions, acute illness and injuries are covered. Facility-based therapy services require precertification.
- Precertification is required for coverage of services rendered in an outpatient setting.
- Outpatient therapy care (including occupational, physical, and speech pathology evaluation and therapy services) are arranged through the Therapy Network of New Jersey (TNNJ). Therapy providers should call TNNJ at 1-855-825-7818 for more information regarding prior approval for outpatient therapy services.

**Skilled Nursing Facility**
- Precertification is required for coverage of all care and services provided in a skilled nursing facility.

**Sleep Medicine/Study**
- Precertification is required.
- Contact AIM at 1-800-714-0400, Monday-Friday from 8 a.m.-8 p.m. Eastern time.

**Sterilization**
- No precertification or notification is required for sterilization procedures, including tubal ligation and vasectomy.
- Sterilization is a covered benefit for members age 21 and older.
- The Sterilization Consent Form is required for claims submission for primary sterilization procedures.
- Reversal of sterilization is not a covered benefit.
- Sterilization services from a nonparticipating provider are not covered.

**Termination of Pregnancy**
Elective, induced abortion and related services are covered by the New Jersey Medicaid fee-for-service (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.

**Transportation**
For all cities and counties, members are directed to the County Board of Social Services or LogistiCare at 1-866-527-9933 to arrange nonemergency transportation, which is covered by the state and not managed care. Amerigroup retains the responsibility to provide nonmedical transportation to MLTSS members.
Vision Care (Medical)
- No precertification is required for testing and procedures.
- Precertification is required for repair of eyelid defects.
- Services considered cosmetic in nature are not covered.

See also the “Diagnostic Testing” section of this QRG.

Vision Care (Routine)
- Self-referral — No precertification is required.
- NJ Medicaid and NJ FamilyCare A, B, C and ABP:
  - Coverage is limited to one routine eye exam per year. Members may contact Superior Vision at 1-800-428-8789.
  - Coverage is provided for one pair of eyeglass lenses once every 12 months for members under age 19 and age 60 and older.
  - 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 — No precertification is required.
- 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

Amerigroup does not require referrals to participating specialists. Amerigroup primarily utilizes current editions of InterQual® Level of Care criteria and Anthem, Inc. Medical Policies and Clinical Utilization Management Guidelines to review the medical necessity and appropriateness of physical health services and Anthem Behavioral Health Medical Necessity Criteria for all behavioral health services, unless superseded by state requirements or regulatory guidance.

Vaccines For Children (VFC): All administration codes require appropriate serum codes.

For Amerivantage precertification and notification guidelines, visit our website at https://providers.amerigroup.com/NJ and consult the Medicare Advantage provider manual or use our Precertification Lookup tool.
Important Contact Information

■ Our Service Partners

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<th>Service Provider</th>
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<tbody>
<tr>
<td>Superior Vision</td>
<td>1-866-819-4298</td>
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<tr>
<td>Accredo Specialty</td>
<td>1-800-870-6419</td>
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<td>CoverMyMeds</td>
<td>1-866-452-5017</td>
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<td>Healthplex</td>
<td>1-888-468-2183</td>
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<td>LabCorp</td>
<td>1-888-LABCORP (1-888-522-2677)</td>
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<td>Quest</td>
<td>1-866-697-8378</td>
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<tr>
<td>AIM Specialty Health</td>
<td>1-800-714-0040</td>
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<tr>
<td>Therapy Network</td>
<td>1-855-825-7818</td>
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■ Managed Long-Term Services and Supports – Provider Services and Ancillary Claims

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<tr>
<td>Provider Services</td>
<td>1-800-454-3730</td>
<td>Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Gloucester, Hunterdon, Monmouth, Morris, Ocean, Salem</td>
</tr>
<tr>
<td>MLTSS department</td>
<td>1-855-661-1996</td>
<td>Essex, Hudson, Mercer, Middlesex, Passaic, Somerset, Sussex, Union, Warren</td>
</tr>
<tr>
<td>NJ MLTSS provider help</td>
<td><a href="mailto:nj1mltssprovhelp@amerigroup.com">nj1mltssprovhelp@amerigroup.com</a></td>
<td>732-452-6000, ext. 66190</td>
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■ Assisted Living, Home- and Community-Based Services, Nursing Facility, Specialty Care Nursing Facility, Chore Services and other nontraditional MLTSS services

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<tr>
<td>Carol Diprisco Network Relations representative</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 representative</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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■ Assessment, Eligibility and Enrollment

