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**How to apply for participation**
If you are interested in applying for participation with Amerigroup Community Care, please visit [https://providers.amerigroup.com/TN](https://providers.amerigroup.com/TN) or call Provider Services at 1-800-454-3730.
Do you need free help with this letter?

If you speak a language other than English, help in your language is available for free. This page tells you how to get help in a language other than English. It also tells you about other help that’s available.

Spanish: Español
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-600-4441 (TTY 711).

Kurdish: کوردی
ناگداری: ناگداری به زامانی کوردی قاسه دەکەیە، خزمەتگزاریکانی بەرەوەیە زامان، بەکەوەیە، بۆ وەکو بەرەوەیە. پاسەوەیە بە TTY (711) 1-800-600-4441

Arabic: العربية
ملحوظة: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 1-800-600-4441 (TTY 711).

Chinese: 繁體中文
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-600-4441 (TTY 711)。

Vietnamese: Tiếng Việt
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-600-4441 (TTY 711).

Korean: 한국어
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-600-4441 (TTY 711) 번으로 전화해 주십시오.

French: Français
ATTENTION : Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-800-600-4441 (ATS 711).

Amharic: እንዳን/Documents/other/20221027/other/20221027.pdf

Gujarati: ગુજરાતી
સુખાના: જો તમે ગુજરાતી બોલતા હો, તો નિઃચુક લાંબા સમય સેવાઓ તમારા માટે ઉપલબ્ધ છ.

Laotian: ເ�체

Tagalog: Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-600-4441 (TTY 711).

Hindi: हिंदी
ध्यान रखे: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में माफ़ी की सहायता सेवाएं, उपलब्ध हैं 1-800-600-4441 (TTY 711) पर कॉल करें.
Do you need help talking with us or reading what we send you?
Do you have a disability and need help getting care or taking part in one of our programs or services?
Or do you have more questions about your health care?

Call us for free at 1-800-600-4441. We can connect you with the free help or service you need. (For TTY call: 711)

We obey federal and state civil rights laws. We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. Do you think we did not help you or you were treated differently because of your race, color, birth place, language, age, disability, religion, or sex? You can file a complaint by mail, by email, or by phone. Here are three places where you can file a complaint:

Amerigroup Nondiscrimination Coordinator
22 Century Blvd., Suite 220
Nashville, TN 37214
Email: tn.nondiscrimination@amerigroup.com
Phone: 1-800-600-4441 (TTY 711)
Fax: 1-866-796-4532

Health Care Finance and Administration
Office of Civil Rights Compliance
310 Great Circle Road, Floor 4W
Nashville, Tennessee 37243
Email: HCFA.Fairtreatment@tn.gov
Phone: 855-857-1673 (TRS 711)

U.S. Department of Health & Human Services Office for Civil Rights
200 Independence Ave SW, Rm 509F,
HHH Bldg
Washington, DC 20201
Phone: 800-368-1019
(TDD): 800-537-7697

You can get a complaint form online at:
Or you can file a complaint online at:
https://ocrportal.hhs.gov/ocr/portal/lobby.js

You can get a complaint form online at:
http://www.tn.gov/hcfa/article/civil-rights-compliance
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1 INTRODUCTION

Welcome to the Amerigroup Community Care network provider family! Incorporated as Amerigroup Tennessee, Inc., we are pleased that you have joined our Tennessee network, which consists of some of the finest health care providers in the state.

The Division of TennCare administers the TennCare™ program, which includes TennCare Medicaid and TennCare Standard. TennCare Medicaid covers all Medicaid mandatory eligibility groups as well as various optional categorically needy and medically needy groups including children, pregnant women, the aged and individuals with disabilities.

We believe hospitals, physicians 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, high-quality provider network. All network 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 quality, coordinated and efficient care for our members and your patients.

Division of TennCare Required Language — Provider Agreements

The Division of TennCare requires specific language in TennCare provider agreements. As noted in the provider agreement, TennCare-required language and state of Tennessee mandates regarding the TennCare program can be updated by inclusion in this provider manual.

For ease of provider review, we’ve included certain required language and TennCare program mandates in a document titled “TennCare Regulatory Appendix, Division of TennCare Required Language — Provider Agreements,” which is routinely appended to Amerigroup TennCare provider agreements. The latest version of this Appendix is also in Appendix C of this provider manual.

When Amerigroup amends your provider agreement to comply with federal and state regulatory requirements, most of these changes may be made within the body of this manual; however, in certain circumstances, those regulatory requirements may require Amerigroup to make changes to confidential portions of your provider agreement, such as the payment provisions. When this type of change is required, Amerigroup may provide you with a separate confidential notice of the regulatory changes to your provider agreement. If the payment provisions are impacted, we will send you a new fee schedule or payment appendix for your records. If we provide you notice of changes in accordance with this paragraph, Amerigroup will limit such changes to those required to comply with the change in regulatory requirements.

Updates and Changes

This provider manual, as part of your provider agreement and related addendums, may be updated at any time and is subject to change. The most updated version is available online at https://providers.amerigroup.com/TN. To request a free, printed copy of this manual, call Provider Services at 1-800-454-3730.

If there is an inconsistency between information contained in this manual and the agreement between you or your facility and Amerigroup, the agreement governs. In the event of a material change to the information contained in this manual, we will make all reasonable efforts to notify you through web-posted newsletters, provider bulletins
and other communications. In such cases, the most recently published information supersedes all previous information and is considered the current directive.

This manual is not intended to be a complete statement of all policies and procedures. We may publish other policies and procedures not included in this manual on our website or in specially targeted communications, including but not limited to bulletins and newsletters.
2 OVERVIEW

Who is Amerigroup?
Amerigroup Tennessee, Inc., doing business as Amerigroup Community Care, is a wholly owned subsidiary of Anthem, Inc. 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 and Medicare Advantage Special Needs Plans.

Our Mission
The Amerigroup mission is to provide real solutions for members who need a little help by making the health care system work better while keeping it more affordable for taxpayers.

Our Vision
Amerigroup will be a different kind of health insurance company — a company that does well by doing good.

Our Values
The Amerigroup values include:

- **Compassion** — We understand the importance of acting with empathy and developing meaningful relationships that will positively influence our associates and members’ lives.
- **Quality** — We provide outstanding products, quality and unsurpassed service that, together, deliver premium value to our stakeholders.
- **Integrity** — We uphold the highest standards in all our actions.
- **Teamwork** — We work together across boundaries and in partnership to meet the needs of our customers and to help the company achieve its goals.
- **Respect for people** — We value our associates and their diversity, encourage their development and reward their performance.
- **Good citizenship** — We seek to find ways in which to engage and support the communities in which we live and work through volunteerism, political involvement and leading by example.
- **Personal accountability** — We keep our commitments to one another and to those we serve through accepting ownership for the quality of the work we produce. We have a strong desire to win in the marketplace and in every aspect of our business, and each associate accepts personal responsibility for achieving organizational success.

Strategy
The Amerigroup strategy is to:

- Improve access to preventive primary care services by ensuring the selection of a PCP who will serve as provider, 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 processes that actively involve providers in re-engineering health care delivery.
- Encourage a customer service orientation with regular measurement of member and provider satisfaction.
Summary
In a world of escalating health care costs, Amerigroup works to educate our members about the appropriate use of our managed care system and their involvement in all aspects of their health care.
3 QUICK REFERENCE INFORMATION

Amerigroup Website
Our provider website, [https://providers.amerigroup.com/TN](https://providers.amerigroup.com/TN), offers you a full complement of online tools including:

- Enhanced account management tools
- Detailed eligibility lookup tool with downloadable panel listing
- More comprehensive downloadable member listing tool
- Easier authorization submission tool
- New provider data, termination and roster tools

Amerigroup Phone Numbers
Please have your Amerigroup provider ID number and NPI number available when you call. Listen carefully and follow the appropriate prompts.

<table>
<thead>
<tr>
<th>Provider Services telephone</th>
<th>1-800-454-3730</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Services fax</td>
<td>1-800-964-3627</td>
</tr>
<tr>
<td>TTY users</td>
<td>711</td>
</tr>
<tr>
<td>Automated provider inquiry line for member eligibility</td>
<td>1-800-454-3730</td>
</tr>
<tr>
<td>24-hour NurseLine</td>
<td>1-800-600-4441</td>
</tr>
<tr>
<td>Member Services</td>
<td>1-800-600-4441</td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td>1-800-454-3730</td>
</tr>
<tr>
<td>Behavioral Health Inpatient Services fax</td>
<td>1-800-877-5211</td>
</tr>
<tr>
<td>Behavioral Health Outpatient Services fax</td>
<td>1-866-920-6006</td>
</tr>
<tr>
<td>Behavioral Health Neuro-Psych fax</td>
<td>1-800-505-1193</td>
</tr>
<tr>
<td>Amerigroup services for injectable and home infusion drug (prior authorizations only)</td>
<td>1-800-454-3730</td>
</tr>
<tr>
<td>Electronic Data Interchange (EDI) Hotline</td>
<td>1-800-590-5745</td>
</tr>
<tr>
<td>Durable Medical Equipment And Medical Supply Referrals — Amerigroup Utilization Management (UM)</td>
<td>1-800-454-3730</td>
</tr>
</tbody>
</table>

Providers and trading partners can:

- Verify TennCare eligibility
- Upload or download HIPAA transactions
- Submit or inquire about pre-admission evaluation status
- Use the TennCare messaging system

Providers and partners who wish to use this online service must be a TN.gov subscriber.

If you cannot verify an enrollee's eligibility via this online system, you should contact the enrollee's TennCare MCO. You may also contact TennCare Provider Services at the phone numbers to the right.

**TennCare Phone Numbers**
Dental Services: DentaQuest is TennCare’s dental benefits manager | 1-855-418-1622
TennCare Pharmacy
Call Magellan Health Services (toll free) for questions related to the pharmacy program and general prior authorization.
Also see the TennCare Pharmacy website: https://www.tn.gov/tenncare/providers/pharmacy.html 1-866-434-5524

TennCare Solutions Unit (for medical appeals)
See also: https://www.tn.gov/tenncare/members-applicants/how-to-file-a-medical-appeal.html 1-800-878-3192

Mobile Crisis Services (behavioral health) operates 24 hours a day, 7 days a week and is open to anyone who needs mental health crisis services.
Adults aged 18 and older 1-855-CRISIS1 or 1-855-274-7471
Children under the age of 18, please call Youth Villages:
- Memphis region: 1-866-791-9226
- Rural West TN: 1-866-791-9227
- Rural Middle TN: 1-866-791-9222
- Nashville region: 1-866-791-9221
- Upper Cumberland: 1-866-791-9223
- Southeast TN: 1-866-791-9225
- Knoxville region: 1-866-791-9224
- Northeast TN: 1-866-791-9228

TennCare Connect
Fraud and Abuse Hotline
TBI.MFCU@tn.gov or ProgramIntegrity.TennCare@tn.gov 1-800-433-3982
Tennessee Carriers 1-800-680-0633

Ongoing Provider Communications
In order to ensure that providers are up-to-date with information required to work effectively with Amerigroup and our members, we provide frequent communications to providers in the form of broadcast faxes, provider manual updates, newsletters and information posted to the website.

Below you will find additional information that will assist you in your day-to-day interaction with Amerigroup.

# Additional Information

<table>
<thead>
<tr>
<th>Member Eligibility</th>
<th>Contact Provider Services at 1-800-454-3730.</th>
</tr>
</thead>
</table>
| Precertification/Notification | • May be telephoned or faxed to Amerigroup:  
  o Telephone: 1-800-454-3730  
  o Fax: 1-800-964-3627  
  Behavioral Health Inpatient Fax: 1-800-877-5211  
  Behavioral Health Outpatient Fax: 1-866-920-6006  
  Behavioral Health Neuro-Psych Testing 1-800-505-1193 |
| Precertification/Notification | • Data required for complete precertification/notification:  
  o Member ID number  
  o Legible name of referring licensed provider  
  o Legible name of individual referred to provider  
  o Number of visits/services  
  o Date(s) of service  
  o Diagnosis |
In addition, clinical information is required for precertification. Precertification forms are located at: [https://providers.amerigroup.com/QuickTools/Pages/PrecertificationLookup.aspx](https://providers.amerigroup.com/QuickTools/Pages/PrecertificationLookup.aspx)

<table>
<thead>
<tr>
<th>Become a Tennessee Medicaid Provider</th>
<th>You may access this information on the web. Go to <a href="http://www.tn.gov/tenncare/section/providers">http://www.tn.gov/tenncare/section/providers</a></th>
</tr>
</thead>
</table>
| **National Provider Identifier (NPI)** | **NPI:** The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires the adoption of a standard unique provider identifier for health care providers. All Amerigroup participating providers must have an NPI number. NPI is a 10-digit intelligence-free numeric identifier. Intelligence-free means that the numbers do not carry information about health care providers such as the state in which they practice or their specialty. Providers can apply for an NPI by:  
- Completing the application online at [https://nppes.cms.hhs.gov](https://nppes.cms.hhs.gov) (estimated time to complete the NPI application is 20 minutes)  
- Completing a paper copy by downloading it at [https://nppes.cms.hhs.gov](https://nppes.cms.hhs.gov)  
- Calling 1-800-465-3203 and requesting an application |
| **Claims Information** | **Submit paper claims to:**  
TN Claims  
P.O. Box 61010  
Virginia Beach, VA 23466-1010  
- Your organization can submit and receive the following transactions through Availity’s EDI gateway:  
  o 837 — institutional claims  
  o 837 — professional claims  
  o 837 — dental claims  
  o 835 — electronic remittance advice (ERA)  
  o 276/277 — claim status  
  o 270/271 — eligibility request  
- **Get started with Availity:**  
  o If you wish to submit directly to Availity, setup is easy. Go to the Availity Welcome Application and begin the process of connecting to the Availity EDI Gateway for your EDI transmissions.  
  o If you wish to use another clearinghouse or billing company, please work with them to ensure connectivity.  
- For more information about Availity such as how to register, training opportunities and more, visit [www.availity.com](http://www.availity.com) or call 1-800-AVAILITY (1-800-282-4548).  
- Timely filing is within 120 days of the date of service except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date that the third party documents resolution of the claim. For cases of retroactive eligibility, the time frames for filing a claim will begin on the date that Amerigroup receives notification from TennCare of the member’s eligibility/enrollment. |
- A corrected claim or replacement claim may be submitted within 120 calendar days of payment notification (paid or denied). Corrections to a claim should only be submitted if the original claim information was wrong or incomplete.
- For other claims (vision and pharmacy injectables), refer to the Services NOT Covered by Amerigroup section. (Noninjectable pharmacy benefits are covered by a Pharmacy Benefits Manager (PBM) contracted by TennCare.)
- Amerigroup provides access to an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status and referral authorization status. Visit providers.amerigroup.com.
- If you are unable to access the internet, you may receive claims, eligibility and referral authorization status over the telephone at any time by calling the toll-free automated Provider Inquiry Line at 1-800-454-3730.

Medical Appeal Information
- Member appeals are managed by TennCare.
- Members have the right to file appeals regarding adverse benefit determinations taken by Amerigroup. For purposes of this requirement, appeal means a member’s right to contest, verbally or in writing, any adverse benefit determinations taken by Amerigroup to deny, reduce, terminate, delay or suspend a covered service; and any other acts or omissions of Amerigroup that impair the quality, timeliness or availability of such benefits. An appeal may be filed by the member or by a person authorized by the member to do so, including a provider with the member’s written consent. Complaint means a member’s right to contest any other action taken by Amerigroup or service provider other than those that meet the definition of an adverse benefit determinations. Amerigroup will inform members of their complaint and appeal rights in the member handbook. Amerigroup has internal complaint and appeal procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees and court orders governing the appeals process.
- You may call Amerigroup at 1-800-600-4441 to speak to someone who is knowledgeable of appeal procedures and will facilitate all appeals as appropriate, whether the appeal is verbal or the member chooses to file in writing to TennCare.
- Should a member choose to appeal in writing, the member will be instructed to file via mail or fax to the designated TennCare P.O. Box or fax number for medical appeals:

  TennCare Solutions  
  P.O. Box 593  
  Nashville, TN 37202-0593  
  Fax (toll free) 1-888-345-5575

See also: https://www.tn.gov/tenncare/members-applicants/how-to-file-a-medical-appeal.html
**Payment Dispute Process**

We have several options when filing a claim payment dispute. They are described below.

- **Verbal (reconsideration only):** Verbal submissions may be submitted by calling Provider Services at 1-800-454-3730.

- **Website (reconsideration and claim payment appeal):** Amerigroup can receive reconsiderations and claim payment appeals via the secure Provider Availity Payment Appeal Tool at [https://www.availity.com](https://www.availity.com). Supporting documentation can be uploaded to the Availity Portal. You will receive immediate acknowledgement of your submission.

- **Written (reconsideration and claim payment appeal):** Written reconsiderations and claim payment appeals should be mailed along with the *Claim Payment Appeal Form* or the *Reconsideration Form* to:
  
  Provider Payment Disputes  
  P.O. Box 61599  
  Virginia Beach, VA 23466-1599

Submit reconsiderations on the *Reconsideration Form* located at: [https://providers.amerigroup.com/TN](https://providers.amerigroup.com/TN).

Submit written claim payment appeals on the *Claim Payment Appeal form* located at: [https://providers.amerigroup.com/TN](https://providers.amerigroup.com/TN).

**Member Complaints**

The member (or a provider on behalf of the member if the issue is treatment/benefits) may file a complaint by phone by contacting Amerigroup at 1-800-600-4441 or the Division of TennCare at 1-855-286-9085. The member may file a complaint regarding allegations of discrimination by contacting Amerigroup at 1-800-600-4441 or call HCFA’s Office of Civil Rights Compliance for free at 1-855-857-1673 (TRS Dial 711); OCR: 1-800-368-1019 (Voice), 1-800-537-7697 (TDD).

**Provider Complaints**

Amerigroup has a system for nonpayment-related complaints for network and non-network providers. See Section 20, Provider Complaint Procedures.

File a provider complaint to:

- Operations Department  
  Amerigroup Community Care  
  22 Century Boulevard, Suite 220  
  Nashville, TN 37214

**Case Managers**

- Amerigroup case managers are available during normal business hours from 8 a.m. to 5 p.m. Central time.
- For urgent issues at all other times, call 1-800-454-3730.

**Provider Demographic Updates**

- Go online to: [https://providers.amerigroup.com/TN](https://providers.amerigroup.com/TN)
- Fax updates on letterhead to 1-877-423-9973 or mail to: 
  
  Operations Department  
  Amerigroup Community Care  
  22 Century Blvd, Suite 220  
  Nashville, TN 37214

**Provider Service Representatives**

For more information or for hard copies of the guidelines and polices listed below, contact Provider Services at 1-800-454-3730.

**Clinical Practice Guidelines**

[https://providers.amerigroup.com/TN](https://providers.amerigroup.com/TN)

See Provider Resources & Documents > Clinical Practice Guidelines

**Medical Policies**

[https://providers.amerigroup.com/QuickTools/Pages/MedicalPolicies.aspx](https://providers.amerigroup.com/QuickTools/Pages/MedicalPolicies.aspx)
<table>
<thead>
<tr>
<th>Clinical UM Guidelines</th>
<th><a href="https://providers.amerigroup.com/QuickTools/Pages/MedicalPolicies.aspx">https://providers.amerigroup.com/QuickTools/Pages/MedicalPolicies.aspx</a></th>
</tr>
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<tr>
<td>Availity Web Portal</td>
<td>• Available Monday through Friday, 5 a.m. to 4 p.m. Pacific time at 1-800-Availity (1-800-282-4548), excluding holidays</td>
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<tr>
<td>Client Services</td>
<td>• Email questions to <a href="mailto:support@availity.com">support@availity.com</a></td>
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4 CREDENTIALING

Amerigroup uses the current National Committee for Quality Assurance (NCQA) Health Plan Accreditation Requirements for the credentialing and recredentialing of licensed independent providers with whom it contracts and who fall within its scope of authority and action.

Amerigroup will completely process credentialing applications within 30 calendar days of receipt of a completed credentialing application including all necessary documentation, attachments and a signed provider agreement. Completely process means that Amerigroup will review, approve and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not included in the Amerigroup provider network.

Credentialing

Each provider agrees to submit for verification all requested information necessary to credential or recredential providers who provide services in accordance with the standards established by Amerigroup. Each provider will cooperate with Amerigroup as necessary to conduct credentialing and recredentialing pursuant to Amerigroup policies and procedures.

Credentialing Requirements

Each provider must remain in full compliance with the Amerigroup credentialing criteria as set forth in its credentialing policies and procedures and all applicable laws and regulations. Each provider will complete the Amerigroup application form upon request by Amerigroup. Effective January 1, 2018, use of the Council for Affordable Quality Healthcare’s (CAQH) ProView will be required for initial credentialing and recredentialing with Amerigroup. ProView is a free online service that allows health care providers to fill out one application to meet the credentialing data needs of multiple organizations.

All providers applying for initial or continuing participation will be required to complete and submit their credentialing and recredentialing applications through CAQH ProView by accessing the CAQH website. Below are some helpful hints and things to remember when using ProView.

To join CAQH ProView:
2. Select Register Now on the bottom right and follow the instructions.

If you already participate with CAQH and have completed your online application, ensure you authorized Amerigroup access to your credentialing information.

Note: If you have selected Global Authorization, Amerigroup will already have access to your data.

To authorize Amerigroup:
1. Go to https://proview.caqh.org/pr and enter your username and password.
2. Select the cog wheel in the upper right and then select Authorize.
3. Scroll down, locate Amerigroup and check the box beside Amerigroup.
4. Select Save to submit your changes.

For questions about ProView, call the CAQH help desk at 1-888-599-1771 or email providerhelp@proview.CAQH.org.

Each provider will comply with other such credentialing criteria as may be established by Amerigroup.
Credentialing Procedures

Amerigroup is committed to operating an effective, high-quality credentialing program. Amerigroup credentials the following provider types:

- Medical doctors
- Doctors of osteopathy
- Doctors of dental surgery
- Doctors of dental medicine
- Doctors of podiatric medicine
- Doctors of chiropractic
- Physician assistants
- Optometrists
- Dentists
- Nurse practitioners
- Certified nurse midwives
- Licensed professional counselors/social workers
- Psychologists
- Licensed psychological and senior psychological examiners
- Physical/occupational therapists
- Speech/language therapists
- Allied services (ancillary) providers
- Applied behavioral analysts

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

Amerigroup established a credentialing committee and a Medical Advisory Committee (MAC) for credentialing decisions. The credentialing committee will make decisions regarding participation of initial applicants at the time of credentialing and their continued participation at the time of recredentialing. The oversight rests with the MAC.

The Amerigroup credentialing policy is revised periodically based on input from several sources including:

- The health plan credentialing committees
- The health plan medical directors
- The Amerigroup chief medical officer
- State and federal requirements
- NCQA standards

The policy will be reviewed and approved annually and as otherwise needed.

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

Each provider has the right to inquire about the application status. The applicant may do so by telephone, facsimile or contact through the provider’s Provider Relations representative. Additionally, the applicant may call the local Credentialing Operations line at 615-316-2450 to check status.

As an applicant for participation with Amerigroup, each provider has the right to review information obtained from primary verification sources during the credentialing process. Upon request from Amerigroup, the provider shall explain information obtained that may vary substantially from that submitted by the provider, and the provider shall submit proposed corrections to any erroneous information submitted by another party. The provider must submit a written explanation or may appear before the credentialing committee if deemed necessary by the credentialing committee.
Following verifications of all submitted documentation as more specifically described below, the practitioner file will be administratively deemed complete and be submitted to the health plan medical director or credentialing committee for review and approval. To the extent allowed under applicable law or state agency requirements and in accordance with NCQA Standards and Guidelines, the credentialing committee may delegate the authority to review and approve complete files to the medical director. Any file rejected by the medical director will be presented to the credentialing committee for a final determination on Plan 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. **Verification of enrollment.** If group enrollment, verification that the provider is linked appropriately to the group and that the provider is enrolled at the appropriate service locations.

2. **Board certification.** Amerigroup verifies board certification. Board certification is verified by referencing the American Medical Association (AMA) Provider Profile, American Osteopathic Association (AOA), the American Board of Medical Specialties (ABMS), American Board of Podiatric Surgery (ABPS), American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM).

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

4. **Verification of work history.** For individual practitioners, an application or curriculum vitae documenting a minimum of the most recent five years of relevant work history must be submitted. Relevant experience includes work as a health professional. The application or CV must include the beginning and ending month and year for each position in the practitioner’s employment experience. Any gaps in work history greater than six months must be explained in writing and be specifically reviewed by the medical director and/or credentialing committee.

5. **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 attestation is not acceptable under applicable state law or state agency requirements, hospital admitting privileges in good standing are administratively verified for the practitioner by obtaining verification 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 network hospital are documented.

6. **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 contact or the internet access.

7. **DEA number.** Verification of the Drug Enforcement Administration (DEA) number to ensure that the practitioner is currently eligible to prescribe controlled substances. Amerigroup verifies this information via the National Technical Information Service (NTIS) database. 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.

8. **Professional liability coverage.** To the extent allowed under applicable law or state agency requirements, verification of professional liability insurance coverage may be accomplished by the use of an attestation signed by the provider indicating the name of the carrier, policy number, coverage limits, the effective date and expiration date of such insurance coverage. If attestation is not acceptable, the practitioner’s professional liability insurance information is verified by obtaining a copy of the professional liability insurance face sheet from the practitioner or from the insurance carrier. Practitioners are required under applicable law to maintain professional liability insurance in specified amounts. The application form must include specific questions regarding the dates and amount of a practitioner’s current
malpractice insurance. NCQA requires practitioners to attest to the dates and amount of their current malpractice coverage, even if the amount is $0.

9. Professional liability claims history. Verification of an applicant’s history of professional liability claims, if any, reviewed by the health plan 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 gives careful consideration to the medical facts of each case, the total number and frequency of claims during the past five years, and the financial settlements and/or legal judgments.

10. CMS sanctions. Verification that the practitioner’s record is clear of any sanctions by Medicare/Medicaid. This information is verified by accessing the NPDB and OIG database.

11. Disclosures. The Amerigroup Provider Application will require completion of the following:
   - Reasons for the inability to perform the essential functions of the position with or without accommodation
   - History or current problems with chemical dependency, alcohol or substance abuse
   - History of license revocation, suspension, voluntary relinquishment, probationary status or other licensure conditions or limitations
   - History of conviction of any criminal offense other than minor traffic violations
   - History of loss or limitation of privileges or disciplinary activity, including denial, suspension, limitation, termination or nonrenewal of professional privileges
   - History of complaints or adverse action reports filed with a local, state or national professional society or licensing board
   - History of refusal or cancellation of professional liability insurance
   - History of suspension or revocation of a DEA or CDS certificate
   - History of any Medicare/Medicaid sanctions

   You must also provide an:
   - Attestation of the correctness and completeness of the application
   - Explanation in writing of any identified issues; these explanations are presented with the provider’s application to the medical director and credentialing committee

12. Other queries. The NPDB is queried for all applicants. 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 Doctors of Medicine (MDs), Doctors of Osteopathy (DOs) and Physician Assistants (PAs) is queried to verify any restrictions/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 the health plan’s decision to accept or deny the applicant’s participation in the network.

13. Recredentialing. The provider must formally recredential its practitioners at least every 36 months. At the time of recredentialing, information for PCPs from quality improvement activities and member complaints is presented for credentialing committee review. The NPDB is queried for all Amerigroup-contracted providers subject to recredentialing. The resulting NPDB reports are shared with the medical director and the credentialing committee for review and action as appropriate. The Federation of State Medical Boards’ MDs, DOs and PAs are queried to verify any restrictions/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 the health plan’s decision to accept the Amerigroup-contracted provider’s participation in the network or to terminate the Amerigroup contract with the provider.

The provider will be notified by telephone or in writing if any information obtained in support of the credentialing or recredentialing process varies substantially from the information submitted by the provider. The provider has 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 the provider by submitting a written explanation or by appearing before the credentialing committee, if requested.

Amerigroup will completely process credentialing applications within 30 calendar days of receipt of a completed credentialing application, including all necessary documentation, attachments and a signed provider agreement. “Completely process” means that Amerigroup will review, approve and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not included for participation. The 30 calendar days will be calculated from the date of receipt of the last document, attachment or application element from the provider.

**Credentialing — Organizational Providers**

The organizational provider application contains the signature of the provider’s authorized representative that serves as an attestation that the health care facility agrees to the assessment requirements. Organizational providers requiring assessments are hospitals, home health agencies, skilled nursing facilities, nursing homes, ambulatory surgical centers, FQHCs and RHCs, home- and community-based service providers, and behavioral health facilities providing mental health or substance abuse services in an inpatient, residential, or ambulatory setting. The responsible officer of the organizational provider also agrees by signature on the application to a release of information for external credentials verification.

Following verification of all submitted documentation as more specifically described below, the organizational provider file will be deemed complete and be submitted to the medical director/credentialing committee for review and approval.

In addition to the submission of an application and the execution of a Network Provider Agreement, state licensure of the organizational provider 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.

Amerigroup contracts with facilities that meet the requirements of an unbiased and recognized authority. Hospitals (i.e., acute, transitional or rehabilitation) should be accredited by The Joint Commission (TJC), Healthcare Facilities Accreditation Program (HFAP) or the American Osteopathic Association (AOA). The Commission on Accreditation of Rehabilitation Facilities (CARF) may accredit rehabilitation facilities. Home health agencies should be accredited by TJC or the Community Health Accreditation Program (CHAP). Nursing homes should be accredited by TJC. TJC or the Accreditation Association for Ambulatory Health Care (AAAHC) should accredit ambulatory surgical centers. Psychiatric inpatient facilities must be accredited by TJC and accept voluntary and involuntary admissions. Psychiatric residential facilities should be accredited by TJC, CARF or COA. If facilities, ancillaries or hospitals are not accredited, Amerigroup will accept a copy of a recent state or CMS review in lieu of performing an onsite review. If an accreditation review is unavailable, an onsite review will be performed. This does not apply to nonaccredited nursing facilities, for which Amerigroup must conduct an onsite review.

During the onsite review:

- A copy of the professional liability insurance face sheet is required. Organizational providers are required to maintain professional liability insurance in the amounts specified in the Network Provider Agreement consistent with state law requirements and Amerigroup policy.
- The Office of Inspector General (OIG) report is reviewed to ensure the organizational provider is free from Medicare/Medicaid sanctions. If sanctions are identified, the organizational provider is denied participation.
• Amerigroup will track an organizational provider’s reassessment date and reassess every 36 or 12 months as applicable. Responsibilities for the facility/ancillary vendor are the same for reassessment as they are for the initial assessment.
• NCQA requires a site visit for unaccredited facilities that includes a process for ensuring that the provider credentials its practitioners.

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

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

Organizational providers 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 the organizational provider submitting a written explanation or by appearing before the credentialing committee if requested.

**Peer Review**
The peer review process provides a systematic approach for monitoring the quality and appropriateness of care. Peer review responsibilities are to:

• Participate in the implementation of the established peer review system
• Review and make recommendations regarding individual provider peer review cases

Should investigation of a member complaint or other potential quality of care issue result in concern regarding a provider’s compliance with community standards of care or service, all elements of peer review will be followed.

Peer review includes investigation of provider actions by or at the discretion of the medical director. The medical director takes action based on the quality issue and level of severity, invites the cooperation of the provider, and consults the peer review committee as appropriate. The medical director informs the provider of the peer review committee 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 policy is available upon request.
5 PRIMARY CARE PROVIDERS

Medical Home
As a 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 medical home. We promote this concept to all of our members.

The medical home has an ongoing and collaborative relationship that consists of the:

- PCP
- Member
- Member’s family
- Health care providers within the medical home
- Extended network of consultants, treating providers and specialists with whom the members of the medical home works

Providers in the medical home know the special, health-related social and educational needs of the members and their families and are connected to necessary resources in the community that can assist in meeting those needs.

Primary Care Providers
The PCP is a network provider who has the responsibility for the complete care of his or her patient, our member. This practice holds true whether functioning as provider of that care or by referral to the appropriate provider within the network.

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

- Family practitioner
- General practitioner
- General pediatrician
- General internist
- Geriatricians
- Nurse practitioners certified as specialists in family practice or pediatrics
- Federally qualified health centers and rural health centers
- Local health departments

To participate in a TennCare managed care organization (MCO), the provider must have a Tennessee Medicaid provider number and be a licensed provider by the state before signing a contract with Amerigroup.

The provider must be enrolled in the TennCare Medicaid program at the service location where he or she wishes to practice as a PCP before contracting with Amerigroup.

With the exception of members dually eligible for Medicare and TennCare, Amerigroup ensures that each member has an identified PCP who is responsible for coordinating the covered services provided to the member.

My PCP Connection
If a member is not dually eligible for Medicare and TennCare, Amerigroup will assign a PCP. The assigned PCP is responsible for providing care to their members and will not be reimbursed for services unless provided to a member assigned to themselves or their group. Amerigroup provides the member with an opportunity to change his or her PCP upon receipt of notice of PCP assignment. A member is issued an Amerigroup member identification card displaying the name of the member’s PCP.
If a provider is contacted by a member who is either assigned to another PCP or who does not yet have an assigned PCP, the provider should have the member contact our Member Services department at 1-800-600-4441 to request a PCP change or to be assigned a PCP. The member may complete a PCP Change Request form and fax it to us at 1-866-840-4993.

Responsibilities of the Primary Care Provider
The PCP is a network provider who has the responsibility for the complete care of his or her patients, our members, whether providing it himself/herself or by referral to the appropriate provider of care within the network. Federally Qualified Health Clinics (FQHCs), health departments and Rural Health Clinics (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; provide coordination necessary for referrals to specialists, including behavioral health providers and fee-for-service 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 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, meeting the unique needs of members with special health care needs.
- Ensure no person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin or any other classifications protected under federal or state laws shall be excluded from participation in, except as specified in Section A 2.3.5 of the CRA, or be denied benefits of, or be otherwise subjected to discrimination in the performance of provider’s obligation under its agreement with Amerigroup or in the employment practices of the provider. Ensure notices of nondiscrimination are posted in conspicuous places available to all employees and enrollees.
- Participate in the systems established by Amerigroup that facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements.
- Implement policies and procedures for the provision of language assistance to members and/or the member’s representative. Language assistance services include interpretation and translation services and effective communication assistance in alternative formats such as auxiliary aids to any member and/or the member’s representative who needs such services including but not limited to members with limited English proficiency, members who are hearing impaired and individuals with disabilities. Such services will be provided free of charge and be available in the form of in-person interpreters, sign language or access to telephonic assistance (e.g., the TTY universal line). Providers will also employ appropriate auxiliary aids and services free of charge.
- Cooperate with Amerigroup and TennCare during discrimination complaint investigations and to report discrimination complaints and allegations to Amerigroup including allegations of discrimination set forth in Section 2.12.21.1 and 2.15.7.6.3.2.7 of the MCO statewide contract available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf.
- Assist TennCare members and/or member representatives in obtaining discrimination complaint forms and contact information for the Amerigroup nondiscrimination compliance office.
- Participate and cooperate with Amerigroup in any reasonable internal or external quality assurance, utilization review, continuing education, training, technical assistance or other similar program established by Amerigroup.
- Make reasonable efforts to communicate, coordinate and collaborate with specialty providers including behavioral health providers involved in delivering care and services to consumers.
- Participate in and cooperate with the Amerigroup complaint and grievance procedures when notified by Amerigroup of a member grievance.
• Not balance bill members, although PCPs are entitled to collect applicable copayments for certain services.
• Continue care in progress during and after termination of his or her contract for up to 90 days until a continuity of care plan is in place to transition the member to another provider or to transition a pregnant member through postpartum care for pregnant members in their second and third trimester in accordance with TennCare requirements.
• 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 Occupational Safety and Health Administration (OSHA) standards.
• Meet the federal and state physical accessibility standards and those defined in the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973 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 the release of such records as allowed under applicable laws and regulations.
• Provide to members complete information concerning their diagnosis, evaluation, treatment and prognosis.
• 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, including medication treatment options, regardless of whether benefits for such care are provided under the program.
• 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.
• Comply with the Tennessee Prescription Safety Act of 2012.
• Ensure the member is assigned to the provider’s panel of members to provide services. This change can be made via fax (use PCP Change form) or by calling the NCC at 1-800-454-3730. Failure to follow this process/requirement will impact claim payment.

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

Provider Obligations
Amerigroup monitors the quality of services delivered under the provider agreement and initiates corrective action when necessary to improve quality of care. Services must be provided in accordance with either the level of medical, behavioral health or long-term care recognized as the acceptable professional standard of care in the respective community in which the provider practices and/or the standards established by TennCare.
Amerigroup will only pay providers for services provided:

- In accordance with the requirements of the Provider Agreement, Amerigroup policies and procedures, and state and federal law.
- To TennCare enrollees who are enrolled with Amerigroup.

Providers are obligated to:

- Maintain documentation necessary to demonstrate that covered services were provided in compliance with state and federal requirements.
- Ensure that any applicable authorization requirements are met.
- Verify that a person is eligible for TennCare on the date of service.
- Assist a member by providing appeal forms and contact information that include the appropriate address, telephone number and/or fax number for submitting appeals for state-level review.
- Coordinate with other TennCare contractors or Amerigroup subcontractors as may be requested by TennCare or Amerigroup.
- Conduct background checks on employees in accordance with Tennessee law, and such background checks should include at a minimum a check of the Tennessee Abuse Registry, Tennessee Felony Registry, National and Tennessee Sex Offender Registry, the Social Security Master Death File, the Excluded Parties List System (EPLS) and the HHS-OIG List of Excluded Individuals/Entities (LEIE).
- Maintain documentation verifying that the employee’s name does not appear on the State Abuse Registry, State Felony Registry, the State and National Sexual Offender Registry, Social Security Master Death File, the EPLS or LEIE. Individuals who do appear on one of the listed registries are excluded from participating in Medicaid, Medicare and other federal health care programs.
- All providers treating members with opioid use disorder must either provide medication assisted treatment (MAT) or have a policy for referral to a MAT provider for those members wishing to access MAT.
- Maintain all records as described in the Code of Federal Regulations Section 438.3(u) for a period not less than 10 years.

Providers who are compensated via a capitation arrangement are obligated to:

- Notify both Amerigroup and TennCare by certified mail, return receipt requested, if they become aware for any reason that they are not entitled to a capitation payment for a particular enrollee (e.g., a patient dies).
- Submit utilization or encounter data to ensure the ability of Amerigroup to submit encounter data to TennCare that meets the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims.
- Submit utilization or encounter data in a timely manner to support the individual services provided for obstetric care.
- Comply with fraud and abuse requirements.
- Report suspected abuse, neglect and exploitation of adults in accordance with TCA 71-6-103.
- Report suspected brutality, abuse or neglect of children in accordance with TCA 37-1-403 and TCA 37-1-605.
- Adhere to CareMore operational guidelines for designated Shelby County PCPs only. These guidelines are available in the TennCare CHOICES Long-Term Services & Supports (CHOICES) or Employment and Community First CHOICES (ECF CHOICES) Provider Manual Supplement link on our website, [https://providers.amerigroup.com/TN](https://providers.amerigroup.com/TN), under the Manuals & QRCs heading.

Amerigroup may suspend, deny, and refuse to renew or terminate any provider agreement in accordance with the terms of the Amerigroup Agreement with TennCare and applicable law and regulation.
Both parties recognize that in the event of termination of the Agreement between Amerigroup and TennCare, providers will immediately make available to Amerigroup, TennCare, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider’s activities undertaken pursuant to the Amerigroup/provider agreement. The provision of such records will be at no expense to TennCare.

The TennCare Provider Independent Review of Disputed Claims process is available to providers to resolve claims denied in whole or in part by Amerigroup as provided at TCA 56-32-126(b).

**PCP Access and Availability**

All providers are expected to meet the federal and state physical accessibility standards and those defined in the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

Health care services provided through Amerigroup must be accessible to all members. Amerigroup is dedicated to ensuring that:

- The PCP or another physician/nurse practitioner is available to provide medically necessary services.
- Covering physicians follow the referral/precertification guidelines.
- The automatic direction of a member to the emergency room when the PCP is not available never occurs.

We encourage our PCPs to offer after-hours office care in the evenings and on weekends.

PCPs or extenders are required to adhere to the following access standards:

- **Patient Load**: 2,500 or less for physicians; half of physician extenders
- **Appointment/wait times**: usual and customary practice, not to exceed three weeks from date of a patient’s request for regular appointments and 48 hours for urgent care; wait times shall not exceed 45 minutes

To ensure continuous 24-hour coverage, PCPs must maintain one of the following arrangements for their members to contact the PCP after normal business hours:

- Have the office telephone answered after-hours by an answering service that can contact the PCP or another designated network medical practitioner. All calls answered by an answering service must be returned within 60 minutes.
- Have the office telephone answered after normal business hours by a recording in the language of each of the major population groups served by the PCP, directing the member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider’s telephone. Another recording is not acceptable.
- Have the office telephone transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or a designated Amerigroup network medical practitioner who can return the call within 60 minutes.
- An automated answering machine that directs the member to the practitioner or appropriate covering practitioner.

The following telephone answering procedures are not acceptable:

- Office telephone is only answered during office hours
- Office telephone is answered after-hours by a recording that tells members to leave a message
- Returning after-hours calls outside of 60 minutes
PCP Transfers
In order to maintain continuity of care, Amerigroup encourages members to remain with their PCP. However, a member may request to change his or her PCP for any reason by contacting our National Customer Care department at 1-800-600-4441. The effective date of the PCP change will be the date of the request, unless the member has seen another assigned PCP on the same date. In this case, the effective date will be the next business day. The member may also complete a PCP Change Request Form and fax the request to 1-866-840-4993. The effective date of the PCP change request for all received faxes will be the date the fax is received, unless the member has seen another assigned PCP on the same date. In this case, the effective date will be the next business day. Members can request a PCP change any day of the month. Members will receive a new ID card within 10 days.

Covering Physicians/Providers
During a provider’s absence or unavailability, the provider needs to arrange for coverage for his or her members. The provider will either: (i) make arrangements with one or more network providers to provide care for his or her members or (ii) make arrangements with another similarly licensed and qualified provider who has appropriate medical staff privileges at the same network hospital or medical group, as applicable, to provide care to the members in question. In addition, the covering provider will agree to the terms and conditions of the Network Provider Agreement, including without limitation, any applicable limitations on compensation, billing and participation. Providers will be solely responsible for a non-network provider’s adherence to such provisions. Providers will be solely responsible for any fees or monies due and owed to any non-network provider providing substitute coverage to a member on the provider’s behalf.
6  SPECIALTY CARE PROVIDERS

Specialty Care Providers
To participate in a TennCare MCO, the provider must have a Tennessee Medicaid provider number and be a licensed provider by the state before signing a contract with Amerigroup.

The provider must be enrolled in the TennCare Medicaid program at the service location where he or she wishes to practice as a specialist before contracting with Amerigroup.

Amerigroup contracts 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 provider who has the responsibility for providing the specialized care for members, usually upon appropriate referral from a PCP within the network (see Roles and Responsibilities of the Specialty Care Provider). 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
- Neonatal services
- Nephrology services
- Neurology services
- Neurosurgery services
- OB/GYN services
- Ophthalmology services
- Orthopedic surgery services
- Otolaryngology services
- Perinatal services
- Pediatric services
- Psychiatry (adult) services
- Psychiatry (child and adolescent) services
- Trauma services
- Urology services

Role and Responsibility of the Specialty Care Providers
Specialist providers will only treat members who have been referred to them by network PCPs (with the exception of mental health and substance abuse providers and services that the member may self-refer) and will render covered services only to the extent and duration indicated on the referral. 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
- 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
- Ensuring that no person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws shall be excluded from participation in, except as specified in Section A.2.12.9 of the CRA, or be denied benefits of, or be
otherwise subjected to discrimination in the performance of provider’s obligation under its agreement with Amerigroup or in the employment practices of the provider

- Implementing policies and procedures for the provision of language assistance to members and/or the member representatives; language assistance services include interpretation and translation services and effective communication assistance in alternative formats such as auxiliary aids to any member and/or the member’s representative who needs such services including but not limited to members with limited English proficiency, members who are hearing impaired, and individuals with disabilities; such services will be provided free of charge and be available in the form of in-person interpreters, sign language or access to telephonic assistance (e.g., the ATT universal line); providers will also employ appropriate auxiliary aids and services free of charge

- Cooperate with Amerigroup and TennCare during discrimination complaint investigations and report discrimination complaints and allegations to Amerigroup including allegations of discrimination set forth in Section 2.12.21.1 and 2.15.7.6.3.2.7 of the MCO statewide contract available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf.

- Assist TennCare members and/or the member representatives in obtaining discrimination complaint forms and contact information for the Amerigroup nondiscrimination compliance office

The specialist shall also adhere to the requirements stated in the Responsibilities of the PCP section.

**Specialty Care Provider Access and Availability**
Amerigroup will maintain a specialty network to ensure access and availability to specialists for all members. A provider is considered a specialist if he/she has a provider agreement with Amerigroup to provide specialty services to members.

**Access to Specialty Care**
Amerigroup will ensure access to specialty providers (specialists) for the provision of covered services.

**Availability of Specialty Care**

*Specialty Care and Emergency Care*
Referral appointments to specialists (e.g., specialty provider services, hospice care, home health care, substance abuse treatment, rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate at the nearest facility available regardless of contract. Wait times shall not exceed 45 minutes.

*General Optometry Services*
Appointment/wait times: Usual and customary not to exceed three weeks for regular appointments and 48 hours for urgent care. Wait times shall not exceed 45 minutes.

*OB/Prenatal Care*
Appointments for OB/Prenatal care visits must not exceed three weeks.

All other services not specified here will meet the usual and customary standards for the community.

**Specialty Referrals**
In order to reduce the administrative burden on the provider’s office staff, Amerigroup has established procedures that are designed to permit a member with a condition that requires ongoing care from a specialist provider or other health care provider to request an extended authorization.
The provider can request an extended referral authorization by contacting the member’s PCP. The provider must supply the necessary clinical information that will be reviewed by the PCP in order to complete the authorization review.

On a case-by-case basis, an extended authorization will be approved. In the event of termination of a contract with the treating provider, the continuity of care provisions in the provider’s contract with Amerigroup will apply. The specialist provider may renew the authorization by submitting a new request to the PCP. Additionally, Amerigroup requires the specialist provider or other health care provider to provide regular updates to the member’s PCP. Should the need arise for a secondary referral, the specialist provider or other health care provider must contact Amerigroup for a coverage determination.

If the specialist or other health care provider needed to provide ongoing care for a specific condition is not available in the Amerigroup 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 the TennCare appeals process.

**Second Opinions**

A member, parent and/or legally appointed representative, or the member’s PCP may request a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition. The second opinion shall be provided at no cost to the member.

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 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 will notify the member of the outcome of the second opinion.

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

- Whenever there is a concern about care expressed by the member or the provider
- Whenever potential risks or outcomes of recommended or requested care are discovered by the plan during its 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 Amerigroup requests a second opinion, Amerigroup will make the necessary arrangements for the appointment, payment and reporting. Amerigroup will inform the member and the PCP of the results of the second opinion and the consulting provider’s conclusion and recommendation(s) regarding further action.
7 COVERED HEALTH SERVICES

Amerigroup coordinates with the other managed care organizations (MCOs) for members who have Medicaid with Amerigroup and another MCO for Medicare. Information regarding inpatient admissions and discharge planning as well as special requests for collaborative assistance is shared between the insurance companies. Members who have both Medicaid and Medicare (Amerivantage) with Amerigroup are managed seamlessly at the health plan. Providers will continue to follow their current process for requesting prior authorization for services under Amerivantage; requests will be processed for both Medicare coverage and Medicaid coverage as needed at the health plan.

Medically Necessary Services — Medical Necessity
Amerigroup uses these terms interchangeably. Medically necessary is defined by Tennessee Code Annotated, Section 71-5-144, and applies to TennCare enrollees. Implementation of the term “medically necessary” is provided for in TennCare Regulations at Chapter 1200-13-16-.05. The regulations are consistent with the statutory provisions and control in case of ambiguity. No enrollee is entitled to receive, and TennCare is not required to pay for any items or services that fail to fully satisfy all criteria of medically necessary items or services, as defined either in the statute or in the medical necessity regulations at Sections 1200-13-13-.01(79), 1200-13-14-.01(84) and 1200-13-16-.05.

1. To be determined to be medically necessary or a medical necessity, a medical item or service must be recommended by a licensed physician who is treating the enrollee or other licensed health care provider practicing within the scope of his or her license who is treating the enrollee and must satisfy each of the following criteria:
   a. It must be recommended by a licensed physician who is treating the enrollee or other licensed health care provider practicing within the scope of his or her license who is treating the enrollee
   b. It must be required in order to diagnose or treat an enrollee’s medical condition
   c. It must be safe and effective
   d. It must not be experimental or investigational
   e. It must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee’s medical condition

2. The convenience of an enrollee, the enrollee’s family, the enrollee’s caregiver or a provider shall not be a factor or justification in determining that a medical item or service is medically necessary.

3. Services required to diagnose an enrollee’s medical condition:
   a. Provided that all the other medical necessity criteria are satisfied, services required to diagnose an enrollee’s medical condition may include screening services as appropriate.
   b. Screening services are appropriate if they meet one of the following three categories:
      i. Services required to achieve compliance with federal statutory or regulatory mandates under the EPSDT program
      ii. Newborn testing for metabolic/genetic defects as set forth in the Tennessee Code Annotated, Section 68-5-401
      iii. Pap smears, mammograms, prostate cancer screenings, colorectal cancer screenings, and screenings for tuberculosis and sexually transmitted diseases including HIV in accordance with nationally accepted clinical guidelines adopted by the Division of TennCare
   c. Unless specifically provided for herein, other screening services are appropriate only if they satisfy each of the following criteria:
      i. The Division of TennCare, a managed care contractor or a state agency performing the functions of a managed care contractor determines the screening services are cost effective
      ii. The screening must have a significant probability of detecting the disease
      iii. The disease for which the screening is conducted must have a significant detrimental effect on the health status of the affected person
      iv. Tests must be available at a reasonable cost
v. Evidence-based methods of treatment must be available for treating the disease at the disease stage which the screening is designed to detect
vi. Treatment in the asymptomatic phase must yield a therapeutic result
d. Services required to diagnose an enrollee’s medical condition include diagnostic services mandated by EPSDT requirements.

4. Services required to treat an enrollee’s medical condition:
   a. Provided that all other elements of medical necessity are satisfied, treatment of an enrollee’s medical condition may only include:
      i. Medical care that is essential in order to treat a diagnosed medical condition, the symptoms of a diagnosed medical condition, or the effects of a diagnosed medical condition and which, if not provided, would have a significant and demonstrable adverse impact on quality or length of life
      ii. Medical care that is essential in order to treat the significant side effects of another medically necessary treatment (e.g., nausea medications for side effects of chemotherapy)
      iii. Medical care that is essential, based on an individualized determination of a particular patient’s medical condition, to avoid the onset of significant health problems or significant complications that, with reasonable medical probability, will arise from that medical condition in the absence of such care

Ethical or Religious Directives
If you are not providing the care or treatment a TennCare member needs or wants due to your ethical or religious directives and the TennCare member needs help finding a provider, please call us at 1-800-600-4441. We can help the member find the care or treatment needed.

Home Health Services
1. Home health aide services are necessary to treat an enrollee’s medical condition only if such services:
   a. Are of a type that the enrollee cannot perform for himself or herself
   b. Are of a type for which there is no caregiver able to provide the services
   c. Consist of hands-on care of the enrollee

2. All other home health services are necessary to treat an enrollee’s medical condition only if they are ordered by the treating physician, are pursuant to a plan of care and meet the requirements described at subparagraph (a), (b), or (c) immediately above or 4(f) immediately below. Services that do not meet these requirements, such as general child care services, cleaning services or preparation of meals, are not required to treat an enrollee’s medical condition and will not be provided. Because children typically have nonmedical care needs which must be met, to the extent that home health services or private duty nursing services are provided to a person under 18 years of age, a responsible adult (other than the health care provider) must be present at all times in the home during provision of home health or private duty nursing services unless all of the following criteria are met:
   a. The child is nonambulatory
   b. The child has no or extremely limited ability to interact with caregivers
   c. The child shall not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the home health provider or private duty nurse is in the home without the presence of another responsible adult
   d. No other children shall be present in the home during the time the home health provider or private duty nurse is present in the home without the presence of another responsible adult

3. Private-duty nursing services are separate services from home health services. When private duty nurses are authorized by the MCO to provide home health aide services pursuant to TennCare Rule 1200-13-13-.04(6)(f), these services must meet the requirements described at part one immediately above.