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<td>Akanksha Kapoor Process Improvement</td>
<td><a href="mailto:Akanksha.Kapoor@amerigroup.com">Akanksha.Kapoor@amerigroup.com</a> 732-452-6000, ext. 66388</td>
</tr>
<tr>
<td>Yanira Ceara MLTSS member representative</td>
<td><a href="mailto:Yanira.Ceara-Almodovar@amerigroup.com">Yanira.Ceara-Almodovar@amerigroup.com</a>, 732-452-6000, ext. 66034</td>
</tr>
<tr>
<td>Linda Cruz MLTSS Manager</td>
<td><a href="mailto:Linda.Cruz@amerigroup.com">Linda.Cruz@amerigroup.com</a>, 732-452-6000, ext. 66291</td>
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■ Hospice

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<td>Linda Cruz MLTSS manager</td>
<td><a href="mailto:Linda.Cruz@amerigroup.com">Linda.Cruz@amerigroup.com</a>, 732-452-6000, ext. 66291</td>
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■ Behavioral Health

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<td>Ann Basil MLTSS manager</td>
<td><a href="mailto:Ann.Basil@amerigroup.com">Ann.Basil@amerigroup.com</a>, 732-452-6000, ext. 65835</td>
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■ Hospital Billing Inquiries

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<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>
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Provider Experience Program

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

Provider Website and IVR Available 24/7/365:
Visit https://providers.amerigroup.com/NJ to:
- Verify eligibility.
- Check claims and referral authorization status.
- Look up precertification/notification requirements.
- Access provider education information, tools and resources.

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

Availity

The Availity Portal is an online multipayer portal that gives physicians, hospitals and other health care professionals access to multiple payer information with a single, secure sign-on.

The Availity Portal offers the following for Amerigroup providers:
- Eligibility and benefits inquiries
- Claim status inquiries
- Claim submissions

There is also a direct link to the Amerigroup provider self-service website for all other functionality, including panel listings, precertification requests and appeals. You can access the link located under the My Payer Portal in the left-hand navigation menu.

If your office is not registered to use the Availity Portal, register at https://www.availity.com today so you and your staff can have immediate access to the online tools. Select the Register button, then complete the online registration wizard.

If you have questions about Availity or need assistance with registration, contact Availity Client Services at 1-800-AVAILITY (1-800-282-4548) or email questions to support@availity.com.

Credentiaing and Provider Data Services

Enrollment
Providers who are interested in enrolling in the Amerigroup network may submit an application request at https://providers.amerigroup.com. Under Join Our Network, select Get Started and then New Jersey. Providers may also call Provider Services at 1-800-454-3730, Monday-Friday from 8 a.m.-8 p.m. Eastern time.

To view the Amerigroup network of participating PCPs and specialists, go to https://providers.amerigroup.com and select Find a Doctor from the menu at the top. To submit an application for network consideration, send to the following:
For medical, home- and community-based services and other:
- Credentialing Department
- Amerigroup Community Care
- 101 Wood Ave. S.
- Iselin, NJ 08830

For dental:
- Healthplex
  - 333 Earle Ovington Blvd., Suite 300
  - Uniondale, NY 11553
  - 1-888-468-2183

For questions regarding the status of an application, call 732-452-6000, ext. 66265, or send an email to nj1credentialing@amerigroup.com. 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 (e.g., death or loss of license). Members are automatically assigned to another PCP to ensure continuous access to Amerigroup covered services. 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 (e.g., retirement). You must provide written notice to us within the time frames specified in your Participating Provider Agreement. Members receiving care from a voluntarily disenrolled PCP will be notified to self-select a new PCP.

Claims Services

Timely filing is within 180 calendar days from the last date of service in the course of treatment. Timely filing is within 180 days from:
- The date of service for outpatient treatment.
- The date of discharge for inpatient treatment.

Electronic Data Interchange (EDI)
Call our EDI hotline at 1-800-590-5745 to get started. We accept claims through three clearinghouses:
- Emdeon (payer 27514)
- Availity (payer 26375)
- Capario (payer 28804)

Electronic Funds Transfer/Electronic Remittance Advice (EFT/ERA)
If you would like to enroll in this service or have questions, please contact one of the vendors below:
- PaySpan: 1-877-331-7154 or www.payspanhealth.com
- Emdeon: 1-866-742-4355, option 1 or www.emdeon.com/epayment

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

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

Please note: AMA- and CMS-approved modifiers must be used appropriately based on the type of service and procedure code.