4. Home health services may not be denied on any of the following grounds:
a. Because such services are medically necessary on a long term basis or are required for the
treatment of a chronic condition
b. Because such services are deemed to be custodial care
c. Because the enrollee is not homebound
d. Because private insurance utilization guidelines, including but not limited to those published by
Milliman & Robertson or developed in-house by TennCare managed care contractors, do not
authorize such health care as referenced above
e. Because the enrollee does not meet coverage criteria for Medicare or some other health insurance
program other than TennCare
f. Because the home health care that is needed does not require or involve a skilled nursing service
g. Because the care that is required involves assistance with activities of daily living
h. Because the home health service that is needed involves home health aide services
i. Because the enrollee meets the criteria for receiving Medicaid nursing facility services

Home Health Requirements

1. All provider agreements between Amerigroup and a home health agency (HHA) will require the HHA to
comply with the federal regulations delineating the conditions of participation that HHAs must meet in
order to participate in the Medicaid program. Each provider agreement must contain a general provision
to that effect.

2. Each provider agreement must specify the contracted HHA supply each enrollee with the following:
   - Written and verbal notice of the enrollee's rights and responsibilities as a home health patient
     as required under 42 CFR §484.50(a).
   - Written and verbal notice of the HHA’s policy for transfer and discharge as required under 42
     CFR §484.50(d) including an explanation in plain language that disruptive, abusive, or
     uncooperative behaviors could give rise to a discharge for cause, and the requirements that
     must be satisfied by the HHA in order for transfer or a discharge to be effectuated.
   - Written and verbal notice of the HHA’s obligation to accept complaints made by the enrollee
     about the care that is (or fails to be) furnished, and of the HHA’s obligation to investigate,
     document and resolve these enrollee complaints (as well as complaints of mistreatment,
     neglect, or verbal, mental, sexual, and physical abuse, or injuries of unknown source, or
     misappropriation of the enrollee’s property by anyone furnishing care on behalf of the HHA) as
     required under 42 CFR §484.50(e).
   - The HHA must explain to the enrollee the scope of the home health services that the enrollee
     will be receiving. Afterward, the HHA must obtain the signature of the enrollee verifying an HHA
     staff member has explained the scope of services to the enrollee. Likewise, the HHA must
     obtain, as required under 42 C.F.R. § 484.50(a)(2), the enrollee’s or the legal representative’s
     signature confirming they received written notice of the enrollee’s rights and responsibilities as
     required by Section A.2.12.23.1.1 of the TennCare Contractor Risk Agreement. The HHA must
     maintain all signature(s) in their record of the enrollee.
   - The HHA must develop a backup plan for each enrollee to be implemented during missed visits,
     as defined by Section A.2.15.9.1 of the TennCare Contractor Risk Agreement, or when otherwise
     necessary.
   - When the HHA is notified before a missed visit occurs or as it is occurring, the HHA must contact
     the enrollee and implement the backup plan or offer a suitable alternative service. The HHA
     must report all missed visits to Amerigroup in writing within three calendar days of the missed
     visit. This report must be submitted on an Amerigroup-approved form capturing all of the
     information Amerigroup requires including, but not limited to, the following: the identity of the
     enrollee; the type of service involved; the date of the missed visit; the cause(s); what corrective
     action was taken to mitigate the cause(s) of the missed visit. The HHA must ensure the staff
     member enters notes about the circumstances of a missed visit in every instance where notes
     are possible.
• When a conflict arises between an enrollee and an assigned HHA staff member, or when an enrollee refuses to allow an assigned staff member to begin or to complete their assigned visit, the staff member will immediately notify the HHA. Once notified, the HHA will contact the enrollee and offer to either 1) implement the existing backup plan or 2) staff the care with a qualified alternative staff member. In every instance, the HHA must record these missed visits, as described above, and submit them timely to Amerigroup. All of the aforementioned facts should be included in the reports with as much written explanation as possible regarding the causes and factors contributing to the conflict. If additional conflicts arise between the enrollee and the HHA or alternative staff member (e.g., if an enrollee refuses to admit the alternative staff member into enrollee’s home), the HHA must notify Amerigroup and must continue making reasonable efforts to staff the approved care with qualified alternative staff members until the HHA, in its discretion, plans to discharge the enrollee for cause. At that point, the HHA must notify Amerigroup of its decision to discharge or transfer the enrollee.

Personal Care Services
1. Personal care services are necessary to treat an enrollee’s medical condition only if such services are ordered by the treating physician pursuant to a plan of care to address a medical condition identified as a result of an EPSDT screening. Personal care services must be supervised by a registered nurse and delivered by a home health aide. In addition, the services must:
   a. Be of a type that the enrollee cannot perform for himself or herself
   b. Be of a type for which there is no caregiver able to provide the services
   c. Consist of hands-on care of the enrollee
2. Services that do not meet these requirements, such as general child care services, cleaning services or preparation of meals, are not required to treat an enrollee’s medical condition and will not be provided. For this reason, to the extent that personal care services are provided to a person under 18 years of age, a responsible adult (other than the home health aide) must be present at all times during provision of personal care services.
   a. The following preventive services:
      i. Prenatal and maternity care delivered in accordance with standards endorsed by the American College of Obstetrics and Gynecology
      ii. Family planning services
      iii. Age-appropriate childhood immunizations delivered according to guidelines developed by the Advisory Committee on Immunization Practices
      iv. Health education services for TennCare-eligible children under age 21 in accordance with 42 U.S.C. Section 1396d
      v. Other preventive services that are required to achieve compliance with federal statutory or regulatory mandates under the EPSDT program
      vi. Other preventive services that have been endorsed by the Division of TennCare or a particular managed care contractor as representing a cost-effective approach to meeting the medically necessary health care needs of an individual enrollee or group of enrollees
3. The Division of TennCare may make limited special exceptions to the medical necessity requirements described at TennCare Rule 1200-13-16-.05(1) for particular items or services such as long term care, or such as may be required for compliance with federal law.
4. Transportation services that meet the requirements described at rule 1200-13-13-.04 and 1200-13-14-.04 shall be deemed medically necessary if provided in connection with medically necessary items or services.

* Note: Please reference the CHOICES or ECF CHOICES Provider Manual Supplement for information regarding personal care services provided under the CHOICES or ECF CHOICES program.
### Amerigroup Covered Services

#### Physical Health Benefits Chart

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abortions</strong></td>
<td>Amerigroup will cover abortions and services associated with the abortion procedure only if the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. We ensure a Certification of Medical Necessity for Abortion form, which is available on TennCare’s website, <a href="https://www.tn.gov/tenncare/providers/miscellaneous-provider-forms.html">https://www.tn.gov/tenncare/providers/miscellaneous-provider-forms.html</a>, is completed. Medical records will be required for both possible and absolute abortion procedures. Should the claim be submitted for a possible or absolute procedure without medical records, your claim will be denied.</td>
</tr>
<tr>
<td><strong>Chiropractic Services</strong></td>
<td>Medicaid eligible, age 21 and older: Not covered. Medicaid/Standard eligible, under age 21: Covered as medically necessary in accordance with TennCare Kids requirements. Chiropractic services may be covered as a cost-effective alternative at the sole discretionary authority of Amerigroup.</td>
</tr>
<tr>
<td>Chlamydia Screenings</td>
<td>As medically necessary.</td>
</tr>
<tr>
<td><strong>Dental Services</strong></td>
<td>Dental services will be provided to members under the age of 21 by the Dental Benefits Manager (DBM). However, the provision of transportation to and from said services, as well as the facility, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist’s office will be covered services provided by Amerigroup when the dental service is covered by the DBM. This requirement only applies to Medicaid/Standard eligibles under age 21. Dental services will be provided to members under the age of 21 by the DBM or in some cases, through a Home- and Community-Based Services (HCBS) waiver program for persons with intellectual disabilities (e.g., mental retardation). However, facility, medical and anesthesia services related to dental services not provided by a dentist or in a dentist’s office will be covered services provided by Amerigroup when the dental service is covered by the DBM or through an HCBS waiver program for persons with intellectual disabilities (e.g., mental retardation).</td>
</tr>
<tr>
<td><strong>Diabetic Services</strong></td>
<td>As medically necessary.</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>As medically necessary. Specified DME and medical supplies will be covered/noncovered in accordance with TennCare rules and regulations. DME is provided by Amerigroup Utilization Management (UM). Call 1-800-454-3730 or submit referrals at 1-877-423-9958. For more information on DME, see page 55.</td>
</tr>
</tbody>
</table>
Emergency Air And Ground Ambulance Transportation

As medically necessary.

<table>
<thead>
<tr>
<th>Part-time or Intermittent Home Health Care</th>
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</table>
| For children under the age of 21: as medically necessary and are not subject to the limits below. Because children have nonmedical care needs which must be met, a responsible adult (other than the home health care provider) must be present at all times in the home during the provision of home health services unless:
  - The child is nonambulatory; and
  - The child has no or extremely limited ability or no ability to interact with caregivers; and
  - The child shall not reasonably be expected to have needs falling outside of the scope of medically necessary TennCare covered benefits (for example, the child has no need for general supervision or meal preparation) during the time the home health provider is present in the home without the presence of another responsible adult; and
  - No other children requiring adult care or supervision will be present in the home during the time the home health provider is present in the home without the presence of another responsible adult, unless these children meet all the criteria above and are receiving TennCare-reimbursed home health services.

For adults age 21 and over, please see guidelines below:

### Limits for Most Adult TennCare Enrollees

#### Home Health Aide Care
- Up to 35 hours per week
  - No more than eight hours/day
  - No more than two visits/day
  - HH aide and nurse care combined cannot exceed 35 hours per week
  - A single HH aide may provide services to multiple enrollees in the same home and during the same hours.

- For example, 35 hours/week equals
  - 7 hours, 5 days/week
  - 5 hours, 7 days/week

#### Home Health Nurse Care
- Up to 27 hours per week
  - Each visit must be less than eight hours
  - No more than one visit/day
  - HH nurse and aide care combined cannot exceed 35 hours per week

- For example, 27 hours/week equals
  - 5 hours, 5 days/week
  - 3.5 hours, 7 days/week

### Limits for TennCare Adults Who Qualify for Level 2 (Skilled) Nursing Facility Care

#### Home Health Aide Care
- Up to 40 hours per week
  - No more than eight hours/day
  - No more than two visits/day
  - HH aide and HH nurse care combined cannot exceed 40 hours per week

#### Home Health Nurse Care
- Up to 30 hours per week
  - Each visit must be less than eight hours
  - No more than one visit/day
  - HH nurse and HH aide care combined cannot exceed 40 hours per week

- For example, 30 hours/week equals
A single HH aide may provide services to multiple enrollees in the same home and during the same hours.

- For example, 40 hours/week equals
  - 8 hours, 5 days a week (nursing 6 hours, 5 days/week plus HH aide 2 hours, 5 days/week)
  - 5.5 hours, 7 days a week

Home health services orders require precertification by Amerigroup. The ordering physician must provide **specific information** regarding the services the nurse or aide is expected to perform (not just an order for a number of hours of care). The following information must be provided when seeking prior authorization for home health nurse, home health aide and private duty nursing services:
  - Name of physician prescribing the service(s)
  - Specific information regarding the patient’s medical condition and any associated disability that creates the need for the requested service(s)
  - Specific information regarding the service(s) the nurse or aide is expected to perform including the frequency with which each service must be performed (e.g., tube feed patient 7 a.m., noon and 5 p.m. daily; bathe patient once per day; administer medications three times per day; catheterize patient as needed from 8 a.m. to 5 p.m. Monday through Friday; change dressing on wound three times per week); such information should also include the total period of time that the services are anticipated to be medically necessary by the treating physician (e.g., total number of weeks or months)

- A home health nurse visit for an adult will **not** be extended in order to perform skilled nursing functions at more than one point during the day, unless skilled nursing services are medically necessary throughout the intervening period.

- **Home health nurses/aides do not:**
  - Provide general supervision, safety monitoring or sitter services
  - Provide nonhands-on care such as housecleaning and meal preparation
  - Person ally transport patients

- **Home health nurses/aides may accompany patients outside the home if all of the following criteria are met:**
  - The home health nurse or home health aide shall not transport the patient.
  - The home health agency will have discretion as to whether or not to accompany a patient outside the home. The circumstance under which a home health agency may exercise such discretion includes, without limitation, when a home health agency has concern regarding any of the following:
    - The scheduling or safety of the transportation
    - The health or safety of their employee or the patient
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Care Program</td>
<td>The ability to safely and effectively deliver services in the alternative setting. The additional expense required to accompany a patient outside the home; additional visits or hours of care will not be approved for coverage for the purpose of accompanying a patient outside the home; services will be limited to services to which the patient would be entitled if the services were provided exclusively at the patient’s place of residence. The additional expense required for home health agency staff to accompany a patient outside the home; no additional reimbursement shall be paid to the home health agency in association with the decision of the home health agency to accompany a patient outside the home.</td>
</tr>
<tr>
<td>Hospice Care Program</td>
<td>As medically necessary. Must be provided by a Medicare-certified hospice.</td>
</tr>
</tbody>
</table>
| Hysterectomies                  | Amerigroup will cover hysterectomies only if the following requirements are met:  
  - The hysterectomy is medically necessary.  
  - The member or her authorized representative, if any, has been informed orally and in writing that the hysterectomy will render the member permanently incapable of reproducing.  
  - The member or her authorized representative, if any, has signed and dated a Hysterectomy Acknowledgement Form, which is available on TennCare’s website, [https://www.tn.gov/tenncare/providers/miscellaneous-provider-forms.html](https://www.tn.gov/tenncare/providers/miscellaneous-provider-forms.html), prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age in accordance with federal requirements. The form will be available in English and Spanish. Assistance must be provided in completing the form when an alternative form of communication is necessary. Refer to the instructions on the Hysterectomy Acknowledgement Form for additional guidance and exceptions.  
  Amerigroup will not cover a hysterectomy under the following circumstances:  
  - If it is performed solely for the purpose of rendering an individual permanently incapable of reproducing.  
  - If there is more than one purpose for performing the hysterectomy, but the primary purpose is to render the individual permanently incapable of reproducing.  
  - It is performed for the purpose of cancer prophylaxis.  |
| Inpatient Rehab Hospital Services| Medicaid eligible, age 21 and older: As medically necessary. Inpatient rehabilitation hospital facility services may be covered for adults as a cost-effective alternative at the sole discretionairy authority of Amerigroup.  
Medicaid/Standard eligible, under age 21: As medically necessary, including rehabilitation hospital facility.  |
| Lab and X-ray Services           | As medically necessary.  
Compliance with the Clinical Laboratory Improvement Act (CLIA) of 1988: Amerigroup will require that all laboratory testing sites providing services have either a current CLIA certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver will provide only the types of tests permitted under the terms of their waiver. Laboratories with
| Medical Supplies | As medically necessary. Specified medical supplies will be covered/noncovered in accordance with TennCare rules and regulations. 

Medical supplies are provided by Amerigroup Utilization Management (UM). Call 1-800-454-3730 or submit referrals to 1-877-423-9958. For more information on DME, see page 55. |
| Nonemergency Transportation (including Nonemergency Ambulance Transportation) | As necessary to get a member to and from covered services, dental services (provided by the DBM) and pharmacy services (provided through the PBM) for enrollees not having access to transportation. 

If Amerigroup is unable to meet the access standards for a member, transportation must be provided regardless of whether or not the member has access to transportation. If the member is a child, transportation must be provided in accordance with TennCare Kids requirements. As with any denial, all notices and actions must be in accordance with the requirements of the TennCare CRA. 

Amerigroup may require advance notice of the need for transportation in order to timely arrange transportation. Transportation must be coordinated through Tennessee Carriers at 1-866-680-0633. |
| Occupational Therapy | Medicaid/Standard eligible, age 21 and older: Covered as medically necessary when provided by a licensed occupational therapist to restore, improve or stabilize impaired functions. 

**Medicaid/Standard eligible, under age 21:** Covered as medically necessary in accordance with TennCare Kids requirements. |
| Organ and Tissue Transplant And Donor Organ Procurement | Medicaid eligible, age 21 and older: All medically necessary and noninvestigational/experimental organ and tissue transplants, as covered by Medicare, are covered. These include: 

- Bone marrow/stem cell 
- Cornea 
- Heart 
- Heart/Lung 
- Kidney 

- Kidney/pancreas 
- Liver 
- Lung 
- Pancreas 
- Small bowel/multi-visceral 

**Medicaid/Standard eligible, under age 21:** Covered as medically necessary in accordance with TennCare Kids requirements. Experimental or investigational transplants are not covered. |
| Outpatient Hospital Services | As medically necessary. |
| Pharmacy Services | Pharmacy services will be provided by the TennCare PBM unless otherwise described below. 

Amerigroup is responsible for reimbursement of specific covered injectable drugs administered in an office/clinic setting and for reimbursing providers providing both covered home infusion services and the drugs and biologics. Amerigroup requires that all claims for medications contain NDC coding and unit information in order to be |
considered for payment. Services reimbursed by Amerigroup will not include any pharmacy benefits otherwise covered by TennCare for pharmacy services.

<table>
<thead>
<tr>
<th>Physical Therapy</th>
<th>Medicaid eligible, age 21 and older: Covered as medically necessary when provided by a licensed physical therapist to restore, improve or stabilize impaired functions.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicaid/Standard eligible, under age 21: Covered as medically necessary in accordance with TennCare Kids requirements.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician Inpatient Services</th>
<th>As medically necessary.</th>
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</thead>
<tbody>
<tr>
<td>Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services</td>
<td>As medically necessary.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventive Care Services</th>
<th>Preventive services include initial and periodic evaluations, family planning services, prenatal care, laboratory services and immunizations in accordance with TennCare rules and regulations. These services shall be exempt from TennCare cost sharing responsibilities.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The following preventive medical services (identified by applicable CPT procedure codes) are covered subject to any limitations described below, within the scope of standard medical practice and are exempt from any deductibles and copayments.</td>
</tr>
<tr>
<td></td>
<td>Dental services and laboratory services not specifically listed below, which are required pursuant to the TennCare Kids program for persons under age 21, shall be provided in accordance with the TennCare periodicity schedule for such services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Office Visits</th>
<th>1. New Patient</th>
<th>2. Established Patient</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>99381 — Initial evaluation</td>
<td>99391 — Periodic reevaluation</td>
</tr>
<tr>
<td></td>
<td>99382 — Age 1 through 4 years</td>
<td>99392 — Age 1 through 4 years</td>
</tr>
<tr>
<td></td>
<td>99383 — Age 5 through 11 years</td>
<td>99393 — Age 5 through 11 years</td>
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<td></td>
<td>99384 — Age 12 through 17 years</td>
<td>99394 — Age 12 through 17 years</td>
</tr>
<tr>
<td></td>
<td>99385 — Age 18 through 39 years</td>
<td>99395 — Age 18 through 39 years</td>
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<tr>
<td></td>
<td>99386 — Age 40 through 64 years</td>
<td>99396 — Age 40 through 64 years</td>
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<tr>
<td></td>
<td>99387 — Age 65 years and over</td>
<td>99397 — Age 65 years and over</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Counseling and Risk Factor Reduction Intervention</th>
<th>1. Individual</th>
<th>2. Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>99401 — Approximately 15 minutes</td>
<td>99411 — Approximately 30 minutes</td>
</tr>
<tr>
<td></td>
<td>99402 — Approximately 30 minutes</td>
<td>99412 — Approximately 60 minutes</td>
</tr>
<tr>
<td></td>
<td>99403 — Approximately 45 minutes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>99404 — Approximately 60 minutes</td>
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</tr>
</tbody>
</table>

Family planning services, if not part of a preventive services office visit, should be billed using the codes above.

<p>| Prenatal/Postpartum Care | 59400 — Routine obstetric care, including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care |</p>
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59410</td>
<td>Vaginal delivery only (with or without episiotomy and/or forceps), including postpartum care</td>
</tr>
<tr>
<td>59430</td>
<td>Postpartum care only (separate procedure)</td>
</tr>
<tr>
<td>59510</td>
<td>Routine obstetric care, including antepartum care, cesarean delivery and postpartum care</td>
</tr>
<tr>
<td>59515</td>
<td>Cesarean delivery only, including postpartum care</td>
</tr>
</tbody>
</table>

**Other Preventive Services**
- 99420 — Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)
- 90700 through 90742 — Immunizations
- 92551 — Screening test, pure tone, air only (audiologic function)
- 96110 — Developmental screening
- 99173 — Visual screening

Any laboratory test or procedure listed in the preventive services periodicity schedule when the service CPT code is one of the above preventive medicine codes. This includes mammography screening (76092) as indicated in the US Preventive Services schedule.

**Adult Private Duty Nursing**
- As medically necessary when:
  - Prescribed by an attending physician for treatment and services rendered by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) who is not an immediate relative
  - There are competent family members or caregivers

Amerigroup will only cover Private Duty Nursing (PDN) for adult patients (age 21 and over) who:
- Are ventilator dependent (for at least 12 hours per day) with an invasive patient end of the circuit (in other words, tracheostomy cannula; or
- Ventilator dependent with a progressive neuromuscular disorder or spinal cord injury and is ventilated using noninvasive positive pressure ventilation by mask or mouth piece for at least 12 hours each day in order to avoid or delay tracheostomy; or
- Has a functioning tracheostomy which:
  - Requires suctioning and;
  - Oxygen supplementation;
  - Receives nebulizer treatment or requires use of Cough Assist/in-exsufflator device;
  - In addition, at least one sub-item from each of the following must be met:
    - Medication received by gastrostomy tube or by PICC line or central port; and
    - Nutrition bolus or continuous feeds through a permanent G-tube, Mickey Button, G-J tube; or total parenteral nutrition
- Private duty nursing orders require precertification by Amerigroup. The ordering physician must provide specific information regarding the services the nurse or aide is expected to perform (not just an order for a number of hours of care). The specific information required is outlined under Home Health Services.
- Private duty nurses do not:
  - Provide general supervision, safety monitoring or sitter services
  - Provide nonhands-on care such as housecleaning and meal preparation
  - Transport patients personally
| For children under the age of 21 — Private Duty Nursing | • Private duty nurses may accompany patients outside the home as outlined under Home Health Services.  
• Private duty nursing includes services to teach and train the patient and the patient’s caregivers to manage the patient’s treatment regimen.  
• To ensure the health and safety of the patient, in order to receive PDN, the patient must have a family member or other caregiver trained and willing to meet the patient’s nursing and non-nursing needs.  

Private duty nursing services are covered as medically necessary for children under the age of 21 in accordance with EPSDT requirements. As a general rule, only a child who is dependent upon technology-based medical equipment requiring constant nursing supervision, visual assessment, and monitoring of both equipment and child will be determined to need private duty nursing services. However, determinations of medical necessity will continue to be made on an individualized basis.  

A child who needs less than eight hours of continuous skilled nursing care during a 24-hour period or an adult who needs nursing care but does not qualify for private duty may receive medically necessary nursing care as an intermittent service under home health.  

Because children have nonmedical care needs which must be met, a responsible adult (other than the home health care provider) must be present at all times in the home during the provision of home health services unless:  
• The child has no or extremely limited ability or no ability to interact with caregivers; and  
• The child shall not reasonably be expected to have needs falling outside of the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the home health provider is present in the home without the presence of another responsible adult; and  
• No other children requiring adult care or supervision will be present in the home during the time the home health provider is present in the home without the presence of another responsible adult, unless these children meet all the criteria above and are receiving TennCare-reimbursed home health services.  

When a child reaches the age of 21 and they are receiving private duty nursing services above the limits:  
• The private duty nursing rules will apply as stated above plus the amount of private duty nursing services the member will be eligible for will be equal to the care they would receive in a skilled nursing facility. For example, a member who is receiving 24/7 skilled nurse and meets the criteria for private duty nursing will be reduced to 16/7 skilled nursing.  

For members receiving more than 35 hours of home health aide, 27 hours of skilled nursing, or 40 hours of combined skilled nurse and home health aide, will require an in-home assessment to determine the number of hours of service the member will be eligible for. |
| Prosthetics and Orthotics | As medically necessary. Specified prosthetics and orthotics will be covered/noncovered in accordance with TennCare rules and regulations. |
| **Reconstructive Breast Surgery** | Coverage for all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as surgical procedures on the nondoned breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a nondoned breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a nondoned breast occurs within five years of the date the reconstructive breast surgery was performed on a diseased breast. |
| **Renal Dialysis Services** | As medically necessary. |
| **Speech Therapy** | **Medicaid eligible, age 21 and older:** Covered as medically necessary by a licensed speech therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder.  
**Medicaid/Standard eligible, under age 21:** Covered as medically necessary in accordance with TennCare Kids requirements. |
| **Sterilizations** | Sterilization means any medical procedure, treatment or operation done for the purpose of rendering a member permanently incapable of reproducing. Amerigroup will cover sterilizations only if the following requirements are met:  
- The member has given informed consent no less than 30 full calendar days (or no less than 72 hours in the case of premature delivery or emergency abdominal surgery) but no more than 180 calendar days before the date of the sterilization. The member may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since the member gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 calendar days before the expected date of delivery.  
- The member is at least 21 years old at the time consent is obtained.  
- The member is mentally competent.  
- The member is not institutionalized (i.e., not involuntarily confined or detained under a civil or criminal status in a correctional or rehabilitative facility or confined in a mental hospital or other facility for the care and treatment of mental illness, whether voluntarily or involuntarily committed).  
- The member has voluntarily given informed consent on the approved Sterilization Consent Form, which is available at https://www.tn.gov/tenncare/providers/miscellaneous-provider-forms.html  
- The form will be available in English and Spanish. Amerigroup will provide assistance in completing the form when an alternative form of communication is necessary. |
| **TennCare Kids Services** | **Medicaid eligibles, age 21 and older:** Not covered.  
**Medicaid/Standard eligibles, under age 21:** Covered as medically necessary, except that the screenings do not have to be medically necessary. Children may also receive screenings in-between regular checkups if a parent or caregiver believes there is a problem.  
Periodic screenings, Interperiodic screenings, diagnostic and follow-up treatment services as medically necessary in accordance with federal and state requirements. |
| **Vision Services** | **Medicaid eligible, age 21 and older:** Medical eye care, meaning evaluation and management of abnormal conditions, diseases and disorders of the eye (not including
evaluation and treatment of refractive state), will be covered as medically necessary. This includes coverage for annual retinal eye examination to screen for diabetic retinopathy. Routine periodic assessment, evaluation or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.

**Medicaid/Standard eligible, under age 21:** Preventive, diagnostic and treatments services (including eyeglasses) are covered as medically necessary in accordance with TennCare Kids requirements.

Providers may contact EyeQuest at 1-800-526-9202 for more information.

**Services Not Covered by Amerigroup**

For more information about services not covered by Amerigroup or TennCare Medicaid/Standard, please call Provider Services at 1-800-454-3730.

**General Exclusions**

In general, the following items and services are not covered services by Amerigroup or TennCare:

- Provision of medical assistance that is outside the scope of benefits as defined in TennCare Rules and Regulations and identified in the Amerigroup Covered Services section of this manual.
- Provision of services to persons who are not enrolled in TennCare either on the date the services are delivered or retroactively to the date the services are delivered, except for limited special appeal provisions pertaining to children who are placed in Youth Development Centers.
- Services for which there is no Federal Financial Participation.
- Services provided outside the United States or its territories.
- Services provided outside the geographic borders of Tennessee, including transportation to return to Tennessee to receive medical care except in the following circumstances:
  - Emergency medical services are needed because of an emergency medical condition.
  - Nonemergency urgent care services are requested because the recipient’s health would be endangered if he were required to travel, but only upon the explicit precertification of Amerigroup.
  - The covered medical service would not be readily available within Tennessee if the member was physically located in Tennessee at the time of need and the covered service is explicitly precertified by Amerigroup.
  - The out-of-state provider is participating in the Amerigroup network.
- Investigative or experimental services or procedures including:
  - A drug or device that lacks FDA approval except when medically necessary as defined by TennCare.
  - A drug or device that lacks approval of facility’s Institutional Review Board.
  - A requested treatment that is the subject of Phase I or Phase II clinical trials or the investigational arm of Phase III clinical trials.
  - A requested service about which prevailing opinion among experts is that further study is required to determine safety, efficacy or long-term clinical outcomes of requested service.
- Services which are delivered in connection with, or required by, an item or service not covered by TennCare, including the transportation to receive such noncovered services, except that treatment of conditions resulting from the provision of noncovered services may be covered if medically necessary, notwithstanding the exclusions set out herein.
- Items or services furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Nonemergency services that are ordered or furnished by an out-of-network provider and that have not been approved by Amerigroup for out-of-network care. An exception exists for dually eligible members. In-network care ordered by out-of-network providers is covered for dually eligible members unless Amerigroup has informed the member in advance of a request for a service that the specific service requires precertification and an order from an in-network provider.

- Services that are free to the public, with the exception of services delivered in the schools pursuant to the Individuals with Disabilities in Education Act (IDEA).

- Items or services ordered, prescribed, administered, supplied or provided by an individual or entity that has been excluded from participation in the Medicaid program under the authority of the United States Department of Health and Human Services or the Division of TennCare.

- Items or services ordered, prescribed, administered, supplied or provided by an individual or entity that is not licensed by the appropriate licensing board.

- Items or services outside the scope and/or authority of a provider’s specialty and/or area of practice.

- Items or services to the extent that Medicare or a third-party payer is legally responsible to pay or would have been legally responsible to pay except for the member’s or the treating provider’s failure to comply with the requirements for coverage of such services.

- Medical services for inmates confined in a local, state or federal prison, jail or other penal or correctional facility, including a furlough from such facility.

- Services delivered by a specific provider, even a provider who is an in-network provider with Amerigroup, when Amerigroup has offered the member the services of a qualified provider who is available to provide the needed services.

- Items or services that are not covered by Medicare or a third-party payer for an individual enrollee when the item or service is essentially equivalent to a Medicare or third-party payer service that is being covered (e.g., home health services for individuals receiving hospice care).

Amerigroup has discretionary authority to offer medically appropriate cost effective alternative services that are not covered under the mandatory benefit package on a case-by-case basis. Amerigroup may offer the medical care that Amerigroup and the health care provider deem appropriate in each individual case from a preapproved list of alternative services. An example of a cost-effective alternative service includes the use of a nursing home as a step down alternative to continued acute care hospitalization. Amerigroup will follow all procedures in instances where it chooses to consider a cost effective alternative service option.

**Specific Exclusions**

The following services, products and supplies are specifically excluded from coverage except as medically necessary for children under the age of 21. However, some of these services may be covered under the CHOICES or ECF CHOICES programs or an HCBS waiver when provided as part of an approved plan of care in accordance with the appropriate TennCare HCBS rule:

- Audiological therapy or training
- Augmentative communication devices
- Beds and bedding equipment as follows:
  - Powered air flotation beds, air fluidized beds (including Clinitron beds), water pressure mattress or gel mattress. For persons age 21 and older: Not covered unless a member has both severely impaired mobility (i.e., unable to make independent changes in body position to alleviate pain or pressure) and any stage pressure ulcer on the trunk or pelvis combined with at least one of the following: impaired nutritional status, fecal or urinary incontinence, altered sensory perception, or compromised circulatory status.
  - Bead beds or similar devices
  - Bed boards
  - Bedding and bed casings
  - Ortho-prone beds
  - Oscillating beds
- Springbase beds
- Vail beds or similar bed
- Biofeedback
- Chiropractor’s services
- Cushions, pads and mattresses as follows:
  - Aquatic K Pads
  - Elbow protectors
  - Heat and massage foam cushion pads
  - Heating pads
  - Heel protectors
  - Lamb’s wool pads
  - Steam packs
- Diagnostic tests conducted solely for the purpose of evaluating the need for a service that is excluded from coverage under these rules
- Ear plugs
- Floor standers (i.e., stationary devices not attached to a wheelchair base and not built into the operating system of a power wheelchair, designed to hold an individual who uses a wheelchair and/or has limited or no ability to stand on his own in an upright position)
- Food supplements and substitutes including formulas
  - For persons 21 years of age and older: Not covered, except that parenteral nutrition formulas, enteral nutrition formulas for tube feedings and phenylalanine-free formulas (not foods) used to treat PKU are covered for adults. In addition, oral liquid nutrition may be covered when medically necessary for adults with swallowing or breathing disorders who are severely underweight (BMI < 15 kg/m2) and physically incapable of otherwise consuming a sufficient intake of food to meet basic nutritional requirements.
- Hearing services including the prescribing, fitting or changing of hearing aids
- Humidifiers (central or room) and dehumidifiers
- Inpatient rehabilitation facility services
- Medical supplies, over-the-counter, as follows:
  - Alcohol, rubbing
  - Band-aids
  - Cotton balls
  - Eyewash
  - Peroxide
  - Q-tips or cotton swabs
- Methadone clinic services
- Nutritional supplements and vitamins, over-the-counter, except that prenatal vitamins for pregnant women and folic acid for women of childbearing age are covered
- Orthodontic services (with some exceptions)
- Purchase, repair or replacement of materials or equipment when the reason for the purchase, repair or replacement is the result of enrollee abuse
- Purchase, repair or replacement of materials or equipment that has been stolen or destroyed except when the following documentation is provided:
  - Explanation of continuing medical necessity for the item
  - Explanation that the item was stolen or destroyed
  - Copy of police, fire department or insurance report if applicable
- Radial keratotomy
- Reimbursement to a provider or enrollee for the replacement of a rented durable medical equipment (DME) item that is stolen or destroyed
- Repair of DME items not covered by TennCare
- Repair of DME items covered under the provider’s or manufacturer’s warranty
• Repair of a rented DME item
• Speech, language and hearing services to address speech problems caused by mental, psychoneurotic or personality disorders
• Standing tables
• Vision services for persons 21 years of age and older that are not needed to treat a systemic disease process including:
  o Eyeglasses, sunglasses and/or contact lenses for persons aged 21 and older, including eye examinations for the purpose of prescribing, fitting or changing eyeglasses, sunglasses and/or contact lenses; procedures performed to determine the refractive state of the eye(s); one pair of cataract glasses or lenses is covered for adults following cataract surgery
  o LASIK
  o Orthoptics
  o Vision perception training
  o Vision therapy

The following services, products and supplies are specifically excluded from coverage under the TennCare program:

• Air cleaners, purifiers or HEPA filters
• Alcoholic beverages
• Animal therapy including:
  o Dolphin therapy
  o Equine therapy
  o Hippo therapy
  o Pet therapy
• Art therapy
• Autopsy
• Bathtub equipment and supplies as follows:
  o Paraffin baths
  o Sauna baths
• Beds and bedding equipment as follows:
  o Adjust-a-Beds, lounge beds or similar devices
  o Pillows
  o Waterbeds
• Bioenergetic therapy
• Body adornment and enhancement services including:
  o Body piercing
  o Breast augmentation
  o Breast capsulectomy
  o Breast implant removal that is not medically indicated
  o Ear piercing
  o Hair transplantation and agents for hair growth
  o Tattoos or removal of tattoos
  o Tongue splitting or repair of tongue splitting
  o Wigs or hairpieces
• Breathing equipment as follows:
  o Intrapulmonary Percussive Ventilators (IPVs)
  o Spirometers except for peak flow meters for medical management of asthma
  o Vaporizers
• Carbon dioxide therapy
• Care facilities or services, the primary purpose of which is nonmedical, including:
  o Day care
- Evening care centers
- Respite care, with the exception of Mental Health Crisis Services or Hospice Care benefits (as noted under covered services)
- Rest cures
- Social or diversion services related to the judicial system

- Carotid body tumor, excision of, as treatment for asthma
- Chelation therapy, except for the treatment of heavy metal poisoning or secondary hemochromatosis in selected settings. Chelation therapy for treatment of arteriosclerosis or autism is not covered. Chelation therapy for asymptomatic individuals is not covered. In the case of lead poisoning, the lead levels must be extremely high. For children, a minimum level of 45 ug/dl is recommended. Because chelation therapy and its after effects must be continuously monitored for possible adverse reactions, chelation therapy is covered only in inpatient or outpatient hospital settings, renal dialysis facilities and skilled nursing facilities. It is not covered in an office setting, an ambulatory surgical center or a home setting.
- Clothing, including adaptive clothing
- Cold therapy devices
- Comfort and convenience items, including:
  - Corn plasters
  - Garter belts
  - Incontinence products (diapers/liners/underpads) for persons younger than three years of age
  - Support stockings, when light or medium weight or prescribed for relief of tired or aching legs or treatment of spider/varicose veins. Surgical weight stockings prescribed by a doctor or other qualified licensed health care practitioner for the treatment of chronic foot/ankle swelling, venous insufficiencies or other medical conditions and thrombo-embolic deterrent support stockings for pre/post-surgical procedures are covered as medically necessary.
- Computers, personal and peripherals including printers, modems, monitors, scanners and software including their use in conjunction with an augmentative communication device
- Convalescent care
- Cosmetic dentistry, cosmetic oral surgery and cosmetic orthodontic services
- Cosmetic prosthetic devices
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem, including scar revision. The following services are not considered cosmetic services:
  - Reconstructive surgery to correct the results of an injury or disease
  - Surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function
  - Surgery to reconstruct a breast after mastectomy that was done to treat a disease or as a continuation of a staged reconstructive procedure
  - In accordance with Tennessee law, surgery of the nondiseased breast following mastectomy and reconstruction to create symmetrical appearance
  - Surgery for the improvement of the functioning of a malformed body member
  - Reduction mammoplasty when the minimum amount of breast material to be removed is equal to or greater than the 22nd percentile of the Schnur Sliding Scale based on the individual’s body surface area
- Dance therapy
- Dental services for adults age 21 and older
- Services provided solely or primarily for educational purposes including:
  - Academic performance testing
  - Educational tests and training programs
  - Habilitation
  - Job training
  - Lamaze classes
○ Lovaas therapy
○ Picture illustrations
○ Remedial education
○ Sign language instruction
○ Special education
○ Tutors

- Encounter groups or workshops
- Environmental modifications including:
  ○ Air conditioners, central or unit
  ○ Micronaire environmental and similar devices
  ○ Pollen extractors
  ○ Portable room heaters
  ○ Vacuum systems for dust filtering
  ○ Water purifiers
  ○ Water softeners
- Exercise equipment including:
  ○ Exercise equipment
  ○ Exercycles (including cardiac use)
  ○ Functional electrical stimulation
  ○ Gravitronic traction devices
  ○ Gravity guidance inversion boots
  ○ Parallel bars
  ○ Pulse tachometers
  ○ Tilt tables
  ○ Training balls
  ○ Treadmill exercisers
  ○ Weighted quad boots
- Food and food products (distinct from food supplements or substitutes including specialty food items for use in diets such as:
  ○ Low-phenylalanine or phenylalanine-free
  ○ Gluten-free
  ○ Casein-free
  ○ Ketogenic
- Generators and auxiliary power equipment that may be used to provide power for covered medical equipment for any purpose
- Grooming services including:
  ○ Barber services
  ○ Beauty services
  ○ Electrolysis
  ○ Hairpieces or wigs
  ○ Manicures
  ○ Pedicures
- Hair analysis
- Home health aide services or services from any other individual or agency that are for the primary purpose of safety monitoring
- Home modifications and items for use in the home:
  ○ Decks
  ○ Enlarged doorways
  ○ Environmental accessibility modifications such as grab bars and ramps
  ○ Fences
  ○ Furniture, indoor or outdoor
Handrails  
Meals  
Overbed tables  
Patio, sidewalks, driveways and concrete slabs  
Plexiglas  
Plumbing repairs  
Porch gliders  
Rollabout chairs  
Room additions and room expansions  
Telephone alert systems  
Telephone arms  
Telephone service in home  
Televisions  
Tilt tables  
Toilet trainers and potty chairs (positioning commodes and toilet supports are covered as medically necessary)  
Utilities (gas, electric, water, etc.)

- Homemaker services
- Hospital inpatient items that are not directly related to the treatment of an injury or illness (such as radios, TVs, movies, telephones, massage, guest beds, haircuts, hair styling, guest trays, etc.)
- Hotel charges, unless preapproved in conjunction with a transplant or as part of a nonemergency transportation service
- Hypnosis or hypnotherapy
- Icterus index
- Infant/child car seats, except that adaptive car seats may be covered for a person with disabilities such as severe cerebral palsy, spinal bifida, muscular dystrophy and similar disorders who meets all of the following conditions:
  - Cannot sit upright unassisted
  - Infant/child care seats are too small or do not provide adequate support
  - Safe automobile transport is not otherwise possible
- Infertility or impotence services including:
  - Artificial insemination services
  - Purchase of donor sperm and any charges for the storage of sperm
  - Purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers of gestational carriers
  - Cryopreservation and storage of cryopreserved embryos
  - Services associated with a gestational carrier program (surrogate parenting) for the recipient or the gestational carrier
  - Fertility drugs
  - Home ovulation prediction kits
  - Services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal
  - Reversal of sterilization procedures
  - Any other service or procedure intended to create a pregnancy
  - Testing and/or treatment (including therapy, supplies and counseling) for frigidity or impotence
- Injections for the treatment of pain such as:
  - Facet/medial branch injections for therapeutic purposes
  - Medial branch injections for diagnostic purposes in excess of four injections in a calendar year
  - Trigger point injections in excess of four injections per muscle trigger point during any period of six consecutive months
- Epidural steroid injections in excess of three injections during any period of six consecutive months, except epidural injections associated with childbirth

- Lamps such as:
  - Heating lamps
  - Lava lamps
  - Sunlamps
  - Ultraviolet lamps

- Lifts as follows:
  - Automobile van lifts
  - Electric powered recliner, elevating seats and lift chairs
  - Elevators
  - Overhead or ceiling lifts, ceiling track system lifts or wall mounted lifts when installation would require significant structural modification and/or renovation to the dwelling (e.g., moving walls, enlarging passageways, strengthening ceilings and supports). The request for precertification must include a specific breakdown of equipment and installation costs, specifying all required structural modifications (however minor) and the cost associated thereto.
  - Stairway lifts, stair glides and platform lifts, including Wheel-O-Vators

- Ligations of mammary arteries, unilateral or bilateral

- Megavitamin therapy

- Motor vehicle parts and services including:
  - Automobile controls
  - Automobile repairs or modifications

- Music therapy

- Nail analysis

- Naturopathic services

- Necropsy

- Organ and tissue transplants that have been determined experimental or investigational

- Organ and tissue donor services provided in connection with organ or tissue transplants covered including:
  - Transplants from a donor who is a living TennCare enrollee and the transplant is to a non-TennCare enrollee
  - Donor services other than the direct services related to organ procurement (such as, hospitalization, physician services, anesthesia)
  - Hotels, meals or similar items provided outside the hospital setting for the donor
  - Any costs incurred by the next of kin of the donor
  - Any services provided outside of any bundled rates after the donor is discharged from the hospital

- Oxygen except when provided under the order of a physician and administered under the direction of a physician

- Oxygen, preset system (flow rate not adjustable)

- Play therapy

- Primal therapy

- Psychodrama

- Psychogenic sexual dysfunction or transformation services

- Purging

- Recertification of patients in Level 1 and Level 2 Nursing Facilities

- Recreational therapy

- Religious counseling

- Retreats for mental disorders

- Rolfing
• Routine health services which may be required by an employer; or by a facility where an individual lives, goes to school or works; or by the enrollee’s intent to travel
  o Drug screenings
  o Employment and pre-employment physicals
  o Fitness to duty examinations
  o Immunizations related to travel or work
  o Insurance physicals
  o Job related illness or injury covered by workers’ compensation
• Sensitivity training or workshops
• Sensory integration therapy and equipment used in sensory integration therapy including:
  o Ankle weights
  o Floor mats
  o Mini trampolines
  o Poof chairs
  o Sensory balls
  o Sky chairs
  o Suspension swings
  o Trampolines
  o Therapy balls
  o Weighted blankets or weighted vests
• Sensory stimulation services
• Services provided by immediate relatives (i.e., a spouse, parent, grandparent, stepparent, child, grandchild, brother, sister, half brother, half sister, a spouse’s parents or stepparents, or members of the recipient’s household)
• Sex change or transformation surgery
• Sexual dysfunction or inadequacy services and medicine including drugs for erectile dysfunctions and penile implant devices
• Sitter services
• Speech devices as follows:
  o Phone mirror handvoice
  o Speech software
  o Speech teaching machines
• Sphygmomanometers (blood pressure cuffs)
• Stethoscopes
• Supports
  o Cervical pillows
  o Orthotrac pneumatic vests
• Transcutaneous electrical nerve stimulation (TENS) units for the treatment of chronic lower back pain
• Thermograms
• Thermography
• Time involved in completing necessary forms, claims or reports
• Tinnitus maskers
• Toy equipment such as:
  o Flash switches (for toys)
• Transportation costs are as follows:
  o Transportation to a provider who is outside the geographical access standards that Amerigroup is required to meet when a network provider is available within such geographical access standards or, in the case of Medicare beneficiaries, transportation to Medicare providers who are outside the geographical access standards of the TennCare program when there are Medicare providers available within those standards
- Mileage reimbursement, car rental fees or other reimbursement for use of a private vehicle unless precertification by Amerigroup in lieu of contracted transportation services
- Transportation back to Tennessee from vacation or other travel out-of-state in order to access nonemergency covered services (unless authorized by Amerigroup)
- Any nonemergency out-of-state transportation, including airfare, which has not been precertified by Amerigroup; this includes the cost of transportation to obtain out-of-state care that has been certified by Amerigroup; out-of-state transportation must be precertified independently of out-of-state care

- Transsexual surgery
- Urine drug screens in excess of 12, four confirmation urine screens and two specific assay tests during a calendar year
- Vagus nerve stimulators, except after conventional therapy has failed in treating partial onset of seizures
- Weight loss or weight gain and physical fitness programs including:
  - Dietary programs of weight loss programs including Optifast, Nutrisystem and other similar programs or exercise programs; food supplements will not be authorized for use in weight loss programs or for weight gain
  - Health clubs, membership fees (e.g., the YMCA)
  - Marathons, activity and entry fees
  - Swimming pools

- Wheelchairs as follows:
  - Wheelchairs defined by CMS as power operated vehicles (POVs), namely, scooters and devices with three or four wheels that have tiller steering and limited seat modification capabilities (i.e., provide little or no back support)
  - Standing wheelchairs; however, a power standing system is covered as outlined in TennCare’s definition of power seating accessories
  - Stair-climbing wheelchairs
  - Recreational wheelchairs

- Whirlpools and whirlpool equipment such as:
  - Action bath hydro massage
  - Aero massage
  - Aqua whirl
  - Aquasage pump or similar devices
  - Hand-D-Jets or similar devices
  - Jacuzzis or similar devices
  - Turbojets
  - Whirlpool bath equipment
  - Whirlpool pumps

**Weight Management**
Members ages 10 and older who have a body mass index (BMI) ≥ 25 or who wish to make lifestyle changes that focus on healthy eating, behavioral management and increasing physical activity can be referred to the Population Health Program. The program is designed to encourage personal responsibility by actively engaging individuals in the management of their weight problems.

The member will be connected with a nurse who will partner with the member in achieving his or her weight loss goals. The case manager works closely with the member to assist in consulting with his or her physician to explore weight loss options and to determine the safest recommended approach to weight loss. The nurse will work collaboratively with the member and provider to develop a care plan and strategy to help the member be successful. The nurse will provide assistance to locate facilities and programs in the area that are available to support the member’s decision to lose weight. Ongoing education about diet and exercise are provided over the
phone and by mail. Monitoring the member’s progress is an ongoing part of the service the nurses provide along with support and encouragement.

Members can be referred to Population Health for weight loss by calling Member Services at 1-800-600-4441.

<table>
<thead>
<tr>
<th>Mid Cumberland region — nutritionist available by appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dickson: 615-446-2839</td>
</tr>
<tr>
<td>Humphreys: 931-296-2231</td>
</tr>
<tr>
<td>Williamson: 615-794-1542</td>
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<tr>
<td>Rutherford: 615-898-7880</td>
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<tr>
<td>Stewart: 931-232-5329</td>
</tr>
<tr>
<td>Montgomery: 931-648-5747</td>
</tr>
<tr>
<td>Davidson: Matthew Walker Comprehensive Health Center: 615-327-9400</td>
</tr>
<tr>
<td>United Neighborhood Health Services: 615-620-8647</td>
</tr>
</tbody>
</table>

**Pharmacy**

Amerigroup is not responsible for the provision and payment of pharmacy benefits except as described below. TennCare contracts with a Pharmacy Benefits Manager (PBM) to provide these services. However, we coordinate with the PBM as necessary to ensure members receive appropriate pharmacy services without interruption. We monitor and manage both our contract providers’ prescribing patterns and our members’ utilization of prescription drugs. Providers identified as noncompliant as it relates to adherence to the PDL and/or generic prescribing patterns will be contacted by Amerigroup via letter, phone call and/or face-to-face visit. Amerigroup is responsible for reimbursement of specified injectable drugs administered in an office/clinic setting and to providers providing home infusion service. Providers must obtain precertification of these drugs by contacting the Amerigroup pharmacy department at 1-800-454-3730.

For all J-codes billed and all other codes representing billing for drugs, NDC code and drug pricing information (NDC quantity, unit price and unit of measurement) are required. Exceptions are:

- Vaccines for children which are paid as an administrative fee
- Inpatient administered drugs
- Radiopharmaceuticals unless the drug is billed separately from the procedure

Additional information is located in Section 16, Claim Submission and Adjudication Procedures.

Services reimbursed by Amerigroup are not included in any pharmacy benefit limits established by TennCare for pharmacy services.

We require providers to inform all members being considered for prescription of psychotropic medications of the benefits, risks and side effects of the medication, alternate medications, and other forms of treatment.

All providers should seek precertification/prior authorization from the pharmacy benefits manager when they feel they cannot order a drug on the TennCare Preferred Drug List (PDL), as well as take the initiative to seek precertification or change or cancel the prescription when contacted by a member or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication).

TennCare’s PBM is Magellan Health Services (MHS). You can reference PDL information online at https://TennCare.magellanhealth.com.

Drugs deemed self-injectable should be obtained through the TennCare pharmacy program. There are a number of drug products that are administered by intramuscular (IM) or intravenous (IV) route that, due to established
channels of distribution, should be obtained through the designated specialty pharmacy. There may be instances where an emergency exists, the provider does not have access to the needed drug or a caregiver has been trained to administer the drug. In these situations, an override may be requested by calling the Magellan Health Services Clinical Call Center at 1-866-434-5524 or by faxing the request to 1-866-434-5523. The drug can be administered in the provider’s office or another clinical setting.

For a list of drugs considered self-injectable available through the TennCare pharmacy program, please visit https://tenncare.magellanhealth.com/static/docs/Program_Information/Covered_Injectable_Drugs.pdf.

Drugs that cannot be self-administered should be billed as a medical benefit to Amerigroup only after receiving precertification. Drugs given intravenously are considered nonself-administered by the patient. Drugs given by intramuscular injection may be presumed to be nonself-administered by the patient. Additionally, products whose package literature does not list or support self-administration are considered nonself-administered.

Amerigroup precertification requirements by procedure code are searchable through our Precertification Look-up Tool online at: https://providers.amerigroup.com/Pages/PLUTO.aspx.

**Pharmacy Copays**

Pharmacy copays apply to all TennCare Standard members as well as noninstitutionalized Medicaid adults who are eligible to receive pharmacy services in the TennCare program. Medicaid eligibles are exempt from nonpharmacy copays. These copays are administered by the PBM, who should be contacted directly for related questions or issues.

The pharmacy copay amounts are as follows:

- **Generic** $1.50
- **Brand name** $3.00

Pharmacy copayments do not apply to family planning services, pregnant women, enrollees in long-term care institutions (including HCBS) or members receiving hospice care. Members who are pregnant or receiving hospice care must self-declare at the pharmacy prior to obtaining any medications in order for the copay to be waived.

There are no annual out-of-pocket maximums.

**The TennCare Pharmacy Manual**

To help prescribers provide appropriate and timely drug treatment therapy, TennCare and Magellan Health have written their own pharmacy manual. We strongly encourage you to regularly review this document online at https://TennCare.magellanhealth.com for the appropriate and current information concerning:

- Preferred drug list
- Clinical criteria for prior authorizations
- ICD-10 prior authorization bypass codes
- Prior authorization drug forms
- TennCare’s auto-exemption list
- TennCare’s prescriber attestation list
- Drug titration override list
- Covered over-the-counter medications
- Emergency supply medication list

**Durable Medical Equipment and Medical Supplies**

All DME and medical supplies that require precertification are reviewed and managed by the Amerigroup Utilization Management (UM) Department. Requests should be submitted to the health plan for review via:
• The Interactive Care Reviewer (ICR), which is accessible through the Availity Portal
• Fax to 1-877-423-9958.
• Phone at 1-800-454-3730.

Providers are encouraged to use the Precertification Lookup Tool to determine whether the item or procedure requires precertification. This feature can be found under the Quick Tools on the provider self-service login page at https://providers.amerigroup.com/Pages/PLUTO.aspx.

Medical necessity is required for all services. All precertification requests must contain, at a minimum, the following information:
• First and last name of the patient
• Address where the service is to be rendered
• Patient or caregiver’s phone number with area code
• Patient’s date of birth and gender
• Current and clear physician orders
• Ordering physician’s name and phone number
• Diagnosis and documentation to support the medical necessity of the requested service(s) or equipment (e.g., oxygen saturation levels for home O2)
• Allergies, disability status, height, weight or diabetic status
• Desired date of service
• Services or equipment required including size, quantity, frequency, brand, etc.
• Details and description regarding the requested service or equipment including brand name, size, quantity, frequency and expected duration, etc.
• Amerigroup subscriber ID

Retroactive reviews or requests received after the date of service is performed are not accepted by the health plan for review. If Amerigroup receives a claim for DME or medical supplies that normally require authorization and there is not a corresponding authorization on file, the claim will be denied. If Amerigroup receives claims for DME or medical supplies, the claims will be denied.

Vision
Vision benefits are administered through EyeQuest. Providers may contact EyeQuest at 1-800-526-9202, Monday through Friday, 7 a.m. to 5 p.m. CT, for more information.

Providers must have a separate contract with EyeQuest to perform vision services. If Amerigroup receives claims for vision services that are not associated with a medical diagnosis, the claims will be denied and the EOP will direct the provider to submit the claim to EyeQuest for services to be reimbursed.

Amerigroup offers vision coverage for:
• **Medicaid eligible, age 21 and older**: Medical eye care, meaning evaluation and management of abnormal conditions, diseases and disorders of the eye (not including evaluation and treatment of refractive state), will be covered as medically necessary. This includes coverage for annual retinal eye examination to screen for diabetic retinopathy. Routine periodic assessment, evaluation or screening of normal eyes, and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.
• **Medicaid/Standard eligible, under age 21**: Preventive, diagnostic and treatment services (including eyeglasses) are covered as medically necessary in accordance with TennCare Kids requirements.
Nonemergency Medical Transportation

Nonemergency medical transportation benefits are administered through Tennessee Carriers. Providers may contact Tennessee Carriers at 1-866-680-0633 for more information.

Transporters must have a separate contract with Tennessee Carriers to perform nonemergency medical transportation services. If Amerigroup receives claims for nonemergency transportation services that are not coordinated through Tennessee Carriers, the claims will be denied and the Explanation of Payment (EOP) will direct the provider to submit the claim to Tennessee Carriers for services to be reimbursed.
8 TENNCARE KIDS PROGRAM

TennCare Kids Mission
TennCare Kids is the name for Tennessee’s Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) program. Tennessee has made a commitment to promoting good health in children from birth until age 21. TennCare Kids is a full program of health checkups and health care services for children with TennCare. These services make sure babies, children, teens and young adults receive health care they need.

Providers are required to:
- Provide TennCare Kids services
- Make appropriate TennCare Kids referrals and document the referrals in the member’s medical record
- Make arrangements for necessary follow-up when all of the components of screening cannot be completed in a single visit
- Have a process for documenting services declined by a parent or legal representative that specifies the particular service that was declined

Amerigroup will educate providers about proper coding and encourage them to submit the appropriate diagnosis codes identified by TennCare in conjunction with the evaluation and management (E&M) procedure codes for TennCare Kids services.

A child age 14 through 17 is presumed to be competent to seek his or her own medical care, to consent to release medical records, and to obtain transportation to and from medical services without the knowledge and consent of his or her parents or legal custodians. The child must be counseled by the provider to determine that the child actually is competent, and the record must reflect such determination by the provider. Release of medical records by an individual age 14 through 17 must be signed by the child. If it is determined that the child is incompetent, the services should not be provided without consent of the legal guardian or parent.

This determination of competency is essentially the same as an adult providing informed consent to receive health care services.

A child age 7 through 13 is presumed to be incompetent to seek his or her own medical care, etc. However, if counseling of the child shows the child is competent, the medical services may be provided. The child’s medical record must reflect such counseling and determination.

A child under the age of seven is incompetent to seek his or her own medical care. No care can be provided without the consent of the parent or legal custodian.

Examples:
- Practitioners may treat juvenile drug abusers without prior legal guardian or parent consent. Practitioners should use their own discretion in determining whether to notify the child’s legal guardian or parent.
- A practitioner may diagnose, examine and treat a minor without knowledge or consent of the legal guardian or parent for purposes of providing prenatal care.
- Contraceptive supplies and information may be supplied to a minor without consent of the legal guardian or parent.
- The practitioner may diagnose and treat STDs without the knowledge or consent of the parent or legal guardian. Legal reporting requirements to the Department of Health still exist.

To comply with the TennCare Kids requirements, transportation for a minor child may not be denied pursuant to any policy that poses a blanket restriction due to the member’s age or lack of an accompanying adult. Any
decision to deny transportation of a minor child due to a member’s age or lack of an accompanying adult shall be made on a case-by-case basis and shall be based on the individual facts surrounding the request and state of Tennessee law.

For members under 16 years of age seeking behavioral health TennCare Kids services and the member’s parent or legal guardian is unable to accompany the member to the examination, providers must

- Contact the member’s parents or legal guardian to discuss the findings
- Inform the family of any other necessary health care, diagnostic services, treatment or other measures recommended for the member
- Notify Amerigroup to contact the parent(s) or legally appointed guardian with the results

Referrals are not required for TennCare Kids members to access behavioral health providers. Members and their parents or guardians can request names of behavioral health providers from their PCPs.

**TennCare Kids Early and Periodic Screening**

Amerigroup joins TennCare in this screening requirement. These early and periodic screening services are provided to members without cost. These screens will include periodic and interperiodic screens and be provided at intervals that meet reasonable standards of medical, behavioral and dental practice. Reasonable standards of medical and dental practice are those standards set forth in the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care for medical practice and American Academy of Pediatric Dentistry (AAPD) guidelines for dental practice. Tools used for screening will be consistent with the screening guidelines recommended by the state, which are available at [https://www.tn.gov/tenncare/tenncare-kids.html](https://www.tn.gov/tenncare/tenncare-kids.html).

These include recommended screening guidelines for developmental/behavioral surveillance and screening, hearing screenings and vision screenings. Preventive Visit Forms, EPSDT and TennCare Kids Encounter Documentation forms, and the Tennessee Chapter of the American Academy of Pediatrics EPSDT/TennCare Kids manual are also available on the following websites:

- [https://www.tnaap.org/programs/epsdt-coding/coding-resources](https://www.tnaap.org/programs/epsdt-coding/coding-resources)
- [https://www.tnaap.org/resources/developmental-behavioral-health-screening-tools](https://www.tnaap.org/resources/developmental-behavioral-health-screening-tools)
- [https://www.tnaap.org/programs/epsdt-coding/oral-health](https://www.tnaap.org/programs/epsdt-coding/oral-health)

The screens include:

- Comprehensive health (physical and mental) and developmental history
  - Initial and interval history
  - Developmental/behavioral assessment
- Comprehensive unclothed physical exam
- Vision screening
- Hearing screening
- Laboratory tests
- Immunizations
- Health education/anticipatory guidance

Providers must notify Amerigroup if a screening reveals the need for other health care services and if the provider is unable to make an appropriate referral for those services. In these cases, Amerigroup will make an appropriate referral and contact the member to offer scheduling assistance and transportation for members who lack access to transportation.
Amerigroup does not require precertification for periodic and interperiodic screens conducted by PCPs. Amerigroup will cover all medically necessary covered services regardless of whether the need for the services was identified by a provider who had received precertification from Amerigroup or a network provider.

Providers are encouraged to refer children to dentists for periodic dental screens beginning no later than age 3 and earlier as needed.

**TennCare Kids checkups can be provided by a child’s PCP or local health department and include the following:**

- Comprehensive health and developmental history
  - Physical
  - Behavioral/developmental
  - Dental
- Complete physical exam (unclothed)
  - Compare child's physical growth against what is considered normal for child's age
- Vision screening
  - Includes age-appropriate vision assessment. Tools used for screenings shall be consistent with the screening guidelines
- Hearing screening
  - Includes an age-appropriate hearing assessment. Tools used for hearing screenings shall be consistent with the screening guidelines
- Lab tests
  - Blood lead test should be performed at 12 and 24 months; assessed at each visit beginning at 6 months. Children 36-72 months of age shall receive a screening blood lead test if they have not been previously screened for lead poisoning.
- Immunizations
  - Age-appropriate and current status of shots in accordance with the most current Advisory Committee on Immunization Practices (ACIP) schedule
- Health education
  - Anticipatory guidance (e.g., car seat safety, sex education, smoking, etc.)
  - Counseling parents and child regarding child's development

The periodicity schedule is recommended by the American Academy of Pediatrics. It indicates when screenings should be scheduled. Members are encouraged to contact their physician within the first 90 days of enrollment to schedule a checkup and within 24 hours after the birth of a newborn.

**Infants/toddlers should have 12 TennCare Kids checkups before their third birthdays:**

- Newborn
- 2 months
- 9 months
- 18 months
- 3-5 days of age
- 4 months
- 12 months
- 24 months
- 1 month
- 6 months
- 15 months
- 30 months

Children 3-20 years of age should get a TennCare Kids checkup every year.
### Tools Recommended For Use in TennCare Kids Screenings

<table>
<thead>
<tr>
<th>Measure</th>
<th>Age range</th>
<th>Description</th>
<th>Scoring</th>
<th>Accuracy</th>
<th>Time frame</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child Development Inventories</strong> <em>(formerly Minnesota Child Development Inventories)</em> (1992) Behavior Science Systems, Box 580274, Minneapolis, MN 55458 Phone: 612-929-6220</td>
<td>Birth to 72 months</td>
<td>Sixty yes/no descriptions with separate forms for 0-18 months, 18-36 months and 3-6 years. Can be mailed to families, completed in waiting rooms, administered by interview or by direct elicitation.</td>
<td>A single cutoff tied to 1.5 standard deviations below the mean</td>
<td>Sensitivity¹ was 75 percent or greater across studies and specificity² was 70 percent</td>
<td>About 10 minutes (if interview needed)</td>
</tr>
<tr>
<td><strong>Parents’ Evaluations of Developmental Status (PEDS)</strong> (1997) Ellsworth &amp; Vandemeer Press, Ltd., P.O. Box 68164, Nashville, TN 37206 Phone: 615-226-4460; fax: 615-227-0411 <a href="http://www.pedstest.com">www.pedstest.com</a></td>
<td>Birth to 9 years</td>
<td>Ten questions eliciting parents’ concerns. Can be administered in waiting rooms or by interview. Available in Spanish. Written at the 5th grade level. Normed in teaching hospitals and private practice.</td>
<td>Categorizes patients into those needing referrals, screening, counseling, reassurance, extra monitoring</td>
<td>Sensitivity ranged from 74 percent to 79 percent and specificity ranged from 70 percent to 80 percent</td>
<td>About two minutes (if interview needed)</td>
</tr>
<tr>
<td><strong>Pediatric Symptom Checklist</strong> Jellinek MS, Murphy JM, Robinson J. et al. Pediatric Symptom Checklist: Screening School age children for psychosocial dysfunction. Journal of Pediatrics, 1988; 112:201-209 (the test is included in the article and in the PEDS manual)</td>
<td>6 to 16</td>
<td>Thirty-five short statements of problem behaviors to which parents respond with never, sometimes or often. The PSC screens for academic and emotional/behavioral difficulties.</td>
<td>Single refer/nonrefer score</td>
<td>Sensitivity ranged from 80 percent to 95 percent; specificity in all but one study was 70 percent to 100 percent</td>
<td>About seven minutes (if interview needed)</td>
</tr>
</tbody>
</table>

¹Sensitivity = percentage of children with disabilities identified as probably delayed by a screening test.

²Specificity = percentage of children without disabilities identified as probably normal by a screening test.

### Tools Recommended for Secondary Screening Involving Direct Testing of Children

<table>
<thead>
<tr>
<th>Measure</th>
<th>Age range</th>
<th>Description</th>
<th>Scoring</th>
<th>Accuracy</th>
<th>Time frame</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brigance Screens</strong> Billerica, MA: Curriculum Associates, Inc. (1985) 153 Rangeway Road, N. Billerica, MA 01862 1-800-225-0248</td>
<td>21 to 90 months</td>
<td>Seven separate forms, one for each 12-month age range. Taps speech-language, motor, readiness and general knowledge at younger ages and also reading and math at older ages. Uses direct elicitation and observation.</td>
<td>Cutoff and age equivalent scores</td>
<td>Sensitivity and specificity to giftedness and to developmental and academic problems was 70 percent to 82 percent</td>
<td>10 minutes (direct testing only)</td>
</tr>
</tbody>
</table>
Individual Educations Plans
TennCare, which includes the CoverKids Program, is committed to the coordination of school-based, medically necessary services. TennCare worked closely with the Department of Education (DOE) and managed care organizations (MCOs), including Amerigroup, to ensure coordination of care and the delivery of medically necessary services to TennCare-enrolled school age children. For any medically necessary service provided in the school setting, TennCare continues to require an individual education plan (IEP) with the service included and confirmation a parental consent form was obtained.

We do not require schools to send eligible students’ IEPs to us before paying for the covered, medically necessary services. Instead, we audit IEPs as we do with other services, which means each school must prepare and maintain updated IEPs for each eligible student and then provide any requested IEP to us upon request. At a minimum, we’re required to conduct regular post-payment sample audits of IEPs and all other documentation to support the medical necessity of the school-based services reimbursed by us.

When we require a copy of an IEP, the provider must also include a copy of the appropriate parental consent. TennCare has updated the authorization forms, which can be found at https://www.tn.gov/tenncare/tenncare-kids/school-based-services.html. Additionally, the school can coordinate with Amerigroup to arrange for services to be provided during school or outside of a school setting.

As a reminder, failure to abide by the requirements and our requests may subject the school to recoupments and, potentially, other penalties.

Vaccines for Children Program
The Vaccines for Children (VFC) program was established by Congress in 1993. The VFC program is an entitlement program (a right granted by law) for eligible children age 18 years and younger. VFC helps families of children who may not otherwise have access to vaccines by providing free vaccines to doctors who serve them. VFC is administered at the national level by the CDC that contracts with vaccine manufacturers to buy vaccines at reduced rates. Tennessee enrolls physicians in the VFC program who serve eligible children and provide routine immunizations. More than 600 private physicians, health department clinics, Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) participate in VFC in Tennessee.

Children from birth through 18 years of age who meet at least one of the following criteria are eligible to receive VFC services:
- TennCare eligible: A child who is eligible for Medicaid or enrolled in the TennCare program
- Uninsured: A child who has no health insurance coverage
- American Indian or Alaska Native: As defined by the Indian Health Care Improvement Act (25 U.S.C. 1603)
- Underinsured: A child who has commercial (private) health insurance but the coverage does not include vaccines, a child whose insurance covers only selected vaccines (VFC-eligible for noncovered vaccines only), or a child whose insurance caps vaccine coverage at a certain dollar amount. Once that coverage amount is reached, the child is categorized as underinsured. In Tennessee, underinsured children are eligible to receive VFC services only through an FQHC, RHC or local health department.

Children whose health insurance covers the cost of vaccinations are not eligible for VFC services, even when a claim for the cost of the vaccine and its administration would be denied for payment by the insurance carrier because the plan’s deductible had not been met.

VFC enrollment and re-enrollment is managed through the Tennessee Immunization Information System web portal, known as TennIIS. To enroll or re-enroll please go to https://www.tennesseeiis.gov/tnsiis and select the
Register to use TennIIS heading and follow the instructions provided. If you have questions about the enrollment process, please contact the VFC program at VFC.Enrollment@tn.gov.

Providers interested in joining the VFC program may contact the Tennessee Immunization Program at 1-800-404-3006 for enrollment information or visit https://www.tennesseeiis.gov/tnsiis.

Lead Toxicity Screening Program
All children are considered at risk and must be screened for lead poisoning. TennCare requires the use of the blood lead test when screening children for lead poisoning. Physicians should use each office visit as an opportunity for anticipatory guidance and risk assessment for lead poisoning. All children from 6 to 72 months of age are considered at risk and must be screened. Any additional diagnostic and treatment services determined to be medically necessary must also be provided to a child diagnosed with an elevated blood lead level (BLL).

Once the initial BLL screen is performed, further testing may be required. See below:

<table>
<thead>
<tr>
<th>Screening test result (µg/dL)</th>
<th>Time to confirmation testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-9</td>
<td>1-3 months</td>
</tr>
<tr>
<td>10-44</td>
<td>1 week-1 month*</td>
</tr>
<tr>
<td>45-59</td>
<td>48 hours</td>
</tr>
<tr>
<td>60-69</td>
<td>24 hours</td>
</tr>
<tr>
<td>≥ 70</td>
<td>Urgently as emergency test</td>
</tr>
</tbody>
</table>

*The higher the BLL on the screening test, the more urgent the need for confirmatory testing.

The child’s medical record must contain a laboratory report of test results. Diagnosis, treatment, education and follow-up should also be documented in the medical record.

Amerigroup is required to track and follow up with members that have an elevated BLL (blood lead result with a level equal to or higher than 5 µg/dL (or the most current level of concern for blood lead prescribed by CDC). Providers should complete the Elevated Blood Lead Level form located in Appendix A and fax it to the designated number within one week of receipt of the test results from the laboratory.

TennCare Kids Visits Reminder Program
Amerigroup has a minimum of six outreach contacts per member per calendar year in which Amerigroup provides information about TennCare Kids to members. The minimum outreach contacts include one member handbook, four quarterly member newsletters and one reminder notice issued before a screening is due. The reminder notice will include an offer of transportation and scheduling assistance.

Amerigroup has a mechanism for systematically notifying families when TennCare Kids screens are due.

Amerigroup has a process in place to follow up with members who do not get their screenings on a timely basis. This process includes provisions for documenting all outreach attempts and maintaining records of efforts made to reach out to members who have missed screening appointments or who have failed to receive regular check-ups. Amerigroup will make at least one effort per quarter in excess of the six outreach contacts to get the member in for a screening. The efforts, whether written or oral, will be different each quarter.

Amerigroup will determine if a member who is eligible for TennCare Kids has used no services within a year and will make two reasonable attempts to renotify such members about TennCare Kids. One of these attempts can be a referral to the Department of Health.
Local Health Departments
The provider agreement with a local health department must meet the minimum requirements and must also specify for the purpose of TennCare Kids screening services that:

- The local health department agrees to submit encounter data timely to Amerigroup
- Amerigroup agrees to timely process claims for services
- The local health department may terminate the agreement for cause with 30 days advance notice
- Amerigroup agrees precertification will not be required for the provision of TennCare Kids screening services

Amerigroup will reimburse contracted local health departments for TennCare Kids screenings to members under age 21 at no less than the following rates, unless specified otherwise by TennCare. Although the codes include preventive visits for individuals 21 and older, this section only requires Amerigroup to pay local health departments for the specified visits for members under age 21.

<table>
<thead>
<tr>
<th>Preventive Visits</th>
<th>85 percent of 2001 Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381 New pt. Up to 1 year</td>
<td>$80.33</td>
</tr>
<tr>
<td>99382 New pt. 1-4 years</td>
<td>$88.06</td>
</tr>
<tr>
<td>99383 New pt. 5-11 years</td>
<td>$86.60</td>
</tr>
<tr>
<td>99384 New pt. 12-17 years</td>
<td>$95.39</td>
</tr>
<tr>
<td>99385 New pt. 18-39 years</td>
<td>$93.93</td>
</tr>
<tr>
<td>99391 Estab. pt. Up to 1 year</td>
<td>$63.04</td>
</tr>
<tr>
<td>99392 Estab. pt. 1-4 years</td>
<td>$71.55</td>
</tr>
<tr>
<td>99393 Estab. pt. 5-11 years</td>
<td>$70.96</td>
</tr>
<tr>
<td>99394 Estab. pt. 12-17 years</td>
<td>$79.57</td>
</tr>
<tr>
<td>99395 Estab. pt. 18-39 years</td>
<td>$78.99</td>
</tr>
</tbody>
</table>

TennCare may conduct an audit of the Amerigroup reimbursement methodology and related processes on an annual basis to verify compliance with this requirement. In addition, the local health department may initiate the independent review procedure at any time it believes the Amerigroup payment is less than the required minimum reimbursement rate.
9 BEHAVIORAL HEALTH SERVICES

Behavioral Health Services
Amerigroup provides behavioral health services in accordance with best practice guidelines, rules and regulations, and policies and procedures set forth by TennCare. This includes mental health services such as psychiatric inpatient hospital services, 24-hour psychiatric residential treatment services, outpatient mental health services, intensive community based treatment, Tennessee Health Link, psychiatric rehabilitation services and behavioral health crisis services. All behavioral health services referenced in this area are in accordance with TennCare’s Contractor Risk Agreement.

Amerigroup also provides substance abuse treatment through inpatient, residential and outpatient services. Detoxification services can be rendered as part of inpatient, residential or outpatient services as clinically appropriate. All member detoxifications are supervised by Tennessee licensed physicians with a minimum daily re-evaluation by a physician or registered nurse.

Providers are required to inform children and adolescents for whom residential treatment is being considered, their parent(s) or legally appointed guardian, and adults for whom voluntary inpatient treatment is being considered of:

- All of their options for residential and/or inpatient placement
- Alternatives to residential and/or inpatient treatment
- Benefits, risks and limitations of each so that they can provide informed consent

Providers must inform all members being considered for prescription of psychotropic medications of the benefits, risks and side effects of the medication, alternate medications, and other forms of treatment.

Behavioral Health Services Chart

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Inpatient Hospital Services (including physician services)</td>
<td>As medically necessary</td>
</tr>
<tr>
<td>24-hour Psychiatric Residential Treatment</td>
<td>Medicaid/standard eligible, age 21 and older: As medically necessary Medicaid/standard eligible, under age 21: As medically necessary</td>
</tr>
<tr>
<td>Outpatient Mental Health Services (including physician services)</td>
<td>As medically necessary</td>
</tr>
<tr>
<td>Inpatient, Residential and Outpatient Substance Abuse Benefits</td>
<td>Medicaid/standard eligible, age 21 and older: As medically necessary Medicaid/standard eligible, under age 21: As medically necessary</td>
</tr>
<tr>
<td>Behavioral Health Intensive Community Based Treatment</td>
<td>As medically necessary</td>
</tr>
<tr>
<td>Psychiatric-Rehabilitation Services</td>
<td>As medically necessary</td>
</tr>
<tr>
<td>Behavioral Health Crisis Services</td>
<td>As medically necessary</td>
</tr>
<tr>
<td>Lab and X-ray Services</td>
<td>As medically necessary</td>
</tr>
<tr>
<td>Nonemergency Transportation (including Nonemergency Ambulance Transportation)</td>
<td>Same as for physical health (see Physical Health Benefits)</td>
</tr>
<tr>
<td>I/DD Behavioral Health Stabilization Systems of Support (SOS)</td>
<td>Time-limited, based on the needs of each member</td>
</tr>
</tbody>
</table>

1 Behavioral health access standards are in the Behavioral Health Access Standards section of this manual.
2 When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services. Methadone clinic services are not covered for adults.
Behavioral Health Specialized Service Descriptions

Behavioral Health Intensive Community Based Treatment (ICBT)

Behavioral Health Intensive Community Based Treatment (ICBT) Services provide frequent and comprehensive support to individuals with a focus on recovery and resilience. Amerigroup will ensure the provision of Behavioral Health Intensive Community Based Treatment Services to adults and youth with complex needs including individuals who are at high risk of future hospitalization or placement out of the home and require both community support and treatment interventions. Behavioral Health Intensive Community Based Treatment Services shall be rendered through a team approach which shall include a therapist and Care Coordinator who work under the direct clinical supervision of a licensed behavioral health professional. The primary goal of these services is to reach an appropriate point of therapeutic stabilization so the individual can be transitioned to less in home based services and be engaged in appropriate behavioral health office based services.

Intensive Community Based Treatment Services should include, at a minimum, the following elements and services as clinically appropriate:
- System Of Care principles
- Direct clinical supervision
- Evidenced-based comprehensive assessments and evaluations
- An average of one to two visits per week for individual therapy, family therapy or care coordination

Intensive Community Based Treatment Services shall be outcome-driven including but not limited to these treatment outcomes:
- Strengthened family engagement in treatment services
- Increased collaboration among formal and informal service providers to maximize therapeutic benefits
- Progress toward child and family goals
- Increased positive coping skills
- Increased family involvement in the community
- Developed skills to independently navigate the behavioral health system

Intensive Community Based Treatment Services include CTT, CCFT and PACT treatment models as described below:

Continuous Treatment Team (CTT)
CTT is a coordinated team of staff (to include physicians, nurses, case managers and other therapists as needed) who provide a range of intensive, care coordination, treatment and rehabilitation services to adults and children and youth. The intent is to provide intensive treatment to adults and families of children and youth with acute psychiatric problems in an effort to prevent removal from the home to a more restrictive level of care. An array of services are delivered in the home or in natural settings in the community and are provided through a strong partnership with the family and other community support systems. The program provides services including crisis intervention and stabilization, counseling, skills building, therapeutic intervention, advocacy, educational services, medication management as indicated, school-based counseling and consultation with teachers, and other behavioral health services deemed necessary and appropriate.

Comprehensive Child and Family Treatment (CCFT)
CCFT services are high intensity, time-limited, therapeutic services designed for children and youth to provide stabilization and deter from out-of-home placement. There is usually family instability and high-risk behaviors exhibited by the child/adolescent. CCFT services are concentrated on child, family and parental/guardian behaviors and interaction. CCFT services are more treatment oriented and situation specific with a focus on short-term stabilization goals.
Program of Assertive and Community Treatment (PACT)

PACT is a service delivery model for providing comprehensive community-based treatment to adults with severe and persistent mental illness. It involves the use of a multi-disciplinary team of mental health staff organized as an accountable, mobile mental health agency or group of providers who function as a team interchangeably to provide the treatment, rehabilitation and support services persons with severe and/or persistent mental illnesses need to live successfully in the community. The service components of PACT include:

1. Services targeted to a specific group of individuals with severe mental illness
2. Treatment, support and rehabilitation services provided directly by the PACT team
3. Sharing of responsibility between team members and individuals served by the team
4. Small staff (all team staff including case managers) to individual ratios (approximately 1 to 10)
5. Comprehensive and flexible range of treatment and services
6. Interventions occurring in community settings rather than in hospitals or clinic settings
7. 24 hour a day availability of services
8. Engagement of individuals in treatment and recovery

Tennessee Health Link

Tennessee Health Link is a team of professionals associated with a mental health clinic or other behavioral health provider who provides whole-person, patient-centered, coordinated care for an assigned panel of members with behavioral health conditions. Members who would benefit from Tennessee Health Link will be identified based on diagnosis, health care utilization patterns or functional need. They will be identified through a combination of claims analysis and provider referral. Health Link professionals will use care coordination and patient engagement techniques to help members manage their healthcare across the domains of behavioral and physical health including:

- Comprehensive care management (e.g., creating care coordination and treatment plans)
- Care coordination (e.g., proactive outreach and follow up with primary care and behavioral health providers)
- Health promotion (e.g., educating the patient and his/her family on independent living skills)
- Transitional care (e.g., participating in the development of discharge plans)
- Patient and family support (e.g., supporting adherence to behavioral and physical health treatment)
- Referral to social supports (e.g., facilitating access to community supports including scheduling and follow through)

Psychiatric Rehabilitation

Definition

Psychiatric rehabilitation is an array of consumer-centered recovery services designed to support the individual in the attainment or maintenance of his or her optimal level of functioning. These services are designed to capitalize on personal strengths, develop coping skills and strategies to deal with deficits and develop a supportive environment in which to function as independent as possible on the individual’s recovery journey.

The service components included under psychiatric rehabilitation are as follows:

- Psychosocial Rehabilitation is a community-based program that promotes recovery, community integration and improved quality of life for members who have been diagnosed with a behavioral health condition that significantly impairs their ability to lead meaningful lives.
- The goal of Psychosocial Rehabilitation is to support individuals as active and productive members of their communities through interventions developed with a behavioral health professional or certified peer recovery specialist, in a nonresidential setting. These interventions are aimed at actively engaging the member in services and forming individualized service plan goals that will result in measurable outcomes in the areas of educational, vocational, recreational and social support, as well as developing
structure and skills training related to activities of daily living. Such interventions are collaborative, person-centered, individualized and ultimately results in the member’s wellness and recovery being sustainable within the community without requiring the support of Psychosocial Rehabilitation.

- Psychosocial Rehabilitation must meet medical necessity criteria and may be provided in conjunction with routine outpatient services.
- Psychosocial Rehabilitation services vary in intensity, frequency, and duration in order to resolve the member’s ability to manage functional difficulties.

**Supported Employment**

Supported employment consists of evidenced based practices (e.g., individual placement and support) to assist individuals to choose, prepare for, obtain and maintain gainful employment that is based on individuals’ preferences, strengths and experiences. This service also includes support services to the individual, including side-by-side support on the job. These services may be integrated into a psychosocial rehabilitation center.

**Peer Recovery Services**

Peer recovery services are designed and delivered by people who have lived experience with behavioral health issues. A Certified Peer Recovery Specialist (CPRS) is someone who has self-identified as being in recovery from mental illness, substance use disorder, or co-occurring disorders of both mental illness and substance use disorder. In addition, a Certified Peer Recovery Specialist has completed specialized training recognized by the Tennessee Department of Mental Health and Substance Abuse Services on how to provide peer recovery services based on the principles of recovery and resiliency. Certified Peer Recovery Specialists can provide support to others with mental illness, substance use disorder, or co-occurring disorder and help them achieve their personal recovery goals by promoting self-determination, personal responsibility, and the empowerment inherent in self-directed recovery.

Under the direct clinical supervision of a licensed behavioral health professional, peer recovery services provided by a Certified Peer Recovery Specialist may include: assisting individuals in the development of a strengths-based, person-centered plan of care; serving as an advocate or mentor; developing community support; and providing information on how to successfully navigate the behavioral health care system. Activities which promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills are provided so individuals can educate and support each other in the acquisition of skills needed to manage their recovery and access resources within their communities. Services are often provided during the evening and weekend hours.

**Family Support Services**

Family support services are used to assist other caregivers of children or youth diagnosed with emotional, behavioral, or co-occurring disorders, and are provided by a Certified Family Support Specialist under the direct clinical supervision of a licensed behavioral health professional. A Certified Family Support Specialist is a person who has previously self-identified as the caregiver of a child or youth with an emotional, behavioral or co-occurring disorder and who has successfully navigated the child-serving systems to access treatment and resources necessary to build resiliency and foster success in the home, school, and community. This individual has successfully completed and passed training recognized by the Tennessee Department of Mental Health and Substance Abuse Services on how to assist other caregivers in fostering resiliency in their child based on the principles of resiliency and recovery; and has received certification from the Tennessee Department of Mental Health and Substance Abuse Services as a Certified Family Support Specialist.

These services include assisting caregivers in managing their child’s illness and fostering resiliency and hope in the recovery process. These direct caregiver-to-caregiver support services include, but are not limited to, developing formal and informal supports, assisting in the development of strengths-based family and individual goals, serving as an advocate, mentor, or facilitator for resolution of issues that a caregiver is unable to resolve.
on his or her own, or providing education on system navigation and skills necessary to maintain a child with emotional, behavioral or co-occurring disorders in their home environment.

**Illness Management & Recovery**

Illness management and recovery services refer to a series of weekly sessions with trained mental health practitioners for the purpose of assisting individuals in developing personal strategies for coping with mental illness and promoting recovery. Illness management and recovery is not limited to one curriculum but is open to all evidenced-based and/or best practice classes and programs such as WRAP (Wellness Recovery Action Plan).

**Support Housing**

Supported housing services refer to transitional services rendered at facilities that provide behavioral health staff supports for individuals who require treatment services in a highly structured, safe, and secure setting. Supported housing services are for TennCare Priority Enrollees and are intended to prepare individuals to live independently in a community setting. At a minimum, supported housing services include coordinated and structured personal care services to address the individuals’ behavioral and physical health needs in addition to 15 hours per week of psychosocial rehabilitation services to assist individuals in achieving recovery and resiliency based goals and developing the life skills necessary to live independently in a community setting. The required 15 hours per week of psychosocial rehabilitation is not inclusive of the psychosocial rehabilitation services received in day programs. Supported housing services do not include the payment of room and board.

**I/DD Behavioral Health Stabilization Systems of Support (SOS)**

Amerigroup provides I/DD Behavioral Health Stabilization SOS services according to I/DD Behavioral Health Stabilization SOS standards set by TennCare. I/DD Behavioral Health Stabilization SOS is a comprehensive, person-centered approach to the delivery of behavioral health crisis prevention, intervention and stabilization services for individual with intellectual and developmental disabilities (I/DD) who experience challenging behaviors that place themselves and others at risk of harm. The system is designed to provide a full array of necessary behavioral services and supports for individuals with I/DD and co-occurring mental health and/or behavioral disorder including behavioral health crisis prevention, intervention, stabilization and when necessary, inpatient services.

This proactive model is designed to improve quality of life by promoting behavioral crisis planning and prevention. Behavioral health crisis prevention includes person-centered assessment and planning and will require the development of an individualized crisis plan that includes linkage, coordination and collaboration with current state crisis teams.

The contracted I/DD Systems of Support provider will be the first point of contact in crisis events for members that have been enrolled into the Systems of Support program. The provider will assess the member for the purpose of stabilization in the individual’s environment, however should the member need further assessment for potential hospitalization; the provider will collaborate with our state crisis service teams.

**Procedures for Requesting Psychological or Neuropsychological Testing**

To request psychological or neuropsychological testing, providers must complete the Request for Authorization-Psychological Testing Authorization form or the Behavioral Health Neuropsychological Testing form (see Appendix A — Forms). All sections of the forms must be completed in full as may not be able to process incomplete requests.
The completed form should be faxed to 1-800-505-1193 or mailed to:

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

Providers will be notified of the disposition of the request within the time standards for completing noncurrent preservice requests.

### Behavioral Health Access Standards

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Geographic Access Requirement</th>
<th>Maximum Time for Admission/Appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychiatric Inpatient Hospital Services</strong></td>
<td>Transport access ≤ 90 miles travel distance and ≤ 120 minutes travel time for all child and adult members.</td>
<td>4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)</td>
</tr>
<tr>
<td><strong>24-hour Psychiatric Residential Treatment</strong></td>
<td>Not subject to geographic access standards.</td>
<td>Within 30 calendar days</td>
</tr>
<tr>
<td><strong>Outpatient (non-MD services)</strong></td>
<td>Transport access ≤ 30 miles travel distance and ≤ 45 minutes travel time for at least 75% of child and adult members and ≤ 60 miles travel distance and ≤ 60 minutes travel time for all child and adult members.</td>
<td>Within 10 business days; if urgent, within 48 hours</td>
</tr>
<tr>
<td><strong>Intensive Outpatient (may include day treatment (adult), intensive day treatment (children and adolescent) or partial hospitalization)</strong></td>
<td>Transport access ≤ 90 miles travel distance and ≤ 90 minutes travel time for 75% of child and adult members and ≤ 120 miles travel distance and ≤ 120 minutes travel time for all child and adult members.</td>
<td>Within 10 business days; if urgent, within 48 hours</td>
</tr>
<tr>
<td><strong>Inpatient Facility Services (substance abuse)</strong></td>
<td>Transport access ≤ 90 miles travel distance and ≤ 120 minutes travel time for all child and adult members.</td>
<td>Within two calendar days; for detoxification — within four hours in an emergency and 24 hours for nonemergency</td>
</tr>
<tr>
<td><strong>24-hour Residential Treatment Services (substance abuse)</strong></td>
<td>Not subject to geographic access standards.</td>
<td>Within 10 business days</td>
</tr>
<tr>
<td><strong>Outpatient Treatment Services (substance abuse)</strong></td>
<td>Transport access ≤ 30 miles travel distance and ≤ 30 minutes travel time for 75% of child and adult members and ≤ 45 miles travel distance and ≤ 45 minutes travel time for all child and adult members.</td>
<td>Within 10 business days; for detoxification — within 24 hours</td>
</tr>
<tr>
<td><strong>Opioid Use Disorder (OUD) Treatment Providers (providers treating with Buprenorphine)</strong></td>
<td>Transport access ≤ 45 miles travel distance and ≤ 45 minutes travel time for at least 75% of non-dual members and ≤ 60 miles travel distance and ≤ 60 minutes travel time for ALL non-dual members</td>
<td>Within 10 business days</td>
</tr>
<tr>
<td>Service Type</td>
<td>Geographic Access Requirement</td>
<td>Maximum Time for Admission/Appointment</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Intensive Community Based Treatment Services</td>
<td>Not subject to geographic access standards.</td>
<td>Within seven calendar days</td>
</tr>
<tr>
<td>Tennessee Health Link Services</td>
<td>Not subject to geographic access standards.</td>
<td>Within 30 calendar days</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation (may include supported employment, illness management and recovery, peer recovery services or family support)</td>
<td>Not subject to geographic access standards.</td>
<td>Within 10 business days</td>
</tr>
<tr>
<td>Supported Housing</td>
<td>Not subject to geographic access standards.</td>
<td>Within 30 calendar days</td>
</tr>
<tr>
<td>Crisis Services (mobile)</td>
<td>Not subject to geographic access standards.</td>
<td>Face-to-face contact within two hours for emergency situations and four hours for urgent situations</td>
</tr>
<tr>
<td>Crisis Stabilization</td>
<td>Not subject to geographic access standards.</td>
<td>Within four hours of referral</td>
</tr>
</tbody>
</table>

*24-hour residential treatment substance abuse services may be provided by facilities licensed by TDMHSAS as Halfway House Treatment Facilities (TDMHSAS Rule Chapter 0940-05-41), Residential Detoxification Treatment Facilities (TDMHSAS Rule Chapter 0940-05-44) or Residential Rehabilitation Treatment Facilities (TDMHSAS Rule Chapter 0940-05-45).

**Coordination of Behavioral Health**

Amerigroup network providers are required to notify a member’s PCP when the member first enters behavioral health care and anytime there is a significant change in care, treatment or need for medical services, provided that the behavioral health provider has secured the necessary release of information. The minimum elements to be included in such correspondence are:

- Patient demographics
- Date of initial or most recent behavioral health evaluation
- Recommendation to see PCP if medical condition identified or need for evaluation by a medical practitioner has been determined for the enrollee (e.g., EPSDT screen, complaint of physical ailments)
- Diagnosis and/or presenting behavioral health problem(s)
- Prescribed medication(s)
- Behavioral health clinician’s name and contact information

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

- Ongoing communication and coordination between PCPs and specialty providers including behavioral health (mental health and substance abuse) providers
- Screening for co-occurring disorders including:
  - Behavioral health screening by PCPs
  - Medical screening by behavioral health providers
  - Screening of mental health patients for co-occurring substance abuse disorders
  - Screening of consumers in substance abuse treatment for co-occurring mental health and/or medical disorders
- Screening tools for PCPs and behavioral health providers that can be located at [https://providers.amerigroup.com](https://providers.amerigroup.com)
Referrals to PCPs or specialty providers, including behavioral health providers, for assessment and/or treatment for consumers with co-occurring disorders

Development of individualized treatment plans for each consumer and coordinating those plans with the PCP and/or other active specialty providers

Case management and population health programs to support the coordination and integration of care between providers

Consultation for providers wishing assistance in coordinating care for consumers with co-occurring disorders through the Amerigroup Provider Services line

Recovery and Resiliency

All behavioral health services shall be rendered in a manner that supports the recovery of persons experiencing mental illness and enhance the development of resiliency of children and families who are impacted by mental illness, serious emotional disturbance and/or substance abuse issues. Recovery is a consumer-driven process in which consumers are able to work, learn and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life with a disability. The Substance Abuse and Mental Health Services Administration (SAMHSA) has released a consensus statement on mental health recovery. The components listed in this consensus statement are reflective of TDMHSAS’s desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency.

The 10 fundamental components of recovery include:

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

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

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

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

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

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

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

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

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

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

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

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

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

Source: TDMHSAS
Training

Amerigroup must monitor and ensure all participating providers that deliver Behavioral Health services provide relevant staff with training in accordance with TDMHSAS requirements. As a contracted provider of Amerigroup, your organization is required to provide training to your staff as appropriate. Your organization is also responsible for complying with any updates in training requirements, which can be found on the TDMHSAS website at https://www.tn.gov/behavioral-health/for-providers.html. Additionally, Amerigroup will conduct audits to ensure compliance with training requirements.

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<th>Training Topic</th>
<th>Staff to Receive</th>
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| **Consumer Rights and Responsibilities**                                        | Any staff member, licensed staff and those for whom a license is not required      | • Initially within the first 90 days of employment either through training or assessment of competency  
• Every three years thereafter either through retraining or assessment of competency |
| Consumer rights and responsibilities, including (as appropriate) such topics as consumer advocacy and alternative decision making, educational rights, declarations for mental health treatment, durable power of attorney, guardianship and conservatorships* |                                                                                  |                                                                                          |
| **Cultural Competence and Diversity**                                           | Any staff member, licensed staff and those for whom a license is not required      | • Initially within the first 90 days of employment either through training or assessment of competency  
• Annually thereafter either through retraining or assessment of competency |
| Cultural competence — recognizing any unique aspects of members; these may include language, dress, traditions, notions of modesty, eye contact, health values, help-seeking behaviors, work ethics, spiritual values, attitudes regarding treatment of mental illness and substance abuse, concepts of status and issues of privacy and personal boundaries |                                                                                  |                                                                                          |
| **Prevention/Intervention and Recovery/Resiliency Strategies**                  | Any direct care staff member, licensed staff and those for whom a license is not required | • Initially within the first 90 days of employment either through training or assessment of competency  
• Every three years thereafter either through re-training or assessment of competency |
| Prevention and intervention techniques to address the management of potentially aggressive behavior |                                                                                  |                                                                                          |
| Recovery and resiliency-based approaches to providing services*                 | Any direct care staff member, licensed staff and those for whom a license is not required | • Initially within the first 90 days of employment either through training or assessment of competency  
• Every three years thereafter either through re-training or assessment of competency |
<p>| <strong>Behavioral Health/Substance Use Disorders and Associated Medical Conditions and Care</strong> |                                                                                  |                                                                                          |
| Etiology, treatment and diagnostic categories of mental illness; serious emotional disturbance; substance use and/or abuse; physical and sexual abuse; suicidal ideation; developmental disabilities and mental retardation, as | Any direct care staff member for whom a license is not required | • Initially within the first 90 days of employment either through training or assessment of competency  |</p>
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<td>• Family psychoeducation</td>
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<td>• Program of Assertive and Community Treatment (PACT)</td>
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<td>• Integrated co-occurring disorders treatment (substance use and mental illness)*</td>
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<td>TDMHSAS Best Practice Guidelines – adult behavioral health services and</td>
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<td>behavioral health services for children and adolescents*</td>
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<td>drug reactions and medication use in pregnancy and lactation.*</td>
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<td>Persons in the following categories may be exempted: physicians, pharmacists,</td>
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<td>nurse practitioners and physician assistants</td>
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| **System of care values and principles for the treatment of children and adolescents that are child-centered and family-focused, community-based, culturally-competent and evaluated for effectiveness in addition to wraparound supports tailored to fit the individual child and family unit** Resource: [https://www.tn.gov/behavioral-health/mental-health-services/mental-health-services-for-children-and-youth/system-of-care-initiative.html](https://www.tn.gov/behavioral-health/mental-health-services/mental-health-services-for-children-and-youth/system-of-care-initiative.html) | Any staff member for whom a license is required that works directly with children and adolescents and their families | - Initially within the first 90 days of employment either through training or assessment of competency  
- Every three years thereafter either through retraining or assessment of competency |
| **Age appropriate developmental principles and EPSDT requirements for children and adolescents** | Any staff member for whom a license is required that works directly with service recipients age 20 and under | - Within the first 90 days of employment either through training or assessment of competency |
| **Tennessee Health Link principles, assessment for treatment planning, intervention techniques, philosophy and facilitating access to community resources** | Tennessee Health Link staff and Tennessee-certified peer support specialists, as applicable | - Initially within the first 90 days of employment either through training or assessment of competency  
- Every three years thereafter either through retraining or assessment of competency |
| **Crisis Services Curriculum** | Crisis services staff and Tennessee-certified peer support specialists as applicable | - Initially within the first 90 days of employment either through training or assessment of competency  
- Every three years thereafter either through retraining or assessment of competency |
| **Psychiatric Rehabilitation Principles** | Staff at psychiatric rehabilitation facilities or facilities that implement psychiatric rehabilitation programs that work directly with service recipients, as well as Tennessee-certified peer support specialists | - Initially within the first 90 days of employment either through training or assessment of competency  
- Every three years thereafter either through retraining or assessment of competency |

*Training should be appropriate to the type of staff and the population served.

Documentation of training and/or competency should be maintained by the agency in which staff members are employed.

- Documentation may take the form of:
  - Certificates
- Descriptions of training PLUS sign-in sheets
- Letters of confirmation

Competence will be determined by the agency. One or more of the following tools might be used as documentation:

- Posttest results
- Supervisor check-off forms

Staff members currently employed with a provider will have one year after the effective date of a provider’s contract with an MCC to receive any trainings listed above that they have not already successfully completed. Required training may be obtained either through the agency/provider or through outside entities that offer continuing education unit (CEU) credits or contact hours. The agency/provider may accept comparable training completed within one year prior to employment if the employee has demonstrated competence in the area.

**Member Records and Treatment Planning**

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

1. Information related to the provision of appropriate services to a member must be included in his or her record to include documentation in a prominent place whether there is an executed declaration for mental health treatment.

2. For members in the priority population, a comprehensive assessment that provides a description of the consumer’s physical and mental health status at the time of admission to services. This comprehensive assessment covers:
   - A psychiatric assessment which includes:
     - Description of the presenting problem
     - Psychiatric history and history of the member’s response to crisis situations
     - Psychiatric symptoms
     - Diagnosis using the most current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM)
     - Mental status exam
     - History of alcohol and drug abuse
   - A medical assessment that includes:
     - Screening for medical problems
     - Medical history
     - Present medications
     - Medication history
   - A substance use assessment that includes frequently used over-the-counter medications, alcohol and other drugs and history of prior alcohol and drug treatment episodes. The history should reflect impact of substance use in the domains of the community functioning assessment.
   - A community functioning assessment or an assessment of the member’s functioning in the following domains:
     - Living arrangements, daily activities (vocational/educational)
     - Social support
     - Financial
     - Leisure/recreational
     - Physical health
     - Emotional/behavioral health
   - An assessment of the member’s strengths, current life status, personal goals and needs.
3. An individualized treatment plan, which is based on the psychiatric, medical, substance use and community functioning assessments listed above, must be completed for any member who receives behavioral health services for 30 calendar days or longer.
   - The treatment plan must be completed within the first 30 days of admission to behavioral health services and updated every six months, or more frequently as necessary based on the member’s progress towards goals or a significant change in psychiatric symptoms, medical condition and/or community functioning.
   - Provide documentation that the member and, as appropriate, his or her family members or legal guardian, participated in the development and subsequent reviews of the treatment plan.
   - For providers of multiple services, one comprehensive treatment plan is acceptable as long as at least one goal is written and updated as appropriate for each of the different services that are being provided to the member.
   - The treatment plan must contain the following elements:
     - Identified problem(s) for which the member is seeking treatment
     - Member goals related to problem(s) identified
     - Measurable objectives to address the goals identified
     - Target dates for completion of objectives
     - Responsible parties for each objective
     - Specific measurable action steps to accomplish each objective
     - Individualized steps for prevention and/or resolution of crisis, which includes identification of crisis triggers (situations, signs and increased symptoms); active steps or self-help methods to prevent, de-escalate or defuse crisis situations; names and phone numbers of contacts that can assist the member in resolving crisis; and the member’s preferred treatment options, to include psychopharmacology, in the event of a mental health crisis

4. Progress notes are written to document status related to goals and objectives indicated on the treatment plans.

5. Correspondence concerning the member’s treatment and signed and dated notations of telephone calls concerning the member’s treatment.

6. A brief discharge summary must be completed within seven calendar days following discharge from services or death.

7. Discharge summaries for psychiatric hospital and residential treatment facility admissions that occur while the member is receiving behavioral health services.

**Behavioral Health Supervision for Nonlicensed Clinicians**

Amerigroup expects ongoing supervision is provided by mental health/substance abuse facilities/CMHC providers who employ nonlicensed clinical staff to complete clinical activities (such as clinical assessments and psychotherapy). The facility should ensure all nonlicensed clinicians are regularly supervised by a licensed clinician. The supervising clinician will have regular, in-person, one-on-one supervision with the noncredentialed clinician to review the treatment and services provided to members.

Under the supervision of an independently licensed clinician, nonlicensed master’s level clinicians who render behavioral health professional services must receive clinical supervision specific to the rendered service. The supervision will include a minimum of direct supervision during service initiation, which may be followed by general supervision for the remainder of the service at the discretion of the supervisory practitioner.

- **Direct supervision** means the supervising provider must be immediately available (i.e., in person, by phone or through telehealth/video conferencing) to furnish assistance and direction throughout the rendered service and may include the supervisor’s review and signing of the treatment plan during service initiation.
• **General supervision** means the service is performed under the supervisory clinician’s overall direction and control but his or her presence is not required during the performance of the intervention.

**Crisis Services**

**Definition**
Behavioral health crisis services shall be rendered to individuals with a mental health or substance use/abuse issue when there is a perception of a crisis by an individual, family member, law enforcement, hospital staff or others who have closely observed the individual experiencing the crisis. Crisis services are available 24 hours a day, 7 days a week. Crisis services include 24-hour toll-free telephone lines answered in real time by trained crisis specialists and face-to-face crisis services including but not limited to: prevention, triage, intervention, evaluation/referral for additional services/treatment, and follow-up services. Certified peer recovery specialists and/or certified family support specialists shall be utilized in conjunction with crisis specialists to assist adults and children in alleviating and stabilizing crises and promote the recovery process as appropriate. Behavioral health crisis service providers are not responsible for pre-authorizing emergency involuntary hospitalizations.

The Mental Health Crisis Response Services Community Face-to-Face Response Protocols provide guidance for calls that are the responsibility of a crisis response service to determine if a face-to-face evaluation is warranted and those that are not the responsibility of the crisis response service. These Protocols were developed to ensure that consumers who are experiencing a behavioral health crisis and have no other resources receive prompt attention. All responses are first determined by clinical judgment.

**Guidance for All Calls**
- For calls originating from an emergency department, telehealth is the preferred service delivery method for the crisis response service.
- After determining there is no immediate harm, ask the person if they can come to the closest walk-in center.
- If a Mandatory Prescreening Agent (MPA) not employed by a crisis response service is available, there may be no need for a crisis evaluation by mobile crisis.
- For all other calls, unless specified in the protocols, if a person with mental illness is experiencing the likelihood of immediate harm, then a response is indicated.

**Mandatory Prescreening Agent**
Tennessee law requires a face-to-face evaluation, known as prescreening, of each member in crisis to assess eligibility for emergency involuntary admission to a Regional Mental Health Institute (RMHI) and to determine whether all available, less drastic, alternative services and supports are unsuitable to meet the member’s needs. An MPA is required to complete one of the certificates of need (CONs) prior to an emergency admission to a RMHI. Private hospitals that have been approved by TDMHSAS and accept the authority of an MPA may also accept CONs from an MPA for emergency involuntary admissions.

**Behavioral Health Crisis Respite**
All behavioral health crisis service providers must provide access to crisis respite 24 hours a day, 7 days a week for all members meeting guidelines for this level of treatment including:
- Diagnosed or suspected mental illness
- Mental status exam reveals no immediate intent to harm self or others
- Respite is deemed a safe level of treatment
- Respite would be an appropriate and beneficial level of treatment

Behavioral health crisis respite services are intended to provide immediate shelter to those members with emotional/behavioral problems who are in need of emergency respite. These services involve short-term respite
with overnight capacity for room and board, while meeting the member’s crisis need(s). Trained crisis respite staff members typically provide crisis respite. However, others who are deemed appropriate by crisis staff members may render respite services. For children/youth, authorization must be given for the use of crisis respite services by the parent, legal guardian, legal custodian, legal caretaker or court with appropriate jurisdiction.

If a behavioral health crisis respite service provider is unable to obtain a current treatment plan, then the behavioral health crisis respite service provider will complete a respite plan that is developed and agreed upon in writing by the member, respite staff and family/care givers/support system as applicable. The plan should include actions to attain stabilization or alleviation of the crisis situation. Crisis respite must be rendered in a community location approved by the managed care company or a site licensed by TDMHSAS that can be facility-based, home-based or hospital-based in nature, depending on the need and availability.

Behavioral health crisis respite services will continue to be utilized by those members that continue to be serviced on the DIDDS (Department of Intellectual and Developmental Disabilities) waiver to provide immediate shelter to I/DD members with emotional/behavioral problems who are in need of emergency respite in the event that the member cannot be stabilized in the current living environment. These services are delivered by contracted providers in community locations approved by the health plan.

Facility-Based Crisis Respite Services
Crisis respite services that use a placement in a facility with direct care from trained crisis respite staff in direct response to a consumer’s acuity level based on the assessment of risk.

Home-Based Crisis Respite Services
Crisis respite services that use a placement in a home approved by the behavioral health crisis services provider with direct care from trained crisis respite staff or family members/significant others in direct response to a consumer’s acuity level based on the assessment of risk.