You may check claims statuses by going to our website or by calling our automated 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.
Corrected Claims
Timely filing is within 365 days from the date of service, per your provider agreement.
- Paper corrected claims must be clearly marked “Corrected Claim.”
- Electronic submissions must have the applicable frequency code.

Payment Disputes
Claims payment disputes must be filed within 60 days of the adjudication date on your explanations of payment. Forms for provider appeals are available on our website. Mail to:
- Payment Dispute Unit
  Amerigroup Community Care
  P.O. Box 61599
  Virginia Beach, VA 23466-1599

Hospital Billing Questions
For hospital billing inquiries contact Lisa Cunningham-Hill at 732-452-6000, ext. 66301 or at Lisa.Cunningham-Hill@amerigroup.com.

Medical Appeals
Member Appeals
Member medical appeals for adverse determinations based on medical necessity may be initiated by the member or the member’s representative, or the provider acting on behalf of the member with the member’s written consent. Medical appeals may be submitted orally or in writing.

Provider Appeals
Provider medical appeals may be initiated by the provider without the member’s written consent. The appeals must be submitted in writing.

Member and provider requests for medical appeals must be submitted within 60 days of the date of the adverse determination letter. For oral member appeal requests, the member can call 1-800-600-4441 (TTY 711). For written member and provider appeals, submit the request to:
- Quality Management Department
  Amerigroup Community Care
  101 Wood Ave. S., 8th Floor
  Iselin, NJ 08830

Coordination of Benefits
Amerigroup follows New Jersey-specific guidelines when coordination of benefits is necessary. We use covered medical and hospital services whenever available, or other public or private sources of payment for services rendered to members. Coordination of benefits (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. Following are some frequently asked questions and answers about coordination of benefits.

1. If a member is dually eligible or has a third-party liability (TPL) policy, how often do I have to submit a denial from Medicare and/or the TPL insurer?
On each claims submission, Amerigroup must obtain a copy of the explanation of payment (EOP) to coordinate the payment. Exception: If a member has Medicare A or B and the service is not covered by the Medicare portion, Amerigroup does not need an EOP.

2. Do I submit the denial from the Medicare and/or commercial insurance provider electronically or as a hard copy via postal mail?
A hard copy must be mailed in. Amerigroup is unable to accept attachments to claims electronically. Submit the denial to:
- Amerigroup Community Care
  P.O. Box 61010
  Virginia Beach VA 23466-1010

3. How do I track the progress of paper copies of explanation of benefits (EOBs) for individual members?
Providers can call our Provider Services team at 1-800-454-3730 to check if an EOB was received by verifying the following:
- The EOB is located in the member’s folder.
- The claim has been processed and paid.

4. What is required for me to submit to Amerigroup if the member has Medicare and/or commercial insurance, and I don’t participate in the Medicare and/or commercial network?
Because Amerigroup is usually a secondary payer, the primary EOP must be included to determine payment as primary or secondary responsibility. The claim will deny without the attached EOP.

5. Who do I contact for technical assistance regarding claims submission and coordination of benefits for dually eligible members and members with commercial insurance?
You can call our Provider Services team at 1-800-454-3730 for assistance.

Any questions or inquiries regarding paid, denied or pended claims should be directed to Provider Services at 1-800-454-3730. For questions specific to coordination of benefits for MLTSS, contact your Provider Relations representative.

Health Services
Care Management Services • 1-800-454-3730
We offer care management services to members who are likely to have extensive health care needs. Our nurse care managers work with you to develop individualized care plans, including identifying community resources, providing health education, monitoring compliance, assisting with transportation, etc. Members may call Care Management Services Monday-Friday from 8 a.m.-5 p.m. Eastern time.

Disease Management Centralized Care Unit (DMCCU) Services • 1-888-830-4300
DMCCU services include educational information like local community support agencies and events in the health plan’s service area. Services are available for members with the following medical conditions: asthma, bipolar disorder, COPD, CHF, CAD, diabetes, HIV/AIDS, hypertension, major depressive disorder, schizophrenia and substance use disorder.

24/7/365 Nurse HelpLine • 1-800-600-4441 • TTY 711
Members may call our 24-hour Nurse HelpLine for medical advice 7 days a week, 365 days a year.

Member Services • 1-800-600-4441 • TTY 711
Members may call Member Services Monday-Friday from 8 a.m.-6 p.m. Eastern time.