Hospital-Based Crisis Respite Services
Crisis respite services that use hospital emergency rooms or other acute psychiatric services based on the assessment of risk to the member and/or the need for a medically supervised setting.

Crisis Stabilization Services
Crisis stabilization services are short-term supervised care services, accessed to prevent further increase in symptoms of a behavioral health illness or to prevent acute hospitalization. Crisis stabilization services are more intensive than regular crisis respite services in that they require more secure environments, highly trained staff, and have typically longer stays. For adults, these services are provided in Crisis Stabilization Units licensed by TDMHSAS. Crisis stabilization services should include availability and utilization of the following types of services on a short-term basis as appropriate:

- Individual and/or family counseling/support
- Medication management/administration
- Stress management counseling
- Individualized treatment plan development that empowers the consumer
- Mental illness/substance abuse awareness/education
- Identification and development of natural support systems

If a crisis stabilization service provider is not able to obtain a current treatment plan, then the crisis stabilization services provider shall complete a crisis stabilization plan that is developed and agreed upon in writing by the individual, staff and the individual’s significant others if appropriate. This plan identifies services and assistance needed to achieve stabilization as well as the components needed for discharge or transition to a lower level of
care. Discharge/transition plans are to address what criteria are needed for the individual to move safely to a less restrictive level of care. This plan may also detail what is needed to move an individual to a higher level of care if it is deemed appropriate.

**Follow-Up Services**

Follow-up services can be telephone call(s) or face-to-face assessment(s) between crisis staff and the member following crisis intervention, respite or stabilization to ensure the safety of the member until treatment is scheduled or treatment begins and/or the crisis is alleviated and/or stabilized. Follow-up services can include crisis services contacting the member only one time or can include several contacts a day for several days as deemed appropriate by crisis staff.

A follow-up contact with the member must be made within 12 hours of an MPA face-to-face assessment or anytime a physician or psychologist conducts a face-to-face assessment because an MPA was not available within two hours when it is determined that psychiatric inpatient criteria is not met. A follow-up contact with the member must be made within 24 hours of a crisis specialist face-to-face assessment that does not involve an MPA or a physician or psychologist acting in place of an MPA when it is determined that psychiatric inpatient criteria is not met. Should a crisis specialist’s face-to-face assessment result in psychiatric inpatient criteria being met, contact with the inpatient facility to verify admission must be completed within 24 hours.

**Adverse Occurrences**

Adverse occurrence reports must be reported by each network provider to all appropriate agencies and Amerigroup as required by licensure and state and federal laws within the specified time frames required immediately following the event.

The applicable providers required to report are:

- Inpatient psychiatric hospitals
- Psychiatric residential treatment centers
- Substance abuse inpatient psychiatric hospitals
- Substance abuse residential treatment centers
- Crisis stabilization units

The reportable categories of incidents are:

- Suicide death
- Nonsuicide death
- Death, cause unknown
- Homicide
- Homicide attempt with significant medical intervention*
- Suicide attempt with significant medical intervention*
- Accidental injury with significant medical intervention*
- Use of restraints or seclusion (physical, chemical or mechanical) requiring significant medical intervention*
- Treatment complications (medical errors and adverse medical reactions) requiring significant medical intervention.*
- Elopement (specific to inpatient and residential services only, as related to minors or involuntary admits for adults)
- Allegation of physical, sexual or verbal abuse or neglect, including peer-to-peer
- Medical emergency (e.g., heart attack, medically unstable, etc.)

* For purposes of behavioral health adverse occurrences, significant medical intervention is defined as requiring an ER visit or inpatient hospital stay.
Adverse occurrences should be reported within 24 hours of detection or notification. A form for reporting these incidents is included in the Forms section of this manual and on our provider website. Providers should complete all portions of the form and fax to 1-877-423-9976. Any questions concerning this form may be directed to the Quality Management department at 615-316-2400.
10 MEMBER ENROLLMENT

Member Enrollment Process
The Division of TennCare will process all member enrollments. Enrollment will begin at 12:01 a.m. on the effective date of enrollment with Amerigroup and will end at midnight on the date that the enrollee is disenrolled from Amerigroup. After becoming eligible for TennCare and enrolling in Amerigroup (whether the result of selection by the enrollee or assignment by TennCare), enrollees will have one opportunity, anytime during the 45-day period immediately following the effective date of enrollment with Amerigroup or the date TennCare sends the member notice of enrollment in Amerigroup, whichever is later, to request to change MCOs. Children eligible for TennCare as a result of being eligible for SSI may request to enroll in another MCO or re-enroll with TennCare Select during this 45-day period.

TennCare will provide an opportunity for members to change MCOs (excluding TennCare Select) every 12 months. Children eligible for TennCare as a result of being eligible for SSI may request to enroll in another MCO or re-enroll with TennCare Select every 12 months.

Members who do not select another MCO will be deemed to have chosen to remain with their current MCO.

A member may request disenrollment or be disenrolled if:
- The member chooses another MCO during the 45-day change period after the member’s enrollment is effective
- The member chooses another MCO during the annual choice period
- An appeal by the member to change MCOs based on hardship criteria (pursuant to TennCare rules and regulations) is decided by TennCare in favor of the member
- The member is assigned incorrectly to the MCO by TennCare and requests enrollment in another MCO
- The member moves outside the Amerigroup service area
- During the appeal process, if TennCare determines it is in the best interest of the enrollee and TennCare
- The member loses eligibility for TennCare
- TennCare grants the member the right to terminate enrollment and the member exercises that right
- Amerigroup no longer participates in TennCare

Newborn Enrollment Process
TennCare-eligible newborns and their mothers, to the extent that the mother is eligible for TennCare, should be enrolled in the same MCO with the exception of newborns who are SSI eligible at birth. Newborns who are SSI eligible at birth will be assigned to TennCare Select but the parent or guardian may choose to opt out of TennCare Select and choose Amerigroup as the baby’s MCO.

Member Eligibility Listing
The PCP may access a listing of his or her panel of assigned members online at https://providers.amerigroup.com. If a member calls to change his or her PCP, the change will be effective as of the date of the request, unless the member has been seen by his or her assigned PCP on the same date of the request. If this is the case, the effective date will be the next business day. The PCP should verify that each Amerigroup member receiving treatment in his or her office is on the PCP’s membership listing. For questions regarding a member’s eligibility, providers may access https://providers.amerigroup.com or call the automated provider inquiry line at 1-800-454-3730.
**Member Identification Cards**

Each Amerigroup member will be provided an identification card, which identifies the member as a participant in the TennCare program within 30 calendar days of notification of enrollment into Amerigroup or prior to the member’s enrollment effective date. The identification card will include:

- The member’s identification number
- The member’s name (first and last name and middle initial)
- The member’s date of birth
- The member’s enrollment effective date
- Phone numbers for information and/or authorizations including for behavioral health services
- Descriptions of procedures to be followed for emergency or special services
- Copay responsibility
- The HIPAA adopted identifier
- The words Medicaid or Standard based on eligibility
- The appropriate Amerigroup address and telephone number
- The PCP’s name

**Amerigroup member identification card sample:**

![Amerigroup Identification Card Sample](image-url)

**Front**

- **Effective Date:** Date of Birth
- **ID Number:** Benefit Indicator

**Back**

- **MEMBERS:** Please the card at all times. Store this card before you get medical care. You do not need to show this card before you get emergency care. If you have an emergency, call 911 or go to the nearest emergency room. Always call your Amerigroup PCP for nonemergency care. If you have questions, call Member Services at. If you are deaf or hard of hearing, please call 711.
- **HOSPITALS:** Preauthorization certification is required for all nonemergency admissions including outpatient surgery. For emergency admissions, notify Amerigroup within one business day after treatment at.
- **SUBMIT CLAIMS TO:**
  - Amerigroup P.O. Box 51010  Virginia Beach, VA 23456-5110

**TN-PM-0034-18**
11 MEMBER MANAGEMENT SUPPORT

Welcome Call
As part of our member management strategy, Amerigroup offers a welcome call to new members. Additionally, Member Services representatives offer to assist the member with any current needs such as scheduling an initial checkup and transportation to the appointment if needed.

Appointment Scheduling
Amerigroup, through its participating providers, ensures that 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 an Amerigroup member’s needs and requests in a timely manner. The PCP must schedule members for appointments using the guidelines outlined in the section of this manual entitled PCP Access and Availability.

Member Missed Appointments
Members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. Amerigroup requires providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling the 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.

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 1-800-454-3730 to address the situation. Amerigroup staff will contact the member and provide more extensive education and/or case management as appropriate. The goal of Amerigroup is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCP. Providers may not bill members for missed appointments.

Nonadherent Members
Amerigroup recognizes that providers may need help in managing nonadherent members. If you have an issue with a member regarding behavior, treatment cooperation and/or completion of treatment and/or making or appearing for appointments, please contact our Provider Services at 1-800-454-3730.

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

Member Dismissal
The provider may determine that the member should be dismissed from his or her panel. The provider must send a certified letter to the member or head of household indicating that the member must select a new PCP within 30 days of the notice. The provider must continue to provide care until the effective date for assignment to the new PCP. A copy of the letter must be mailed to the National Customer Care department at:

National Customer Care
Amerigroup Community Care
22 Century Boulevard, Suite 220
Nashville, TN 37214
24-hour Nurse HelpLine
The 24-hour Nurse HelpLine provides triage services and helps direct members to appropriate levels of care. The 24-hour Nurse HelpLine telephone number is 1-800-600-4441 and is listed on the member’s ID card. This ensures that members have an additional avenue of access to health care information when needed. Available 24 hours a day, 7 days a week, the Nurse HelpLine is a service designed to support the provider by offering information and education to members after normal physician practice hours about medical conditions, health care and prevention. The 24-hour Nurse HelpLine includes:
- Information based upon nationally recognized and accepted guidelines
- Free translation services for 170 different languages and for members with difficulty hearing, use of a TDD line
- Education for members about appropriate alternatives for handling nonemergent medical conditions

A member’s assessment report will be faxed to the member’s provider office within 24 hours of receipt of a call to the 24-hour Nurse HelpLine.

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

Amerigroup manages projects that offer our members education and information regarding their health. Ongoing projects include:
- A quarterly member newsletter
- The creation and distribution of Ameritips, a health education tool used to inform members of health promotion issues and topics
- Health Tips on Hold, recordings of educational telephone messages while a member is on hold
- A monthly calendar of health education programs offered to members
- The development of health education curricula and procurement of other health education tools (e.g., breast self-exam cards)
- Partnering with providers to offer Clinic Day events promoting the patient/physician relationship and closure of care gaps
- Providing various member and provider incentives aimed at improving clinical outcomes
- Relationship development with community-based organizations to enhance opportunities for members

Population Health
Our Population Health program is part of a comprehensive Healthcare Management Services program that offers a continuum of services including wellness, low- and high-risk maternity, health risk management, care coordination, chronic care management and complex case management. Members are stratified at regular intervals for the various population health programs. The stratification is based on risk and includes many factors including pharmacy and other utilization data, and other available information concerning health risks. These programs are based on a system of coordinated care management interventions and communications designed to assist physicians and other health care professionals in managing members with chronic conditions. Services include a holistic, member-centric care management approach that allows case managers to focus on multiple needs of members.
Wellness
Members identified as eligible for our Wellness program receive quarterly member newsletters that address specific topics focused on health promotion and disease prevention.

Health Risk Management
Members in our Health Risk Management program receive educational materials based on their primary conditions intended to emphasize self-management strategies for healthy behaviors such as accessing health care services, maintaining collaborative working relationships with providers, practicing good health habits, maintaining a healthy weight through activity and nutrition, being tobacco-free, and promoting self-monitoring activities. Members will receive an introductory package upon enrollment in Health Risk Management, which will also provide information on the availability of nurse coaching for members who choose to participate.

Chronic Care Management
Our Chronic Care Management program offers a continuum of targeted interventions, education and enhanced access to services intended to encourage member self-management. Chronic Care Management supports members through screenings, assessments and tailored interventions. Through the utilization of these tools, the member’s behavioral, social and physical health care needs are addressed while working collaboratively with the case manager. Members enrolled in Chronic Care Management will receive condition-specific educational materials that address:

- Information about their primary diagnoses
- Self-management strategies
- Medication adherence
- Coordination of services

Low- and High-Risk Maternity
The Low- and High-Risk Maternity programs provide varying levels of support based on the member’s clinical risk factors. Once identified as pregnant from enrollment, the OB screener weighted questions stratify the member based on responses and assign a score of low, medium, high or urgent risk OB. Certain behaviors or fast track question responses indicative of smoking or substance use during pregnancy will flag a member as high risk OB. Pregnant members considered low-to-medium risk are assigned to the Low-Risk Maternity program. Pregnant members considered a high-to-urgent risk are assigned to the High-Risk Maternity program.

All identified pregnant members, regardless of stratification level, receive the Taking Care of Baby and Me© program packets. Included in the packets are educational materials and information on rewards to encourage the members to make and keep prenatal and postpartum appointments. All pregnant members have access to educational materials and access to the 24-hour Nurse HelpLine to call for questions or to learn more about the Low- or High-Risk Maternity program. Taking Care of Baby and Me packets and the number of rewards used by members are tracked and reported.

As part of the Taking Care of Baby and Me program, all pregnant members are offered the My Advocate™ program regardless of stratification. This program provides pregnant women proactive, culturally appropriate outreach and education through Interactive Voice Response (IVR), text or smart phone application. This program does not replace the high-touch case management approach for high-risk pregnant women. However, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high-risk, to facilitate connections between them and our case managers, and improve member and baby outcomes. Eligible members receive regular calls with tailored content from a voice personality (Mary Beth). For more information on My Advocate, visit https://myadvocatehelps.com.
**Care Coordination**
Members from any Population Health program are eligible at any time for Care Coordination enrollment. Members may benefit from care coordination services when they have short-term, immediate, targeted needs and do not require complex case management services. Additionally, members who have more intensive needs and are appropriate for complex case management but refuse those services may be appropriate for Care Coordination services. Members engaged in Care Coordination may receive various interventions including:

- Assistance with resources such as transportation and pharmacy benefits
- Arranging PCP appointments
- Telephonic contact for coaching
- Mailings of disease-specific educational materials
- Information regarding Amerigroup On Call (24-hour Nurse HelpLine)

**Complex Case Management**
We administer an initial health risk assessment to members who are identified for and agree to enroll in the Complex Case Management program. The case manager assesses the member’s total health care needs in a holistic manner including physical, behavioral, functional, cognitive and social factors. As part of the assessment process, the case manager completes a gap analysis to determine health care needs and prioritize goals. Upon identification of health care needs, the case manager will work with the member, his or her health care providers, and the member’s family and caregivers to develop interventions to support the achievement of the identified health goals. Interventions may include:

- Health education
- Interpretation of benefits
- Community resource referrals
- Post-discharge service authorizations and member outreach (e.g., DME, home health services and coordination of physician appointments)
- Service coordination
- Medication reconciliation review
- Assistance in developing a self-management plan
- Community-based services (e.g., home or hospital visits)
- Provider-based intensive case management (behavioral health)
- Special needs program interventions
- Ongoing assessment of barriers to meeting goals or complying with the care plan
- Interventions to address those barriers

**Program Features:**
- Proactive population identification processes
- Evidence-based national practice guidelines from recognized sources
- 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 management for high-risk members
- Ongoing process and outcomes measurement, evaluation and management
- Ongoing communication with providers regarding patient status

Additionally, all Amerigroup programs are based on nationally-approved Clinical Practice Guidelines located at https://providers.amerigroup.com/TN. Under Provider Resources & Documents, select Clinical Practice
Guidelines. A copy of the guidelines can be printed from the website or upon request by contacting Provider Services at 1-800-454-3730.

Who Is Eligible?
Members are identified as eligible for Population Health based on their overall clinical risk, which takes into account their age, gender, diagnosis history, service utilization history and self-reported risk factors. We derive this information through continuous case finding efforts, welcome calls and referrals from both internal and external sources.

Population Health services are provided whether members are well, have an ongoing health problem or have a terrible health episode. Population Health services are available to members depending on individual health risks and need for the service and may include but are not limited to the following:

- Asthma
- Hypertension
- Bipolar disorder
- Major depressive disorder
- Chronic obstructive pulmonary disease (COPD)
- Obesity/weight management
- Congestive heart failure (CHF)
- Schizophrenia
- Coronary artery disease (CAD)
- Smoking cessation
- Diabetes
- Substance use disorder
- HIV/AIDS
- High-risk pregnancy

You can refer patients who can benefit from additional education and care management support. Our case managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk-stratified based on the severity of their disease. 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. Provider feedback is given as needed regarding patient status and progress.

Provider Rights and Responsibilities
The provider has the right to:

- Obtain information about us on our programs and services, our staff and their qualifications, and any contractual relationships.
- Decline participation in our programs and services for his or her patients.
- Be informed of how we coordinate our Population Health-related interventions with your patient treatment plans.
- Know how to contact the person responsible for managing and communicating with the provider’s patients.
- Be supported by the organization to make decisions interactively with patients regarding their health care.
- Receive courteous and respectful treatment from our staff.
- Communicate complaints about Population Health programs as outlined in our Provider Complaint and Grievance Procedure.

Hours of Operation
Our case managers are licensed nurses and social workers and are available from 8 a.m. to 5 p.m. Central time, Monday through Friday. We also have confidential voicemail available 24 hours a day. The 24-hour Nurse HelpLine is available for our members 24 hours a day, 7 days a week at 1-800-600-4441.
Contact Information
Please call 1-888-830-4300 to reach a case manager. Find more information about Population Health by visiting https://providers.amerigroup.com/TN. Members can get information about our Population Health program by visiting https://myamerigroup.com or calling 1-888-830-4300.

WIC Program
WIC provides specific nutritious supplemental food and nutrition education at no cost to low-income pregnant, postpartum, breastfeeding women, infants and children up to their 5th birthday. They must meet income guidelines, a state residency requirement, and be individually determined to be at nutritional risk by a health professional such as a physician, nutritionist or nurse. WIC serves as an adjunct to good health care. Many TennCare families are WIC recipients. More information about the WIC Program is available at https://www.tn.gov/health/health-program-areas/fhw/wic.html.

Taking Care of Baby and Me Program
Amerigroup offers Taking Care of Baby and Me to all expectant mothers. The program objective is to provide coordinated, comprehensive prenatal management with the intent of identifying members prior to an adverse health event and provide them with care management, education, and rewards to promote good health outcomes and timely prenatal care through Population Health. Notification to Amerigroup Provider Services department at 1-800-454-3730 is required at the first prenatal visit. Taking Care of Baby and Me provides care management to:

- Improve the level of knowledge of the member about her pregnancy stage
- Create systems that support the delivery of quality of care
- Measure and maintain or improve member outcomes related to the care delivered
- Facilitate care with providers to promote collaboration, coordination and continuity of care

Health education is provided and encouraged through prenatal and postpartum health promotion packets that include provider education, resources and information on rewards. Information about available health-related community services is provided to members as appropriate. All identified pregnant members will automatically receive information on Taking Care of Baby and Me.

As part of the Taking Care of Baby and Me program, members are offered the My Advocate program. This program provides pregnant women proactive, culturally appropriate outreach and education through Interactive Voice Response (IVR), text or smart phone application. This program does not replace the high-touch case management approach for high-risk pregnant women. However, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high-risk to facilitate connections between them and our case managers and improve member and baby outcomes. Eligible members receive regular calls with tailored content from a voice personality (Mary Beth). For more information on My Advocate, visit https://myadvocatehelps.com.

Provider Disenrollment Process
Providers may cease participating with Amerigroup for either mandatory or voluntary reasons.

Mandatory disenrollment occurs when a provider becomes unavailable due to immediate, unforeseen reasons. An example of this could include loss of license. In the case of a mandatory disenrollment of a PCP, members will be auto-assigned to another PCP to ensure that members have continuous access to the TennCare covered services, as appropriate. Amerigroup will notify members of any termination for PCPs or other providers from whom they receive ongoing care.
Amerigroup will provide notice to affected members when a provider disenrolls for voluntary reasons, such as retirement. Providers must provide written notice to Amerigroup within the time frames specified in their participating provider agreement with Amerigroup. Members linked to a PCP who has disenrolled for voluntary reasons will be notified to self-select a new PCP.

Amerigroup is responsible for submitting notification of all provider disenrollments to the Division of TennCare.

**Reporting Changes in Address and/or Practice Status**

Any status changes are to be reported to:

Provider Relations Department  
Amerigroup Community Care  
22 Century Blvd., Suite 220  
Nashville, TN 37214
12 MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights and Responsibilities
Members have rights and responsibilities when participating with an MCO. Our Member Services representatives are advocates for our members. The following lists the rights and responsibilities of members:

Members have the right to:

- Be treated with respect with due consideration for dignity and privacy
- Participate in Amerigroup without being discriminated against on the basis of handicap and/or disability, age, race, color, religion, sex, national origin, or any other classification protected under applicable federal and state laws
- Privacy during a visit with their doctor
- Talk about their medical record with their PCP and ask for a summary of that record and request to amend or correct the record as appropriate
- Be properly educated about and helped to understand their illnesses and the available health care options
- Have a candid discussion with their provider of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Participate in decision-making about the health care services they receive
- Refuse health care (to the extent of the law) and understand the consequences of their refusal
- Be free from any form of restraint or seclusion as a means of coercion, discipline, inconvenience or retaliation as specified in other federal regulations on the use of restraints and seclusion
- Decide ahead of time the kinds of care they want if they become sick, injured or seriously ill by executing an advance directive
- Expect that their records (including medical and personal information) and communications will be treated confidentially
- If under age 18 and married, pregnant or have a child, be able to make decisions about themselves and/or their child’s health care
- Choose their PCP from the Amerigroup network of providers
- Have information about Amerigroup, its services, providers and member rights and responsibilities
- Receive information on the Notice of Privacy Practices as required by HIPAA
- Get a current member handbook and a provider referral directory
- Choose any Amerigroup network specialist after getting a referral from their PCPs; some services do not require a referral, such as family planning
- Be referred to health care providers for ongoing treatment of chronic disabilities
- Have access to their PCPs or backups 24 hours a day, 365 days a year for urgent or emergency care
- Get care right away from any hospital when their symptoms meet the definition of an emergency medical condition
- In certain circumstances, get post-stabilization services following an emergency medical condition
- Call the 24-hour Nurse HelpLine toll free 24 hours a day, 7 days a week at 1-800-600-4441
- Call the Amerigroup Member Services staff toll free from 7 a.m. to 7 p.m. Central time Monday through Friday at 1-800-600-4441
- Know what payment methodology Amerigroup uses with health care providers
- File a medical appeal with TennCare
- Freely exercise the right to file a complaint or an appeal without adversely affecting the way members are treated
- Receive notification to present supporting documentation for their complaints
- Continue to receive benefits pending the outcome of appeal or fair hearing under certain circumstances
- Only be responsible for cost-sharing as defined in the cost-sharing section of this manual
• Make recommendations regarding the organization’s member rights and responsibilities policies

**Members have the responsibility to:**

• Treat their doctors, their doctors’ staff and Amerigroup employees with respect and dignity
• Not be disruptive in their doctor’s offices
• Respect the rights and property of all providers
• Cooperate with people providing health care
• Tell their PCP and/or their treating physician about their symptoms and problems and ask questions
• Get information and understand their health problems and consider treatments to participate in developing mutually agreed upon treatment goals before services are performed
• Discuss anticipated problems with following their doctor’s directions
• Consider the outcome of refusing treatment recommended by a doctor
• Help their doctor obtain medical records from their previous doctors and help their doctor complete new medical records as necessary
• Respect the privacy of other people waiting in doctors’ offices
• Secure referrals from their PCPs, when specifically required, before going to another health care provider unless they have a medical emergency
• Call Amerigroup to change their PCPs before seeing any new PCPs
• Make and keep appointments and be on time; members should always call if they need to cancel appointments, change appointment times or if they will be late
• Discuss complaints, concerns and opinions in an appropriate and courteous way
• Tell their doctor who they want to receive their health information
• Obtain medical services from their PCPs
• Learn and follow the Amerigroup policies outlined in the member handbook
• Read the member handbook to understand how Amerigroup works
• Notify TennCare if a family member who is enrolled in Amerigroup has died
• Notify TennCare if addresses and/or status change
• Give TennCare proper identification when they enroll
• Become involved in their health care and cooperate with their doctor about recommended treatment and care that they have agreed on with their doctor
• Know the correct way to take their medications
• Carry their Amerigroup ID card at all times and report any lost or stolen cards to Amerigroup quickly; members should contact TennCare of the Tennessee Department of Human Services if there are changes to their name, address or marital status
• Show their ID cards to each provider
• Tell Amerigroup about any doctors they are currently seeing
• Notify their PCPs as soon as possible after they receive emergency services
• Go to the emergency room when they have an emergency
• Report suspected fraud and abuse

**Member Rights under Title VI of the Civil Rights Act of 1964**

Title VI of the Civil Rights Act of 1964 is a federal law that protects members from discrimination based on their race, color or national origin in programs and activities that receive federal financial assistance. If members are eligible for Medicaid, other health care or human services, he/she cannot be denied assistance because of race, color or national origin. The Office for Civil Rights in the U.S. Department of Health and Human Services (DHHS) enforces Title VI as well as other civil rights laws.

Some of the institutions or programs that may be covered by Title VI are:

• Extended care facilities
• Mental health centers
Public assistance programs  
Nursing homes  
Adoption agencies  
Hospitals  
Day care centers  
Senior citizen centers  
Medicaid and Medicare  
Family health centers and clinics  
Alcohol and drug treatment centers

Prohibited Discriminatory Acts

There are many forms of illegal discrimination based on race, color or national origin that frequently limit the opportunities of minorities to gain equal access to services. A recipient of federal financial assistance may not, based on race, color or national origin:

- Be denied services or other benefits provided as a part of health or human service programs.
- Be provided a different service or other benefit or provide them in a different manner from those provided to others under the program.
- Be segregated or separately treat members in any matter related to the receipt of any service, financial aid or other benefit.

For information on how to file a complaint of discrimination or to obtain information regarding civil rights in the TennCare program, you may contact:

- Amerigroup: 1-800-600-4441
- HCFA’s Office of Civil Rights Compliance
  310 Great Circle Rd., 3rd Floor
  Nashville, TN 37243
  Phone: 615-507-6474 or for free at 1-855-857-1673 (TRS Dial 711)
  Email: HCFA.fairtreatment@tn.gov
  ¿Habla español y necesita ayuda con esta carta? Llámenos gratis al 1-855-857-1673
- U.S. Department of Health & Human Services — Office of Civil Rights
  o Call: 1-800-368-1019 (toll free)
  o Write to:
    Director — Office of Civil Rights
    U.S. Department of Human Services
    200 Independence Ave. SW, Room 506 F
    Washington, DC 20201
  o TDD: 1-800-537-7697

Information can also be obtained at [www.hhs.gov/ocr](http://www.hhs.gov/ocr). The TennCare Different Treatment Complaint form in English and Spanish is located in Appendix A.

Member Rights under the Nondiscrimination in Health Programs and Activities Final Rule

Amerigroup does not engage in, aid or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color or national origin in providing aid, benefits or services to beneficiaries. Amerigroup does not utilize or administer criteria having the effect of discriminatory practices on the basis of gender or gender identity. Amerigroup does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of or subjecting them to discrimination on the basis of sex. In addition, in compliance with the Age Act, Amerigroup may not discriminate against any person on the basis of age, or aid or perpetuate age discrimination by providing significant assistance to any agency, organization or person that discriminates on the basis of age. Amerigroup provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of sex, race, color, age, religion, national origin, physical or mental disability, other protected statuses, or type of illness or condition.
Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when an Amerigroup representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and is assisted in doing so, if the member requests assistance. We document, track and trend all alleged acts of discrimination.

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

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


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

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

- Mail: 22 Century Blvd., Suite 220, Nashville, TN 37214
- Phone: 615-316-2400, ext. 22529
- Email: tn.nondiscrimination@amerigroup.com

**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, sex, 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.

**Americans with Disabilities Act Requirements**

The Amerigroup policies and procedures are designed to promote compliance with Title II and Title III of the Americans with Disabilities Act of 1990. Providers are required to take actions to remove existing barriers 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
- Handicap parking clearly marked unless there is street-side parking
- The provision of communication assistance in alternative formats
Auxiliary Aids or Services to Ensure Effective Communication

The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with the method of communication used by the member and/or the member’s representative; the nature, length, and complexity of the communication involved; and the context in which the communication is taking place. In determining what types of auxiliary aids and services are necessary, providers shall give primary consideration to the requests of members with disabilities, and/or the member’s representative, in accordance with 28 C.F.R. § 35.160 and 28 C.F.R. § 36.303. In order to be effective, auxiliary aids and services must be provided in accessible formats, in a timely manner, and in such a way as to protect the privacy and independence of the individual with a disability. If a member and/or the member’s representative requests an auxiliary aid or service that the provider can demonstrate would result in a fundamental alteration in the nature of its services or result in an undue financial and administrative burden, the provider does not have to provide the requested auxiliary aid or service to the member and/or the member’s representative. However, if available, the provider shall provide the member and/or the member’s representative with another form of an auxiliary aid or service that would achieve effective communication with the member and/or the member’s representative and not result in a fundamental alteration in the nature of the provider’s services or result in an undue financial and administrative burden.

Specifications for Member Materials

All written materials shall be printed with the notice of nondiscrimination and taglines as required by TennCare and set forth in TennCare’s tagline template. In addition to any other requirements specified in Section A.2.17 of the MCO statewide contract, Amerigroup may also provide required member materials/information electronically or on its website pursuant to the specifications set forth in section 2.28.10.3, TennCare’s tagline template, and the following requirements: 1) the material/information must be placed on the Amerigroup website in a location that is prominent and readily accessible for applicants and members to link to from the Amerigroup home page; 2) the material/information must be provided in a format that can be electronically saved and printed; and 3) if a member or applicant requests that Amerigroup mail them a copy of the material/information, Amerigroup must mail free of charge the material/information to them within five days of that request. To the extent that Amerigroup and its providers and/or subcontractors are using electronic and information technology to fulfill its obligations under this contract, the entities shall comply with section 2.28.10.

Cost-Sharing Information

Copays

There are no copays or cost-sharing for TennCare Medicaid enrollees. For TennCare Standard enrollees, copays may be required based on income levels. Copays are due at the time of service and are collected by the health care provider.

For adults who have TennCare Medicaid and Medicare, Medicare pays first for health care. Then, TennCare Medicaid will pay the part of the service not paid for by Medicare so long as the service is medically necessary and is a TennCare covered service.

Copays for TennCare Standard enrollees with incomes at or above 100 percent of poverty level are similar to commercial copays. To encourage good preventive health habits, there will be no copays for preventive care visits such as:

- Well-child visits
- Immunizations
- Checkups
- Pap smears
- Prostate examinations
- Mammograms
- Family planning services
- Prenatal services
There are no deductibles or annual out-of-pocket (OOP) maximums, which apply to persons with copay obligations.

Members do not have cost sharing responsibilities for TennCare coverage and covered services, except that TennCare Medicaid adults (age 21 and older) who receive pharmacy services have nominal copays for these services. The copays are $3.00 for each branded drug and $1.50 for each covered generic drug. Generic drugs that exceed the limit of five prescriptions or refills per member per month are not covered. Family planning drugs and emergency services are exempt from copays. Members may not be denied a service for inability to pay a copayment. There is no OOP maximum on copays. Copays are administered by the PBM. Please contact the PDM directly for related questions or issues.

The following adult groups are exempt from copays:
- Members receiving hospice services who provide verbal notification of such to the pharmacy provider at the point of service
- Members who are pregnant who provide verbal notification of such to the pharmacy provider at the point of service
- Members who are receiving services in a nursing facility, an intermediate care facility for the mentally retarded or based on a home- and community-based services waiver

### Nonpharmacy Copay Schedule (unless otherwise directed by TennCare)

<table>
<thead>
<tr>
<th>Poverty Level</th>
<th>Copay Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 percent-99 percent</td>
<td>$0.00</td>
</tr>
<tr>
<td>100 percent-199 percent</td>
<td>$10.00 Hospital Emergency Room (waived if admitted)</td>
</tr>
<tr>
<td></td>
<td>$5.00 PCP and Community Mental Health Agency Services Other Than Preventive Care*</td>
</tr>
<tr>
<td></td>
<td>$5.00 Physician Specialists (including psychiatrists)</td>
</tr>
<tr>
<td></td>
<td>$5.00 Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode)</td>
</tr>
<tr>
<td>200 percent and above</td>
<td>$50.00 Hospital Emergency Room (waived if admitted)</td>
</tr>
<tr>
<td></td>
<td>$15.00 PCP and Community Mental Health Agency Services Other Than Preventive Care*</td>
</tr>
<tr>
<td></td>
<td>$20.00 Physician Specialists (including psychiatrists)</td>
</tr>
<tr>
<td></td>
<td>$100.00 Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode)</td>
</tr>
</tbody>
</table>

* The copay amounts at the community mental health agencies exclude Tennessee Health Link and Intensive Community Based Treatment Services (e.g., CTT, CCFT, PACT).

### Member Complaints

TennCare member complaint and appeals processes are compliant with all applicable federal and state laws and regulations. In addition, TennCare operates under a number of federal court orders and Consent Decrees, certain of which modify and/or enhance federal requirements regarding notice and hearing rights.

Members may file a complaint for causes other than adverse benefit determination taken by Amerigroup to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of Amerigroup that impair the quality, timeliness or availability of such benefits. A member has the option of filing an appeal at every step of the complaint process (see Chapter 13, Adverse Actions/Appeals). For complaints related to allegations of discrimination, see the Prohibited Discriminatory Acts section of this chapter.
When a complainant member notifies Amerigroup in writing or orally of a complaint, Amerigroup fully investigates each complaint and documents the substance of the complaint, including any aspect of clinical care involved. The Amerigroup member complaint specialist oversees and coordinates the member complaint process. Amerigroup has educated its staff concerning the importance of the complaint procedure, the rights of the member and the time frames, including clinically urgent situations in which action must be taken by Amerigroup regarding the handling and disposition of a complaint.

The complainant member, within three business days of Amerigroup receipt of a complaint, is sent an acknowledgement letter, which includes any requests for additional information necessary to investigate the complaint. The total time for an Amerigroup acknowledgment, investigation and resolution of the complaint will be within 30 calendar days from the date Amerigroup receives the initial complaint from the complainant member. A clinically urgent complaint will be handled in 72 hours. If delays are outside of the control of Amerigroup (e.g., the result of the third party’s failure to provide documentation in a timely fashion or awaiting response from the complainant for additional information), Amerigroup may extend the time to respond for up to an additional 14 calendar days if within the original time frame, Amerigroup demonstrates in writing to the complainant reasonable cause for the delay beyond its control and provides a written progress report.

Amerigroup ensures that a complaint is resolved by individuals who are not directly or indirectly involved in the action or inaction which gave rise to the complaint. After Amerigroup investigates the complaint, Amerigroup issues a resolution letter to the complainant member explaining the Amerigroup resolution. The letter will include:

- A statement of the specific contractual reasons for the resolution
- The facts established in relation to the complaint
- The actions, if any, that Amerigroup has taken or will take in response to the complaint

A copy of the resolution letter will be provided to:

- Any provider identified in the complaint upon request
- The TennCare Administration or ombudsman program representative if Amerigroup received the complaint from the state

**Complaint Tracking and Reporting**

Upon receipt of a member complaint, Amerigroup will track the complaint through its system including tracking of all materials/records requested and received, communications with applicable parties and all required correspondence. Complaint trending data will be reported on a quarterly and annual basis to the Quality Management Committee to identify trends and patterns for intervention. The report provides a written summary analyzing the categories of complaints, brief statements of the problem, resolution and resulting corrective actions as required.

Records will include:

- Date complaint filed
- Date and outcome of all actions and findings
- Date and decision of any complaint proceedings
- Date and proceedings of any litigation
- All letters and documentation submitted regarding the complaint

Amerigroup maintains a complaint log categorized by cause and disposition and including length of time for resolution of each complaint. Amerigroup compiles information from the complaint log for use by the Quality Management Committee.
Complaints will be categorized by cause including:

- Billing and financial or plan administration (e.g., marketing, EOBs sent to members, policy holder service or similar administrative functions, member balance billing)
- Attitude and service issues with the treating physician or provider care (e.g., lack of courteous treatment)
- Access (e.g., participating provider lacked available appointments)
- Quality of care concerns
- Quality of provider office site (e.g., lack of wheelchair accessibility, office and/or exam rooms are dirty, office is cluttered and unorganized, etc.)

Documentation for all complaints and actions taken are maintained for a period of 10 years from the date of the receipt of the complaint. The member has a right to a copy of the complaint record within 30 calendar days of the request.

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

**Member Appeals**

Please see Adverse Action section in Section 13, Medical Management.
13 MEDICAL MANAGEMENT

Medical Review Criteria
On December 24, 2012, Anthem, Inc. acquired Amerigroup and its subsidiaries. Anthem has its own nationally recognized medical policy process for all of its subsidiary entities.

Effective May 1, 2013, Anthem medical policies, which are publicly accessible from its 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. The website is https://medicalpolicies.amerigroup.com/wps/portal/appculdesac?content_path=amerigroup/noapplication/f1/s0/t0/pw_e216383.htm&na=onlinepolicies&rootLevel=0&label=Overview.

Amerigroup utilized the following criteria for behavioral health and medical health services:

<table>
<thead>
<tr>
<th>Behavioral Health Services</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>All requests: Outpatient, Inpatient and Concurrent Reviews</td>
<td>MCG Care Guidelines</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Health Services</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>Anthem’s Medical Policies and Clinical Utilization Management Guidelines</td>
</tr>
<tr>
<td>Inpatient Site of Service</td>
<td>MCG Care Guidelines</td>
</tr>
<tr>
<td>Inpatient Concurrent Reviews</td>
<td>McKesson InterQual Level of Care — Long-Term Acute Care, Rehabilitation and Sub/Acute Skilled Nursing Facility</td>
</tr>
<tr>
<td></td>
<td>MCG Care Guidelines — <em>Acute Adult, Acute Pediatric</em></td>
</tr>
<tr>
<td>Outpatient Health Home Care</td>
<td>McKesson InterQual Level of Care — Home Care</td>
</tr>
<tr>
<td>Outpatient Rehabilitation and Chiropractic</td>
<td>McKesson InterQual Level of Care — Outpatient Rehabilitation and Chiropractic</td>
</tr>
</tbody>
</table>

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 all cases, state Medicaid contracts or CMS requirements will supersede Anthem medical policy criteria. Medical technology is constantly evolving, and we reserve the right to review and periodically update medical policy and utilization management criteria.

McKesson InterQual will continue to be used for nonbehavioral health concurrent review determinations only. Amerigroup utilization reviewers use these criteria as part of the precertification process, for scheduled admissions, concurrent review, and discharge planning to determine clinical appropriateness and medical necessity for coverage during continued hospitalization. Amerigroup also works with network providers to develop clinical guidelines of care for its membership. The Quality Management Committee (QMC) assists Amerigroup in formalizing and monitoring guidelines.

Determinations of medical necessity are made on a case-by-case basis in accordance with the TennCare Program definition of medical necessity. Tenn. Code Ann. §71-5-144 and Tenn. Comp. R. & Regs. 1200-13-16-.05 To be determined to be medically necessary or a medical necessity, a medical item or service must be recommended by a physician who is treating the member or other licensed health care provider practicing within the scope of the physician’s license who is treating the member and must satisfy each of the criteria outlined in the Medically
Necessary Services — Medical Necessity section of this manual. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member’s needs and medical history.

Amerigroup may deny services that are noncovered except as otherwise required by TennCare Kids or unless otherwise directed to provide by TennCare.

All medically necessary services will be covered for members less than 21 years of age in accordance with TennCare Kids requirements.

If precertification of a service is granted by Amerigroup, payment for the precertified service will not be denied based on the lack of medical necessity, assuming that the member is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances which were described at the time that precertification was granted.

If Amerigroup uses noncommercial criteria, the following standards apply to the development of the criteria:

- Criteria are developed with involvement from appropriate providers with current knowledge relevant to the content of treatment guidelines under development.
- Criteria are based on review of local market practice and national standards/best practices.
- Criteria are evaluated at least annually by appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria of treatment guidelines under review and updated as necessary. The criteria must reflect the names and qualifications of those involved in the development, the process used in the development and the timing and frequency at which the criteria will be evaluated and updated.

Practitioners may obtain Utilization Management (UM) criteria upon request. If a medical necessity decision results in an adverse determination, practitioners may discuss the denial decision with an Amerigroup medical director by contacting Provider Services at 1-800-454-3730.

It is the policy of Amerigroup to make available to treating practitioners a physician-to-physician (P2P) review to discuss by telephone determinations based on medical appropriateness. A physician-to-physician discussion can be arranged by calling Utilization Management at 615-232-2121 Monday through Friday from 7 a.m. to 5 p.m. CT. Provider office staff should only initiate a physician-to-physician discussion with one of our medical directors when the attending or ordering physician requests.

Affirmative statement concerning UM decisions: UM decision-making is based only on appropriateness of care and service and existence of coverage. Amerigroup does not specifically reward practitioners or other individuals for issuing denials of coverage or care. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Precertification/Notification Process
Amerigroup may require members to seek a referral from their PCP prior to accessing nonemergency specialty physical health services. “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 request. “Prospective” means that the service request occurred prior to the provision of the service being provided. “Notification” is the telephonic, facsimile or electronic communication received from a provider informing Amerigroup of the intent to render covered medical services to a member prior to the rendering of such services. There is no review against medical necessity criteria. However, member eligibility and provider status (network and non-network) are verified. The purpose of notification is to identify members who may benefit from case management such as members who require high-risk obstetrics.
If Amerigroup requires members to obtain PCP referral, Amerigroup may exempt certain services identified in the Amerigroup member handbook from PCP referral.

If a service requires precertification/notification, the provider must contact Amerigroup via phone, facsimile or electronic communication to either obtain approval or provide the notification prior to the rendering of services. All relevant clinical information needed to determine medical necessity must be included in the request for prior authorization in order for a decision to be made. See Section 14 for more detailed information regarding utilization management processes for hospital and elective admission processes.

For members determined to need a course of treatment or regular care monitoring, Amerigroup allows members to directly access a specialist via PCP referral/extended referral as appropriate for the members’ condition and identified needs.

Amerigroup will not require that a woman go in for an office visit with her PCP in order to obtain the referral for prenatal care.

**Referral Provider Listing**
Amerigroup provides all PCPs with a current hard copy listing of referral providers, including behavioral health providers at least 30 calendar days prior to the start date of operations. Thereafter, Amerigroup will mail PCPs an updated version of the listing on a quarterly basis. Amerigroup will also maintain an updated electronic, web-accessible version of the referral provider listing.

**Exceptions to Precertification and/or Referrals**

**Emergency and Post-Stabilization Care Services**
Amerigroup provides emergency services without requiring precertification or PCP referral regardless of whether these services are provided by a contract or noncontract provider. Amerigroup provides post-stabilization care services.

**TennCare Kids**
Amerigroup does not require precertification or PCP referral for the provision of TennCare Kids screening services.

**Access to Women’s Health Specialists**
Amerigroup will allow female members direct access (without requiring a referral) to a women’s health specialist who is a contract provider for covered services necessary to provide women’s routine and preventive health care services. This is in addition to the member’s designated source of primary care if that source is not a women’s health specialist.

**Behavioral Health Services**
Amerigroup does not require a PCP referral for members to access a behavioral health provider.

**Transition of New Members**
Amerigroup provides for the continuation of medically necessary covered services regardless of precertification or referral requirements. However, in certain circumstances, Amerigroup may require precertification for continuation of services beyond the initial 30 days.
Clinical Practice Guidelines
Using nationally recognized standards of care, Amerigroup works with providers to develop clinical policies and guidelines for the care of its membership. The QMC oversees and directs Amerigroup in formulating, adopting and monitoring guidelines.

Clinical guideline forms are located online at [https://providers.amerigroup.com/TN](https://providers.amerigroup.com/TN). Amerigroup selects at least four evidence-based clinical practice guidelines that are relevant to the member population. Amerigroup will measure performance against at least two important aspects of each of the four clinical practice guidelines annually.

Advance Directives

Amerigroup respects the right of the member to control decisions relating to his or her own medical care, including the decision to have any medical or surgical means or procedures calculated to prolong his or her life either provided, withheld or withdrawn. This right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession.

Amerigroup adheres to the Tennessee Health Care Decisions Act, Tenn. Code Ann. Sections 68-11-1801 et. seq., and the Tennessee Right to Natural Death Act, Tenn. Code Ann. Sections 32-11-101 et. seq. and maintains written policies and procedures regarding Advance Directives. Advance Directives are documents signed by competent persons giving direction to health care providers about treatment choices under certain circumstances. An Advance Directive, an Appointment of Health Care Agent or other instrument signed by the individual complying with the terms of Tenn. Code Ann. Sections 32-11-101 et. seq., or a durable power of attorney for health care complying with the terms of Tenn. Code Ann. Sections 34-6-part 2, will be given effect and interpreted in accord with those respective acts. Any advance directive that does not evidence an intent to be given effect under those acts but that complies with Tenn. Code Ann. Section 68-11-1803 may be treated as an advance directive under the law. See also [https://www.tn.gov/health/health-program-areas/health-professional-boards/hcf-board/hcf-board/advance-directives.html](https://www.tn.gov/health/health-program-areas/health-professional-boards/hcf-board/hcf-board/advance-directives.html).

Member Services and outreach associates encourage members at their first appointment with their PCP to request an Advance Directive form and to seek education on advance directives.

Amerigroup will provide its policies and procedures to all members 18 years of age and older and will educate members about their ability to direct their care using this mechanism. Amerigroup will designate staff members and/or providers responsible for providing this education. Neither Amerigroup nor its providers will discriminate or retaliate based on whether a member has or has not executed an advance directive.

Amerigroup, for behavioral health services, will provide its policies and procedures to all members 16 years of age and older and will educate members about their ability to direct their care using advance directives including the use of Declarations for Mental Health Treatment. Amerigroup will designate staff members and/or providers responsible for providing this education.

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

Member Services and outreach associates will answer questions about advance directives. No associate of Amerigroup may give legal advice or serve as witness to an advance directive or as a member’s designated agent or representative.
A Living Will form is located in Appendix A along with educational member information and forms for an Advanced Care Plan and an Appointment of a Health Care Agent.

**Cultural Competency**

With the increasing diversity of the American population, it is important for us to work 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 clearly and understand your recommended treatments. You should promote the delivery of services in a culturally competent manner to all patients including those with limited English proficiency, disabilities, nontraditional communications styles and diverse cultural and ethnic backgrounds regardless of a patient’s handicap and/or disability, age, race, color, religion, sex, national origin or any other classifications protected under federal or state laws. You must also ensure physical access, accommodations and accessible equipment for the furnishing of services to a patient with physical or intellectual disabilities and/or mental illness.

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 crosscultural relations.
- Understand cultural and linguistic differences.
- Strive to expand your cultural knowledge.
- Exercise individual rights by ensuring the member clearly understands their supports and decisions about their care.

Providers from culturally and linguistically diverse groups are underrepresented. Because behaviors and values vary across cultures, the following should be considered when providing care:

- Perceptions of illness, disease and their causes
- Belief systems on health, healing and wellness
- The way different individuals communicate their health care needs, present symptoms and pain
- Help-seeking behaviors and attitudes toward providers
- Individual preferences towards traditional and nontraditional approaches to health care
- Personal biases toward health care systems

Cultural barriers can affect your relationship with your patient including:

- Our member’s comfort level and their 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
- Use of nontraditional methods of communication such as communication devices, use of sign language or other individualized methods of communication
- Consideration of expressive versus receptive language skills when communicating with the member, to ensure understanding of both what is communicated to the member and what the member is trying to communicate to the provider
- Considering history of abuse or trauma, how that is perceived or understood and assessment of the member’s comfort during examination

To help overcome these barriers, you need the following:

**Cultural Awareness**

- Recognize the cultural factors that shape personal and professional behavior including:
- Norms
- Values
- Communication patterns
- World views

- Modify your own behavioral style to respond to others’ needs while maintaining your objectivity and identity, considering potential history of abuse, trauma or cultural preferences and mode of communication

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 crosscultural 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

Patient Safety
Amerigroup promotes patient safety in all aspects of care and treatment and believes that communication is a powerful tool in improving patient safety. Providers are encouraged to educate themselves and their members on actions that can be taken to improve safety. Providers can take some of the following actions to support patient safety:
Use approved Clinical Practice Guidelines to ensure safe and appropriate care and treatment
Identify at-risk members and use available screening tools to intervene appropriately
Update and review members’ medications including over the counter medications at each health care encounter
Communicate legibly and clearly when writing prescriptions and when using telephonic prescribing; completely spell the medications and clearly state the prescribing instructions; adhere to The Joint Commission’s official Do Not Use list of abbreviations and symbols: https://www.jointcommission.org/facts_about_do_not_use_list
Keep legible and organized medical records and follow Amerigroup documentation and Medical Record Keeping Standards
Review lab, radiology and other diagnostic tests when they are received and notify members of the results in a timely manner
Encourage members to be actively involved in their care, to ask questions and share any concerns they have about following prescribed treatments
Communicate effectively with other providers with whom you are involved in concurrently treating members
Keep informed about the quality performance of contracted hospitals within your network by reviewing the comparison data compiled by the Leapfrog Group’s Hospital Quality and Safety Survey: www.leapfroggroup.org

Notices of Adverse Benefit Determinations/Benefit Appeals

Adverse Benefit Determinations
The Amerigroup medical director or designee, a licensed physician, will make all decisions for adverse benefit determinations. The reviewer must have appropriate clinical expertise in treating the member’s condition or disease.

The decision regarding an authorization request for service must be made within 14 calendar days for standard request or 72 hours for expedited. TennCare may approve an extension for a standard authorization up to 14 additional days (48 additional hours for an expedited authorization request) if the extension is in the best interest of the member.

For adverse benefit determinations, both the use of explicit medical criteria and the process of daily review by an Amerigroup medical director assure consistency in the determination of medical necessity.

Notification of Adverse Benefit Determination
If the decision is to deny, delay, reduce, suspend or terminate services, a notification to the member must be made in writing. The notification is based on the TennCare approved templates and includes:

- Service type and amount
- Identity of prescriber
- Reason(s) for the proposed action, including specific facts personal to the beneficiary
- Plan and concise statement of cited legal or policy basis that is consistent with federal law, the TennCare waiver, rules and contract provisions
- Official legal citation
- Member appeal rights
- When the decision is deemed medically necessary, identity of the consulting clinician, medical records used to make the determination, unmet medical necessity criteria and explanation regarding the evidentiary weight given the treating physician's opinion
Readable explanation of discharge plan or description of specific arrangements in place to provide for continuing care (if applicable)

The attending physician and/or other ordering health care provider, the facility rendering service, and the member will be notified 10 business days prior to an adverse benefit determination by Amerigroup that reduces, suspends or terminates ongoing services (with the exception of inpatient hospital treatment). In instances of Amerigroup-initiated reduction, termination or suspension of psychiatric inpatient hospital treatment, the notice must be provided to a member at least two business days in advance of the proposed action.

In instances of any provider-initiated reduction, termination or suspension of the following services, the notice must be issued by said provider to a member at least two business days in advance of the proposed action:

- Any behavioral health service for a severely and/or persistently mentally ill (SPMI) adult member or seriously emotionally disturbed (SED) child
- Any inpatient psychiatric 24-hour or psychiatric residential service
- Any service being provided to treat a patient’s chronic condition across a continuum of services when the next appropriate level of medical service is not immediately available
- Home health services

How to submit a request for generating a Provider Initiated Notification (PIN) to Amerigroup

Log in to our secure provider website and download a copy of the PIN Request form. Access it by selecting the Downloadable Forms link in the Office Support drop-down menu.

Fill in the form and submit it via one of the following options:

- Fax to 1-877-579-6674
- Email to tn1pin@amerigroupcorp.com or tn1pin@amerigroup.com

Once we receive the completed PIN request form, Amerigroup will generate the appropriate Grier letter and PIN waiver. The Grier letter and the waiver are mailed to the member and a copy is faxed to the requesting provider. The provider should review the Grier letter and the waiver with the member. The provider is responsible for ensuring the member receives the Grier letter and the waiver if inpatient. If the member chooses to waive the Grier days, the provider shall submit the signed waiver to Amerigroup.

Benefit appeal — Reconsideration

Members have the right to file benefit appeals regarding adverse benefit determinations taken by Amerigroup. Appeal means a member’s right to contest, verbally or in writing, any adverse benefit determinations taken by Amerigroup to deny, reduce, terminate, delay or suspend a covered service and any other acts or omissions of Amerigroup that impair the quality, timeliness or availability of such benefits.

Amerigroup ensures that punitive action is not taken against a provider who files an appeal on behalf of a member with the member’s written consent, supports a member’s appeal, or certifies that a member’s appeal is an emergency appeal and requires an expedited resolution in accordance with TennCare policies and procedures.

Amerigroup will include a clear and understandable description of the method to appeal an adverse benefit determination in member handbooks, in provider manuals and through https://providers.amerigroup.com/TN.

Upon request, Amerigroup will provide members a TennCare approved appeal form(s).

Amerigroup will provide reasonable assistance to all appellants during the appeal process.
Members and their representative(s), including a member’s provider, have 60 calendar days from receipt of the adverse benefit determination in which to file an appeal. The member may use the TennCare Medical Appeal form but it is not required.

The member or member’s representative will file an Appeal of an adverse benefit determination with TennCare Solutions Unit (TSU):

TennCare Solutions
P.O. Box 000593
Nashville, TN 37202-0593
Fax: 1-888-345-5575
Phone: 1-800-878-3192
TTY/TDD: 1-866-771-7043
Español: 1-800-878-3192

TSU will forward any valid factual disputes to Amerigroup for reconsideration. An On Request Report will be faxed to Amerigroup by TSU requesting reconsideration of the member’s appeal.

Notification of Appeal Reconsideration
In addition to the information indicated in the notification of adverse benefit determination section of this procedure, the following will also be included in the notice of the appeal reconsideration:

- The results of the resolution process and the date the decision was completed.
- The member’s right to request continuation of benefits during the appeal to the state’s fair hearing process and that the member may be held liable for the cost of those continued benefits if the state fair hearing decision upholds the Amerigroup decision.
- Member eligibility and eligibility-related grievances and appeals including termination of eligibility, effective dates of coverage, and the determination of premium and copay responsibilities will be directed to the Department of Human Services.

The medical director who reviews the clinical documentation for the appeal cannot be a subordinate of the reviewer who made the initial adverse benefit determination and must not have been involved in making the original denial.

The reconsideration of the adverse benefit determination previously made includes at least one practitioner in the same or similar specialty, including chiropractic, that typically manages the medical or dental condition, procedure or treatment under discussion for review of the adverse benefit determination, unless otherwise indicated by the state.

The review will be conducted by an actively-licensed, practicing medical doctor, doctor of osteopathy or doctor of dental surgery not involved in the initial determination.

Amerigroup is responsible for eliciting pertinent medical history information from the treating health care provider(s) for the purpose of making medical necessity coverage determinations. Amerigroup will take action (e.g., sending a provider representative to obtain the information and/or discuss the issue with the provider, imposing financial penalties against the provider for failure to request, etc.), to address the problem if a treating health care provider is uncooperative in supplying needed information. Amerigroup will make documentation of such action available to TennCare, upon request. Providers who do not provide requested medical information for purposes of making a medical necessity determination for a particular item or service will not be entitled to payment for the provision of such item or service.
Continuation or Reinstatement of Services
The following services or benefits are subject to continuation or reinstatement if all applicable conditions are met:

- Those services currently or most recently provided to a member
- Those services being provided to a member in an inpatient psychiatric facility or residential treatment facility where the discharge plan has not been accepted by the member or appropriate step-down services are not available
- Those services being provided to treat a member’s chronic condition across a continuum of services when the next appropriate level of covered services is not available
- Those services prescribed by the member’s provider on an open-ended basis or with no specific ending date where Amerigroup has not reissued precertification
- A different level of covered service offered by Amerigroup and accepted by the member for the same illness or medical condition for which the disputed service has previously been provided

For the services noted above, the member has the right to continue (or have reinstated) services pending final resolution of an appeal if the member appeals and requests:

- Continuation of services within 10 days of the receipt of notice of action to terminate, suspend or reduce other ongoing services.

For all other timely requests for continuation or reinstatement requests for covered services, the services will be continued or reinstated pending appeal only if they are prescribed by the member’s treating clinician.

Services will not be continued but may be immediately reduced, terminated or suspended if the services are determined medically contraindicated.

Standard Appeal
The total time for an Amerigroup reconsideration of the appeal will not be more than 14 calendar days from the date Amerigroup receives appeal from the TSU. Amerigroup provides a written notice of the outcome of the reconsideration to TSU and the member is notified.

If Amerigroup completes the reconsideration and overturns its previous action and approves the service, corrective action will be provided within 72 hours.
If Amerigroup completes the reconsideration and upholds its earlier denial, in whole or in part, the state then proceeds with its review of the reconsideration response, including review of the timeliness of the member’s initial request for precertification of the service (if applicable) and review of the initial notice of adverse benefit determination to the member.

Expedited Appeals
An expedited appeal process is available for adverse benefit determinations related to time-sensitive care. Care qualifies as time-sensitive if the acute presentation of this medical condition is of sufficient severity that the absence of a decision within three business days could seriously jeopardize the enrollee’s life; physical health; mental health; or their ability to attain, regain or maintain full function.

For internal purposes, Amerigroup has one calendar day to determine if the appeal is considered expedited. If the appeal is considered expedited, Amerigroup has 72 hours to respond to TennCare with the reconsideration decision. However, if the appeal is not considered expedited, it will be downgraded to an accelerated appeal.*

A physician or provider who has not previously reviewed the case will conduct the review. The physician or provider will be the same or a similar specialty as one that typically manages the medical condition, procedure
or treatment under review. He or she will have no direct financial interest or connection with the case. The physician or provider will review and render a final decision. The review may include an interview of the patient or patient’s representative.

The Amerigroup time frame in which the reconsideration of an expedited appeal must be completed is based on the medical or dental immediacy of the condition, procedure or treatment, but may not exceed three calendar days from the date the reconsideration request is received from TSU. If Amerigroup upholds its original adverse benefit determination through its reconsideration process, the state then proceeds with its review of the reconsideration response, including review of the timeliness of the member’s initial request for precertification of the service (if applicable) and review of the initial notice of adverse benefit determination to the member.

* An **accelerated appeal** is where the member or provider has asked for an urgent/expedited appeal, but we have determined the member does not meet the criteria for an expedited appeal. An accelerated appeal will be adjudicated within 31 days.

For internal purposes, Amerigroup has five calendar days to respond to the Division of TennCare.

A physician or provider who has not previously reviewed the case will conduct the review. The physician or provider will be the same or a similar specialty as one that typically manages the medical condition, procedure or treatment under review. He or she will have no direct financial interest or connection with the case. The physician or provider will review and render a final decision. The review may include an interview of the patient or patient’s representative.

The Amerigroup time frame in which the reconsideration of an accelerated appeal must be completed is based on the medical or dental immediacy of the condition, procedure or treatment, but may not exceed five calendar days from the date the reconsideration request is received from TSU. However, Amerigroup may request an extension if additional time is required to obtain a member’s medical/dental records.

Care is not time sensitive and an appeal is not expedited if the member’s treating physician certifies in writing that the matter is not time sensitive.

If Amerigroup upholds its original adverse benefit determination through its reconsideration process, the state then proceeds with its review of the reconsideration response, including review of the timeliness of the member’s initial request for precertification of the service (if applicable) and review of the initial notice of adverse benefit determination to the member.

**Request for Correction of a Defective Notice**

When a notice of adverse benefit determination that has been issued by Amerigroup is determined to be defective, the state faxes an On Request Report to Amerigroup, identifying the notice defect(s) and requesting submission of a corrected notice that cures the deficiencies of the notice to the state within two business days for review/approval prior to issuance to the member. The state is bound by the original notice of adverse benefit determination or, if a corrected notice has been issued, by the corrected notice at hearing.

**Medicaid Fair Hearing**

If the state upholds the Amerigroup reconsideration determination, the member’s appeal is automatically forwarded to TennCare and docketed for fair hearing before an Administrative Law Judge (ALJ).

Neither Amerigroup nor TennCare will prohibit or discourage any individual from testifying on behalf of a member.
If the ALJ rules in favor of the member, a directive is issued to Amerigroup for the requested service. Implementation of the corrective action and proof of such action must be submitted to the Directive Services Unit within 72 hours except upon demonstration of good cause.

TennCare may develop additional appeal process guidelines or rules, including requirements as to content and timing of notices to members, which will be followed by Amerigroup. However, Amerigroup will not be precluded from challenging any judicial requirements; and to the extent judicial requirements that are the basis of such additional guidelines or rules are stayed, reversed or otherwise rendered inapplicable, Amerigroup will not be required to comply with such guidelines or rules during any period of inapplicability.

Demonstration of Good Cause
Good cause is limited to circumstances that are beyond the control of Amerigroup and that have been shown, based on documented diligent efforts to implement the decision, to prevent its timely implementation. Good cause may also be requested if Amerigroup believes the directive requires the provision of a medical item or service that is medically contraindicated for the member. Such request must then include documentation that supports the Amerigroup finding of medical contraindication for review by the TennCare Office of the Medical Director (OMD).

A good cause request for extension of the 72-hour timeline for implementation of corrective action must be submitted in writing to the DSU and must be received by the DSU on or before the compliance date along with documentation of diligent efforts to provide corrective action within five calendar days or documentation that supports a finding of medical contraindication. If the good cause request is approved by the OCCP (or, in the case of contraindication, by the OMD), written notification including a revised compliance date, if applicable, will be provided.

Single State Agency Review and Final Agency Action
Pursuant to Section 1902(a)(3) of the Social Security Act and federal regulations at 42 C.F.R. 431, subpart E., the single state agency must retain the authority to review or overturn the decisions of nonagency hearing officers when contrary to applicable law, regulations or agency policy interpretations.

An ALJ order is not, therefore, deemed final pending review and final agency action by the single state agency in order to determine whether such ruling is contrary to applicable law, regulations or agency policy interpretations, including decisions regarding the defined package of covered benefits, determinations of medical necessity, and decisions based on incorrect interpretation/application of the TennCare Rules. Review by the single state agency does not relieve Amerigroup of its responsibility to implement prompt corrective action within five calendar days of a decision in favor of the member. However, to the extent that the ruling is subsequently determined by the state to be contrary to applicable law, regulations or agency policy interpretations, the state will not be prohibited from taking timely final agency action and immediately implementing such order to reduce, suspend or terminate such service for which corrective action had been provided since the fifth day from issuance of the order by the ALJ.

TennCare Solutions
P.O. Box 000593
Nashville, TN 37202-0593
Fax (toll free): 1-888-345-5575

Appeals Tracking and Reporting
Upon receipt of an On Request Report (ORR) from the TSU, Amerigroup will track the appeal through its core processing and document management systems including tracking of all materials and records requested and received, communications with applicable parties, and all required correspondence. Appeals and data will be
trended through our Quality Management department. Appeals trending data will be reported on an annual basis to the Quality Improvement Council (QIC) meeting.

Records will include:

- Date filed
- Date and outcome of all actions and findings
- Date and decision of any appeal proceeding
- Date and proceedings of any litigation
- All letters and documentation submitted regarding the appeal

The Amerigroup appeal system modules will categorize by cause and disposition and include length of time for resolution of each appeal. Amerigroup compiles information from the system for use by the Quality Management Committee.

Documentation for all appeals and actions taken are maintained for a period of six years from the date of the receipt of the ORR. The member has a right to a copy of the record within 30 calendar days of the request.

Amerigroup requires providers to display notices of members’ rights to appeal adverse benefit determinations affecting services in public areas of each facility in accordance with TennCare rules and regulations. Amerigroup will ensure that providers have correct and adequate supply of public notices.

**Permitted Sanctions**

Amerigroup may impose sanctions for a provider’s failure to comply with contractual and/or credentialing requirements, or failure or refusal to respond to the request for information by Amerigroup including credentialing documentation, medical records and other records demonstrating the medical care provided to members. At the discretion of Amerigroup or by specific directive of TennCare, Amerigroup may impose sanctions against the provider as appropriate generally in accordance with the following chart:

### Examples of Permitted Sanctions

<table>
<thead>
<tr>
<th>Program issues</th>
<th>Damage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to comply with the TennCare Contractor Risk Agreement and federal rules/law regarding sterilizations/abortions/hysterectomies</td>
<td>$500 per occurrence or the actual amount of any federal penalty for the failure of Amerigroup to comply, whichever is greater</td>
</tr>
<tr>
<td>Failure to provide coverage for prenatal care without a delay in care</td>
<td>$500 per day per occurrence for each calendar day that care is not provided in accordance with the terms of this Agreement</td>
</tr>
<tr>
<td>Failure to provide complete documentation including medical records and comply with the timelines for responding to a medical appeal as set forth in TennCare rules and regulations and all court orders and consent decrees governing appeals procedures as they become effective</td>
<td>$500 per calendar day for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Agreement or required by TennCare</td>
</tr>
<tr>
<td>Failure to provide a written discharge plan or provision of a defective discharge plan from a psychiatric inpatient facility or mental health residential treatment facility</td>
<td>$1,000 per occurrence per case</td>
</tr>
<tr>
<td>Program issues</td>
<td>Damage</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Failure to timely provide an approved service as required in this Agreement or required by or within reasonable promptness; or failure to issue appropriate notice of delay with documentation upon request of ongoing diligent efforts to provide such approved service | The cost of the services not provided plus $500 per day per occurrence for each day:  
   1. Approved care is not provided timely  
   2. Notice of delay is not provided and/or Amerigroup fails to provide upon request sufficient documentation of ongoing diligent efforts to provide such approved service |
| Failure to comply in any way with encounter data submission requirements (excluding the failure to address or resolve problems with individual encounter records in a timely manner as required by TennCare) | Up to $25,000 per occurrence depending on the circumstances |
| Failure to address or resolve problems with individual encounter records in a timely manner as required by TennCare | An amount equal to the paid amount of the individual encounter record(s) that was rejected or, in the case of capitated encounters, the fee-for-service equivalent thereof as determined by TennCare |

Amerigroup retains the right to impose sanctions on a provider in an amount up to the amount assessed by any regulatory agency for any Amerigroup deficiency that is directly caused by that provider’s actions or omissions. Amerigroup will retain a record of the sanctions imposed as required by TennCare.
14 SERVICE AUTHORIZATIONS

Hospital and Elective Admission Management
Amerigroup requires precertification of all inpatient elective admissions. The referring primary care or specialist physician is responsible for precertification.

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

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

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 make inquiries on previously submitted requests regardless of how they were sent (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, 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.

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

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

Amerigroup will not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition.

Amerigroup may deny services that are not covered except as otherwise required by TennCare Kids or unless otherwise directed to provide them by TennCare and/or an Administrative Law Judge.

All medically necessary services will be covered for members under 21 years of age in accordance with TennCare Kids requirements.

If medical necessity criteria for the admission are not met on the initial review, the medical director may attempt to contact the requesting physician to discuss the case. The provider will be asked in this instance to provide further explanation and/or evidence in support of the requested service and the medical director will evaluate the new information in light of the member’s individual circumstances. If the provider fails to provide additional justification or the additional justification fails to cure the original deficiency, the medical director may issue a denial of coverage.

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. Again, the provider will be asked to provide further information as described above.

If the medical director denies coverage of the request, the appropriate notice of action (including the member’s appeal rights) will be faxed to the requesting provider and mailed to the member within mandated time frames.

**Newborn Authorization Requirements**

Only non-normal newborn inpatient services require an authorization. When billing non-normal newborn level of care, the required approved authorization must be on file in order for us to consider the claim for non-normal newborn reimbursement.

For newborn inpatient claims billing services other than a normal newborn admission for which there is no authorization on file, reimbursement will equal the normal newborn rate (DRG 795) if the mother's delivery admission is authorized and on file.

Newborn claims for which neither the mother nor the newborn have an authorization on file will be denied for No Authorization. Normal newborns do not require authorization. These claims will be processed under the mother’s approved authorization.

This will appear on your Explanation of Payment for newborn claims billing a higher level of care without the required authorization on file. You must notify us of any newborn admissions that are not normal newborns within one business day of the admission. It is not necessary to notify us of normal-newborn admissions.

For non-normal newborn admissions, please fax your request to 1-877-423-9975.
Emergent Admission Notification Requirements
Amerigroup prefers immediate notification by network hospitals of emergent admissions. Network hospitals must notify Amerigroup of emergent admissions within one business day. The Utilization Management nurse will review the requested admission and the supporting medical documentation to determine the medical appropriateness.

If the documentation is incomplete or inadequate, the Utilization Management nurse will not approve coverage of the request but will notify the referring provider to submit the additional necessary documentation. Again, the provider will be asked to provide further information as described above.

If the medical director denies coverage of the request, the appropriate notice of action (including the member’s appeal rights) will be faxed to the requesting provider and mailed to the member within mandated time frames. We are available 24 hours a day, 7 days a week to accept emergent admission notification at 1-800-454-3730.

Nonemergent Outpatient and Ancillary Services — Precertification and Notification Requirements
Amerigroup requires precertification for coverage of selected nonemergent outpatient and ancillary services (see chart below). To ensure timeliness of the authorization, the expectation of the facility and/or provider is that the following must be provided at the time of the request for prior authorization:

- Member name and ID
- Name, telephone number and fax number of physician performing the selective service
- Name of the facility and telephone number where the service is to be performed
- Date of service, frequency of service and length of time if known
- 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)

Requests for prior authorization with all supporting documentation should be submitted at least 72 hours prior to the rendering of services. This will allow Amerigroup to verify benefits and process the precertification request. For services requiring precertification, Amerigroup makes case-by-case determinations that consider the individual’s health care needs and medical history in conjunction with the TennCare required medical necessity rules and regulations and appropriate Amerigroup review criteria.

Amerigroup is available 24 hours a day, 7 days a week to accept precertification requests via phone, fax or web portal (ICR) submission. 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.

Amerigroup may administratively deny any request for service rendered prior to receipt of the request.

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 provider in identifying alternatives for health care delivery as supported by the medical director.

When the clinical information received is in accordance with the Tennessee definition of medical necessity and in conjunction with the approved Amerigroup review criteria, an Amerigroup reference number will be issued within 14 days (or as expeditiously as the member’s health condition warrants) to the provider. All utilization
guidelines must be supported by an individualized determination of medical necessity based on the member’s needs and medical history.

Amerigroup will not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition.

Amerigroup may deny services that are noncovered except as otherwise required by TennCare Kids or unless otherwise directed to provide them by TennCare.

All medically necessary services will be covered for members under 21 years of age in accordance with TennCare Kids requirements.

If the request is urgent in nature (expedited service authorization), the decision will be made within 72 hours upon receipt of all necessary documentation.

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 medical necessity criteria for the service are not met on the initial review, the requesting provider may contact the health plan and request to discuss the case with the medical director conducting the review. The provider will be asked in this instance to provide further explanation and/or evidence in support of the requested service and the medical director will evaluate the new information in light of the member’s individual circumstances. If the provider fails to provide additional justification or the additional justification fails to cure the original deficiency, the medical director may issue a denial of coverage.

If the medical director denies the request for coverage, the appropriate notice of action will be faxed to the requesting provider, the member’s primary physician, the facility, and mailed to the member within mandated time frames. For expedited requests, the answer is provided verbally and then followed by a letter within mandated time frames.

Hospice

Hospice authorizations (Q codes) are not required for all members (members enrolled in both Medicare and Medicaid) as of July 1, 2017.

Authorization is required for Service Intensity Add-On (SIA) procedure codes G0299, G0300 and G0155. SIAs are post-authorization requests and can be requested up to two weeks after a member’s death. When completing the Precertification Request form, please include all member and provider information, as well as the member’s date of death, dates of service for SIA, number of visits/hours and procedure code(s). Fax the request to 1-866-495-5789.

Outpatient Concurrent Review

If the provider deems additional services are indicated beyond the approved services, the provider must recontact Amerigroup prior to the expiration of the orginal authorization to obtain an extension. The provider should use the same process used to obtain the prior authorization for the services.
<table>
<thead>
<tr>
<th>Service</th>
<th>Requirement</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Rehabilitation</td>
<td>Precertification</td>
<td>Precertification is required for coverage of all services.</td>
</tr>
</tbody>
</table>
| Chemotherapy                     |               | • Procedures related to the administration of approved chemotherapy medications do not require approval when performed in outpatient settings by a participating facility, provider office, outpatient hospital or ambulatory surgery center.  
  • **For information on coverage of and precertification requirements for chemotherapy drugs, please refer to the Precertification Lookup Tool on our website.**  
  • Precertification is required for coverage of inpatient chemotherapy.                                                                                                                      |
| Court-ordered Services           |               | Court-ordered behavioral health services will be provided in accordance with state laws. Amerigroup may apply medical necessity criteria after 24 hours of emergency services unless there is a court order prohibiting release. 
  Mandatory Outpatient Treatment: Amerigroup will provide mandatory outpatient treatment for members found not guilty by reason of insanity following a 30- to 60-day inpatient evaluation or for other reasons. Treatment can be terminated only by the court. |
| Dermatology Services             |               | No precertification is required for network provider for evaluation and management (E&M), testing and most procedures. Services considered cosmetic in nature are not covered. Services related to previous cosmetic procedures are not covered. See Diagnostic Testing. |
| Diagnostic Testing               |               | • No precertification is required for routine diagnostic testing.  
  • No precertification is required for tests performed in conjunction with a precertified inpatient stay.  
  • Precertification through AIM Specialty Health Outpatient Imaging Utilization Manager is required for coverage of CTA, MRA, MRI, CT scans, nuclear cardiology, stress echocardiography (SE), Echo, resting transthoracic echocardiography (TTE) and PET scans  
  • To initiate a review request with AIM, please visit [www.aimspecialtyhealth.com/goweb](http://www.aimspecialtyhealth.com/goweb) or call AIM at 1-800-714-0040 Monday through Friday from 8 a.m. to 5 p.m. Fax requests will no longer be accepted for imaging. AIM will locate a preferred imaging facility from the Amerigroup network of radiology service providers. |
<p>| Durable Medical Equipment (DME)  |               | All DME, including all referrals, should be coordinated through Amerigroup Utilization Management (UM). Please <a href="http://www.aimspecialtyhealth.com/goweb">refer to the Precertification Lookup Tool on our website for information on coverage of and precertification requirements</a>. |
| Educational Consultation         | No precertification | No notification or precertification is required for diabetic/nutritional or weight management counseling.                                                                                       |</p>
<table>
<thead>
<tr>
<th>Service</th>
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<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room</td>
<td>Self-referral</td>
<td>No notification is required for emergency care given in the ER. If emergency care results in admission, notification to Amerigroup is required within 24 hours or the next business day. For observation precertification requirements, see Observation.</td>
</tr>
</tbody>
</table>
| ENT Services (Otolaryngology) |             | • No precertification required for network provider for E&M, testing and most procedures.  
• Precertification required for tonsillectomy and/or adenoidectomy; nasal/sinus surgery and cochlear implant surgery and services. See Diagnostic Testing. |
| Family Planning/STD Care      | Self-referral | • Members may self-refer to an in-network provider.  
• Covered services include pelvic and breast examinations, lab work, drugs, biological, genetic counseling, devices and supplies related to family planning (e.g., an intra-uterine device).  
• Infertility services and treatments are not covered. |
| Gastroenterology Services     |             | No precertification required for network provider for E&M, testing and most procedures. Precertification is required for upper endoscopy, bariatric surgery, including insertion, removal and/or replacement of adjustable gastric restrictive devices and subcutaneous port components. See Diagnostic Testing. |
| Hearing Aids                  |             | Precertification is required for digital hearing aids for members under 21 years of age. Hearing aids, including the prescribing, fitting or changing of hearing aids for members older than 21 years of age are not a covered benefit. |
| Hearing Screening             | No precertification | No notification or precertification is required for coverage of diagnostic and screening tests, hearing aid evaluations and counseling. Audiological therapy or training not covered for members older than 21 years of age. |
| Home Health Care              | Precertification | Precertification is required. Covered services include skilled nursing; home health aide; physical, occupational and speech therapy services; and physician-ordered supplies. Skilled nursing and home health aide require precertification. Rehabilitation Therapy, drugs and DME requires separate precertification. |
| Hospice                       |             | • Hospice Q codes do not require authorization.  
• Authorization is required for G0299, G0300 and G0155 |
| Hospital Admission            | Precertification | • Elective admissions require precertification for coverage.  
• Emergency admissions require notification within 24 hours or the next business day.  
• To be covered, preadmission testing must be performed by an Amerigroup preferred lab vendor. See provider referral directory for a complete listing of participating vendors.  
• No coverage for rest cures, personal comfort and convenience items, services and supplies not directly related to the care of the patient (such as telephone charges, take-home supplies and similar costs).  
• For non-normal newborn inpatient admissions, please refer to Non-Normal Newborn Admissions below. |
<table>
<thead>
<tr>
<th>Service</th>
<th>Requirement</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Laboratory Services (Outpatient) |             | • No precertification is required if lab work is performed in a participating physician’s office or in a participating lab provider’s patient service centers.  
• Precertification is required for all laboratory services furnished by non-network providers, except for hospital laboratory services in the event of an emergency medical condition.  
• Hospitals may only perform STAT labs.  
• To ensure outpatient laboratory services are directed to the most appropriate setting, providers may perform laboratory testing in their offices but must otherwise direct outpatient diagnostic laboratory tests to an Amerigroup participating lab such as Quest Diagnostics or LabCorp. You can find a list of participating laboratories in our provider referral directory available on our website. |
| Medical Supplies     |             | All medical supplies, including all referrals, should be coordinated through Amerigroup Utilization Management (UM). Please refer to the Precertification Lookup Tool on our website for information on coverage of and precertification requirements. |
| Newborn Nursery Inpatient Admissions | No Precertification | Normal newborn inpatient admissions do not require authorization if approved authorization for the mother is on file. For non-normal newborn inpatient admissions, refer to the Non-Normal Newborn Admissions below. |
| Non-Normal Newborn Admissions | Precertification | Precertification is required for non-normal newborn inpatient admissions. Fax your precertification requests to 1-877-423-9975. |
| Observation          | No precertification | No precertification or notification 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 services, including obstetrical visits, diagnostic tests and laboratory services when performed by a participating provider.  
• Notification to Amerigroup is required at the first prenatal visit.  
No precertification is required for coverage of labor, delivery and circumcision for newborns up to 12 weeks of age.  
• No precertification is required for the ordering physician for OB diagnostic testing.  
• Notification of delivery is required within 24 hours with newborn information. OB case management programs are available.  
• See Diagnostic Testing. |
<table>
<thead>
<tr>
<th>Service</th>
<th>Requirement</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td></td>
<td>No precertification required for E&amp;M, testing and most procedures. Precertification is required for repair of eyelid defects. Services considered cosmetic in nature are not covered. See Diagnostic Testing.</td>
</tr>
<tr>
<td>Otolaryngology (ENT) Services</td>
<td>See ENT Services (Otolaryngology)</td>
<td></td>
</tr>
<tr>
<td>Out-of-area/Out-of-plan Care</td>
<td>Precertification</td>
<td>Precertification is required except for coverage of emergency care (including self-referral).</td>
</tr>
<tr>
<td>Outpatient/Ambulatory Surgery</td>
<td></td>
<td>Precertification requirement is based on the service performed. For information on coverage of and precertification requirements, please refer to the Precertification Lookup Tool on our website.</td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
<td>Outpatient pharmacy benefits are covered by TennCare. Products considered nonself-administered and obtained in an office or clinic setting are to be billed to Amerigroup. Injectable drugs obtained directly from a pharmacy provider are to be billed directly to the TennCare program. The injectable drugs covered under the pharmacy benefit, located at <a href="https://tenncare.magellanhealth.com/static/docs/Program_Information/Covered.Injectable_Drugs.pdf">https://tenncare.magellanhealth.com/static/docs/Program_Information/Covered.Injectable_Drugs.pdf</a> are available by having the member obtain the drug through his or her local pharmacy. The pharmacy must bill TennCare. Some of these drugs require precertification through TennCare to ensure clinical criteria are met. For full details, please refer to the TennCare program. Amerigroup reimburses providers for certain injectables administered in a provider’s office as well as home infusion. Please refer to the Precertification Lookup Tool on our website at <a href="https://providers.amerigroup.com">https://providers.amerigroup.com</a> under Quick Tools &gt; Precertification Lookup.</td>
</tr>
<tr>
<td>Physical Medicine and Rehabilitation</td>
<td>Precertification</td>
<td>Precertification is required for coverage of all services and procedures related to pain management.</td>
</tr>
<tr>
<td>Service</td>
<td>Requirement</td>
<td>Comments</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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</tr>
</tbody>
</table>
| Plastic/Cosmetic/Reconstructive Surgery (Including Oral Maxillofacial Services) |                      | - No precertification is required for coverage of E&M codes.  
- All other services require precertification for coverage. Services considered cosmetic in nature are not covered. Services related to previous cosmetic procedures are not covered (e.g., scar revision or keloid removal resulting from pierced ears). Reduction mammoplasty requires medical director’s review.  
- No precertification is required for coverage of oral maxillofacial E&M services.  
- Precertification is required for the coverage of trauma to the teeth and oral maxillofacial medical and surgical conditions including temporomandibular joint disorder.                                                                                                                                                                                                                   |
| Podiatry                                                               |                      | No precertification for coverage of E&M, testing and most procedures when provided by a participating podiatrist.                                                                                                                                                                                                                                                                                                                                                           |
| Radiation Therapy                                                     | Precertification     | All radiation therapies and procedures are reviewed by AIM. To initiate a review request with AIM, please visit [http://www.aimspecialtyhealth.com/goweb](http://www.aimspecialtyhealth.com/goweb) or call AIM at 1-800-714-0040 Monday through Friday from 8 a.m. to 5 p.m.                                                                                                                                                                                                                   |
| Radiology Services                                                    | See Diagnostic Testing |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Rehabilitation Therapy (Short Term): OT, PT, RT and ST                | Precertification     | - No precertification required for initial evaluation.  
- No precertification required for members under 21 years of age.  
- Precertification from Amerigroup is required for coverage of treatment. Therapy services that are required to improve a child’s ability to learn or participate in a school setting should be evaluated for school-based therapy. Other therapy services for rehabilitative care will be covered as medically necessary.                                                                                                                                                                                                                           |
| Skilled Nursing Facility                                               | Precertification     | Precertification is required for coverage. Requests should be faxed to 1-866-920-6005.                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Sleep Study                                                           | Precertification     | Precertification is required. All sleep management studies are reviewed by AIM. To initiate a review request with AIM, please visit [www.aimspecialtyhealth.com/goweb](http://www.aimspecialtyhealth.com/goweb) or call AIM at 1-800-714-0040 Monday through Friday from 7 a.m. to 7 p.m. Central time.                                                                                                                                                                                                                      |
| Sterilization                                                         | No precertification  | - Sterilization services are a covered benefit for members age 21 and older.  
- No precertification or notification is required for coverage of sterilization procedures including tubal ligation and vasectomy, performed as an out-patient procedure.  
- **A sterilization consent form is required for claims submission for the procedure, not the consultation.**  
- Reversal of sterilization is not a covered benefit.                                                                                                                                                                                                                                                                                                                                  |
<p>| TennCare Kids/EPSDT Office Visits                                     | Self-referral        | Use TennCare Kids schedule and <strong>document</strong> visits.                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Transportation                                                        |                      | All nonemergency medical transportation, including facility discharges should be coordinated through Tennessee Carriers.                                                                                                                                                                                                                                                                                                                                                                         |</p>
<table>
<thead>
<tr>
<th><strong>Service</strong></th>
<th><strong>Requirement</strong></th>
<th><strong>Comments</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Center</td>
<td></td>
<td>No notification or precertification is required for a participating facility.</td>
</tr>
<tr>
<td>Weight Management Services</td>
<td></td>
<td>Members who need or are interested in weight management services can be referred to Member Services at 1-800-600-4441. For in-network providers, no notification or precertification is required for diabetic/nutritional or weight management counseling.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Mid Cumberland Region — Lifestyle Balance Program via County Health Departments</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dickson: 615-797-5056</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Humphreys: 931-296-2231</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Williamson: 615-794-1542</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rutherford: 615-898-1891</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stewart: 931-232-5329</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Montgomery: 931-648-5747</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Davidson:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Matthew Walker Comprehensive Health Center: 615-327-9400</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• United Neighborhood Health Services: 615-226-1695</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Member should contact local health department or FQHC for an appointment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Local Health Department — Registered Dietician or Nutritionist available by appointment only.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bedford: 931-684-3426</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maury: 931-388-5757</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Upper Cumberland Region — Local Health Departments (Nutritionist available by appointment only)</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>All counties in the region</td>
</tr>
<tr>
<td>Well-woman Exam</td>
<td>Self-referral</td>
<td>Well-woman exams are covered one per calendar year when performed by a PCP or in-network GYN. Exam includes routine lab work, STD screening, Pap smear and mammogram (age 35 or older), every two years or more frequently on physician recommendation for ages 40-50 and annually for ages 50 and older.</td>
</tr>
<tr>
<td>Revenue (RV) Codes</td>
<td></td>
<td>To the extent the following services are covered benefits, precertification (preauthorization) or notification is required for all services billed with the following revenue codes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• All inpatient and behavioral health accommodations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 0023 — Home health prospective payment system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 0240 through 0249 — All-inclusive ancillary psychiatric</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 0250 — Pharmacy general</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 0632 — Pharmacy multiple source</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 3101 through 3109 — Adult day care and foster care</td>
</tr>
<tr>
<td>Service</td>
<td>Precertification Required for In-Network Provider?</td>
<td>Precertification Required for Out-of-Network Provider?</td>
</tr>
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<td>--------------------------------------------------</td>
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</tr>
<tr>
<td>Psychiatric Inpatient Hospital Services</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>23-hour Observation Bed</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>24 Hour Psychiatric Residential Treatment</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Outpatient Mental Health Services:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD Services (Psychiatry)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Outpatient Non-MD Services</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Inpatient, Residential and Outpatient Substance Abuse Services:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility Services (including detoxification)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Residential Treatment Services</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Partial Hospital</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Outpatient Treatment Services</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Ambulatory Detoxification</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Intensive Community Based Treatment (includes Continuous Treatment Team (CTT), Comprehensive Child and Family Treatment (CCFT), Program of Assertive Community Treatment (PACT))</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Psychiatric Rehabilitation Services (includes psychosocial rehabilitation, supported employment, peer recovery, family support services, illness management and recovery)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Psychiatric Rehabilitation Services Supported Housing</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Enhanced Supported Housing</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Behavioral Health Crisis Services</strong></td>
<td></td>
<td></td>
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<tr>
<td>Mobile Crisis Services</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Crisis Respite</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Crisis Stabilization</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Psychological/Neuropsychological Testing</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Injectable Drugs</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Electroconvulsive Therapy</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Court-ordered Services</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Transportation, Nonemergency For Medically Necessary Treatment</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Note: For any inpatient or outpatient behavioral health services that are not covered by contract, precertification is needed.
Inpatient Reviews

Inpatient Admission Reviews
All inpatient hospital admissions, including urgent and emergent admissions, should be requested the next business day for authorization. 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 the review is initiated. Cases may be referred to our medical director who renders a decision regarding the coverage of hospitalization. Diagnoses meeting specific criteria are referred to our medical director for possible coordination by the Case Management program.

If members have behavioral health (BH) questions, they can access the BH department at 1-800-600-4441 and follow the respective prompts. If there is a crisis, they are prompted on the front end to enter 9.

Inpatient Concurrent Review
Each network hospital will have an assigned Amerigroup UM clinician when possible. Each UM clinician will conduct a review of the hospital medical record at the hospital or by telephone to determine the authorization of coverage of medical necessity for a stay.

When an Amerigroup UM clinician reviews the medical record at the hospital, he or she may also attempt to meet with the member and family to discuss any discharge planning needs and verify that the member or family is aware of the member’s PCP name, address and telephone number. Our UM clinicians will conduct continued stay reviews daily as indicated 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, an authorization will be communicated to the hospital for the stay.

Prior to discharge, the Amerigroup 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.

Amerigroup will authorize covered length of stay one day at a time based on the clinical information that supports the continued stay for per diem hospitals. Exceptions to the one-day length of stay authorization are made for confinements when the severity of the illness and subsequent course of treatment is likely to be several days or is predetermined by state law. Examples of confinement and/or treatment include the following:

- Critical Care Unit
- Behavioral health inpatient or residential treatment
- C-section or vaginal deliveries

Exceptions may be made by our medical director.

If, based upon appropriate criteria and after attempts to speak to the attending physician, the medical director denies coverage for an inpatient request, the appropriate notice of action or letter will be faxed to the provider and mailed to the member. The facility is notified of the determination telephonically.
Discharge Planning
Discharge planning begins on admission and is designed to assist the provider and member in the coordination of health care services post-discharge when acute care (hospitalization) is no longer necessary.

When long-term care is necessary, Amerigroup works with the provider, member and significant other to help plan the member’s discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital facility such as a:
- Hospice facility
- Skilled nursing or convalescent facility
- Home health care program (e.g., home I.V. antibiotics)

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

In the case of a behavioral health discharge, the following minimum requirements should be incorporated and documented in all discharge plans for inpatient and residential treatment:
1. Discharge planning beginning at admission.
2. Involvement of member, family (if appropriate), treatment team and the Amerigroup UM care manager/any active case managers, as appropriate, in the discharge planning process.
3. Seeking collateral information from established outpatient providers, if applicable, and referring back to established providers.
4. Ensuring adequate/appropriate housing on discharge, equivalent to living situation prior to admission.
5. Coordinating medical and behavioral health services as necessary.
6. Evaluating for additional treatment needs post-discharge. If patient is to be discharged to outpatient care, ensuring follow-up with Tennessee Health Link or Intensive Community Based Treatment Provider is scheduled to occur within seven calendar days of discharge if appropriate.
7. Notifying Amerigroup care management staff of a pending discharge in accordance with the Grier Consent Decree.
8. Upon discharge, contacting the Amerigroup UM care manager with the following information:
   - Confirmation of the date of discharge
   - Member’s home address and phone number
   - Axis 1 through 5 at discharge
   - Current medications
   - Aftercare plans (include agency name and telephone number of Tennessee Health Link or Intensive Community Based Treatment provider if appropriate, other outpatient appointment date/time)

Discharge plan authorizations follow individualized medical necessity criteria and documentation guidelines including InterQual criteria. Authorizations include transportation, home health, DME, follow-up visits to practitioners or outpatient procedures.

Emergency Services
Amerigroup provides a 24 hours a day, 7 days a week Nurse HelpLine service (1-800-600-4441) with clinical staff to provide triage advice, 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. Emergency medical services are available at any available emergency care facility 24 hours a day, 7 days a week (including services outside the usual service area).
Amerigroup does not discourage members from using the 911 emergency system 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.

An emergency medical condition is defined as a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- 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 EMS departments, juvenile probation, the judicial system, child protective services, chemical dependency services, emergency services and local mental health authorities if applicable.

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

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

If the member is admitted, notify us to request an authorization for the inpatient admission. An Amerigroup review nurse will implement the review process. Medical necessity criteria will be applied based on the severity of illness and intensity of service.

If members have BH questions, they can access the BH department at 1-800-600-4441 and follow the respective prompts.

**Urgent Care**
Although Amerigroup requires its members to contact their PCP in situations where urgent, unscheduled care is necessary, precertification with Amerigroup is not required for a member to access a participating urgent care center.
15 QUALITY MANAGEMENT

Quality Management Program

Overview
Amerigroup maintains a comprehensive Quality Management/Quality Improvement (QM/QI) program to objectively monitor and systematically evaluate the care and service provided to members. The scope and content are to comply and coordinate QM program activities with applicable state and federal regulations, the National Committee for Quality Assurance (NCQA), the Utilization Review Accreditation Commission (URAC) and/or the Accreditation Association for Ambulatory Health Care (AAAHC) Accreditation standards while reflecting the demographic and epidemiological needs of the population served. We inform members and practitioners annually about the QM/QI program, and they have opportunities to make recommendations for areas of improvement. The QM/QI program goals and outcomes are available upon request to providers and members, and studies are planned across the continuum of care and service with proactive evaluation and refinement of the program.

This initial program development is based on reviewing the needs of the specific population we serve. Systematic re-evaluation of those needs occur on an annual basis. This includes not only age/sex distribution and language and specialized needs, but also a review of utilization data (i.e., inpatient, emergent/urgent care and office visits by type, cost and volume). This information defines high-volume or problem-prone areas.

There is a comprehensive committee structure in place with oversight from Amerigroup. This structure includes traditional committees, such as a peer review committee and credentialing committee, community/member advisory committees for CHOICES and ECF CHOICES services, and a Medical Advisory Committee (MAC) for practitioner engagement and feedback. In addition, there are informal opportunities for provider engagement and feedback, via town halls and topic-specific workgroups.

Practitioners and providers must allow Amerigroup to use performance data in cooperation with our QI program and activities. Pursuant to Section 5.1 of the provider contract, performance data includes access to medical records including but not limited to HEDIS® reporting and other reports aimed at improving clinical outcomes. Amerigroup is included in the reference of applicability to state and federal agency access.

Providers will permit Amerigroup or its designated agent to review records directly related to services provided to covered persons, by making records available to Amerigroup onsite at a provider’s facility upon reasonable notice from Amerigroup and during regular business hours. Providers must obtain all necessary releases, consents and authorizations to permit Amerigroup access to Amerigroup members’ medical records. Providers must also supply one copy of the records described above to Amerigroup at no charge upon request. This would include performance data in cooperation with the Amerigroup QI program and activities, and access to medical records for HEDIS reporting and other reports aimed at improving clinical outcomes. Subsequent requests or medical records will be at the provider’s current charge.

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

The QMC’s responsibilities are to:
- Establish strategic direction and monitor and support implementation of the QM program
- Establish processes and structure that ensure accreditation compliance
- Review planning, implementation, measurement and outcomes of clinical and service QI studies
- Coordinate communication of QM activities throughout the health plans
- Review HEDIS and CAHPS® data and action plans for improvement
- Review and approve the annual QM/QI program description, work plans for each service area and evaluation
- Provide oversight and ensure compliance delegated services
- Provide oversight and review of subordinate committees
- Review and approve the annual UM program description, work plans for each service area and evaluation
- Review and approve the annual Population Health program description
- Work plans for each service area and evaluation
- Ensure full integration of CHOICES and ECF CHOICES members in all aspects contained within the QI program, including reporting, analysis and interventions designed to improve overall health and well-being
- Ensure practitioner involvement through direct input from Medical Advisory Committees or other mechanisms that allow practitioner involvement
- Monitor practice patterns in order to identify appropriateness of care and for improvement/risk prevention activities

**Medical Advisory Committee (MAC)**

The purpose of the MAC is to:
- Provide applicable advice and input to the corporate committee with oversight over the development and updating of Clinical Practice Guidelines (CPGs)
- Solicit advice regarding aspects of health plan policy and operations affecting network providers or members
- Assess the levels and quality of care provided to members
- Recommend, evaluate, and monitor minimum standards of care for members
- Provide guidance and feedback regarding technology assessments

A TennCare Medical Director is invited as a guest and receives notice of the meetings no fewer than 10 days prior to the meeting date.

The MAC’s responsibilities are to:
- Review and provide input, based on characteristics of the local delivery system, including clinical protocols/guidelines to facilitate the delivery of quality care and appropriate resource utilization
- Review clinical study results and develop action plans/recommendations regarding clinical QI studies
- Review and provide input to clinically-oriented health plan policies and procedures
- Support a review of demographic and epidemiologic information targeting high-volume, high-cost, high-risk and problem-prone conditions
- Utilize an ongoing peer review system to assess levels of care and quality of care provided; consider and act in regard to physician sanctions
- Monitor practice patterns in order to identify appropriateness of care and to improve risk prevention activities

Peer review activities performed by the MAC are legally protected from discovery. The MAC is considered a peer review body as defined by the Healthcare Quality Improvement Act and Tennessee Peer Review Stature (Tennessee Code Annals §63-1-150. Applicability; Quality Improvement Committee; record confidentiality; discovery; liability).
Credentialing Committee
The purpose of the Credentialing Committee is to credential and recredential all participating practitioners according to health plan, state, federal and accreditation standards and to consider or act in regard to practitioner sanctions. The Credentialing Committee conducts review for all providers who apply for participation in the plan and reviews all participating providers for recredentialing purposes, including the review of any quality or utilization data and reports.

Clinical Services Committee
The purpose of the clinical services committee is to bring multidisciplinary leaders together to address over-and-underutilization management that present significant challenges and/or risks to the organization. The utilization operations committee also identifies opportunities to improve services and clinical performance based on a review of demographic and epidemiologic information targeting high-volume, high-cost, high-risk and problem-prone conditions.

Quality of Care
All physicians, nurse practitioners, physician assistants (PA) and other contracted facilities and ancillary providers are evaluated for compliance with pre-established standards as described in the Amerigroup credentialing program. We monitor and evaluate individual practitioner performance in the areas of health care quality and service, administration, and member satisfaction and provide appropriate feedback and remediation of individual findings when needed. Quality review of individuals may result in significant interventions depending on severity including termination from the network, reporting to state licensing agencies, the National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB).

Review standards are based on medical community standards, external regulatory and accrediting agencies requirements, and contractual compliance. Reviews are accomplished by 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.

Our quality program includes review of quality of care issues identified for all care settings. QM staff use member complaints, reported adverse occurrences (i.e., “never events”), potential quality of care or service issues and other information to evaluate the quality of service and care provided to our members.
16 CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

Secondary Non-Billing Provider Requirements
Effective June 1, 2017, all secondary/non-billing Medicaid providers (e.g., referring, rendering, ordering, etc.) must be registered with TennCare during the claims date of service. If not, the claim will reject or deny. This is for both participating and nonparticipating providers.

Medication Therapy Management Pilot (MTM)
For specific information on the requirements that need to be met to bill for MTM services, please see the MTM Provider Operations Manual, which can be found at https://www.tn.gov/tenncare/providers/pharmacy/medication-therapy-management-pilot-program.html.

Tennessee Payment Reform Initiatives
Tennessee is changing how the state pays for health care services by designing health care reform initiatives aimed to have value and outcome-based reimbursement models. Payment reform will reward high-quality care and outcomes and will encourage clinical effectiveness.

According to CRA Section A.2.13.1.9, Amerigroup will implement, and its providers will adhere to, the retrospective episode-based reimbursement and Primary Care Transformation strategies, inclusive of Patient Centered Medical Home and Tennessee Health Link, consistent with Tennessee’s multi-payer payment reform initiative in a manner and on a timeline approved by TennCare. This includes:

- Using a retrospective administrative process to reward cost and quality outcomes for the initiative's payment reform strategies that is aligned with the models designed by TennCare
- Implementing key design choices as directed by TennCare including the definition of each episode and the definition of quality measures for the initiative’s payment reform strategies
- Delivering performance reports for the initiative’s payment reform strategies with same appearance and content as those designed by the State/Payer coalition
- Implementing payment reform strategies at a pace dictated by the state; for episodes, this is approximately three to six new episodes per quarter with appropriate lead time to allow payer and provider contracting
- Participating in a state-led process to design and launch new episodes including the seeking of clinical input from payer medical teams and clinical leaders throughout Tennessee
- Implementing this aligned TennCare PCMH strategy with at least 34 percent of Amerigroup members enrolled in TennCare beginning January 1, 2019, and at least 35 percent beginning January 1, 2020.

Amerigroup is required by CRA Section A.2.13.1.10 to implement state budget reductions and payment reform initiatives including retrospective episode-based reimbursement as described by TennCare.

Electronic Submission
Amerigroup encourages the submission of claims electronically through Electronic Data Interchange (EDI). Providers must submit claims so that they are received by Amerigroup within 120 days from the date of discharge for inpatient services or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date that the third-party documents resolution of the claim. For cases of retroactive eligibility, the time frames for filing a claim will begin on the date that Amerigroup receives notification from TennCare of the member’s eligibility/enrollment. A corrected claim or replacement claim may be submitted within 120 calendar days of payment notification (paid or denied). Corrections to a claim should only be submitted if the original claim information was wrong or incomplete.
Electronic claims submission is available through (Emdeon has changed its name):

- Change Healthcare (formerly Emdeon) — Claim Payer ID 27514
- Change Healthcare (formerly Emdeon One/Capari) — Claim Payer ID 28804
- Availity — Claim Payer ID 26375
- Smart Data Solutions — Claim Payer ID 81237

Claims can be submitted electronically through the Availity web portal. For more information about Availity such as how to register, training opportunities and more, visit www.availity.com or call 1-800-AVAILITY (1-800-282-4548).

Paper Claims Submission

Providers also have the option of submitting paper claims. Paper claims must be submitted on original Red claim forms in black and white, laser printed or typed in a large, dark font. The time frames for submitting and Amerigroup receiving an original Institutional UB-04/CMS-1450 or Professional CMS-1500 (02-12) Claim form must be within 120 days from the date of discharge for inpatient services or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. A corrected claim or replacement claim may be submitted within 120 calendar days of payment notification (paid or denied). Corrections to a claim should only be submitted if the original claim information was wrong or incomplete. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date that the third-party documents resolution of the claim. For cases of retroactive eligibility, the time frames for filing a claim will begin on the date that Amerigroup receives notification from TennCare of the member’s eligibility/enrollment.

Please make sure that corrected claims are marked appropriately and submitted separately for each member and episode of care. If a corrected claim is not appropriately marked the claim may be processed as a new claim and may deny for timely filing or as a duplicate claim. Please ensure that the words “Corrected” or “Corrected Claim” are printed on each page of the claim in blue or black ink. Make certain that claims with multiple pages are labeled accordingly (e.g., 1 of 3, 2 of 3, etc.). Please note that corrected claims cannot be accepted by batch, bulk or packaged submissions. That is, one cover letter or claim that is stamped “corrected” cannot represent the status of the claims that follow; each corrected claim must be labeled individually and accompanied by the appropriate Provider Payment Dispute and Correspondence Form. This will help ensure that your claim and correspondence are scanned, interpreted and processed efficiently.

For additional information or if you have any questions, please contact our EDI Hotline at 1-800-590-5745.

CMS-1500 (02-12) and UB-04 CMS-1450 must include the following:

- Patient’s ID number
- Patient’s name
- Patient’s date of birth
- Diagnosis code/revenue codes
- Date of service
- Place of service
- Resubmission code (when applicable)
- Procedures, services or supplies rendered
- CPT-4 codes/HCPC codes/DRGs with appropriate modifiers if necessary
- Itemized charges
- Days or Units
- Provider tax ID number
- Provider name according to contract
• Amerigroup provider number
• NPI number of billing, attending and rendering provider when applicable
• State Medicaid ID number
• COB/other insurance information
• Authorization/precertification number or copy of authorization/precertification
• Name of referring physician when applicable
• NPI number of referring physician when applicable
• Any other state required data

You can access the CMS-1500 form and completion instructions at: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1188854.html.

Amerigroup cannot accept claims with alterations to billing information. Amerigroup does not accept computer-generated or typewritten claims with information that is marked through, handwritten or whitened out. Claims that have been altered will be returned to the provider with an explanation of the reason for the return.

Behavioral health practitioners must use the appropriate modifier associated with their licensure for CPT codes:

<table>
<thead>
<tr>
<th>Service description</th>
<th>Billing code</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist/M.D.</td>
<td>CPT</td>
<td>–</td>
</tr>
<tr>
<td>Licensed psychologist/Ph.D.</td>
<td>CPT</td>
<td>HP</td>
</tr>
<tr>
<td>Licensed master’s clinician</td>
<td>CPT</td>
<td>HO</td>
</tr>
<tr>
<td>Clinical nurse specialist</td>
<td>CPT</td>
<td>SA</td>
</tr>
</tbody>
</table>

Paper claims must be submitted to the following address:

Amerigroup — TN Claims
P.O. Box 61010
Virginia Beach, VA 23466-1010

Web Portal Submission
Submit claims on our website by:
• Entering claims on a preformatted CMS-1500 or 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.

Availity Web Portal for claim filing, claim status inquiries, member eligibility and benefits information:

www.availity.com
1-800-Avality (1-800-282-4548)
Support@availity.com

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.

National Drug Code Reporting Requirements
Federal and state guidelines mandate the inclusion of National Drug Code (NDC) codes on all claims with provider-administered drugs and Amerigroup will edit claims for these NDC codes. This requirement originated from the Federal Deficit Recovery Act of 2005.

Any claim received by Amerigroup with a Healthcare Common Procedure Coding System (HCPCS) code for a provider-administered drug (generally a J-code) that does not include the applicable NDC code, unit of measure and quantity in the appropriate format (as explained below) will be rejected and will need to be corrected and resubmitted as a new claim. Also, all paper claims submitted with provider-administered drugs must use the CMS-1500 (02-12) claim form. You can access the new CMS-1500 (02-12) form at [www.cms.hhs.gov](http://www.cms.hhs.gov).

Professional claims that are submitted via EDI (837P) should include applicable NDC codes in Loop 2410, LIN03 segment. In addition, providers must submit the NDC Quantity in Loop 2410, CTP04 and the unit for measurement code in Loop 2410, CTP05-01.

All paper claims with provider-administered drugs must include each drug’s NDC code in the shaded area of Form Locator 24A for each applicable claim line. Form Locator 24A must have the NDC qualifier N4 followed immediately (no spaces) by the NDC code (11 digits, no dashes) in the shaded area. The codes must be 11 digits in a 5-4-2 format. That is, the first five digits identify the manufacturer of the drug and are assigned by the FDA. The remaining digits are assigned by the manufacturer and identify the specific product and package size. Some packages will display less than 11 digits, but leading zeroes can be assumed and need to be used when billing. See below for further details. You must also include each drug’s 2-digit NDC unit of measure and numeric quantity administered to the patient in the shaded area following the NDC code of Form Locator 24A for each applicable claim line. There are five valid units of measure qualifiers that can be used (F2-International Unit, GR-Gram, ML-Milliliter, UN-unit or ME-Milligram). If reporting a fraction of a unit, use the decimal point. Nine numbers may precede the decimal and three numbers may follow the decimal.

NDC 5-4-2 formatting for 10 digit NDC codes:

XXX-X-XX = XXXX-XXXX-XX – Submitted as XXXXXXXXXXX

XXX-X-XX = XXXX-XXXXXX-XX – Submitted as XXXXXXXXX

XXX-X-XX = XXXX-XXXX-0X – Submitted as XXXXXXXXX0X
Below is an example of reporting NDC information on a CMS-1500 paper form:

<table>
<thead>
<tr>
<th>A.</th>
<th>B.</th>
<th>C.</th>
<th>D.</th>
<th>E.</th>
<th>F.</th>
<th>G.</th>
<th>H.</th>
<th>I.</th>
<th>J.</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 01 05</td>
<td>10 01 05</td>
<td>11</td>
<td>J0400</td>
<td>1</td>
<td>250.00</td>
<td>40</td>
<td>N</td>
<td>NPI</td>
<td>0123456789</td>
</tr>
</tbody>
</table>

N45914801665 UN1

10 01 05 10 01 05 11 | 12345678901 |

Should you have any questions on proper NDC formatting and submissions, please contact our EDI Helpdesk at 1-800-590-5745 or VA1Claims@amerigroup.com for assistance.

**NDC Reporting Requirements for Facilities (837I/CMS-1450 Form)**

Federal and state guidelines mandate the inclusion of NDC codes on all claims with provider-administered drugs and Amerigroup will edit claims for these NDC codes.

The Federal Deficit Recovery Act of 2005 contains requirements for all state Medicaid agencies to obtain certain claim information (including NDC, unit of measure, quantity and unit price) for all provider-administered drugs except inpatient services, radiopharmaceuticals (unless billed separate from the related procedure) and vaccines. Amerigroup will edit claims to ensure that all 837I electronic claims or CMS-1450 paper claims include this required information. This drug information is required on all Medicaid-related claim forms, even if Medicaid is a secondary or tertiary payer.

Any institutional claim received by Amerigroup with a Healthcare Common Procedure Coding System (HCPCS) code for a provider-administered drug (generally a J-code) that does not include the applicable NDC code and other quantity and pricing information in the appropriate format (as explained below) will be denied and will require additional information for reconsideration.

Each J-code submitted must have a corresponding NDC on each claim line. If the drug administered is comprised of more than one ingredient (e.g., compound drugs, same drug different strengths, etc.), each NDC must be represented. For the same drug with different strengths, the J-code should be repeated as necessary to cover each unique NDC. For compound drugs, each NDC should be represented via repeating the appropriate NDC or utilizing the compound drug section of the claim, depending on what is appropriate for the claim form.

A valid NDC must be used on all J-code drugs. To be considered valid, an NDC must be present in the correct field, in the correct format, using the 5-4-2 HIPAA standard 11-digit code, and be found on TennCare’s drug file.

Institutional claims that are submitted via EDI (837I) should include applicable NDC codes in Loop 2410, LIN03 segment. In addition, providers must submit the NDC Quantity in Loop 2410, CTP04 and the unit of measure code in Loop 2410, CTP05-01.

All paper claims with provider-administered drugs must include each drug’s NDC code in Form Locator 43 for each applicable claim line. Form Locator 43 must have the NDC qualifier N4 followed immediately (no spaces) by the NDC code. The NDC codes must be 11 characters (5-4-2 format as required by HIPAA guidelines with zeros or asterisks acting as placeholders), so it will be necessary to look up the 5-4-2 format code if something different is printed on the drug packaging.

You must also include each drug’s two-digit NDC unit of measure and numeric quantity administered to the patient in Form Locator 43 with a space between the NDC number and the NDC unit of measure for each...
applicable claim line. There are five valid units of measure qualifiers that can be used (F2-International Unit, GR-Gram, ME-Milligram, ML-Milliliter, UN-unit, or ME-Milligram). If reporting a fraction of a unit, use the decimal point. Nine numbers may precede the decimal and three numbers may follow the decimal.

Should you have any questions on proper NDC formatting and submissions, please contact our EDI Helpdesk at 1-800-590-5745 or VA1Claims@amerigroup.com for assistance.

Here are some examples for the UB-04 CMS-1450 paper form:

<table>
<thead>
<tr>
<th>42 REV. CD.</th>
<th>43 DESCRIPTION</th>
<th>44 HCPCS/DATE/HIPPS CODE</th>
<th>45 SERV DATE</th>
<th>46 SERV UNITS</th>
<th>47 TOTAL CHARGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>0259</td>
<td>N400025016608 UNI</td>
<td>J3490</td>
<td>041207</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>0450</td>
<td>EMERGENCY ROOM</td>
<td>99282</td>
<td>041207</td>
<td>1</td>
<td>36</td>
</tr>
<tr>
<td>0636</td>
<td>N465174*84021 ML1</td>
<td>J1270</td>
<td>041207</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>0636</td>
<td>N4120162.91*3 ML122</td>
<td>J29J6</td>
<td>041207</td>
<td>10</td>
<td>47</td>
</tr>
</tbody>
</table>

**Encounter Data**

Amerigroup has established and maintains a system to collect member encounter data. Due to reporting needs and requirements, network providers who are reimbursed by capitation must send encounter data to Amerigroup for each member encounter. Encounter data can be submitted through EDI submission methods or on a CMS-1500 (02-12) claim form unless other arrangements are approved by Amerigroup. Data will be submitted in a timely manner, but no later than 90 days from the date of service.

The encounter data will include the following:
- Member ID number
- 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 and state Medicaid ID number

Encounter data should be submitted to the following address:

Amerigroup — TN Claims
P.O. Box 61010
Virginia Beach, VA 23466-1010

Through claims and encounter data submissions, HEDIS information is collected. This includes the following:
- Preventive services (e.g., childhood immunization, mammography and Pap smears)
- Prenatal care (e.g., LBW and general first trimester care)
- Acute and chronic illness (e.g., ambulatory follow-up and hospitalization for major disorders)

Compliance is monitored by our utilization and quality improvement staff, coordinated with the medical director and reported to the Quality Management Committee on a quarterly basis. The PCP is monitored for compliance with reporting of utilization. Lack of compliance will result in training and follow-up audits and could result in provider termination.
Claims Adjudication
Amerigroup is dedicated to providing timely adjudication of provider claims for services rendered to members. All network and non-network provider claims that are submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by the CPT-4 and ICD-10 manuals. Hospital facility claims should be submitted using the UB-04 CMS-1450 and provider services using the CMS-1500.

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

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

Claims with diagnosis-related group (DRG) outlier charges will require an itemized bill to substantiate the outlier payment. If an itemized bill is not submitted with the claim, Amerigroup will pay the contracted DRG amount only, deny the outlier charge(s) and request an itemized bill through an explanation code on the explanation of payment (EOP). The explanation code will be “GMU” and the detailed description will read: “Billed DRG contains outlier charges. For outlier consideration, submit an itemized bill to Equian at 300 Union Blvd., Suite 200, Lakewood, CO 80228.”

In addition, if you receive a denial because you did not submit an itemized bill with a claim containing DRG outlier(s), you may email to claimsadmin@equian.com or fax to 1-800-435-2049. There is no need to submit a corrected claim with the itemized bill.

To avoid a split claim, when a provider submits one claim that contains more than one form, the provider should not total each page. The provider should enter “CONT’D” in fields 28, 29 and 30. We also request the provider add page 1 of 2, 1 of 3, etc. if possible.

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

- Claims must be received at Amerigroup within 120 days from the date the service is rendered or for inpatient claims filed by a hospital within 120 days from the date of discharge.
- In the case of other insurance, Amerigroup must receive the claim within 120 days of other insurance EOP date.
- Claims for members whose eligibility has not been added to the state’s eligibility system must be received within 120 days from the date the eligibility is added and Amerigroup is notified of the eligibility/enrollment.
- A corrected claim or replacement claim may be submitted within 120 calendar days of Amerigroup payment notification (paid or denied). Corrections to a claim should only be submitted if the original claim information was wrong or incomplete.
- Claims, including corrected claims, received after the applicable filing deadlines will be denied.

After filing a claim with Amerigroup, review the twice weekly EOP. **If the claim does not appear on an EOP within 15 business days as adjudicated or you have no other written indication that the claim has been received, check the status of your claim at https://providers.amerigroup.com or call Provider Services at 1-800-454-3730.** If the claim is not on file with Amerigroup, resubmit your claim so it is received within the applicable filing time limit for an original or corrected claim. If filing electronically, check the confirmation reports for acceptance of the claim that you receive from your EDI or practice management vendor.
Clean Claims Adjudication
A clean claim is a request for payment for a service rendered by a provider that:

- Is timely submitted by a provider
- Is accurate
- Is submitted on a HIPAA-compliant standard claim form including a CMS-1500 (02-12) or UB-04 CMS-1450 or successor forms thereto or the electronic equivalent of such claim form
- Is a complete claims submission following any and all HIPAA compliance standards (Levels 1-7)
- Includes NPI and taxonomy information for rendering, attending and billing providers
- Includes, for all J-codes billed, NDC code and drug pricing information (NDC quantity, unit price and unit of measurement) are required. Exceptions are:
  - Vaccines for children which are paid as an administrative fee
  - Inpatient administered drugs
  - Radiopharmaceuticals unless the drug is billed separately from the procedure
- Requires no further information, adjustment or alteration by a provider in order to be processed and paid by Amerigroup.

Ninety percent of clean claims are adjudicated within 30 days and 99.5 percent within 60 days of receipt of a clean claim.

Paper or Amerigroup website claims that are determined to be unclean will be returned to the billing provider along with a letter stating the reason for rejection for those claims submitted on paper. Electronic claims (EDI) that are determined to be unclean will be returned to an Amerigroup contracted clearinghouse and in turn will be reported out to either the billing provider or the vendor the billing provider used to submit the claim.

Amerigroup produces and mails an EOP on a twice-per-week basis, which delineates for the provider the status of each claim that has been adjudicated during the previous claim cycle.

Disclosure of Ownership
All contracted providers are required to register with TennCare and provide their disclosure information. TennCare collects this information when a provider registers/re-verifies with them and sends a file to us on a weekly basis as the authorized source of disclosure information. During the initial credentialing process, we verify the provider’s information is in the state file before submitting any application or contract to be completed. If the provider is not in the state DOO file, the credentialing department will contact the provider to ensure he or she registers.

If an existing provider has not registered with TennCare and is not listed on the state file, we will give 120 days from the date of service on the claim for the provider to register with TennCare and reprocess the claim. A provider is required to reatest/revalidate every three years with TennCare. Failure to register/revalidate with TennCare will result in termination from the Amerigroup network.

Claims Status
Providers can check the status of claims at https://providers.amerigroup.com or call Provider Services at 1-800-454-3730 to check claims status. Providers should also use the claims status information available for claims that were electronically submitted through a clearinghouse for information on accepted and rejected claims.

Amerigroup supports the ability to obtain real time claim status information using the 276/277 transaction through Smart Data Solutions. Providers interested in utilizing this functionality can contact Smart Data Solutions directly at 1-855-297-4436 to obtain additional information.
Provider Reimbursement
In accordance with TennCare contractor risk agreement (CRA) section A.2.13.2.2, Amerigroup shall not reimburse providers based on automatic escalators or linkages to other methodologies that escalate, such as current Medicare rates or inflation indexes, unless otherwise allowed by TennCare.

Electronic Funds Transfer and Electronic Remittance Advice
Amerigroup offers Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) with online viewing capability. Providers can choose to receive Amerigroup payments electronically through direct-deposit to their bank accounts. If providers choose to receive Amerigroup payment via EFT, they must contact one of our EFT/ERA vendors for enrollment. In addition, providers can select from a variety of remittance information options including:

- Electronic remittance advice 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

As a provider, you can gain immediate benefits by signing up for PaySpan Health:

- **Improve efficiency for free.** Reduce processing errors. You pay nothing to use PaySpan Health.
- **Improve cash flow.** Get payments electronically, improving cashflow.
- **Reduce accounting expenses.** Import ERAs/835s directly into practice management or health information systems, eliminating the need for manual entry.
- **Match payments to advices/vouchers.** Reconcile electronic payments with advices/vouchers quickly and easily.
- **Maintain control over bank accounts.** Keep total control over the destination of claim payment funds. PaySpan Health supports multiple practices and accounts.
- **Manage multiple payers.** Reuse enrollment information to connect with multiple payers. Assign different payers to different bank accounts as desired.
- **Increase access to information.** Get faster access to adjudicated claim information and get more remittance details.
- **Mailbox capability.** Establish a mailbox for automated delivery of 835s and/or PDFs

To register for ERA/EFT, please visit our website at [https://providers.amerigroup.com](https://providers.amerigroup.com).

PCP Reimbursement
Amerigroup reimburses PCPs according to their contractual arrangement.

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

Specialty care providers 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 by Amerigroup.
Hospice
Effective July 1, 2018, there are no longer distinct Level 1 and Level 2 nursing facility rates in the state of Tennessee. The new blended rate will be loaded to the nursing facility Level 1 Medicaid ID.

Revenue code 0658 and procedure codes Q5003 or Q5004 should be used. The use of T codes will cause the claim to deny.

Hospices must report the NPI of any nursing facility where the patient is receiving hospice services, regardless of the level of care provided when the site of service is not the billing hospice. As of July 1, 2018, the billing hospice provider must obtain the NPI for the facility where the patient is receiving care and report the facility’s name, address, and NPI in box 80 of the UB-04 claim form. If any of the three items are missing in box 80, the claim will deny. Box 80 contains four lines with a 19-character limit on line 1 and a 24-character limit on lines 2-4.

Patient liability information should be in box 39, 40 or 41 with value code 23 and the patient liability amount. If there is no patient liability amount, please enter $0. If patient liability is left blank, the claim will deny.

Providers should bill for date of death.

Routine care (revenue code 0651 with applicable HCPCS Q codes) will be reimbursed depending on the number of days the member is in hospice. The payment will be reduced beginning with day 61. These calculations are subject to the normal wage index.

SIA payment for hospice services will include revenue code 0551 with HCPCS code G0299 (RN) or revenue code 0561 with HCPCS code G0155. Reimbursement will have a max of four hours (in 15-minute intervals) or 16 units per day combined for both disciplines. These services will occur during the last seven days of life. Per CMS, the state period cannot span accounting years.

Claims that are received for a member who has been disenrolled from hospice and elects to re-enroll within 60 days will continue with the current date/payment calculations.

Claims that are received for a member who has been disenrolled from hospice and elects to re-enroll outside of 60 days will restart routine care eligibility and day one for pricing.

Palliative Care and Physician Charges
Services should be billed on a CMS-1500 (professional) claim form.

For palliative care, the claim should include the appropriate required data including CPT codes, practitioner in box 24j and the hospice billing facility in box 33.

There are no benefit or lifetime maximum restrictions for palliative care.

Procedure for Processing Overpayments
Refund notifications may be identified by two entities, Amerigroup Cost Containment Unit (CCU) or the provider. The CCU researches and notifies the provider of an overpayment 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, CCU will notify the provider of the overpayment. The provider will have the option to submit a Refund Notification Form along with the refund check or have the overpayment offset from future claim payments. If a provider identifies the overpayment and returns the
Amerigroup check, 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/TN. The submission of the Refund Notification Form will allow the CCU 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.

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.

**What does this mean for you?**

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.

**Claim Payment Disputes**

**Provider Claim Payment Dispute process**

If you disagree with the outcome of a claim, you may begin the Amerigroup provider payment dispute process. The simplest way to define a claim payment dispute is when the claim is finalized but you disagree with the outcome.

Please be aware, there are three common claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, these are briefly defined below. They are:

- **Claim inquiry:** A question about a claim, but not a request to change a claim payment
- **Claims correspondence:** When Amerigroup requests further information to finalize a claim. Typically, these requests include medical records, itemized bills or information about other insurance a member may have. A full list of correspondence-related materials are in the *Correspondence Section* of this Provider Manual.
- **Medical necessity appeals:** A pre-service appeal for a denied service. For these, a claim has not yet been submitted.

For more information on each of these please refer to the appropriate section in this Provider Manual.

The Amerigroup provider payment dispute process consists of two internal steps and a third external step. You will **not** be penalized for filing a claim payment dispute and no action is required by the member.

1. **Claim payment reconsideration:** This is the first step in the Amerigroup provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.
2. **Claim payment appeal:** This is the second step in the Amerigroup provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.

3. **Regulatory complaint:** The state of Tennessee supports an external review process if you have exhausted both steps in the Amerigroup payment dispute process but still disagree with the outcome. See the Independent Review section of this Provider Manual.

A claim payment dispute may be submitted for multiple reason(s) including:
- Contractual payment issues.
- Disagreements over reduced or zero-paid claims.
- Postservice authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Retroeligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues.*

* Timely filing issues: Amerigroup will consider reimbursement of a claim which has been denied due to failure to meet timely filing if you can 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists. Please refer to Provider Manual for additional information regarding timely filing and good cause requests.

### Claim Payment Reconsideration

The first step in the Amerigroup claim payment dispute process is called the reconsideration. The reconsideration is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally and through our provider website within 365 calendar days from the date on the EOP (see below for further details on how to submit). Reconsiderations filed more than 365 calendar days from the EOP will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect. If a reconsideration requires clinical expertise, it will be reviewed by appropriate clinical Amerigroup professionals.

Amerigroup will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

We will send you our decision in a determination letter, which will include:
- A statement of the provider's reconsideration request.
- A statement of what action Amerigroup intends to take or has taken.
- The reason for the action.
- Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references.
5. An explanation of the provider’s right to request a claim payment appeal within 63 calendar days of the date of the reconsideration determination letter.
6. An address to submit the claim payment appeal.
7. A statement that the completion of the Amerigroup claim payment appeal process is a necessary requirement before requesting a state fair hearing.

If the decision results in a claim adjustment, the payment and EOP will be sent separately.

Claim Payment Appeal
If you are dissatisfied with the outcome of a reconsideration determination you may submit a claim payment appeal.

We accept claim payment appeals through our provider website or in writing within 63 calendar days of the date on the reconsideration determination letter.

Claim payment appeals received more than 63 calendar days after the explanation of payment or the claims reconsideration determination letter will be considered untimely and will be upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. Please note, we cannot process a claim payment appeal without a reconsideration on file.

If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical Amerigroup professionals.

Amerigroup will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

The claim payment appeal determination letter will include:
   1. A statement of the provider’s claim payment appeal request.
   2. A statement of what action Amerigroup intends to take or has taken.
   3. The reason for the action.
   4. Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references.
   5. A statement about how to submit a state fair hearing.

If the decision results in a claim adjustment, the payment and EOP will be sent separately.

How to submit a Claim Payment Dispute
We have several options when filing a claim payment dispute. They are described below.

- Verbal (reconsideration only): Verbal submissions may be submitted by calling Provider Services at 1-800-454-3730.
- Website (reconsideration and claim payment appeal): Amerigroup can receive reconsiderations and claim payment appeals via the secure Provider Availity Payment Appeal Tool at https://www.availity.com. Supporting documentation can be uploaded to the Availity Portal. You will receive immediate acknowledgement of your submission.
- Written (reconsideration and claim payment appeal): Written reconsiderations and claim payment appeals should be mailed along with the Claim Payment Appeal Form or the Reconsideration Form to:
  Provider Payment Disputes
Submit reconsiderations on the *Reconsideration Form* located at: https://providers.amerigroup.com/TN.
Submit written claim payment appeals on the *Claim Payment Appeal* form located at: https://providers.amerigroup.com/TN.

**Required Documentation for Claims Payment Disputes**
Amerigroup requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

- Your name, address, phone number, email, and either your NPI or TIN.
- The member’s name and their Amerigroup or Medicaid ID number.
- A listing of disputed claims, which should include the Amerigroup claim number and the date(s) of service(s).
- All supporting statements and documentation.

If a claim has been denied for timely filing, the following are acceptable forms of documentation for payment reconsideration:

- EOB or Explanation of Medicaid Benefits from the primary health payer dated within 120 days of claim submission to Amerigroup
- Confirmation of denial from the health payer within 120 days of claim submission to Amerigroup
- Documentation regarding the provision of the member’s health plan insurance information dated within 120 days of claim submission to Amerigroup
- Documentation proving Amerigroup contributed to the filing delay
- Electronic report that states Amerigroup accepted the claim
- Computer-generated activity report that shows the date an electronic claim was originally submitted to Amerigroup (an acceptable report must contain a patient name or identification number, the date of service, and an indication the original claim was submitted electronically and accepted by Amerigroup)
- Copy of accounts receivable or billing statement to member showing dates of bills if no other insurance

The following are not acceptable forms of documentation for timely filing payment reconsideration:

- Screenshots showing dates of a claim previously submitted to the health plan
- *CMS-1450* or *UB-04* with print date located in box 31 or box 86, respectively
- Electronic report stating the health plan has rejected the claim

**Claim Inquiry**
A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but outcome of the claim inquiry may result in the initiation of the claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Our Provider Experience program helps you with claim inquiries. Just call 1-800-454-3730 and select the *Claims* prompt within our voice portal. We connect you with a dedicated resource team called the Provider Service unit (PSU), to ensure:

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

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.
**Claim Correspondence**

Claim correspondence is different from a payment dispute. Correspondence is when Amerigroup requires more information in order to finalize a claim. Typically, Amerigroup makes the request for this information through the EOP. The claim or part of the claim may be denied, but it is only because more information is required to process the claim. Once the information is received, Amerigroup will use it to finalize the claim.

The following table provides examples of the most common correspondence issues along with guidance on the most efficient ways to resolve them.

<table>
<thead>
<tr>
<th>Type of Issue</th>
<th>What Do I Need to Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rejected Claim(s)</td>
<td>Use the <strong>EDI Hotline</strong> at 1-800-590-5745 when your claim was submitted electronically but was never paid or was rejected. We’re available to assist you with setup questions and help resolve submission issues or electronic claims rejections.</td>
</tr>
</tbody>
</table>
| EOP Requests for Supporting Documentation (Sterilization/ Hysterectomy/Abortion Consent Forms, itemized bills and invoices) | Submit a **Claim Correspondence Form**, a copy of your EOP and the supporting documentation to:  
  - Claims Correspondence  
  - P.O. Box 61599  
  - Virginia Beach, VA 23466-1599 |
| EOP Requests for Medical Records                               | Submit a **Claim Correspondence Form**, a copy of your EOP and the medical records to:  
  - Claims Correspondence  
  - P.O. Box 61599  
  - Virginia Beach, VA 23466-1599 |
| Need to submit a corrected claim due to errors or changes on original submission | Submit a **Claim Correspondence Form** and your corrected claim to:  
  - Claims Correspondence  
  - P.O. Box 61599  
  - Virginia Beach, VA 23466-1599  
  Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received in a timely manner, a corrected claim must be received within 365 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Amerigroup to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI EOB. |
| Submission of coordination of benefits (COB)/third-party liability (TPL) information | Submit a **Claim Correspondence Form**, a copy of your EOP and the COB/TPL information to:  
  - Claims Correspondence  
  - P.O. Box 61599  
  - Virginia Beach, VA 23466-1599 |
| Emergency Room Payment Review                                   | Submit a **Claim Correspondence Form**, a copy of your EOP and the medical records to:  
  - Claims Correspondence  
  - P.O. Box 61599  
  - Virginia Beach, VA 23466-1599 |
Medical Necessity Appeals
Medical necessity appeals refer to a situation in which an authorization for a service was denied prior to the service. Medical necessity appeals/prior authorization appeals are different than claim payment disputes and should be submitted in accordance with the medical necessity appeal process.

Independent Review
If Amerigroup continues to deny the provider’s claim(s) or if Amerigroup does not respond to the reconsideration request within the specified time frames, then the provider may file a written request with TDCI to submit the payment dispute to an independent reviewer.

The provider must include a copy of the written request for reconsideration with the request for an independent review. If the provider does not have a written contract with Amerigroup on the date the request is filed with TDCI, then the provider must also send TDCI payment satisfactory to TDCI to cover the fees incurred by the independent reviewer. This payment will be refunded to the provider if the provider is not ultimately required to pay the independent reviewer. Otherwise, the payment will be used to reimburse any entity that paid the independent reviewer. The provider will also furnish TDCI any other information needed by TDCI to process the provider’s request.

The provider must file a request for independent review within 365 calendar days after:
- The date Amerigroup denies the claim
- The date Amerigroup recoups the claim
- The date Amerigroup fails to respond within the specified time frames

Claims payment disputes involved in litigation, arbitration or not associated with a TennCare member are not eligible for independent review.

TDCI will use best efforts to refer an equal proportion of the total disputed payment claims to each independent reviewer. A provider may request, and TDCI may allow, the payment claims of a provider involving Amerigroup to be aggregated and submitted for simultaneous review by an independent reviewer when the specific reason for nonpayment of the claims aggregated involve a dispute regarding a common substantive question of fact or law. The mere fact that a claim is not paid does not create a common substantive question of fact or law, unless the provider has received no remittance advice or other appropriate written or electronic notice from Amerigroup, either partially or totally denying a claim, within 60 calendar days of the receipt of the claim by Amerigroup and such claims regard a common substantive question of fact or law. The reviewer will, within 14 calendar days of receipt of the disputed claim or claims, request in writing that both the provider and Amerigroup provide the reviewer any and all information and documentation regarding the disputed claim or claims. The reviewer will request the provider and Amerigroup to identify all information and documentation that has been submitted by the provider to Amerigroup regarding the disputed claim or claims, and advise that the reviewer will not consider any information or documentation not received within 30 calendar days of receipt of the reviewer’s request unless Amerigroup or the provider requests additional time to complete the investigation of independent review requests when a provider elected to aggregate his or her claims. Thereupon, the reviewer may grant Amerigroup or the provider an additional 30 calendar days. The reviewer will then examine all materials submitted and render a decision on the dispute within 60 calendar days of the receipt of the disputed claim or claims, unless either the reviewer requests guidance on a medical issue from the TennCare appeals unit, or the reviewer requests and receives an extension of time from TDCI to resolve the dispute. In reaching a decision, the reviewer will not consider any information or documentation from the provider that the provider did not submit to Amerigroup during that organization’s review of the provider’s disputed claim or claims.
Should the reviewer need assistance on a medical issue connected with the disputed claim or claims, then the reviewer will refer this specific issue for review and response to the person in charge of the TennCare appeals unit within the Division of TennCare, unless the department in writing designates a different contact. Medical issues requiring referral may include whether a medical benefit is a covered service under the TennCare contract. The TennCare appeals unit may respond to the request, refer the request to an independent contractor, or refer the request to the Division of TennCare for review. A request to determine whether a service received was medically necessary must be responded to by a physician licensed by one or more states in the United States. The appeals unit will provide a concise response to the request within 120 calendar days after receipt. If the appeals unit seeks the guidance of the Division of TennCare on whether a benefit is a covered service, then the Division of TennCare must respond to that request in writing in sufficient time to allow the appeals unit to timely respond to the reviewer. The reviewer will make a final decision within 30 calendar days of receipt of the appeals unit’s response.

The reviewer will send Amerigroup, the provider and the TDCI TennCare Oversight Division a copy of the decision. Once the reviewer makes a decision requiring Amerigroup to pay any claims or portion thereof, Amerigroup will send the payment in full to the provider within 20 calendar days of receipt of the reviewer’s decision.

Within 60 calendar days of a reviewer’s decision, either party to the dispute may file suit in any court having jurisdiction to review the reviewer’s decision and to recover any funds awarded by the reviewer to the other party. Any claim concerning a reviewer’s decision not brought within 60 calendar days of the reviewer’s decision will be forever barred. Suits filed pursuant to this section will be conducted in accordance with the Tennessee Rules of Civil Procedure, and the review by the court will be de novo without regard to the reviewer’s decision. The reviewer, or any person assisting the reviewer in reaching a decision, will be prohibited from testifying at the court proceeding considering the reviewer’s decision. Unless the contract between the parties specifies otherwise, venue and jurisdiction will be in accordance with Tennessee law. If the dispute between the parties is not fully resolved prior to the entry of a final decision by the court initially hearing the dispute, then the prevailing party will be entitled to an award of reasonable attorney’s fees and expenses from the nonprevailing party. Reasonable attorney’s fees means the number of hours reasonably expended on the dispute multiplied by a reasonable hourly rate and will not exceed 10 percent of the total monetary amount in dispute or $500, whichever amount is greater.

In lieu of requesting independent review, a provider may pursue any appropriate legal or contractual remedy available to the provider to contest the partial or total denial of the claim.

Providers who are owned by state or local governmental entities will retain the statutory right of setoff if available. Judicial review of a reviewer’s decision regarding a state or local governmental provider will be in the Chancery Court of Davidson County, and not in the Tennessee Claims Commission, unless the provider and Amerigroup have agreed to another appropriate venue and jurisdiction by contract. The Prompt Pay Act, compiled in title 12, chapter 4, part 7, does not impact any claim of sovereign immunity that a state or local governmental provider may possess, although such a provider will be responsible for paying any appropriate attorney’s fees and expenses awarded.

All costs associated with implementing these procedures will be paid by Amerigroup. However, the provider will reimburse Amerigroup the independent reviewer’s fee within 20 calendar days of receipt of the reviewer’s decision, if the reviewer finds that Amerigroup properly denied the claim being reviewed. If a provider fails to properly reimburse Amerigroup, the TDCI TennCare Oversight Division may prohibit that provider from future participation in the independent review process.

Providers who must reimburse Amerigroup the independent reviewer fee should send their check to:
Amerigroup will compensate the independent reviewer pursuant to their written agreement within 30 calendar days of the receipt by Amerigroup of the independent reviewer’s bill for services rendered. If Amerigroup fails to pay any such bill for the independent reviewer’s services, then the independent reviewer may request payment directly from the state from any funds held by the state that are payable to Amerigroup.

**Coordination of Benefits and Third-party Liability Resources**

TennCare Program requirements will be followed when third party liability resources (including subrogation) coordination of benefits procedures are necessary. Amerigroup agrees to use covered medical and hospital services whenever available or other public or private sources of payment for services rendered to members in the Amerigroup plan. Amerigroup and its providers agree that the Medicaid program will be the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicaid members.

Providers have an obligation to request third-party payer information for TennCare enrollees. Providers generally request third-party information from patients at the point of service and should bill the third party prior to billing Amerigroup.

When Amerigroup is aware of third-party resources prior to paying for a medical service, it will avoid payment by denying a provider’s claim and redirecting the provider to bill the appropriate insurance carrier unless certain pay and pursue circumstances apply. If Amerigroup denies a claim for third party liability, the provider may verify other health insurance by visiting our provider website at [https://providers.amerigroup.com](https://providers.amerigroup.com) or by contacting our Provider Services department at 1-800-454-3730 (or 1-866-805-4589 for Medicare providers).

When processing claims previously paid by a third-party resource, Amerigroup first reviews the primary carrier’s EOP, and then the claim is coordinated by using the primary allowed amount or the Amerigroup allowed amount, whichever is the lesser. Third-party liability claims submitted for secondary payment by Amerigroup without the primary carrier’s EOP will be denied stating the member has other insurance.

**Pay and pursue circumstances are:**

- When the services are for preventive pediatric care including EPSDT
- If the claim is for prenatal or postpartum care or if service is related to OB care
- If the billed designated behavioral health services (typically not covered by major medical health plans) contain one of the following procedure codes:
  - H0043-H0044 (supported housing)
  - H2014-H2018 (skills training, community support and psychosocial rehab)
  - H2023-H2027 (employment support)
  - H0038 (peer support)
  - T1016, T2022, T2023, H0036, H0037, H0039, H0049, H2015, H2016 (behavioral health case management services)
  - H0031 (mental health assessments)
  - H0019 (behavioral health residential without room and board)
  - S9484, S9485 (crisis intervention)
- If any service rendered to a child of an absent parent (i.e., primary coverage is through a noncustodial parent after a divorce)
For these types of services, Amerigroup will pay the claim and pursue reimbursement from the appropriate party.

In some situations, Amerigroup may not learn of the existence of a third-party payer until after it has made payment on the claim. In these situations, Amerigroup has several options for recovering claim payment. One option is the provider may refund payments he or she has received from Amerigroup. Once a provider has refunded a payment received from Amerigroup, the provider may not resubmit another claim to Amerigroup for the same service furnished to the same member on the same date.

To return an overpayment to Amerigroup, a provider must complete a Refund Notification Form specifying the reason for the return.

The Refund Notification Form can be found at https://providers.amerigroup.com/TN. Under Provider Resources & Documents, select Forms > Refund Notification Form.

All refunds along with a completed Refund Notification Form should be mailed to:

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

If the provider does not refund the payment, Amerigroup may recover its payment to the provider if the following conditions are met:

- The claim was for a service delivered to an adult aged 21 and older, unless the adult is a pregnant woman who is receiving prenatal care.
- Fewer than nine months have passed since the date of service when there is a commercial insurer involved and fewer than two years have passed since the date of service when Medicare is involved.

Amerigroup will distribute a refund request letter that includes the:

- Name of the provider
- List of claims or a reference to a remit advice date
- Reason for the overpayment
- Contact and policy information for the third-party resource
- Time frames for payment or appeal of the decision of Amerigroup
- Information about how to file an appeal
- Request that the provider bill the commercial insurance carrier or Medicare

If the provider agrees with the refund request letter, the requested amount should be returned to Amerigroup within 45 calendar days from the date of the letter. If the provider does not agree, an appeal can be filed within 45 calendar days from the date of the refund request letter. The provider will have an additional 30 days to provide supporting documentation for the appeal. Providers should include a copy of the denial from the primary insurance carrier, if available, in the appeal request.

Please note that regardless of the type of service rendered, if Amerigroup determines that a duplicate payment has been received for a service (i.e., the provider billed and received payment from both the third-party insurance carrier and Amerigroup), Amerigroup has the right to recover the duplicate payment.
**Medicaid Reclamation and Refunds for TennCare Providers**

TennCare providers have an obligation to identify any available third-party liability (TPL) insurance for a particular enrollee and to bill that TPL insurance before billing TennCare. When you are paid by TennCare or Amerigroup prior to securing payment from the TPL insurance, your payments are subject to reclamations. If you then bill the TPL insurance and are notified your claim is being denied as a duplicate payment, you have an opportunity to get refunds of these payments from us or TennCare. The new TPL Policy can be accessed at https://www.tn.gov/content/dam/tn/tenncare/documents2/con09001.pdf.

If a member’s third-party insurance denies your claim because payment has already been sent to TennCare, you may complete and submit TennCare’s Provider Refund Request Form. You can find this form on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents/medicaidreclamation.pdf. For more detailed information on this process, see the TennCare Policy Manual.

If a member’s third-party insurance denies your claim because payment has already been sent to us, you should contact your Amerigroup Provider Relations representative for assistance. For more detailed information on this process, see our Medicaid Reclamation Refund Request Form, which is available in the forms appendix of this manual and on our website at https://providers.amerigroup.com/TN.

Note: When you contact TennCare with a reclamation refund request, TennCare will only pay the Medicaid amount initially paid to you on behalf of the member by Amerigroup, not the third-party insurer’s rate.

**Billing Members**

**Overview**

Before rendering services, providers should always inform members that the cost of services not covered by Amerigroup will be charged to the member.

A provider who chooses to provide services **not covered** by Amerigroup:

- Understands that Amerigroup only reimburses for services that are medically necessary, including hospital admissions and other services
- Obtains the member’s signature on the Client Acknowledgment Statement specifying that the member will be held responsible for payment of services
- Understands that he or she 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

According to CRA language 2.6.7.5 and the TennCare policy N0: PRO-08-001 (Rev. 9), providers or collection agencies acting on the provider’s behalf may not bill members for amounts other than applicable TennCare cost sharing responsibilities for covered services, including services that the state or Amerigroup has not paid for, except as permitted by TennCare rules and regulations and as described below. Providers may seek payment from a member only in the following situations:

- If the services are not covered services and, prior to providing the services, the provider informed the member that the services were not covered. The provider must inform the member of the noncovered service and have the member acknowledge the information. If the member still requests the service, the provider will obtain such acknowledgment in writing prior to rendering the service. Regardless of any understanding worked out between the provider and the member about private payment, once the provider bills Amerigroup for the service that has been provided, the prior arrangement with the member becomes null and void without regard to any prior arrangement worked out with the member.
- If the member’s TennCare eligibility is pending at the time services are provided and if the provider informs the person that he or she will not accept TennCare assignment whether or not eligibility is established retroactively. Regardless of any understanding worked out between the provider and the
member about private payment, once the provider bills Amerigroup for the service the prior arrangement with the member becomes null and void without regard to any prior arrangement worked out with the member.

- If the member’s TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable TennCare cost sharing amounts must be refunded when a claim is submitted to Amerigroup because the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established (the monies collected will be refunded as soon as a claim is submitted and will not be held conditionally upon payment of the claim).

- If the services are not covered because they are in excess of a member’s hard benefit limit, and the provider complies with applicable TennCare rules and regulations.

Amerigroup will require, as a condition of payment, that the provider accept the amount paid by Amerigroup or appropriate denial made by Amerigroup (or, if applicable, payment by Amerigroup that is supplementary to the member’s third-party payer) plus any applicable amount of TennCare cost-sharing responsibilities due from the member as payment in full for the service. Except in the circumstances described above, if Amerigroup is aware that a provider, or a collection agency acting on the provider’s behalf, bills a member for amounts other than the applicable amount of TennCare cost sharing responsibilities due from the member, Amerigroup will notify the provider and demand that the provider and/or collection agency cease such action against the member immediately. If a provider continues to bill a member after notification by Amerigroup, Amerigroup will refer the provider to the Tennessee Bureau of Investigation.

**Amerigroup members must not be balance-billed for an amount above that which is paid by Amerigroup for covered services.**

In addition, providers may not bill a member if any of the following occurs:

- Failure to timely submit a claim, including claims not received by Amerigroup
- Failure to submit a claim to Amerigroup for initial processing within the 120-day filing deadline
- Failure to submit a corrected claim within 120 calendar days of payment notification (paid or denied)
- Failure to dispute a claim within the 365-day administrative appeal period
- Failure to appeal 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**

A provider may bill an Amerigroup member 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
- The provider obtains and keeps a written acknowledgement statement signed by the member and the provider 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 reasonable and 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: _____________________________________________________

If the provider bills Amerigroup for noncovered services, the member cannot be billed, regardless of any written agreement with the member.

Amerigroup Website and the Provider Inquiry Line
Amerigroup recognizes that in order to provide the best service to members, you need accurate, up-to-date information. Amerigroup offers two methods of accessing claim status, member eligibility and authorization status 24 hours a day, 365 days a year:

- https://providers.amerigroup.com
- Toll-free automated provider inquiry line: 1-800-454-3730

Our website provides a host of online resources, featuring our online provider inquiry tool for real-time claim status, eligibility verification and authorization status. Detailed instructions for use of the online provider inquiry tool can be found on our website.

Toll-free automated provider inquiry line (1-800-454-3730): for real-time member status, claim status and authorization status. This option also offers the ability to be transferred to the appropriate department for other needs such as requesting new authorizations, ordering referral forms or directories, seeking advice in case or care management or obtaining a member roster. Detailed instructions on the use of the Provider Inquiry line are set forth below.

Follow these easy steps to access member status information:
1. Dial 1-800-454-3730. After saying your NPI number or your provider ID and TIN, listen for the prompt.
   - You can say member status, eligibility or enrollment status.
2. Be prepared to say the member’s Amerigroup number, ZIP code and date of service.
3. You can also search by Medicaid ID, Medicare ID or SSN.
   - Just say I don’t have it when asked to say the member’s Amerigroup number, then say the ID type you would like to use when prompted for it.
4. The system will verify the member’s eligibility and PCP
   
   Say another member to access another member’s status
   Say main menu to perform other transactions
   Say representative to be transferred to a live agent
   Or simply hang up if you are done

Follow these easy steps to review claim status:
1. Dial 1-800-454-3730 and listen for the prompt.
   - At the main menu, say claims.
   - You can get the status of a single claim or the five most recent claims.
You can speak to someone about a payment appeal form or an EOP.

2. Be prepared to say the claim number or member number/date of service
   - If you don’t have any of these you can hear the five most recent claims by saying recent claims.

Follow these easy steps to review authorization status:
1. Dial 1-800-454-3730 and listen for the prompt
   - At the main menu, say authorizations or referrals
   - Say authorization status to hear up to ten outpatient statuses or one inpatient authorization status
   - Say new authorization and be transferred to the correct department based on authorization type
   - Be prepared to say the member’s Amerigroup number, ZIP code, date of birth and date of service
   - Say the admission date or the first date for the start of service in MM/DD/CCYY format

Say repeat to hear the information again
Say another claim
Say main menu to perform other transactions
Say representative to be transferred to a live agent
Or simply hang up if you are done.
17 MEDICAL RECORDS

Amerigroup requires medical records to be maintained in a manner that is current, detailed and organized, and that promotes effective and confidential patient care and quality review. Medical records are available in the event use and disclosure of the medical records is required by law for administrative, civil and/or criminal investigations and/or prosecutions.

Providers are required to maintain medical records that conform to professional medical practice standards and appropriate health management. A permanent medical record must be maintained at the primary care site for every member and be available to the PCP and other providers with whom the member has a treatment relationship.

The QM department may assess any provider’s medical record documentation against the plan’s medical record documentation standards as needed based on quality improvement outcomes and initiatives. Additionally, the QM department will perform an annual review on all Contracted Opioid MAT (Medication Assisted Treatment) Providers against the TennCare required standards relevant to the TennCare Opioid MAT Program Description (CRA 2.11.4.1.1.2). QM representatives conduct the audits and utilize a standard tool to measure compliance. To ensure continuity in the assessment of provider compliance, QM representatives must complete and pass an annual Interrator Reliability (IRR) test.

A passing score for providers is 85 percent with the exception of Contracted Opioid MAT Providers for which a passing score is 80 percent. Any score below passing may require the provider to submit a corrective or quality improvement action plan for review and approval by the health plan.

The standards developed for medical record documentation reflect a set of commonly accepted standards, clinical practice guidelines and EPSDT visits. The standards include demographic information, health history, details of ongoing clinical and mental health issues and preventive health care. Records kept in accordance with these standards facilitate effective medical care and continuity of care among practitioners. Only records within one year of the date of audit are reviewed. An equal number of medical records that represent both adults and children are selected for review as appropriate for the practitioner and based on diagnosis representative of targeted clinical practice guidelines.

Medical records must be kept in accordance with Amerigroup, federal and state standards as follows:

**Medical Record Documentation Standards — Primary Care Providers**

<table>
<thead>
<tr>
<th>1. Standard</th>
<th>Core Standards</th>
<th>Rationale</th>
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| Provider has in place policy and procedures to ensure confidentiality to the extent provided by TCA-33-3-101 and HIPPA regulations, security as defined by HIPPA, and member accessibility to the extent provided by TCA 63-2-101/63-2-102/33-3-104 et seq of medical records.  
*CRA A.2.24.8.2.3.2  
*CRA A.2.24.8.2.3.3  
*CRA A.2.24.8.2.3  
*CRA A.2.24.8.2.4* | To ensure the confidentiality, security and member accessibility of medical records |
A policy and procedure is in place for cultural competency training of staff on an annual basis.

Patient demographic data is present in chart and name or ID # is on each document.

To prevent the prescribing of any medication that the patient is allergic to.

A current medication list is present in patient record. (For best practice: dosage, date medication was initiated, and dates of refills are present)

NCQA 2007-02-08-105600-000 Guidelines for Medical Record Documentation

A centrally located listing of a member's maintenance medications assists the provider and support staff with an overview of prescribed medications. The provider can easily assess medications for possible drug interactions, treatment history and management of potential habit-forming medications. Medications when clearly identified prevent duplication of prescriptions.

Maintaining a current problem list enhances information from which a provider can effectively develop a treatment plan and the ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time.

Past medical history is present and includes serious accidents, operations, substance abuse, family history and illnesses. For children ages birth through age 20, developmental/behavioral assessment is included. Infantile histories should be present as appropriate. NCOA 2007-02-08-105600-000 Guidelines for Medical Record Documentation

All patients need to have documentation of medical/social histories in their record base from which planned courses of treatment can be developed. Substance abuse is an important factor when planning a course of treatment and to diagnose a particular problem. Behavioral along with physical assessment for children gauges how well a child's development is progressing based on age.

Adult immunizations are important preventive medical procedures. Documenting tetanus boosters prevents duplication of vaccination at times when urgent care treatment is required. If the status is unknown and not easily obtained from a previous physician, the CDC recommends that the tetanus booster be administered. NCOA 2007-02-08-105600-000 Guidelines for Medical Record Documentation

A history of immunizations is present in the medical record for adults. NCOA 2007-02-08-105600-000 Guidelines for Medical Record Documentation
Yearly flu vaccines help reduce large epidemics in communities and serious complications when a patient’s immune system is compensated.

<table>
<thead>
<tr>
<th></th>
<th>Documentation for each visit supports presenting complaints, clinical findings, evaluation, treatment plan, and follow-up recommendations. The treatment plan is appropriate to findings and patient is not at risk by diagnostic or therapeutic problem. All entries are signed by rendering practitioner with credentials and dated (may be a handwritten signature, unique electronic identifier or initials and credentials). <em>NCQA 2007-02-08-105600-000 Guidelines for Medical Record Documentation</em></th>
<th>To ensure appropriate review of all systems that relate to the problem currently being assessed for treatment, accurate and appropriate assessment of a patient’s problem, and appropriate treatment planning; to prevent injury and unnecessary treatment that may jeopardize the patient’s health; to ensure appropriate identification of treating physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Is there evidence in the chart to indicate that PCPs are making referrals to other levels of care?</td>
<td>To ensure appropriate level of care is provided to members and there is no access to care issues</td>
</tr>
<tr>
<td>11.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is there a policy or procedure for follow-up of missed appointments?</td>
<td>To ensure the resolution of health issue/complaint and there is no access to care issues</td>
</tr>
<tr>
<td>12.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If member has a behavioral health diagnosis and a referral to a behavioral health provider was completed, documentation from the behavioral health (BH) provider is present if member approved coordination of care between PCP and BH provider.</td>
<td>To ensure continuity and coordination of care for members with both physical and behavioral health problems</td>
</tr>
<tr>
<td>13.</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td><strong>Clinical Practice Guidelines</strong></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Obesity and Obesity Prevention Guidelines</strong></td>
<td></td>
</tr>
<tr>
<td>14a.</td>
<td>Provider is utilizing Category II code BMI assessments with claims submission to report closure of gaps in care for preventive screenings.</td>
<td>To improve reporting of gaps in care that will help identify and facilitate quality improvement initiatives towards closing gaps</td>
</tr>
<tr>
<td>15a.</td>
<td>BMI calculated within past two years for adults, calculated and plotted for percentile for children age 3 and older are completed with each visit. For adults with obesity diagnosis, BMI is calculated periodically.</td>
<td>To improve the quality of life and help prevent short- and long-term complications of obesity</td>
</tr>
<tr>
<td>15b.</td>
<td>There is documentation of counseling for nutrition or referral for nutrition education within the past year.</td>
<td>To improve the quality of life and help prevent short- and long-term complications of obesity</td>
</tr>
<tr>
<td>15c.</td>
<td>There is documentation of counseling for physical activity or referral for physical activity within the past year.</td>
<td>To improve the quality of life and help prevent short- and long-term complications of obesity</td>
</tr>
<tr>
<td>15d.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16a.</td>
<td>Provider is utilizing the Category II codes for diabetes with claims submission to report closure of gaps in care for preventive screenings.</td>
<td>To improve reporting of gaps in care that will help identify and facilitate quality improvement initiatives towards closing gaps</td>
</tr>
<tr>
<td>16b.</td>
<td>Annual history and physical exam completed with depression screening.</td>
<td>To assess the overall physical and mental health of the diabetic patient to establish stability of disease state</td>
</tr>
<tr>
<td>16c. HEDIS measure</td>
<td>Annual comprehensive dilated eye exam for adults and children 10 years and older where retinopathy has been previously identified otherwise, if no evidence of retinopathy exams every 2 years.</td>
<td>To assess eye health and for prevention of blindness due to retinopathy</td>
</tr>
<tr>
<td>16d.</td>
<td>Annual foot exam, visual with each visit</td>
<td>To assess for neuropathy and prevention of complications due to poor circulation</td>
</tr>
<tr>
<td>16e. HEDIS measure</td>
<td>Annual medical attention for nephropathy</td>
<td>To evaluate urine for the presence of a protein for the prevention of kidney damage</td>
</tr>
<tr>
<td>16f.</td>
<td>Annual lipid profile with LDL &lt; 100 mg for adults and children age 2 and older</td>
<td>To monitor patient’s effectiveness of pharmacotherapy and severity of illness; for prevention and management of CVD</td>
</tr>
<tr>
<td>16g.</td>
<td>Annual influenza vaccine</td>
<td>To ensure appropriate services for the prevention of communicable disease is accessible to the member and offered and to prevent risk of complications that could arise from exposure and contraction of a communicable disease</td>
</tr>
<tr>
<td>16h.</td>
<td>Pneumococcal vaccination for all members &gt; 2 years old</td>
<td>To ensure appropriate services for the prevention of communicable disease is accessible to the member and offered and to prevent risk of complications that could arise from exposure and contraction of a communicable disease</td>
</tr>
<tr>
<td>16i. HEDIS measure</td>
<td>Documented HgbA1c twice yearly if meeting treatment goals and quarterly if not, all ages</td>
<td>To monitor patient’s effectiveness of pharmacotherapy and severity of illness</td>
</tr>
<tr>
<td>16j.</td>
<td>Advise to quit smoking</td>
<td>Tobacco abuse is an important factor when planning a course of treatment. A patient who has a history of tobacco abuse would need to avoid whenever possible any potential environments where encounters with tobacco smoke would affect him/her during a course of treatment.</td>
</tr>
<tr>
<td>16k.</td>
<td>Education or counseling for physical activity, nutrition, self-monitored blood glucose, weight loss, psychosocial counseling and preconception/pregnancy counseling</td>
<td>To ensure comprehension of treatment goals and plan and the importance of compliance</td>
</tr>
<tr>
<td>16l. HEDIS measure</td>
<td>Blood pressure treatment to attain/maintain a blood pressure of less than 130/80</td>
<td>For prevention and control of hypertension, blood pressure should be measured at every routine diabetes visit</td>
</tr>
</tbody>
</table>

**EPSTD Visit Guideline – Ages 0-20 Years**

*(42 Cfr Part 438.364[A][2])*

<p>| 17a. | Nutrition assessment |</p>
<table>
<thead>
<tr>
<th>17b. HEDIS measure</th>
<th>Past medical history is present and includes serious accidents, operations, substance abuse, family history and illnesses. For children ages birth through age 20, developmental/behavioral assessment is included.</th>
</tr>
</thead>
<tbody>
<tr>
<td>17c. HEDIS measure</td>
<td>A history of immunizations is present in the medical record or offered for children age 0-20. If parents refused vaccines, a signed waiver by parents and reason are documented.</td>
</tr>
<tr>
<td>17d.</td>
<td>Cholesterol risk assessment</td>
</tr>
<tr>
<td>17e.</td>
<td>Lead risk assessment</td>
</tr>
<tr>
<td>17f. HEDIS measure</td>
<td>Comprehensive unclothed physical completed</td>
</tr>
<tr>
<td>17g.</td>
<td>Appropriate laboratory test were performed or ordered for age.</td>
</tr>
<tr>
<td>17h. HEDIS measure</td>
<td>Health education was given as appropriate for age.</td>
</tr>
<tr>
<td>17i.</td>
<td>Vision screening was performed (or referral provided) as appropriate for age.</td>
</tr>
<tr>
<td>17j.</td>
<td>Hearing screening was performed (or referral provided) as appropriate for age.</td>
</tr>
<tr>
<td>17k.</td>
<td>If screening(s) is not completed in a single visit, is there documentation in the chart that a return visit is scheduled?</td>
</tr>
<tr>
<td>17l.</td>
<td>Is there documentation of any concerns or questions from the member or member’s parent or guardian after the screening process?</td>
</tr>
<tr>
<td>17m.</td>
<td>Is there documentation in the chart to indicate that EPSDT services have been refused or declined by a parent, guardian, or member? (Document reason declined in comments.)</td>
</tr>
<tr>
<td>17n.</td>
<td>Is there evidence in the chart to indicate that PCPs are making referrals to other levels of care?</td>
</tr>
<tr>
<td>17o.</td>
<td>Provider is utilizing the appropriate CPT and ICD-10 codes for EPSDT well-child exams with claims submission. <strong>Plan Quality Improvement Activity</strong></td>
</tr>
<tr>
<td>17p.</td>
<td>Documentation is present that the provider has assessed if the child has a dental home. If no dental home is identified, provider has performed a risk assessment at appropriate stages of development based on age. <strong>State Required Standard</strong></td>
</tr>
<tr>
<td>17q.</td>
<td>If provider has not performed a well-child exam during the previous 12 months, did provider</td>
</tr>
</tbody>
</table>

**State requirement to monitor and assess provider compliance to provision of screenings important to the quality of health care of the Medicaid population**

**State requirement to monitor and assess provider compliance to provision of screenings important to the quality of health care and education of the Medicaid population**

To close gaps in care identified through HEDIS measures

To improve reporting of gaps in care that will help identify and facilitate quality improvement initiatives towards closing gaps

To ensure access and availability of dental services and prevention of dental caries; state requirement to monitor and assess provider compliance to provision of screenings important to the quality of health care and education of the Medicaid population

To ensure access and availability of prevention services and close gaps in care
<table>
<thead>
<tr>
<th>Plan Quality Improvement Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hypertension Guidelines</strong></td>
</tr>
<tr>
<td><strong>18a.</strong> Provider is utilizing the Category II codes for hypertension with claims submission to report closure of gaps in care for preventive screenings.</td>
</tr>
<tr>
<td><strong>18b.</strong> Provider conducts history and physical examination on an annual basis and assesses for comorbidities.</td>
</tr>
<tr>
<td><strong>18c.</strong> Provider obtains as indicated laboratory and diagnostic tests to monitor disease progression, development of comorbid conditions and therapeutic levels of medications.</td>
</tr>
<tr>
<td><strong>18d.</strong> Review of member’s current lifestyle and recommendations for lifestyle modifications are documented with each visit.</td>
</tr>
<tr>
<td><strong>18e.</strong> <strong>HEDIS measure</strong> Blood pressure is taken and recorded with each visit, minimally monitored biannually and more frequently if blood pressure is uncontrolled.</td>
</tr>
<tr>
<td><strong>18f.</strong> Provider reviews medication and adherence to drug therapy with each visit, adjusting medications as indicated.</td>
</tr>
<tr>
<td><strong>18g.</strong> Weight is taken and recorded with each visit.</td>
</tr>
<tr>
<td><strong>19.</strong> <strong>ADHD Guidelines</strong></td>
</tr>
<tr>
<td><strong>19a.</strong> Documentation to support diagnosis of ADHD should be present in record.</td>
</tr>
<tr>
<td><strong>19b.</strong> Medication prescribed and dosage for ADHD follows recommendations as outlined in Clinical Practice Guideline.</td>
</tr>
<tr>
<td><strong>19c.</strong> If tricyclic antidepressants are used, a baseline ECG prior to use is present, with a follow-up ECG after each significant dosage change. If a higher level tricyclic medication is documented, blood levels are present in the medical record.</td>
</tr>
<tr>
<td><strong>19d.</strong> <strong>HEDIS measure</strong> Initiation phase: Documentation is present for patients who receive an initial prescription for ADHD medication of at least one follow-up visit with a prescriber within 30 days of initiation of medication and at least two additional visits between four weeks and nine months of the initiation of the medication.</td>
</tr>
</tbody>
</table>
### Continuation and maintenance phase:
After treatment for initiation phase, documentation is present of at least two follow-up visits between 30 days and ten months (300 days) of the initiation of the medication.

Follow-up visits include assessment for:
- Behavioral assessment (school/peer/family)
- Height
- Weight
- Abnormal movement, signs and symptoms
- Follow-up testing with Conners’ scales or equivalent scales to track treatment response.
- School informal plan or Section 504 Plan every two years.

To prevent relapse of symptoms and ensure member compliance with medication treatment.

To ensure appropriate assessment after initiation phase and stability of member’s mental health status.

### Major Depression (Acute and Chronic) Guidelines

**Clinical Practice Guideline outlines available approaches for the management of acute and chronic depression. All member care and related decisions are the sole responsibility of the practitioner. The CPG for Major Depression does not dictate or control the practitioner’s clinical decisions regarding the appropriate care of members, but should be used as a guide for best practice.**

| 20a. | Documentation to support diagnosis of major depression is present in the clinical record. | Evidence that Clinical Practice Guideline is utilized to outline approaches for the management of acute and chronic depression. |
| 20b. | DSM-IV/ICD10 diagnosis is documented. | To ensure appropriate treatment planning and claims processing. |
| 20c. | Medication prescribed and dosage of antidepressant medications follows recommendations as outlined in clinical practice guideline. | To ensure adherence to Clinical Practice Guideline accepted prescribing protocols and criteria. |

**Acute phase:**
After initiation of medication for a new diagnosis of major depression, 3 follow-up contacts occurred during the first 12 weeks of treatment, one of which must have been with the prescribing practitioner.

To ensure effectiveness of medication and dosages prescribed; to ensure member compliance with medication treatment.

| 20d. | Continuation phase: After treatment for acute phase, documentation is present that member is maintaining medications for at least 6 months following remission of symptoms. | To prevent relapse of symptoms and ensure member compliance with medication treatment. |

**Continuation phase:**
After treatment for continuation phase, documentation of assessment for recurrence of depression symptoms, presence of comorbid conditions, suicidal thoughts, and psychotic features is present.

To prevent relapse of symptoms and ensure member compliance with medication treatment.

| 20e. | Maintenance phase: After treatment for continuation phase, documentation of assessment for recurrence of depression symptoms, presence of comorbid conditions, suicidal thoughts, and psychotic features is present. | To prevent relapse of symptoms and ensure member compliance with medication treatment. |
| 20f. | If a hospitalization occurred prior to or during the course of treatment, documentation is present of a follow-up visit within 7 days of discharge and within 30 days of discharge. | To prevent relapse of symptoms and ensure member compliance with medication treatment. |
## Medical Record Documentation Standards — Behavioral Health

<table>
<thead>
<tr>
<th>Standard</th>
<th>Core Standards</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Practitioner has in place policy and procedures to ensure confidentiality to the extent provided by TCA-33-3-101 and HIPPA regulations, the HITECH Act (A.R.R.A.Secs. 13001 et seq.), security as defined by HIPPA, and member accessibility to the extent provided by TCA 33-3-101 et seq for patients/members with behavioral health issues. <strong>CRA 2.24.8.2.3.2</strong> <strong>CRA 2.24.8.2.3.3</strong> <strong>CRA 2.24.8.2.3</strong> <strong>CRA 2.24.8.2.4</strong> <strong>CRA 2.24.82.5</strong></td>
<td>To ensure the confidentiality, security and member accessibility of medical records</td>
<td></td>
</tr>
<tr>
<td>2. Policy and procedure is in place with respect to member, parent or legally-appointed representative involvement with behavioral health. <strong>CRA A.2.18.10.1.1</strong> <strong>CRA A.2.18.10.1.2</strong></td>
<td>To ensure member, parent or legally-appointed representative involvement with behavioral health and provide a description of the quality monitoring activities to be used to measure practitioner compliance with the requirement for member, parent or legally-appointed representative involvement in behavioral health treatment planning as required by state</td>
<td></td>
</tr>
<tr>
<td>3. A policy and procedure is in place for cultural competency training of staff on an annual basis. <strong>CRA A.2.18.2.1</strong></td>
<td>To ensure effective delivery of health care services that meet the social, cultural and linguistic needs of patients</td>
<td></td>
</tr>
<tr>
<td>4. Policy and procedure is in place that defines training provided to relevant unlicensed employees in accordance with TDMHDD TennCare 2010 Specialized Training Requirements for Behavioral Health Staff.</td>
<td>To ensure Amerigroup efforts to monitor organizational network providers that deliver behavioral health services provide relevant unlicensed employees training in accordance with TDMHDD TennCare 2010 specialized training requirements</td>
<td></td>
</tr>
<tr>
<td>5. Patient demographic data is present in chart and name or ID # is on each document. <strong>42 CFR Part 456</strong></td>
<td>To provide biological and identifiable data pertinent to the patients care and treatment planning. To provide emergency information should an incident occur within the physician’s office. Many names are not gender specific. Recording the sex of a patient helps differentiate males from females.</td>
<td></td>
</tr>
<tr>
<td>6. Medication allergies and adverse reactions are prominently noted/displayed in the record. If the member does not have allergies, this should also be noted. <strong>42 CFR Part 456</strong></td>
<td>To prevent the prescribing of any medication that the patient is allergic to</td>
<td></td>
</tr>
<tr>
<td>7. A current medication list is present in patient record. (For best practice: dosage, date medication was initiated, and dates of refills are present.) <strong>NCQA 2007-02-08-105600-000 Guidelines for Medical Record Documentation</strong></td>
<td>A centrally-located listing of a member’s maintenance medications assists the practitioner and support staff with an over view of prescribed medications. In this fashion, the practitioner can easily assess medications</td>
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<tr>
<td>9.</td>
<td>A current problem list that includes significant illnesses, medical conditions and psychological conditions is present. <em>NCQA 2007-02-08-105600-000 Guidelines for Medical Record Documentation</em></td>
<td>Maintaining a current problem list enhances information from which a practitioner can effectively develop a treatment plan and the ability of the physician and other health care professionals to evaluate and plan the patient’s immediate treatment, and to monitor his/her health care over time.</td>
</tr>
<tr>
<td>10.</td>
<td>Past medical history is present and includes serious accidents, operations, substance abuse, family history and illnesses. For children age birth through age 20, developmental/behavioral assessment is included. Interval histories should be present as appropriate. <em>NCQA 2007-02-08-105600-000 Guidelines for Medical Record Documentation</em></td>
<td>All patients need to have documentation of medical/social histories in their record base, from which a planned course of treatment can be developed. Substance abuse is an important factor when planning a course of treatment and attempting to diagnose a particular problem. Behavioral along with physical assessment for children gauges how well a child’s development is progressing based on age.</td>
</tr>
<tr>
<td>11.</td>
<td>Behavioral health screenings and results (substance use, depression, etc.) are present.</td>
<td>To ensure appropriate assessment of presenting symptoms and problems</td>
</tr>
<tr>
<td>12.</td>
<td>For each visit, risk status is clearly documented. Situations such as imminent risk of harm to self or others, homicidal ideation, suicidal ideation, or elopement potential is prominently noted, documented, and revised in the treatment record. Follow-up recommendations are documented, and all entries are signed by rendering practitioner with credentials and dated (may be a handwritten signature, unique electronic identifier or initials and credentials). <em>NCQA 2007-02-08-105600-000 Guidelines for Medical Record Documentation</em></td>
<td>To ensure safety of member and others and appropriate identification of treating practitioner</td>
</tr>
<tr>
<td>13.</td>
<td>Provides for members, parents or legally-appointed representatives a meaningful opportunity to participate in the treatment planning process, both at initial formulation, and when changes or re-evaluations are done. <em>CRA A.2.18.10</em></td>
<td>Empowers individuals involved in treatment planning and makes full use of the unique knowledge and perspectives of the individuals undergoing treatment and their family members or legal representatives as appropriate</td>
</tr>
<tr>
<td>14.</td>
<td>Evidence is present in medical record of coordination of care with member’s PCP and referring practitioner if referring practitioner is other than PCP.</td>
<td>To ensure continuity and coordination of care for members with both physical and behavioral health problems</td>
</tr>
<tr>
<td>15.</td>
<td>Provider has in place a policy or procedure for follow-up of missed appointments.</td>
<td>To ensure the resolution of health issue/complaint and there is no access to care issues</td>
</tr>
</tbody>
</table>

**Clinical Practice Guidelines**

**ADHD Guidelines**
| 16a. | Documentation to support diagnosis of ADHD should be present in record. | Evidence that Clinical Practice Guideline is utilized to outline approaches for the management of ADHD |
| 16b. | Medication prescribed and dosage for ADHD follows recommendations as outlined in Clinical Practice Guideline. | To ensure adherence to Clinical Practice Guideline accepted prescribing protocols and criteria |
| 16c. | If tricyclic antidepressants are used, a baseline ECG prior to use is present, with a follow-up ECG after each significant dosage change. If a higher level tricyclic medication is documented, blood levels are present in the medical record. | To ensure therapeutic results of medication and prevention of overdose |
| 16d. | **Initiation phase:** Documentation is present for patients who receive an initial prescription for ADHD medication of at least one follow-up visit with a prescriber within 30 days of initiation of medication and at least two additional visits between four weeks and nine months of the initiation of the medication. | To ensure effectiveness of medication and dosages prescribed and member compliance with medication treatment |
| 16e. | **Continuation and maintenance phase:** After treatment for initiation phase, documentation is present of at least two follow-up visits between 30 days and ten months (300 days) of the initiation of the medication. | To prevent relapse of symptoms and ensure member compliance with medication treatment |
| 16f. | Follow-up visits include assessment for: Behavioral assessment (school/peer/family) Height Weight Abnormal movement, signs and symptoms Follow-up testing with Conners’ scales or equivalent scales to track treatment response. School informal plan or Section 504 Plan every two years. | To ensure appropriate assessment after initiation phase and stability of member’s mental health status |
| 17. | **Major Depression (Acute and Chronic) Guidelines** |
| 17a. | Documentation to support diagnosis of major depression is present in the clinical record. | Evidence that Clinical Practice Guideline is utilized to outline approaches for the management of acute and chronic depression |
| 17b. | DSM-IV/ICD-10 diagnosis is documented. | To ensure appropriate treatment planning and claims processing |
| 17c. | Medication prescribed and dosage of antidepressant medications follows recommendations as outlined in Clinical Practice Guideline. | To ensure adherence to clinical practice guideline accepted prescribing protocols and criteria |
| 17d. | **Acute phase:** After initiation of medication for a new diagnosis of major depression, 3 follow-up contacts occurred during the first 12 weeks of treatment, one of which must have been with the prescribing practitioner. | To ensure effectiveness of medication and dosages prescribed and member compliance with medication treatment |
### Medical record documentation standards — opioid MAT assessment and program structure

#### References/resources:
- CRA Amendment 9 — 2.11.4.1.1.2
- SAMHSA Treatment Improvement Protocol (TIP) # 40, “Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction”
- SAMHSA Treatment Improvement Protocol (TIP) # 43, “Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs”
- SAMHSA Treatment Improvement Protocol (TIP) # 63, “Medications for Opioid Use Disorder”
- ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use
- Tennessee Nonresidential Buprenorphine Treatment Guidelines: https://www.tn.gov/content/dam/tn/mentalhealth/documents/2018_Buprenorphine_Treatment_Guidelines.PDF

#### Program structure

**Section I: Policy and Procedure**

<table>
<thead>
<tr>
<th>Standard</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The provider has a policy and procedure for conducting a Controlled Substance Monitoring Data (CSMD) review each time and prior to prescribing, dispensing or administering opiates and/or a controlled substance. Evidence is present in clinical record of this process being administered.</td>
</tr>
<tr>
<td>2</td>
<td>Provider employs, contracts, or partners with a behavioral health counselor to provide psychosocial assessment, addiction counseling, individual, group counseling, self-help and recovery support, and therapy for co-occurring disorders.</td>
</tr>
<tr>
<td></td>
<td>Provider employs, contracts, partners, or shows effort towards, engagement with a Certified Peer Recovery Specialist (has certification through TDMHSAS) in the community for consumer education, treatment engagement, and recovery planning.</td>
</tr>
<tr>
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</tr>
<tr>
<td>4</td>
<td>Provider employs, contract, or partner with a local care coordination resource.</td>
</tr>
<tr>
<td>5</td>
<td>A Diversion Control Plan is in place and routine and random pill/film counts are performed.</td>
</tr>
<tr>
<td>6</td>
<td>A written plan to address medical emergencies including naloxone on-site is in place.</td>
</tr>
<tr>
<td>7</td>
<td>A written plan is in place to address psychiatric emergencies including involuntary hospitalization.</td>
</tr>
<tr>
<td>8</td>
<td>A policy and procedure is in place to address timely communications with other providers who are treating the member and with member’s informal support system.</td>
</tr>
<tr>
<td>9</td>
<td>The provider has a policy and procedure for conducting routine and random drug screenings.</td>
</tr>
<tr>
<td>10</td>
<td>Assessments of member experience is completed and collected at providers’ offices.</td>
</tr>
<tr>
<td>11</td>
<td>Components of the survey include minimally the following:</td>
</tr>
<tr>
<td></td>
<td>• Support received during MAT treatment initiation</td>
</tr>
<tr>
<td>12</td>
<td>• Outpatient MAT provider identification</td>
</tr>
<tr>
<td>13</td>
<td>• 7-day follow-up behavioral and/or physical health appointment accessibility</td>
</tr>
<tr>
<td>14</td>
<td>• Ease of pharmacy service</td>
</tr>
<tr>
<td>15</td>
<td>• Ability to obtain prescription fills for both MAT and psychiatric medications</td>
</tr>
</tbody>
</table>

**Member-based assessment**

**Section II: Initial Assessment**
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>A physician performed and documented initial screening for the diagnostic criteria of an opioid use disorder diagnosis as defined in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM Code) determining the MAT program was the most appropriate level of care/treatment.</td>
<td>To ensure appropriate and accurate diagnosing or assessment for substance abuse and mental disorders.</td>
</tr>
<tr>
<td>17</td>
<td>A physician conducted a substance use patient evaluation using standardized assessment and evaluation tools.</td>
<td>To thoroughly delineate a patient’s problem, to identify comorbid or complicating medical or emotional conditions, and to determine the appropriate treatment setting and level of treatment intensity for the patient. To determine the appropriateness of office-based or other opioid agonist treatment.</td>
</tr>
<tr>
<td>18</td>
<td>A physician conducted a psychiatric patient evaluation using standardized assessment and evaluation tools.</td>
<td>To thoroughly delineate a patient’s problem, to identify comorbid or complicating medical or emotional conditions, and to determine the appropriate treatment setting and level of treatment intensity for the patient. To determine the appropriateness of office-based or other opioid agonist treatment.</td>
</tr>
<tr>
<td>19</td>
<td>A physician conducted a medical examination using standardized assessment and evaluation tools.</td>
<td>To thoroughly delineate a patient’s problem, to identify comorbid or complicating medical or emotional conditions, and to determine the appropriate treatment setting and level of treatment intensity for the patient. To determine the appropriateness of office-based or other opioid agonist treatment.</td>
</tr>
<tr>
<td>20</td>
<td>The provider has discussed with the member about a referral to a Primary Care, Behavioral Health and/or Substance Abuse Specialist.</td>
<td>To educate member and ensure psychosocial assessment, addiction counseling, individual, group counseling, self-help and recovery support, and therapy for co-occurring disorders.</td>
</tr>
<tr>
<td>21</td>
<td>There evidence that the member was trained on the provider’s policy concerning involuntary termination of treatment.</td>
<td>Involuntary termination of treatment may occur under certain circumstances but abandonment should be avoided and physicians should have written policies and procedures that should be discussed with members as it is important to convey what procedures must be followed to continue treatment.</td>
</tr>
<tr>
<td>22</td>
<td>A Narcotic or Controlled Substance Agreement (explaining risk/benefit to achieve informed consent) is present in the clinical record.</td>
<td>Agreements reinforce expectations about safe treatment for opioid addiction, makes the treatment plan clear for the patient, the patient’s family, and other providers of the patient, assists in patient education, and clarifies many aspects of treatment.</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td><strong>Section III: Appointment Frequency</strong></td>
<td>A patient in the induction or stabilization phases of treatment has had:</td>
<td>To ensure the medical monitoring for the startup of buprenorphine treatment performed in a qualified physician’s office or certified OTP using approved buprenorphine products.</td>
</tr>
<tr>
<td>23</td>
<td>1. Weekly office visits scheduled;</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>2. Received appropriate counseling sessions at least twice a month;</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>3. Had one observed urine drug screen at least weekly; and</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>4. If indicated, received care coordination services weekly.</td>
<td></td>
</tr>
<tr>
<td>A patient in the maintenance phase of treatment in first year has had:</td>
<td>To ensure the patient is doing well on a steady dose of buprenorphine and ensure the length of time of the maintenance phase is appropriately tailored to each patient with understanding that this phase could be indefinite.</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>1. Office visit at least every two to four weeks;</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>2. Received counseling sessions at least monthly;</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>3. Had an observed random urine drug screen at least eight times annually; and</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>4. If indicated, received care coordination services at least monthly.</td>
<td></td>
</tr>
<tr>
<td>A patient in the maintenance phase of treatment for one year or longer has had:</td>
<td>To ensure continued wellbeing while on a steady dose of buprenorphine and the length of time of the maintenance phase is appropriate.</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>1. Have a scheduled office visit at least every two months;</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>2. Follow-up counseling sessions discussed and/or considered for member (monthly counseling sessions recommended)</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>3. Be subject to a random observed urine drug screen at least four times annually; and</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>4. If indicated, receive care coordination services at least monthly.</td>
<td></td>
</tr>
<tr>
<td><strong>Section IV: Service Delivery</strong></td>
<td>There is evidence in the clinical record of member receiving initial training that includes:</td>
<td>The main focus of substance abuse education is teaching individuals about drug and alcohol abuse, how to avoid, stop, or get help for substance use disorders, and the potential danger of drugs to do harm to the body, mind, and relationships. Drug education campaigns should be ongoing, with recurring programming to fortify the original prevention and treatment message.</td>
</tr>
<tr>
<td>35</td>
<td>(a) Treatment options, including detoxification, benefits/risks associated with each option;</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>(b) Risk of neonatal abstinence syndrome for all female patients of child bearing age (ages 15-44);</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>(c) Prevention and treatment of chronic viral illnesses, such as HIV and hepatitis C;</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>(d) Therapeutic benefits and adverse effects of treatment medication;</td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>(e) Risks for overdose, and</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>(f) Overdose prevention and reversal agents.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>There is evidence in the clinical record of member receiving ongoing training that includes:</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>(a) Treatment options, including detoxification, benefits/risks associated with each option;</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>(b) Risk of neonatal abstinence syndrome for all female patients of child bearing age (ages 15-44);</td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>(c) Prevention and treatment of chronic viral illnesses, such as HIV and hepatitis C;</td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>(d) Therapeutic benefits and adverse effects of treatment medication;</td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>(e) Risks for overdose, and</td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>(f) Overdose prevention and reversal agents.</td>
<td></td>
</tr>
</tbody>
</table>

|   | The main focus of substance abuse education is teaching individuals about drug and alcohol abuse, how to avoid, stop, or get help for substance use disorders, and the potential danger of drugs to do harm to the body, mind, and relationships. Drug education campaigns should be ongoing, with recurring programming to fortify the original prevention and treatment message. |

|   | There is evidence that the Controlled Substance Monitoring Database (CSMD) was queried each time a prescription is written. |

|   | To assess a patient’s prescription history and facilitate, and encourage the identification, intervention with and treatment of persons addicted to prescription drugs. |

|   | A psychosocial assessment was completed by a BH counselor. |

|   | Psychosocial assessments can be used at different stages of drug treatment to identify a problem, treat it and assist with social reintegration after treatment. It is a very important part of every health care program that helps to set up a plan of management and action for the clinical team. |

|   | For member’s BH counseling services, there a treatment plan that is individualized with problem statements specific to the member and are goals/objectives measurable, attainable, and age-appropriate for the member. |

|   | Provides a timely and appropriate treatment guide that ensures consistent treatment and compliance to individualized care. Reassessment of the treatment plan ensures appropriateness of continued treatment. |

|   | An individualized treatment plan was completed within 30-days of treatment initiation. |

|   | Provides a timely and appropriate treatment guide that ensures consistent treatment and compliance to individualized care. Reassessment of the treatment plan ensures appropriateness of continued treatment. |

|   | Member's individualized treatment plan was reviewed every six months. |

|   | Provides a timely and appropriate treatment guide that ensures consistent treatment and compliance to individualized care. Reassessment of the treatment plan ensures appropriateness of continued treatment. |

|   | The medication prescribed for the member reflects the preferred medication of buprenorphine/naloxone combination (as covered by the TennCare formulary) for induction as well as stabilization unless contraindicated (e.g., pregnancy) and then the buprenorphine monotherapy has been prescribed if contraindicated. |

<p>|   | To ensure appropriate medication dispensing and benefit coverage as defined by the TennCare MAT program and drug formulary. |</p>
<table>
<thead>
<tr>
<th>Section V: Coordination of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>53 If the member identified a PCP or other medical specialty involved with care, is there evidence that information was exchanged with the PCP or to other medical health professionals?</td>
</tr>
</tbody>
</table>
18  CONFIDENTIALITY

Confidentiality of Information
Amerigroup complies with all state and federal law regarding the privacy and security of protected health information and the confidentiality of individually identifying information of a member or that of his/her family member. In the event of a conflict among these requirements, Amerigroup will comply with the most restrictive requirement.

All material and information, regardless of form, medium or method of communication, provided to Amerigroup by the state or acquired by Amerigroup pursuant to the TennCare Contractor Risk Agreement (Agreement) will be regarded as confidential information in accordance with the provisions of state and federal law and ethical standards and will not be disclosed. All necessary steps will be taken by Amerigroup to safeguard the confidentiality of such material or information in conformance with state and federal law and ethical standards.

Utilization management, case management, population health, discharge planning, quality management and claims payment activities are designed to ensure that patient-specific information, particularly Protected Health Information (PHI) obtained during review is kept confidential in accordance with applicable laws, including HIPAA and the HITECH Act (A.R.R.A. Secs. 13001 et seq.). 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 within said entities who need access to such information in order to conduct utilization management and related processes.

Amerigroup ensures that all material and information, in particular information relating to members or potential members, which is provided to or obtained by or through the performance of Amerigroup under this Agreement, whether verbal, written, tape, electronic or otherwise, will be treated as confidential information to the extent confidential treatment is provided under state and federal laws. Amerigroup will not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and preservation of its rights in compliance with federal and state law.

All information as to personal facts and circumstances concerning members or potential members obtained by Amerigroup will be treated as privileged communications, held confidential, and not be divulged without the written consent of TennCare or the member/potential member, provided that nothing stated herein will prohibit the disclosure when allowed by federal or state law of information in a limited data set summary, statistical or other form which does not individually identify an individual member/patient or members of his/her family. The use or disclosure of information concerning members/potential members will be limited to purposes directly connected with the administration of this Agreement and will be in compliance with federal and state law.

Nothing in this agreement shall permit Amerigroup or the provider to share, use or disclose protected health information (PHI) in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States without express written authorization from the state.

Providers must adhere to Section 5, Responsibilities of the PCP concerning confidentiality of information.

HIPAA and the HITECH Act Compliance
The Health Insurance Portability and Accountability Act of 1996 (HIPAA), encompasses legislation intended to improve the portability and continuity of health benefits, ensure greater accountability in the area of health care fraud, ensure the privacy and security of individual protected health information, and simplify the administration of health insurance. The HITECH Act, as part of the American Recovery and Reinvestment Act of
was enacted on February 17, 2009 to provide incentives to health care industry participants for the adoption of electronic health records, to set forth a federal data breach law, and to heighten and enhance the privacy and security regulations provided under HIPAA.

In accordance with HIPAA regulations and HITECH, Amerigroup will:

- Comply with requirements of the Health Insurance Portability and Accountability Act of 1996, including the transactions and code set, privacy, security and identifier regulations, by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data partner situations required under the regulations.
- Transmit/receive to/from its providers, subcontractors, clearinghouses and TennCare all transactions and code sets required by the HIPAA regulations in the appropriate standard formats as specified under the law and as directed by TennCare so long as TennCare direction does not conflict with the law.
- Agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security and all subsequent HIPAA standards, that it will be in breach of this Agreement and will then take all reasonable steps to cure the breach or end the violation as applicable. Since inability to meet the transactions and code sets requirements, as well as the privacy and security requirements, can bring basic business practices between TennCare and Amerigroup and between Amerigroup and its providers and/or subcontractors to a halt, if for any reason Amerigroup cannot meet the requirements of this Section, TennCare may terminate this Agreement.
- Ensure that PHI data exchanged between Amerigroup and TennCare is used only for the purposes of treatment, payment or health care operations. Amerigroup shall ensure that requests by and responses to health oversight agencies are in keeping with federal regulations. All PHI data not transmitted for these purposes or for purposes allowed under the federal HIPAA regulations will be de-identified to protect the individual member’s PHI under the privacy and security rules.
- Ensure that disclosures of PHI from Amerigroup to TennCare will be restricted as specified in the HIPAA regulations and will be permitted for the purposes of: treatment, payment or health care operation; health oversight; obtaining premium bids for providing health coverage; or modifying, amending or terminating the group health plan. Disclosures to TennCare from Amerigroup will be as permitted and/or required under the law.
- Report to TennCare immediately upon becoming aware of any use or disclosure of PHI in violation of this Agreement by Amerigroup, its officers, directors, employees, subcontractors or agents or by a third party to which Amerigroup disclosed PHI.
- Execute business associate agreements where required by law and specify in its agreements with any agent or subcontractor that will have access to PHI that such agent or subcontractor agrees to be bound by the same restrictions, terms and conditions that apply to Amerigroup.
- Make available to TennCare members the right to amend their PHI data in accordance with the federal HIPAA regulations. Amerigroup will also send information to members educating them of their rights and necessary steps in this regard.
- Make a member’s PHI data accessible to TennCare immediately upon request by TennCare.
- Make available to TennCare within 10 calendar days of notice by TennCare to Amerigroup such information as in the possession of Amerigroup and is required for TennCare to make the accounting of disclosures required by 45 CFR 164.528. At a minimum, Amerigroup will provide TennCare with the following information:
  - The date of disclosure
  - The name of the entity or person who received the HIPAA protected information, and if known, the address of such entity or person
  - A brief description of the PHI disclosed
  - A brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure
• In the event that the request for an accounting of disclosures is submitted directly to Amerigroup, Amerigroup will within two business days forward such request to TennCare. It will be TennCare’s responsibility to prepare and deliver any such accounting requested. Additionally, Amerigroup will institute appropriate record-keeping processes and procedures and policies to enable Amerigroup to comply with the requirements of this Section.

• Make its internal policies and procedures, records and other documentation related to the use and disclosure of PHI available to TennCare and to the U.S. Secretary of Health and Human Services for the purposes of determining compliance with the HIPAA regulations upon request.

• Create and adopt policies and procedures to periodically audit adherence to all HIPAA regulations, and for which Amerigroup acknowledges and promises to perform the following obligations and actions:
  o Use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the PHI Amerigroup creates, receives, maintains or transmits on behalf of TennCare.
  o Agree to ensure that any agent including a subcontractor to whom it provides PHI that was created, received, maintained or transmitted on behalf of TennCare agrees to use reasonable and appropriate safeguards to protect the PHI.
  o Agree to report to TennCare’s privacy officer immediately upon becoming aware of any unauthorized use or disclosure of member PHI not otherwise permitted or required by HIPAA. Such immediate report will include any security incident of which Amerigroup becomes aware that represents unauthorized access to unencrypted computerized data and that materially compromises the security, confidentiality or integrity of member PHI maintained by Amerigroup. Amerigroup will also notify TennCare’s privacy officer within two business days of any unauthorized acquisition of member PHI by an employee or otherwise authorized user of the Amerigroup system.

• If feasible, return or destroy all PHI, in whatever form or medium (including any electronic medium) and all copies of any data or compilations derived from and allowing identification of any individual who is a subject of that PHI upon termination, cancellation, expiration or other conclusion of the Agreement. Amerigroup will complete such return or destruction as promptly as possible, but not later than 30 days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement. Amerigroup will identify any PHI that cannot feasibly be returned or destroyed. Within such 30 days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement, Amerigroup will:
  o Certify on oath in writing that such return or destruction has been completed
  o Identify any PHI which cannot feasibly be returned or destroyed
  o Certify that it will only use or disclose such PHI for those purposes that make its return or destruction infeasible

• Implement all appropriate administrative, technical and physical safeguards to prevent the use or disclosure of PHI in addition to the terms and conditions of this Agreement and including confidentiality requirements in 45 CFR Parts 160 and 164.

• Set up appropriate mechanisms to limit use or disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure.

• Create and implement policies and procedures to address present and future HIPAA/HITECH regulation requirements as needed to include: use and disclosure of data; de-identification of data; access according to the minimum necessary standard; accounting of disclosures; patients’ rights to amend, access, request restrictions and confidential communications; and right to file a complaint and breach notification.

• Provide an appropriate level of training to its staff and members regarding HIPAA-related policies, procedures, member rights and penalties prior to the HIPAA implementation deadlines and at appropriate intervals thereafter.
• Track training of Amerigroup staff and maintain signed acknowledgements by staff of the Amerigroup HIPAA policies.
• Be allowed to use and receive information from TennCare where necessary for the management and administration of this Agreement consistent with the administration of the Medicaid Plan, or TennCare, and to carry out business operations.
• Be permitted to use and disclose PHI for the legal responsibilities of Amerigroup.
• Adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by Amerigroup employees and other persons, including subcontractors, performing work for Amerigroup to have only minimum necessary access to individually identifiable patient data within Amerigroup.
• For members who are deceased, continue to protect related personally identifiable information for 50 years following the date of death.
• Be responsible for informing its members of their privacy rights in the manner specified under the regulations.
• Make available PHI in accordance with 45 CFR 164.524.
• Make available PHI for amendment and incorporate any amendments to protected health information in accordance with 45 CFR 164.526.
• Obtain a third party certification of its HIPAA standard transaction compliance 90 calendar days before the start date of operations, if applicable, and upon request by TennCare.

Amerigroup will track all security incidents as defined by HIPAA. Amerigroup will periodically report in summary fashion such security incidents.

In the event of a breach, Amerigroup will indemnify and hold TennCare harmless for expenses and/or damages related to the breach. Such obligations will include mailing notifications to affected members.

In accordance with HIPAA regulations, TennCare will adhere to the following guidelines:
• Make its individually identifiable health information available to enrollees for amendment and access as specified and restricted under the federal HIPAA regulations
• Establish policies and procedures for minimum necessary access to individually identifiable health information with its staff regarding MCO administration and oversight
• Adopt a mechanism for resolving any issues of noncompliance as required by law
• Establish similar HIPAA data partner agreements with its subcontractors and other business associates
FRAUD AND ABUSE

The Tennessee Bureau of Investigation Medicaid Fraud Control Unit (TBI MFCU) is the state agency responsible for the investigation of provider fraud and abuse in the TennCare program. Amerigroup will report suspected provider fraud and abuse to TBI MFCU.

The Office of Inspector General (OIG) has the primary responsibility to investigate TennCare administration and member fraud and abuse. Amerigroup will report suspected member fraud to the OIG.

Amerigroup and its network providers are required to cooperate with all state and federal agencies, including TBI MFCU and OIG, in investigating or prosecuting fraud and abuse. Cooperation includes providing, upon request, information, access to records and access to interview providers and/or their employees or consultants, including those with expertise in the administration of the TennCare program and/or in medical or pharmaceutical questions or in any matter related to an investigation. Providers must make available to the TBI MFCU and OIG any and all administrative, financial, and medical records related to the delivery of items or services paid for with TennCare funds. In addition, the TBI MFCU and OIG must be allowed access to the place of business and to all TennCare records maintained by providers during normal business hours. Under certain special circumstances, TBI MFCU and OIG may request after-hours admissions. Said records are to be provided at no cost to the requesting agency.

Amerigroup maintains a written fraud and abuse compliance plan designed to prevent and detect abuse and fraud in the administration and delivery of services to TennCare members. Amerigroup will report all suspected and confirmed fraud and abuse to the appropriate agency including:

- Suspected fraud and abuse in the administration of the TennCare program will be reported to TBI MFCU and/or OIG
- Confirmed or suspected provider fraud and abuse will be immediately reported to TBI MFCU
- Confirmed or suspected member fraud and abuse will be immediately reported to OIG

Amerigroup will use the Fraud Reporting Forms or such other form as may be deemed satisfactory by the agency to which the report is to be made.

Member or provider fraud reporting forms can be accessed at https://www.tn.gov/finance/fa-oig/fa-oig-report-fraud.html. You may also email TBI.MFCU@tn.gov or ProgramIntegrity.TennCare@tn.gov.

Amerigroup will be subject to a civil penalty, to be imposed by the OIG, for willful failure to report fraud and abuse by members, applicants or providers to OIG or MFCU as appropriate.

Amerigroup will promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless preapproval is obtained from the agency to whom the incident was reported or from another agency designated by the agency that received the report after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, Amerigroup will not take any of the following actions as they specifically relate to TennCare claims:

- Contact the subject of the investigation about any matters related to the investigation
- Enter into or attempt to negotiate any settlement or agreement regarding the incident
- Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident

Amerigroup will promptly provide the results of its preliminary investigation to the agency to which the incident was reported, or to another agency designated by the agency that received the report.
More information on identifying and reporting TennCare fraud is located at [https://www.tn.gov/finance/fa-oig/fa-oig-report-fraud.html](https://www.tn.gov/finance/fa-oig/fa-oig-report-fraud.html). You may also email TBI.MFCU@tn.gov or ProgramIntegrity.TennCare@tn.gov.

TennCare defines fraud as 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. It includes any act that constitutes fraud under applicable federal or state law (see 42 CFR 455.2). TennCare defines abuse as provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (see 42 CFR 455.2). Health care fraud costs tax payers increasingly more money every year. State and federal laws are designed to crack down on these crimes and impose stricter penalties. Fraud and abuse in the health care industry may be perpetuated by every party involved in the health care process. There are several stages to inhibiting fraudulent acts, including detection, prevention, investigation and reporting. In this section, we educate providers on how to prevent member and provider fraud by identifying the different types and by staging the first line of defense.

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

- **Member fraud**
  - Benefit sharing
  - Collusion
  - Drug trafficking
  - Forgery
  - Illicit drug seeking
  - Impersonation fraud
  - Misinformation/misrepresentation
  - Subrogation/third-party liability fraud
  - Transportation fraud

- **Provider fraud and abuse**
  - Billing for services not rendered
  - Billing for services that were not medically necessary
  - Unbundling
  - Upcoding

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

Every Amerigroup member identification card lists the following:

- Effective date of Amerigroup membership
- Date of birth of member
- Subscriber number (Amerigroup identification number)
- Carrier and group number (RXGRP number) for injectables
- Amerigroup logo
- Health plan name — Amerigroup Community Care
- PCP
- PCP telephone number
- PCP address
- If applicable, copays for office visits, emergency room visits and pharmacy
- Behavioral health benefit
- Vision service plan telephone number
- Amerigroup Member Services and 24-hour Nurse HelpLine telephone numbers

Presentation of an Amerigroup member identification card does not guarantee eligibility. Therefore, you should verify a member’s status by inquiring online or via telephone. Online support is available for provider inquiries at [https://providers.amerigroup.com](https://providers.amerigroup.com) and telephonic verification may be obtained on the automated Provider Inquiry Line at 1-800-454-3730.

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

Understanding the various opportunities for fraud and working with members to protect their Amerigroup ID card can help prevent fraud. If you suspect fraud, you should report such suspected fraud to any of the following:

- Amerigroup Compliance Hotline at 1-877-725-2702
- Office of Inspector General (OIG) at 1-800-433-3982 for member fraud
- Tennessee Bureau of Investigation (TBI) at 1-800-433-5454 for provider fraud
- The TBI Medicaid Fraud Control Unit at TBI.MFCU@tn.gov or the TennCare Office of Program Integrity at ProgramIntegrity.TennCare@tn.gov

No individual who reports violations or suspected fraud and abuse is subject to retaliation by Amerigroup.

**False Claims Act**

Amerigroup requires its providers and affiliates to abide by federal and state laws and regulations governing the administration and operations of managed care entities within the health care program. This includes provider compliance with Section of 6032 of the Deficit Reduction Act of 2005 through provider’s education of its employees, contractors and agents on the Federal False Claims Act, which establishes liability for the following activities:

- Knowingly presenting or causing to be presented to an officer or employee of the United States and/or applicable state government a false or fraudulent claim for payment or approval
- Knowingly making, using or causing to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the government
- Conspiring to submit a false claim or to defraud the government by getting a false or fraudulent claim allowed or paid
- Possessing, having custody of or controlling property or money used or to be used by the government and intending to defraud the government or to willfully conceal the property, delivers or causes to be delivered less property than the amount for which the person receives a certificate or receipt
- After being authorized to make or deliver a document certifying receipt of property used or to be used by the government and with the intent to defraud the government, makes or delivers the receipt without completely knowing that the information on the receipt is true
- Knowingly buying or receiving as a pledge, obligation or debt public property from an officer or employee of the government or any person who lawfully may not sell or pledge the property
- Knowingly making, using or causing to be made or used a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the government
• Knowingly makes, uses or causes to be made or used any false or fraudulent conduct, representation or practice in order to procure anything of value directly or indirectly from the government

The federal government may impose penalties of not less than $10,781 and not more than $21,563 plus three times the amount of damages sustained by the government if there is a finding of a violation of the False Claims Act. The government may reduce the damages if there is a finding that the person committing the violation reports it within 30 days of discovering the violation and if the person cooperates fully with the federal government’s investigation and if there are no criminal prosecutions, civil or administrative actions commenced at the time of the report and the person reporting does not have any knowledge of any such investigations. The federal government via the OIG may also use administrative remedies for the submission of false statements and/or claims that include administrative penalties of not more than $5,000 per false claim as well as determine whether suspension or debarment from the health care program is warranted.

Any employee who is discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against in the terms and conditions of employment by such employee’s employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for or assistance in an action filed or to be filed under this section, will be entitled to all relief necessary to make the employee whole. Such relief will include reinstatement with the same seniority status such employee would have had but for the discrimination, two times the amount of back pay, interest on the back pay and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys’ fees. An employee may bring an action in the appropriate court for the relief provided in the subsection.

In addition, Amerigroup also requires its providers and affiliates to abide by state laws and regulations governing the administration and operations of managed care entities within the health care program. This includes compliance with the Tennessee Medicaid False Claims Act (T.C.A. § 71-5-181 et seq.) which establishes liability for the following activities:

• Presenting or causing to be presented to the state a claim for payment under the Medicaid program knowing that such claim is false or fraudulent
• Presenting or causing to be presented to the state a claim for payment under the Medicaid program knowing that the person receiving a Medicaid benefit or payment is not authorized or is not eligible for a benefit under the Medicaid program
• Making, using or causing to be made or used, a record or statement to obtain a false or fraudulent claim under the Medicaid program paid for or approved by the state while knowing that such a record or statement is false
• Conspiring to defraud the state by getting a claim allowed or paid under the Medicaid program while knowing that such claim is false or fraudulent
• Making, using or causing to be made or used a record or statement to conceal, avoid or decrease an obligation to pay or to transmit money or property to the state, relative to the Medicaid program, knowing that such record or statement is false
• Knowingly applying for and receiving a benefit or payment on behalf or another person, except pursuant to the lawful assignment of benefits under the Medicaid program, and converting that benefit or payment to his or her own personal use
• Knowingly making a false statement or misrepresentation of material fact concerning the conditions or operation of a health care facility in order that the facility may qualify for certification or recertification required by the Medicaid program
• Knowingly making a claim under the Medicaid program for a service or product that was not provided
Failure by the provider to obtain written approval from Amerigroup for a subcontract that is for the purposes of providing TennCare-covered services may lead to the contract being declared null and void at the option of TennCare. Claims submitted by the subcontractor or by the provider for services furnished by the subcontractor are considered to be improper payments and may be considered false claims. Any such improper payments may be subject to action under federal and state false claims statutes or be subject to be recouped by Amerigroup and/or TennCare as overpayment.

Tennessee False Claims Acts (Tennessee Code Annotated 71-5-181 through 71-5-185) specify that:

A person or entity who presents (or causes to be presented) a claim for payment under the Medicaid program, knowing such claim is false or fraudulent, or who makes, uses or causes to be made or used, a record or statement to get a false or fraudulent claim under the Medicaid program paid for or approved by the state knowing such record or statement is false, is in violation of the Tennessee and federal False Claims Acts, and is subject to federal and state civil penalties. The state civil penalty is not less than $5,000 and not more than $25,000, plus three times the amount of damages that the state sustains because of the act of that person or entity.

Pre-admission evaluation (PAE) is submitted to TennCare for purposes of establishing eligibility for reimbursement of long term services and supports (LTSS), including nursing facility (NF) services and home and community based services (HCBS) received as an alternative to NF services. When approved, a PAE may also result in approval of Medicaid institutional eligibility and in a capitation payment to the MCO, as well as payment of claims for physical and behavioral health, pharmacy and LTSS. It is therefore critical that the information submitted on a PAE is complete and accurate, and does not result in payments being inappropriately authorized to an MCO or to the NF or other health care providers.

One situation in which NFs could submit information to TennCare in violation of the False Claims Acts is submission of an NF PAE when a person has elected to receive hospice services in the NF. Hospice services are not LTSS. When a person has elected to receive hospice services in an NF, the NF is providing hospice room and board and not NF services. However, if a PAE is submitted for NF services with a Medicaid-only payer date (MOPD) that Medicaid-reimbursed NF services will begin and the person meets NF level of care, a CHOICES capitation payment will be generated in error to the MCO, resulting in an overpayment and a violation of the False Claims Act. Further, the physician who certified the PAE may also be in violation of the False Claims Act, because he has certified medical necessity for NF services (which is required for approval of the PAE), when in fact, hospice services are being received.

NFs are therefore advised to NOT submit a PAE when a person has elected to receive hospice services in the NF. Another situation pertains specifically to the MOPD captured on the PAE application. This is the date that the facility certifies that Medicaid reimbursement for NF services will begin because the person has in fact been admitted to the facility and all other sources of reimbursement (including Medicare and private pay) have been exhausted. This date must be known (and not estimated) because it too may result in establishment of eligibility for LTSS and in many cases, eligibility for Medicaid, and in payment of a capitation payment as well as payments for Medicaid (including but not limited to LTSS) services received. To the extent that a facility submits an MOPD that is incorrect, overpayments may be made to the MCO as a result of the NF’s actions, resulting in a violation of the False Claims Act.

NFs are therefore advised to ensure that staff submitting PAEs on behalf of the facility enter a MOPD only when such date is known and confirmed. The MOPD does not have to be submitted at the same time as the PAE. If you don’t know the MOPD when the PAE is submitted, leave it blank. The PAE will still be processed. You can come back and complete the MOPD once it is known; however, do not forget to come back and enter this date.
when it is known. If an MOPD is not entered, the person will not be enrolled into CHOICES, and you will not be reimbursed for NF services.

If anyone acting on behalf of your facility has submitted any of these types of information that has resulted in an overpayment being paid — to you or to an MCO or other health care provider — you have 60 days to return any overpayments you have received and complete these notifications so that appropriate adjustments can be made and potential violations can be avoided (See §6402 of the Affordable Care Act).

In addition, an NF’s failure to provide proper notification of a change in a resident’s status may result in violations of these acts. This includes situations in which a resident discharges from the facility, or remains in the facility but elects to receive hospice benefits. In these cases, if the NF does not timely notify the MCO using the form and process established by TennCare (visit the TennCare LTSS website to view memo and form 9/13/10), TennCare will continue to pay a capitation payment to the MCO for LTSS when the person is no longer receiving such services, resulting in an overpayment. In many cases, this also results in the person’s eligibility in the institutional category being extended in error, payments for physical and behavioral health and pharmacy services for which the person no longer qualifies.

NFs are therefore advised to immediately submit a CHOICES Discharge/Transfer/Hospice Form to the MCO anytime a TennCare CHOICES member is discharged from your facility or is no longer receiving NF services (including when a member elects to receive hospice). This includes:
- Transfers to another nursing facility
- Discharges to the hospital (even when return to the facility is expected)
- Discharges home, with or without HCBS
- Election of hospice services
- Upon a resident’s death

The Discharge/Transfer/Hospice Form is to be completed by the discharging facility and sent to the member’s MCO.

Please note that while a facility is contractually obligated to submit the form for transfers to another facility and such notification is very important in terms of coordinating care for the resident, failure to notify the MCO of a transfer would not result in a potential violation of the False Claims Acts. However, failure to submit the form for discharges and hospice elections will.

When a person admits to an NF specifically for purposes of receiving hospice (rather than NF services), the person may nonetheless qualify in an institutional eligibility category once they have been "continuously confined" in the facility for a period of at least 30 days. Because a PAE is not required and should not be submitted for hospice services, TennCare can’t use the PAE to prospectively establish "continuous confinement". However, upon conclusion of a 30-day institutional stay, TennCare may apply institutional income standards in determining eligibility for Medicaid services, including hospice. TennCare will not authorize Medicaid payment for LTSS; nor will a person receiving hospice in the NF be enrolled into CHOICES, since hospice services are not LTSS. A copy of the Division’s hospice benefit policy is available online on the TennCare website.

For persons receiving hospice in an NF, TennCare will determine patient liability. Facilities are obligated pursuant to federal law to collect patient liability for hospice patients receiving hospice in an NF, and to use such payments to offset the cost of room and board billed to the hospice agency.

A PAE should be submitted ONLY for persons seeking Medicaid reimbursement of NF (not hospice) services. If a patient admits to the facility for NF services, facilities continue to be advised to submit a PAE as soon as you determine that Medicaid reimbursement will be needed, but no later than 10 days after the requested effective
date of reimbursement. As you know, the earliest date of Medicaid reimbursement for NF services is the date that ALL of the following criteria are met:

- Completion of the PASRR process
- Effective date of level of care eligibility by TennCare (i.e., effective date of the PAE), which cannot be more than 10 days prior to date of submission of the approvable PAE
- Effective date of Medicaid eligibility (in most cases, the date of financial eligibility application)
- Date of NF admission

If a person appropriately enrolled into CHOICES for receipt of NF services subsequently elects to receive hospice services, the facility should not withdraw the MOPD, nor should the facility attempt to withdraw the original PAE. The PAE and MOPD are required in order for the facility to be reimbursed for NF services received prior to hospice election. Rather, the facility must submit to the MCO a CHOICES Discharge/Transfer/Hospice Form so that overpayments will not be made to the MCO since the person is no longer receiving NF services. The person who has elected hospice will be disenrolled from CHOICES, but not from Medicaid, so long as he continues to receive hospice services in the NF. The capitation payment will be adjusted accordingly.

Members who withdraw their election of hospice services may request to enroll in the CHOICES program. We would expect that such occurrences are rare, since hospice is by definition "end of life" care. An approved PAE will be required to facilitate this enrollment.

**Conflict of Interest, Disclosures of Ownership and Control, and Criminal Activity**

Amerigroup includes language in all subcontracts and provider agreements and any and all agreements that result from an agreement between Amerigroup and TennCare to ensure that it is maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization. No part of the total agreement amount shall be paid directly, indirectly or through a parent organization, subsidiary or an affiliate organization to any state or federal officer or employee of the state of Tennessee or any immediate family member (a spouse or minor children living in the household) of a state or federal officer or employee of the state of Tennessee as wages, compensation or gifts in exchange for acting as officer, agent, employee, subcontractor or consultant to Amerigroup in connection with any work contemplated or performed under this Agreement unless disclosed to the Commissioner, Tennessee Department of Finance and Administration.

Quarterly, by January 30, April 30, July 30 and October 30 each year, or at other times or intervals as designated by the Deputy Commissioner of the Division of TennCare, disclosure shall be made by Amerigroup to the Deputy Commissioner of the Division of TennCare, Department of Finance and Administration in writing, including a list of any state or federal officers or employees of the state of Tennessee, as well as any immediate family member of a state or federal officer or employee of the state of Tennessee who receives wages or compensation from Amerigroup, and a statement of the reason or purpose for the wages and compensation. The disclosures shall be made by Amerigroup and reviewed by TennCare in accordance with Standard Operating Procedures and the disclosures will be distributed to, among other persons, entities and organizations, the Commissioner, Tennessee Department of Finance and Administration, the Tennessee Ethics Commission, the TennCare Oversight Committee and the Fiscal Review Committee. Provider shall report any disclosures under this section directly to the Deputy Commissioner of the Division of TennCare, Department of Finance and Administration in writing and in accordance with the quarterly intervals required under this section. The provider shall report any disclosures under this section directly to the Deputy Commissioner of the Division of TennCare, Department of Finance and Administration in writing and in accordance with the quarterly intervals required under this section. Amerigroup may be subject to sanctions, including liquidated damages, if it is determined that its agents or employees offered or gave gratuities of any kind to any state or federal officials or employees of the state of Tennessee or any immediate family member of a state or federal officer or employee of the state of Tennessee if the offering or giving of said gratuity is in contravention or violation of state or federal law.
In addition, Amerigroup is required by federal law to secure a current disclosure of ownership and a disclosure of criminal activity from each of its providers and contractors before executing any agreement with said provider or contractor. Such information shall be obtained from all individual physicians and provider entities that will be seeing patients, even if they are under a group agreement and shall be obtained at recontracting, at any time there is change to any such information on the disclosure form, at least once every three years and at any time upon request. Such information shall also be obtained from all of the staff at facilities who are considered managing employees or agents. This requirement also applies to nonparticipating providers when Amerigroup starts paying claims to them. TennCare will perform quarterly audits of randomly selected providers to determine that disclosures have been received. Failure to secure such disclosures may result in the assessment of penalties per occurrence/per day for every day of noncompliance. See Disclosure For Provider Entities, Disclosure For A Provider Person and Practitioner Attestation Forms in Appendix A.

**Required Screenings for Excluded/Sanctioned/Debarred Employees/Contractors**

The OIG of the United States Department of Health and Human Services (HHS-OIG) can exclude individuals and entities from participation in Medicare, Medicaid, the State Children’s Health Insurance Program (SCHIP) and all federal and state health care programs (as defined in section 1128B(f) of the Social Security Act [the Act]) based on the authority contained in various sections of the Act, including sections 1128, 1128A and 1156.

When the HHS-OIG has excluded a provider, federal and state health care programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered or prescribed by excluded individuals or entities (section 1903(i)(2) of the Act and 42 CFR section 1001.1901(b)). This payment ban applies to any items or services reimbursable under a federal or state health care program, like Medicaid, which are furnished by an excluded individual or entity and extends to:

- All methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules or a prospective payment system.
- Payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients when those payments are reported on a cost report or are otherwise payable by the Medicaid program.
- Payment to cover an excluded individual’s salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner or supplier that is not excluded (see 42 CFR section 1001.1901(b)). Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare members.

The listing below sets forth some examples of types of items or services that are reimbursable by Medicaid which, when provided by excluded parties, are not reimbursable:

- Services performed by excluded nurses, technicians or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays or review of treatment plans if such services are reimbursed directly or indirectly (such as through a pay per service or a bundled payment) by a Medicaid program, even if the individuals do not furnish direct care to Medicaid recipients.
- Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed directly or indirectly by a Medicaid program.
• Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and reimbursed directly or indirectly by a Medicaid program
• Items or services provided to a Medicaid recipient by an excluded individual who works for an entity that has a contractual agreement with and is paid by a Medicaid program
• Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of recipients and reimbursed directly or indirectly by a Medicaid program

To further protect against payments for items and services furnished or ordered by excluded parties, Amerigroup requires all current providers and providers applying to participate in the Medicaid program to take the following steps to determine whether your employees and contractors are excluded individuals or entities:

1. Institute a policy requiring all employees and contractors immediately to disclose to you if and when they are or become excluded by the HHS-OIG or any other federal government agency.
2. Screen all employees, owners, managing agents and contractors against the System for Award Management (SAM) database (formerly GSA Excluded Parties List System) and HHS-OIG’s List of Excluded Entities/Individuals database (a) prior to hiring or contracting, and (b) on a monthly basis to capture exclusions and reinstatements that have occurred since the last search.
3. Remove excluded employees and contractors immediately from responsibility for or involvement with business operations related to the federal and state health care programs and remove such employees and contractors from any position for which the employee’s or contractor’s compensation or the items or services furnished, ordered or prescribed by the employee or contractor are paid in whole or part, directly or indirectly, by federal or state health care programs or otherwise with federal or state funds at least until such time as the employee or contractor is reinstated into participation in the federal health care programs.
4. Report to Amerigroup any exclusion information discovered immediately via fax to the attention of the Amerigroup Tennessee Plan Compliance Officer at 1-877-279-2445.

Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by TennCare and Amerigroup dependent upon which entity identifies the payment of unallowable funds to excluded individuals. Additionally, all current providers are required to conduct background checks in accordance with state law and TennCare policy. At a minimum, background checks shall include a check of the Tennessee Abuse Registry, the Tennessee Felony Offender Registry, the National and Tennessee Sexual Offender Registry, the Social Security Master Death File, the Excluded Parties List System (EPLS) and the HHS-OIG List of Excluded Individuals/Entities (LEIE). All background checks required in this section must be completed prior to the start date of employment.

Return of Overpayments
In accordance with the Affordable Care Act and TennCare policy and procedures, providers must report in writing overpayments to Amerigroup and TennCare Office of Program Integrity (OPI), and when it is applicable, return overpayments to Amerigroup within 60 days from the date the overpayment is identified. Overpayments not returned within 60 days from the date the overpayment was identified by the provider may be a violation of state or federal law.

Reporting of Abuse of Adults and Children
All current providers must report suspected abuse, neglect and exploitation of members who are adults to Amerigroup and Adult Protective Services in accordance with T.C.A. 71-6-101 et seq. The reports should provide the following information if known:

• The name and address of the adult or of any other person responsible for the adult’s care
• The age of the adult
- The nature and extent of the abuse, neglect or exploitation, including any evidence of previous abuse, neglect or exploitation
- The identity of the perpetrator if known
- The identity of the complainant if possible
- Any other information that the person believes might be helpful in establishing the cause of abuse, neglect or exploitation

All current providers must report suspected brutality, abuse or neglect of members who are children to Amerigroup and Child Protective Services in accordance with T.C.A. 37-1-401 et seq. To the extent known by the reporter, the report should include:
- The name, address, telephone number and age of the child
- The name, address and telephone number of the person responsible for the care of the child
- The facts requiring the report

**No Payment Outside of the U.S.**
All covered services to be performed by providers shall be performed in the United States of America and the provider shall not provide any payments for covered items or services to any financial institution, entity or person located outside the United States.

**Billing Agents and Alternative Payees**
Providers are not permitted to assign TennCare funds/payment to billing agents or alternative payee without executing a billing agent or alternative payee assignment agreement. Such billing agents and alternative payees are subject to initial and monthly federal exclusion (LEIE) and debarment (SAM) screening if the alternative payee assignment is ongoing. Further, TennCare direct and indirect payments to out-of-country individuals and/or entities are prohibited.

**Payment Error Rate Measurement and Provider Obligations**
Payment Error Rate Measurement (PERM) is a program implemented by CMS to measure improper payments in the Medicaid Program and CHIP. CMS audits TennCare payments for these programs every three years. If you are one of the providers randomly selected to supply medical and payment records, you must comply with the CMS request within 60 days. For more information about PERM, check the TennCare website at www.tn.gov/tenncare/providers.html

**Provider-Preventable Conditions**
Provider shall comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment by, at a minimum, nonpayment of provider preventable conditions, as well as appropriate reporting of these conditions to Amerigroup and TennCare.

**Onsite Inspections and Audit of Records**
TennCare, CMS, OIG, the Comptroller General or their representatives may conduct onsite inspections of premises, physical facilities and equipment of all health facilities and service delivery sites and audit any records or documents to be utilized by Amerigroup in fulfilling the obligations under the contract. Inspections may be made at any time during the contract period and without prior notice. The right to audit exists for 10 years from the final date of the contract period or the from the date of completion of any audit, whichever is later.
20 PROVIDER COMPLAINT PROCEDURES

Amerigroup has a formal process for the handling of complaints pertaining to administrative issues and nonpayment related matters. For payment disputes, see Section 16, Provider Payment Disputes. Providers may access this process by filing a written dispute.

Providers are not penalized for filing complaints. Any supporting documentation should accompany the complaint.

A provider can file a complaint in writing to:

Operations Department
Amerigroup Community Care
22 Century Boulevard, Suite 220
Nashville, TN 37214

Amerigroup will send an acknowledgement letter to the provider within 10 business days of receipt. At no time will Amerigroup cease coverage of care pending a complaint investigation.
APPENDIX A — FORMS

Certification and Claim Submission Forms
1. WIC Form — A sample form that providers may use to make referrals to WIC, a provider agency
2. Precertification Request — Providers can use this form to submit a request for a precertification or for a notification of services
3. Specialist as PCP Form — Specialists are to use this form when requesting to be appointed as a member’s PCP
4. CMS 1500 Claim Form — A sample claim form
5. CMS 1450 Claim Form — A sample claim form
This is a referral to a **Women, Infant and Children (WIC)** provider agency. Medicaid recipients eligible for WIC benefits include the classifications listed below. Please check the category that most appropriately describes the individual that is being referred for services.

- Pregnant woman
- Woman who is breast-feeding her infant(s) up to one year postpartum
- Woman who is not breast feeding her infant(s) up to six months postpartum
- Infant under age one
- Child under age five

Name of individual being referred:

Address:

Telephone Number:

---

I, the undersigned, give permission for my provider to give the WIC Program any required medical information.

Signature of the patient being referred or, in the case of children and infants, signature and printed name of the parent/guardian.

---

Physician’s Name:

Telephone Number:

Date of Referral:

Send completed form to:

Local WIC Program Center:

Address:

Telephone Number:
Authorization Request Form

**TODAY’S DATE:**

| MEMBER INFORMATION (Please verify eligibility prior to rendering service) |
|---|---|---|
| **NAME:** (Last Name, First Name) | **AMERIGROUP #:** | **DOB:** |
| **ADDRESS:** | **CITY, STATE, ZIP:** | **MEDICAID #:** | **OTHER INSURANCE/WORKER’S COMP:** |

| REFERRING PROVIDER INFORMATION |
|---|---|
| **NAME:** | **OFFICE CONTACT NAME:** |
| **MEDICAID PROVIDER #:** | **AMERIGROUP #:** | **GROUP PRACTICE #:** | **NPI #:** |
| **PHONE #:** | **FAX #:** | ☑ Check the box where the | ☑ Fax back |
| **PHONE #:** | **FAX #:** | ☑ referral should be faxed back | **OTHER PHONE #:** |

| SPECIALIST CONSULT |
|---|---|
| **CONSULTANT:** (Last Name, First Name, Provider Specialty) |
| **AMERIGROUP PROVIDER #:** | **NPI #:** | **PHONE #:** | **FAX #:** |
| **ADDRESS:** | **CITY, STATE, ZIP:** |

| ICD-9 CODE/DIAGNOSIS/REASON FOR REFERRAL: |
|---|---|
| **PMH/PREVIOUS STUDIES/TREATMENTS:** |

| MATERNITY CARE |
|---|---|
| For initial notification of pregnancy, please use the Maternity Notification form. |
| For all other services related to pregnancy, please use this form (e.g. ultrasound, fetal non-stress test). |

| DIAGNOSTIC STUDY |
|---|---|
| **FACILITY NAME:** | **DOS:** |
| **DIAGNOSIS/REASON FOR REFERRAL:** |
| **PROCEDURE/CPT-4 CODE:** |
| **PMH/PREVIOUS STUDIES/TREATMENTS:** |

| SURGERY REQUEST |
|---|---|
| **SURGEON’S FULL NAME:** (Last Name, First Name) | **DOS:** | ☑ Inpt ☑ Outpt ☑ Ext Stay |
| **FACILITY NAME:** |
| **DIAGNOSIS/REASON FOR SURGERY:** |
| **PROCEDURE/CPT-4 CODE:** |
| **PMH/PREVIOUS STUDIES/TREATMENTS:** |

| OTHER - Clinical Information Needed |
|---|---|
| ☑ DME ☑ Home Health ☑ Hospice ☑ Other |
| **REFERRED TO PROVIDER:** (Last Name, First Name) | **AMERIGROUP PROVIDER #:** | **NPI #:** |
| **DIAGNOSIS/REASON FOR REFERRAL:** |
| **PROCEDURE/CPT-4 CODE:** |
| **PMH/PREVIOUS STUDIES/TREATMENTS:** |

**PLEASE ATTACH CLINICAL INFORMATION TO SUPPORT MEDICAL NECESSITY**

This referral is valid only for services authorized by this form. Only completed referrals will be processed. If the consultant/provider recommends another service or surgery, additional authorization is required. Certification does not guarantee that benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions, and exclusions.

**To be completed by AMERIGROUP:** **DATE APPROVED:**

| DATE SPAN: | REFERENCE #: | INITIALS OF APPROVER: |
Specialist as PCP Request Form

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>________________________________________________</td>
</tr>
<tr>
<td>Member’s Name:</td>
<td>________________________________________________</td>
</tr>
<tr>
<td>Member’s ID Number:</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 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: ___________________
HEALTH INSURANCE CLAIM FORM

This form (and the form change log and instruction manual) is also available from the Centers for Medicare and Medicaid Services at www.cms.hhs.gov.

READ BACK OF FORM BEFORE COMPLETING AND SENDING THIS FORM.

12. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information. I also certify that I have received a copy of the claim form.

13. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information.

14. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information.

15. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information.

16. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information.

17. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information.

18. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information.

19. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information.

20. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information.

21. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information.

22. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information.

23. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information.

24. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information.

25. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information.

26. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information.

27. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information.

28. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information.

29. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information.

30. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information.

31. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information.

32. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information.

33. I, the party authorized to sign this form, certify that I have read this form and have reviewed the patient information.
BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERENCES TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TENNCARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 C.F.R 411.24(a). If Item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Consurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a,4,6,7,9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including bin not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license number, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an Integral, although Incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TENNCARE claims, I further certify that 1) (or any employee) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contractor employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to line and imprison on under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment was made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. E.g., it may be necessary to disclose information the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.


FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related information may be provided to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response toquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, or other facilities; and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, and other integrated, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties lor withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify Information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)
I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

**SIGNATURE OF PHYSICIAN (OR SUPPLIER):** I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PAA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.
This form is also available from the Centers for Medicare and Medicaid Services at [www.cms.hhs.gov](http://www.cms.hhs.gov).
UNIFORM BILL:

LET NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician’s certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Christian Science Sanitoriums, verifications and if necessary re- verifications of the patient’s need for sanitorium services are on file.

5. Signature of patient or his/her representative on certifications, authorization to release information, and payment request, as required by Federal law and regulations (42 USC 1395f, 42 CFR 424.36, 10 USC 1071 thru 1088, 32 CFR 169) and, any other applicable contract regulations, is on file.

6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare purposes:

   If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon their request, necessary authorization is on file. The patient’s signature on the provider’s request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the patient has employer group health insurance, liability, no-fault, workers’ compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

   This is to certify that the foregoing information is true, accurate, and complete.

   I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

9. For CHAMPUS purposes:

   This is to certify that:

   (a) the information submitted as part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

   (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance where a copy of a Non-Availability Statement is not on file;

   (c) the patient or the patient’s parent or guardian has responded directly to the provider’s request to identify all health insurance coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

   (e) the beneficiary’s cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts, and;

   (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

   (h) if CHAMPUS benefits are to be paid in a participating status. I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

TN-PM-0034-18 - 197 -
Refund Notification Form

Amerigroup
An Anthem Company

https://providers.amerigroup.com

Overpayment Refund Notification Form

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

<table>
<thead>
<tr>
<th>Provider information</th>
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<tbody>
<tr>
<td>Provider name/contact:</td>
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<tr>
<td></td>
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<tr>
<td>Contact number:</td>
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<td>Provider ID:</td>
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<tr>
<td>NPI number:</td>
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<tr>
<td>Provider tax ID:</td>
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<tr>
<td>Subscriber ID:</td>
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<tr>
<td>DCN number (Displayed on CCU letter):</td>
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<thead>
<tr>
<th>Member information</th>
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<tbody>
<tr>
<td>Member name:</td>
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<tr>
<td>Member account number:</td>
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<td>Date of service:</td>
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<tr>
<td>Total billed charges:</td>
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<td>Claim number:</td>
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<table>
<thead>
<tr>
<th>Overpayment information</th>
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<tbody>
<tr>
<td>Total check amount:</td>
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<tr>
<td>Date overpayment identified:</td>
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<tr>
<td>Date range/time frame the issue(s) occurred:</td>
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<tr>
<td>Specific CPT/HCPCS/DRG code(s) involved with the reimbursement:</td>
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<tr>
<td>Have you performed due diligence to ensure this voluntary refund is isolated only to the identified claim(s)?</td>
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<tr>
<td>□ Yes □ No</td>
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<tr>
<td>Did you self-identify the overpayment?</td>
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<tr>
<td>□ Yes □ No</td>
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<tr>
<td>If no, then briefly explain who identified the overpayment and issues or billing codes that were identified.</td>
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TNPEC-2223-18
March 2018

TN-PM-0034-18 - 198 -
<table>
<thead>
<tr>
<th>Additional claim(s)</th>
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<tbody>
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Reason for refund or check return:
- [ ] Amerigroup letter
- [ ] Contract rate change
- [ ] Duplicate payment
- [ ] Incorrect member
- [ ] Incorrect provider
- [ ] Negative balance
- [ ] Other health insurance/third-party liability
- [ ] Payment error
- [ ] Billed in error/adjusted charge
- [ ] Other: ____________________

All refund checks should be mailed with a copy of this form to:
Amerigroup Community Care
P.O. Box 933657
Atlanta, GA 31193-3657

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

Medical Record Forms: These are sample medical record forms that the provider may choose to use.

Clinical Information Form

__________________________________________________
Patient Name

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<tr>
<th>PATIENT DIAGNOSES</th>
<th>DATE DIAGNOSED</th>
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<th>HEALTH SCREENS</th>
<th>DATE PERFORMED</th>
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<tr>
<td>RECTAL EXAM</td>
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<td>PSA</td>
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<td>CHEST X-RAY</td>
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<td>SIGMOIDOSCOPY</td>
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<td>EKG</td>
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Problem List 1

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Addressograph

MEMBER NAME: ________________________________

DOB __________________ EFF DATE __________________

ID #________________ SSN #________________________
Problem List 2

NAME: ________________________________________________________________

DOB: __________________________________________________________________

TELEPHONE: __________________________________________________________________

MEMBER ID NUMBER: _______________________________________________________

PROBLEM LIST

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MEDICATION

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ALLERGIES

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Change in dosage requires new medication entry.

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<th>MD’s initials</th>
<th>Medication/dosage frequency</th>
<th>Date</th>
<th># Refill</th>
<th>MD nurse</th>
<th>Date</th>
<th># Refill</th>
<th>MD nurse</th>
<th>Date</th>
<th># Refill</th>
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</table>

Signature: ___________________________ Date: ____________
Signature: ___________________________ Date: ____________
Signature: ___________________________ Date: ____________
Signature: ___________________________ Date: ____________
Signature: ___________________________ Date: ____________
HIV Antibody Blood Forms

Counsel for HIV Antibody Blood Test: This is a sample counsel form that the provider may choose to use.

Consent for HIV Antibody Blood Test: This is a sample consent form that the provider may choose to use.

Results of the HIV Antibody Blood Test: This is a sample results form that the provider may choose to use.
Counsel for HIV Antibody Blood Test

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 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 test for
(Name or title of person who is to receive results)
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 for 12 months indefinitely or until ________________________, 20____, whichever is shorter unless I withdraw my permission.

I have the right to withdraw my permission at any time. I cannot take back information that has been used to take action on my case or that has been given to you before I take back my permission. To withdraw my permission, I can write the Department of Human Services in my county, or write my doctors, hospitals or other health care providers or insurance company or health plan.

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

G. If this authorization is signed by my personal representative, a description of such representative’s authority to act for me in the capacity of health care decisions must be provided. Legal authority as personal representative, i.e., conservatorship, etc., must be attached or documentation must be on file in plan or provider’s records.

Note: this form must be in at least 8-point type.
Blood Lead Risk Forms

Verbal Blood Lead Risk Assessment: This is a sample assessment form that the provider may choose to use.

Blood Lead Testing for High-risk Children: This is a sample assessment form that the provider may choose to use.

Elevated Blood Lead Testing Result Form: This is a sample results form the provider may choose to use.
**Verbal Blood Lead Risk Assessment**

Member Name: ________________________________
Date: ________________________________
ID Number: _____________
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 1960? 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 1960? 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 1960 with recent, ongoing or planned renovation or remodeling?</td>
<td></td>
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</tr>
<tr>
<td>Have any of your children or their playmates had lead poisoning?</td>
<td></td>
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</tr>
<tr>
<td>Does your child frequently come in contact with an adult who works with lead? Examples include construction, welding or pottery.</td>
<td></td>
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</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 Name: _____________________________
Date: _____________________________________
ID Number: _____________________________________
Person Interviewed/Relationship: _________________

<table>
<thead>
<tr>
<th>Has your child’s blood been tested for lead?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>When your child was 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>
<tr>
<td>When?</td>
<td>Date:</td>
<td></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.
Elevated Blood Lead Testing Result Form

Member Name:___________________________      Date: ________________

ID Number: ___________________________       Date of Birth: _________

Provider Name: ___________________________    Provider ID Number: __________

Has a risk assessment been performed?       ❑ Yes  ❑ No

Environmental risks (please specify):

________________________________________________________________________

________________________________________________________________________

When was the member tested for lead poisoning?      Date:______________

When the member was last tested for lead poisoning? Date:_______________
    Result:__________________

Laboratory that performed testing: __________________________

Planned follow-up treatment:

________________________________________________________________________

________________________________________________________________________

________________________    ______________________
    Provider Signature        Date

Please fax the completed form to Attn: Pediatric CM at 1-866-495-5788 within five days of notification of an elevated lead blood level.
Abortion, Hysterectomy and Sterilization Forms

Every time you submit a claim for the procedures for abortion, hysterectomy and sterilization services and related procedures, (i.e., ancillary procedures such as anesthesia services), you must include one of the following applicable forms for reimbursement and/or such form must be on file for the service. The form must be filled out correctly and in its entirety:

- Certification of Medical Necessity for Abortion
- Sterilization Consent Form
- Hysterectomy Acknowledgment Form

Printable forms and instructions to complete the forms are on the Division of TennCare website at https://www.tn.gov/tenncare/providers/miscellaneous-provider-forms.html. Failure to fully complete these forms in accordance with the applicable instructions will result in the denial of your claim.

Note: Amerigroup and TennCare will only accept the Sterilization Consent form with the 2018 expiration date. Claims with consent forms that show any other expiration date will be denied.
Practitioner Evaluation and Audit Tools

Practitioner Evaluation and Audit Tools: These tools may be used by Amerigroup when auditing provider medical records for credentialing or investigation of quality management issues.
Practitioner Office Site Evaluation

**PRACTITIONER OFFICE SITE EVALUATION - ALL PLANS**

**INFORMATION BELOW MUST BE DOCUMENTED AT TOP OF EACH PAGE OF SITE VISIT FORM! ALL QUESTIONS MUST BE ANSWERED.**

<table>
<thead>
<tr>
<th>Question</th>
<th>Points Value</th>
<th>Y</th>
<th>N</th>
<th>N/A</th>
<th>Point Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Physical Accessibility:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1. Is there accessibility for people with disabilities? (First floor access, ramps or elevator access) If not, does staff have an alternative plan of action? Access throughout the office including bathrooms?</td>
<td>10</td>
<td></td>
<td></td>
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<tr>
<td>2. Is accessible parking clearly marked? (Sign/painted symbols on pavement) Only applies to off-street parking.</td>
<td>2</td>
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<tr>
<td>N/A is parking street-side only.</td>
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<tr>
<td>3. Are doorways and stairways that provide access free from obstructions at all times and allow easy access by wheelchair or stretcher?</td>
<td>2</td>
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<tr>
<td>4. Are exits clearly marked and in an emergency lighting in instances of power failure?</td>
<td>2</td>
<td></td>
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<tr>
<td>5. Are building and office site clearly identifiable (clearly marked office sign)?</td>
<td>2</td>
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<tr>
<td>B. Physical Appearance:</td>
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<tr>
<td>1. Is the office clean and well kept? (No trash on floor, furniture in good repair, no significant spills on floors / furnishings)</td>
<td>10</td>
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<tr>
<td>2. Is treatment area clean and well kept? (No significant spills on floors, counters or furnishings, no trash on floor)</td>
<td>2</td>
<td></td>
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<tr>
<td>3. Does office have smoke detectors?</td>
<td>2</td>
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<tr>
<td>4. Is there a clean, supplied bathroom? (Soap, toilet paper, trashcans and hand washing instructions)</td>
<td>2</td>
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<tr>
<td>5. Are extinguishers clearly present and fully charged and recently inspected (even if office has fire extinguishers)?</td>
<td>2</td>
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<tr>
<td>C. Adequacy of Waiting and Examining Room Space:</td>
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<tr>
<td>1. Are there adequate seating in the waiting area (based on number of physicians/practitioners)?</td>
<td>1</td>
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<td>2. Does the staff provide extra seating when the waiting room is full?</td>
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<tr>
<td>3. Is there a minimum of 2 exam rooms per scheduled provider? (2 consultation rooms for Behavioral Health (BH) Providers)</td>
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<tr>
<td>4. Is there privacy of exam/consultation rooms? (Doors or curtain closures; rooms cannot be visualized from waiting room)</td>
<td>1</td>
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<tr>
<td>5. Are exam/consultation rooms reasonably sound proof? (Conversations cannot be heard from waiting room or other exam rooms)</td>
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<tr>
<td>6. An otoscope, otoscope, reflex ophthalmoscope, blood pressure cuff and scale readily accessible? N/A for BH Providers</td>
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<tr>
<td>7. Are OB/GYNs only or any physicians/practitioners providing OB Care?</td>
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<td>Does the office have the following readily accessible? (if not OB/GYN, check N/A)</td>
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<tr>
<td>7a. - A fetoscope (Doppler and/or Doppler) and a measuring tape for fundus height measurement?</td>
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<td>7b - Supplies for digital urine analysis (glucometer, protein)</td>
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<td>D. Adequacy of Medical Records:</td>
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<tr>
<td>1. Are there individual patient records?</td>
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<tr>
<td>2. Are records stored in a manner which ensures confidentiality - are they kept in an area not accessible by patients?</td>
<td>2</td>
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<td>3. Are all items secured in the chart?</td>
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<td>4. Are medical records readily available? (Within 15 minutes of request) Are they if they are.</td>
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<tr>
<td>5. Medical Records log book: Pinecrest Medical Records</td>
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<td>5a. Is there a space to document allergy?</td>
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<td>5b. Is there a place to document current medication list?</td>
<td>2</td>
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<tr>
<td>5c. Is there a space to document current chronic problems list?</td>
<td>2</td>
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<tr>
<td>5d. Is there an immunization record on pediatric chart? N/A for BH Providers</td>
<td>2</td>
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<tr>
<td>5e. Is there a growth chart on pediatric chart? N/A for BH Providers</td>
<td>2</td>
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<tr>
<td>5f. Is there a place to document presence/absence and discussion of a patient self-determination / advance directive? (If not appropriate, check N/A)</td>
<td>2</td>
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</table>

* 1 Provider = 6 seats, 2 Providers = 8 seats, 3 Providers = 11 seats, 4 Providers = 14 seats, 5 Providers = 17 seats
<table>
<thead>
<tr>
<th>E. Appointment Availability: Is the physician/practitioner available?</th>
<th>Point Value</th>
<th>Y</th>
<th>N</th>
<th>N/A</th>
<th>Point Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Routinely within a wait time of 45 minutes or less? (Ask office manager)</td>
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<td>2. At least 4 days or 20 hours per week? NY: At least 16 hours per week at this office location or has waiver been granted?</td>
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<tr>
<td>3. IL Only: Are same day appointments available for 1st dose? (following 2 doses)</td>
<td>1</td>
<td></td>
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<tr>
<td>4. IL Only: Are same day appointments available for 2nd dose? (following 1st dose)</td>
<td>1</td>
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<tr>
<td>5. GA Only: Are same day appointments available for 1st dose? (following 2 doses)</td>
<td>1</td>
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<td></td>
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<tr>
<td>6. GA Only: Are same day appointments available for 2nd dose? (following 1st dose)</td>
<td>1</td>
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<td></td>
</tr>
<tr>
<td>7. GA Only: Are same day appointments available for 1st dose? (following 2 doses)</td>
<td>1</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>8. GA Only: Are same day appointments available for 2nd dose? (following 1st dose)</td>
<td>1</td>
<td></td>
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<tr>
<td>9. 24 hour call coverage for emergencies (by themselves or by on-call provider)</td>
<td>1</td>
<td></td>
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<td></td>
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<tr>
<td>10. Urgent care within 24 hours?</td>
<td>1</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>11. Routine/problem care within 2 weeks FL, NY, NY, OH, SC, TN, TX: 10 days VA, MD/DC: 3 weeks GA, IL: 28 days NJ: of visit</td>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>(All except GA - including first visit after pregnancy determination that includes home pregnancy test) Please circle appropriate Health Plan</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>P. Documentation Evaluation: Does the office have the following?</th>
<th>Point Value</th>
<th>Y</th>
<th>N</th>
<th>N/A</th>
<th>Point Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No-show follow-up procedure/policy? If not written, can the staff verbally explain the process?</td>
<td>2</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>2. A chartreuse policy? If provider does not have written chartreuse policy, office must provide statement on letterhead indicating chartreuse will be in exam room. THIS ELEMENT IS A MUST HAVE TO PASS SITE VISIT &amp; PARTICIPATE</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>3. Is the Patient Bill of Rights posted?</td>
<td>1</td>
<td></td>
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</tr>
<tr>
<td>4. Is Medical License/Occupational License displayed?</td>
<td>1</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5. TX and FL only: Is there a posted notice of member complaint process?</td>
<td>1</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6. FL Only: Is the HMO hotline number posted?</td>
<td>1</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7. FL Only: If provider does not carry malpractice insurance, is required patient notification statement posted in prominent place in reception area?</td>
<td>1</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>G. HIPAA Requirements/Regulations</th>
<th>Point Value</th>
<th>Y</th>
<th>N</th>
<th>N/A</th>
<th>Point Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is there a written P&amp;P addressing permitted uses (disclosures and required disclosures of patient PHI/IIIHP)</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Does Provider have authorization forms available to designate Personal Representative(s) to which PHI/IIIHP may be released and/or disclosed?</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Are there physical safeguards in place to protect the privacy of patient PHI/IIIHP?</td>
<td>2</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>4. Is there a designated Compliance &amp; Privacy Person? Name:</td>
<td>2</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

---

**TN-PM-0034-18 - 215 -**
PRACTITIONER OFFICE SITE EVALUATION - ALL PLANS

INFORMATION BELOW MUST BE DOCUMENTED AT TOP OF EACH PAGE OF SITE VISIT FORMS. ALL QUESTIONS MUST BE ANSWERED.

Physician/Practitioner Name(s):

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Office Manager:

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

Physician/Practitioner Name(s):

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<th>First</th>
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</table>

Office Address

Specialty(ies)  Date  Reviewer Name

<table>
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<tr>
<th>Last</th>
<th>First</th>
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</table>

### H. Office Evaluation

<table>
<thead>
<tr>
<th>Question</th>
<th>Y</th>
<th>N</th>
<th>N/A</th>
<th>Point Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is there an approved process for bio-hazardous disposal?</td>
<td></td>
<td></td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>2. Are pharmaceutical supplies and medication stored in a locked area that is not readily accessible to patients?</td>
<td>2</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3. Is there a plan/procedures for narcotics inventory, control and disposal?</td>
<td>2</td>
<td></td>
<td></td>
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<tr>
<td>4. Are vaccines and other biologics refrigerated, as appropriate?</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Observe 2-3 office staff interactions: Are they professional and helpful?</td>
<td>2</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6. Is emergency equipment available (i.e. defib, oxygen and ambu bag)? If not, note how staff accommodates emergency situations.</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


To complete the form, answer every question, then total the number of points and record here. 160  TOTAL

A copy of this complete profile was received by:

Office Manager / Physician/Practitioner (please circle one)

REMEMBER - DO NOT DEDUCT POINTS FOR THOSE QUESTIONS THAT ARE ANSWERED N/A
INCLUDE THOSE POINTS FOR N/A ANSWERS IN TOTAL SCORE

REMEMBER - IF PROVIDER HAS A CLIA CERTIFICATE/CERTIFICATE OF WAIVER AND/OR RADIOLoGY LICENSURE
YOU MUST ATTACH A COPY OF THE DOCUMENTS TO THIS SITE VISIT FORM
Advance Directive

I, __________________, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

If at any time I should have a terminal condition and my attending physician has determined there is no reasonable medical expectation of recovery and which, as a medical probability, will result in my death, regardless of the use or discontinuance of medical treatment implemented for the purpose of sustaining life, or the life process, I direct that medical care be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medications or the performance of any medical procedure deemed necessary to provide me with comfortable care or to alleviate pain.

ARTIFICIALLY PROVIDED NOURISHMENT AND FLUIDS:
By checking the appropriate line below, I specifically:
- ______ Authorize the withholding or withdrawal of artificially provided food, water or other nourishment or fluids.
- ______ DO NOT authorize the withholding or withdrawal of artificially provided food, water or other nourishment or fluids.

ORGAN DONOR CERTIFICATION:
Notwithstanding my previous declaration relative to the withholding or withdrawal of life-prolonging procedures, if as indicated below I have expressed my desire to donate my organs and/or tissues for transplantation, or any of them as specifically designated herein, I do direct my attending physician, if I have been determined dead according to Tennessee Code Annotated, § 68-3-501(b), to maintain me on artificial support systems only for the period of time required to maintain the viability of and to remove such organs and/or tissues.
By checking the appropriate line below, I specifically:
- ______ Desire to donate my organs and/or tissues for transplantation
- ______ Desire to donate my __________________________________________________________
  (Insert specific organs and/or tissues for transplantation)
- ______ DO NOT desire to donate my organs or tissues for transplantation

In the absence of my ability to give directions regarding my medical care, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical care and accept the consequences of such refusal.

The definitions of terms used herein shall be as set forth in the Tennessee Right to Natural Death Act, Tennessee Code Annotated, § 32-11-103.

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

In acknowledgment whereof, I do hereinafter affix my signature on this the ______ day of _______, 20__.

______________________________________________
Declarant

We, the subscribing witnesses hereto, are personally acquainted with and subscribe our names hereto at the
request of the declarant, an adult, whom we believe to be of sound mind, fully aware of the action taken herein and its possible consequence.

We, the undersigned witnesses, further declare that we are not related to the declarant by blood or marriage; that we are not entitled to any portion of the estate of the declarant upon the declarant’s decease under any will or codicil thereto presently existing or by operation of law then existing; that we are not the attending physician, an employee of the attending physician or a health facility in which the declarant is a patient; and that we are not persons who, at the present time, have a claim against any portion of the estate of the declarant upon the declarant’s death.

_________________________________________________________
Witness

________________________________________________________________________
Witness

STATE OF TENNESSEE
COUNTY OF __________________

Subscribed, sworn to and acknowledged before me by ____________, the declarant, and subscribed and sworn to before me by _______ and ________, witnesses, this _______ day of ____________, 20___.

_________________________________________________________
Notary Public

My Commission Expires: __________________________
Advanced Care Plan

TennCare’s Advance Directive forms are available at https://www.tn.gov/health/health-program-areas/health-professional-boards/hcf-board/hcf-board/advance-directives.html.
Appointment of Health Care Agent

I, _________________________________, give my agent named below permission to make health care decisions for me if I cannot make decisions for myself, including any health care decision that I could have made for myself if able. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent’s place.

Agent:

Alternate:

Name

Name

Address

Address

City State ZIP Code

City State ZIP Code

Area Code Home Phone Number

Area Code Home Phone Number

Area Code Work Phone Number

Area Code Work Phone Number

Area Code Mobile Phone Number

Area Code Mobile Phone Number

Patient’s name (please print or type) Date

Signature of patient (must be at least 18 or emancipated minor)

To be legally valid, either block A or block B must be properly completed and signed.

---

Block A Witnesses (two witnesses required)

1. I am a competent adult who is not named above. I witnessed the patient’s signature on this form.

Signature of witness number 1

2. I am a competent adult who is not named above. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient’s estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient’s signature on this form.

Signature of witness number 2

---

Block B Notarization

STATE OF TENNESSEE
COUNTY OF ____________________

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is shown above as the “patient.” The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: ______________________________

Signature of Notary Public

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 3, 2005
**Behavioral Health Forms**

**Behavioral Health Forms:** On the following pages, you will find sample behavioral health forms that you may choose to use.

- Discharge Report Form
- Request for Substance Abuse PHP/IOP Services Form (PF-TN-0007-11)
- Request for Comprehensive and Family Treatment – CCFT (PF-TN-0009-12)
- Request for Continuous Treatment Team Services Form – Adults Only (PF-TN-0010-12)
- Request for Continuous Treatment Team Services Form – Child/Adolescent Only (PF-TN-0011-12)
- Request for Supported Housing Services Form (PF-TN-0012-12)
- Request for Residential Treatment Services Form (PF-TN-0013-12)
**Discharge Report Form**

<table>
<thead>
<tr>
<th>Type of service:</th>
<th>CTT</th>
<th>CCFT</th>
<th>IP</th>
<th>IOP</th>
<th>PACT</th>
<th>PHP</th>
<th>SH/SR</th>
<th>Subacute</th>
<th>RTC</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Type of discharge:</th>
<th>Successful/goals met</th>
<th>Treatment refusal</th>
<th>Eligibility change/termination</th>
<th>Unsuccessful/treatment baseline</th>
<th>AMA</th>
<th>Eligible change/termination</th>
<th>Administrative discharge (i.e., rule violation)</th>
</tr>
</thead>
</table>

**DEMOGRAPHICS**

<table>
<thead>
<tr>
<th>Admission date:</th>
<th>Discharge date:</th>
<th>Units/days used:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s name:</td>
<td>SS#:</td>
<td>DOB:</td>
</tr>
<tr>
<td>Discharge address:</td>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>Guardian/conservator:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**AFTERCARE APPOINTMENTS**

<table>
<thead>
<tr>
<th>Provider:</th>
<th>Service type:</th>
<th>Appointment date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact #:</td>
<td>Appointment time:</td>
<td></td>
</tr>
<tr>
<td>Provider:</td>
<td>Service type:</td>
<td>Appointment date:</td>
</tr>
<tr>
<td>Contact #:</td>
<td>Appointment time:</td>
<td></td>
</tr>
<tr>
<td>Provider:</td>
<td>Service type:</td>
<td>Appointment date:</td>
</tr>
<tr>
<td>Contact #:</td>
<td>Appointment time:</td>
<td></td>
</tr>
<tr>
<td>Provider:</td>
<td>Service type:</td>
<td>Appointment date:</td>
</tr>
<tr>
<td>Contact #:</td>
<td>Appointment time:</td>
<td></td>
</tr>
</tbody>
</table>

**DISCHARGE DIAGNOSIS**

<table>
<thead>
<tr>
<th>AXIS I:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AXIS II:</td>
<td></td>
</tr>
<tr>
<td>AXIS III:</td>
<td></td>
</tr>
<tr>
<td>AXIS IV:</td>
<td></td>
</tr>
<tr>
<td>AXIS V:</td>
<td></td>
</tr>
</tbody>
</table>

**DISCHARGE MEDICATIONS (include dosage and frequency)**

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

**DISCHARGE MENTAL HEALTH STATUS**

<table>
<thead>
<tr>
<th>Alert:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thought content and process:</td>
<td>Coherent</td>
<td>Illogical</td>
</tr>
<tr>
<td>Orientation to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Person</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Place</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Time</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Memory:</td>
<td>Remote</td>
<td>Recent</td>
</tr>
<tr>
<td>Appearance:</td>
<td>Appropriate</td>
<td>Disheveled</td>
</tr>
<tr>
<td>Attention concentration:</td>
<td>Distracted</td>
<td>Attentive</td>
</tr>
<tr>
<td>Mood:</td>
<td>Euthymic</td>
<td>Depressed</td>
</tr>
<tr>
<td>Affect:</td>
<td>Broad</td>
<td>Flat</td>
</tr>
<tr>
<td>Judgment:</td>
<td>Poor</td>
<td>Fair</td>
</tr>
<tr>
<td>Insight:</td>
<td>Poor</td>
<td>Fair</td>
</tr>
<tr>
<td>Impulse control:</td>
<td>Poor</td>
<td>Fair</td>
</tr>
</tbody>
</table>

**MEDICAL CONDITIONS/CONCERNS**

| PCP: | |
| Provider signature: | Date / / |

Provider/discharging agency: ______________________
# Request for Substance Abuse PHP/IOP Services Form

**Service Requested:** IOP [ ] PHP [ ]

**Review Type:** Precertification [ ] Concurrent [ ]

*(Please note: Failure to complete this form in its entirety with all information necessary to make medical necessity determination may result in delay or denial of services. Additional information attached is considered supplemental.)*

<table>
<thead>
<tr>
<th>Fax:</th>
<th>Under 18: 1-888-881-6309</th>
<th>Adults: 1-888-881-6305</th>
<th>Phone:</th>
<th>1-800-600-4441 or 615-316-2400</th>
<th>Address:</th>
<th>Behavioral Health Unit, 22 Century Blvd., Suite 310, Nashville, TN 37214</th>
</tr>
</thead>
</table>

## REQUESTING PROVIDER INFORMATION

**Treating Provider**
- *Name/title:*
- Phone #: 
- Fax #: 

**Facility/Program (referral source):**
- Phone #: 

**Medicaid ID:**
- Tax ID: 
- Provider ID: 

If member has received/is receiving substance abuse services, list service type and length of stay:

- Currently in treatment? [ ] Yes [ ] No
- If yes, list facility name/service type:

## MEMBER INFORMATION

**Member’s Name:**
- DOB: 

**Amerigroup #:**
- SSN: 

**Member’s Address:**
- City/State: 
- ZIP Code: 

**Member’s Phone #:**
- Alternate Phone #: 

**Legal Guardian/Conservator Name:**

## AUTHORIZATION REQUEST INFORMATION

**Start Date Requested (dd/mm/yy):**

**Last Authorized Date (Concurrent Review ONLY):**

**Number of Units/Days Requested:**

## DSM-IV TR DIAGNOSIS

<table>
<thead>
<tr>
<th>Axis I</th>
<th>Axis II</th>
<th>Axis III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis IV</td>
<td>Axis V</td>
<td>Highest in Past Year:</td>
</tr>
</tbody>
</table>

## SUBSTANCE ABUSE HISTORY

**Drug:**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Date of Onset/Age:</th>
<th>Method/Route:</th>
<th>Amount:</th>
<th>Frequency:</th>
<th>Recent increase?</th>
<th>Date of last use:</th>
</tr>
</thead>
<tbody>
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<td>[ ] Yes [ ] No</td>
<td>[ ] Yes [ ] No</td>
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<td>[ ] Yes [ ] No</td>
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</table>

*(Continued on next page.)*
## TREATMENT HISTORY

**Substance Abuse Treatment** (List all prior treatment episodes—most recent first):

<table>
<thead>
<tr>
<th>Date of Admission</th>
<th>Date of Discharge</th>
<th>Facility Name</th>
<th>Level of Care Episodes (ER, crisis services, INPT, PHP, IOP, home-based treatment, other pertinent clinical treatment)</th>
<th>Was treatment effective?* (Describe in explanation box below.)</th>
</tr>
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</table>

*If yes indicated above, describe effective aspects of prior treatment; if no indicated, describe level of participation and barriers to stabilization.

**Mental Health Treatment** (List all prior treatment episodes — most recent first):

<table>
<thead>
<tr>
<th>Date of Admission</th>
<th>Date of Discharge</th>
<th>Facility Name</th>
<th>Level of Care Episodes (ER, crisis services, INPT, PHP, IOP, home-based treatment, other pertinent clinical treatment)</th>
<th>Was treatment effective?</th>
</tr>
</thead>
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<td>Yes</td>
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<td>No</td>
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</table>

**PRESENT RISK FACTORS**

- Is there current suicidal ideation? □ Yes □ No
  Explain:

- Is there current homicidal ideation? □ Yes □ No
  Explain:

- Are there current self-injurious behaviors? □ Yes □ No
  Explain:

- Is there difficulty completing ADLs due to substance abuse-related issues? □ Yes □ No
  Explain:

If psychiatric/mental health issues are present currently, specify how this will be/is being addressed in current treatment:

Medical History:

(Continued on next page.)
### MEDICATIONS

<table>
<thead>
<tr>
<th>Name:</th>
<th>Dosage:</th>
<th>Frequency:</th>
<th>Compliant:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes ☐ No ☐</td>
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<td>Yes ☐ No ☐</td>
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<td>Yes ☐ No ☐</td>
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<td>Yes ☐ No ☐</td>
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<td>Yes ☐ No ☐</td>
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<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

### OUTPATIENT TREATMENT INFORMATION

<table>
<thead>
<tr>
<th>Psychiatrist:</th>
<th>Number of visits:</th>
<th>Frequency:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Therapist (PhD, LPC, LCSW):</th>
<th>Number of visits:</th>
<th>Frequency:</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>PCP (name and contact number):</th>
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</thead>
<tbody>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of other mental health providers:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Reason for referral (Provide supporting clinical symptoms/factors for level of care requested/precertification ONLY.):**

**Continued Stay Criteria (Concurrent Review ONLY)**

**Rationale for Continued Stay (List specific factors contributing to need for continued services/concurrent review ONLY.):**

<table>
<thead>
<tr>
<th>Continued Service Criteria</th>
<th>Was treatment effective?</th>
<th>If yes, provide summary of member-specific status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals.</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>Member is not yet making progress but has the capacity to resolve his or her problems. He or she is actively working toward the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the member to continue to work toward his or her treatment goals.</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
</tbody>
</table>

*(Continued on next page.)*
New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the member’s new problems can be addressed effectively.  

### PRECERTIFICATION AND CONCURRENT REVIEW

#### Additional Clinical Factors Supporting Current Level of Care
(Provide specific details regarding symptoms/issues supporting continued level of care.):

#### Supporting System
(Family/guardian/others involvement in treatment):

#### Measurable Goals for IOP/PHP:

### TREATMENT PLAN COORDINATION

I have requested permission from the member to release information to the PCP.  
Yes  No

If no, rationale why this is inappropriate:

I have discussed the treatment plan with the member.  
Yes  No

I have discussed the treatment plan with the member, and the member understands and agrees to the treatment plan goals?  
Yes  No

If no, explain:

### Discharge Plan
(To be updated with each review):

Next level of care:

Multidisciplinary after-care plan:

Preparation of support system:

(Continued on next page.)
Follow-up appointments:

Continuity of care/discharge recommendations:

Barriers to discharge:

Projected discharge date:

Submission Documents (optional)

<table>
<thead>
<tr>
<th>Document</th>
<th>Document Included?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric evaluation (within 60 days):</td>
<td>Yes No</td>
</tr>
<tr>
<td>Psychosocial evaluation (within 60 days):</td>
<td>Yes No</td>
</tr>
<tr>
<td>All treating provider notes for the last 30 days:</td>
<td>Yes No (Concurrent reviews only)</td>
</tr>
<tr>
<td>Other (list):</td>
<td>Yes No</td>
</tr>
</tbody>
</table>

**Treating Practitioner Certification:**

As the *treating practitioner, I certify that this member meets the criteria for ☐ IOP/☐ PHP level of care.

(*Treating provider/practitioner is defined as a member of the treatment team who has direct knowledge of the member’s clinical needs and progress AND who can sufficiently participate in peer-to-peer reviews when additional clinical information is needed to determine medical necessity.)

_____________________________  ________________
Treating Practitioner’s Signature  Date

_____________________________  ________________
Print Treating Practitioner’s Name  Date

Authorization indicates that Amerigroup determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon member eligibility and benefit limitations at the time services are rendered.

FOR AMERIGROUP USE ONLY:

Authorization #____________________________
Request for Comprehensive Child and Family Treatment (CCFT) Form

Review Type: Precertification [ ] Concurrent [ ]

(Please note: Failure to complete this form in its entirety with all information necessary to make medical necessity determination may result in delay or denial of services. Additional information attached is considered supplemental.)

Fax: 1-888-881-6309    Phone: 1-800-454-3730 or 615-316-2400    Address: Behavioral Health Unit, 22 Century Blvd., Suite 310 Nashville, TN 37214

REQUESTING PROVIDER INFORMATION

| Treating provider *name/title: | Phone #: | Fax #: |
| Facility/program (referral source): | | |
| Medicaid ID: | Tax ID: | Provider ID: |

If currently enrolled in a lower level of care, list service type and current length of stay:

Currently in hospital? [ ] Yes    [ ] No

If yes, list facility name/service type:

MEMBER INFORMATION

| Member’s name: | DOB: |
| Amerigroup #: | SSN: |
| Member’s address: | City/State: | ZIP Code: |
| Member’s phone #: | Alternate phone #: |
| Legal guardian/conservator name: | |

AUTHORIZATION REQUEST INFORMATION

Start date requested (dd/mm/yy):

Last authorized date (Concurrent review ONLY):

Number of units/days requested:

Number of CCFT visits within the past 90 days:

DSM-IV TR DIAGNOSIS

<table>
<thead>
<tr>
<th>Axis I</th>
<th>Axis II</th>
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<tr>
<td>Axis IV</td>
<td>Axis V</td>
<td>Highest in past year:</td>
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(Continued on next page.)
## TREATMENT HISTORY

### Substance Abuse Treatment (List all prior treatment episodes — most recent first):

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### Reason for Referral (List specific precipitant including factors contributing to need for service — precertification ONLY.):

### Current Clinical Information (Include mental status exam and severity of each symptom/problem.):

### Support System (Family involvement in treatment):

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### Measurable Goals for CCFT (Include findings from EPSDT if appropriate):

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**TREATMENT PLAN COORDINATION**

I have requested permission from the member to release information to the PCP. ☐ Yes ☐ No

If no, rationale why this is inappropriate:

Was the treatment plan discussed with the member? ☐ Yes ☐ No

Does the member understand and agree to treatment plan goals? ☐ Yes ☐ No

If no, explain:

Discharge Plan (Include specific services.):

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<th>Projected Discharge Date:</th>
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**SUBMISSION DOCUMENTS (optional)**

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Certification for CCFT

(Must check one box for each item.)

A. Both of the following criteria must be met:
   1. Does the member have primary DSM IV TR diagnosis per the priority enrollee definition? ☐ Yes ☐ No
   2. Does the member meet the criteria for a priority enrollee? ☐ Yes ☐ No

B. Two of the following criteria must be met:
   1. Is there imminent risk of out-of-home placement as a result of the mental illness, current DCS involvement and/or hospitalization in an acute psychiatric setting? ☐ Yes ☐ No
   2. Is there a major time-limited weakening of the child’s/adolescent’s support system and ability to function independently or within the current support system? ☐ Yes ☐ No
   3. Is there documentation within the preceding six months of inability to meet identified service goals while in traditional case management? ☐ Yes ☐ No
   4. Is the child/adolescent being discharged or has the child/adolescent been discharged from a more restrictive level of care, or has the child/adolescent exhibited behavior that has escalated in the home, school or elsewhere in the community to suggest that this more restrictive level of care is imminent and the use of this level of services is appropriate to stabilize the current placement? ☐ Yes ☐ No
   5. Has the family/guardian agreed to participate in this service? ☐ Yes ☐ No

(Continued on next page.)

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Priority Enrollee: An enrollee who has been identified as a priority enrollee by the Division of TennCare by using specified diagnoses. Priority identification occurs when the Division receives claims information from its contracted Managed Care Contractors (MCCs). A claim must be received that includes a diagnosis designated as priority in order for the member to remain a priority member. A member only becomes nonpriority if the Division does not receive a claim with a diagnosis from the priority list during the following 13 months. If a member is deemed priority and a claim is received during the following 13 months with a nonpriority diagnosis, the member will not automatically be reclassified as nonpriority. Designation as a priority enrollee is applicable to all age groups with a priority diagnosis. Priority diagnoses are available via the provider web site at https://providers.realsolutions.com/pages/home.aspx or upon request.
**Treating Practitioner Certification:**
As the *treating practitioner, I certify that this member meets criteria for CCFT level of care.

(*Treating provider/practitioner is defined as a member of the treatment team who has direct knowledge of the member’s clinical needs and progress AND who can sufficiently participate in peer-to-peer reviews when additional clinical information is needed to determine medical necessity.)

______________________________
Treating Practitioner’s Signature       Date

______________________________
Print Treating Practitioner’s Name     Date

Authorization indicates that Amerigroup determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon member eligibility and benefit limitations at the time services are rendered.

FOR AMERIGROUP USE ONLY:

Authorization #________________________

TN-PM-0034-18 - 232 -
Request for Continuous Treatment Team Services Form
Adults ONLY

Review Type: Precertification  Concurrent  

*(Please note: Failure to complete this form in its entirety with all information necessary to make medical necessity determination may result in delay or denial of services. Additional information attached is considered supplemental.)*

Fax: 1-866-920-6006  Phone: 1-800-454-3730 or 615-316-2400  Address: Behavioral Health Unit, 22 Century Blvd., Suite 310 Nashville, TN 37214

REQUESTING PROVIDER INFORMATION

| Treating provider *Name/title: | Phone #: | Fax #: |
| Facility/program (referral source): | Phone #: |
| Medicaid ID: | Tax ID: | Provider ID: |

If currently enrolled in lower level of care, list service type and current length of stay:

Currently in hospital?  Yes  No  If yes, list facility name/service type:

MEMBER INFORMATION

| Member’s name: | DOB: |
| Amerigroup #: | SSN: |
| Member’s address: | City/State: | ZIP Code: |
| Member’s phone #: | Alternate phone #: |
| Legal guardian/conservator name: |

AUTHORIZATION REQUEST INFORMATION

| Start date requested (dd/mm/yy): | |
| Last authorized date (Concurrent review ONLY): | |
| Number of units/days requested: | |
| Number of CTT visits during the past 90 days: | |

DSM-IV TR DIAGNOSIS

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### TREATMENT HISTORY

**Substance Abuse Treatment** (List all prior treatment episodes — most recent first.):

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**Reason for Referral** (List specific precipitant, including factors contributing to need for service — precertification ONLY.):

**Progress Since Last Review** (Concurrent review ONLY.):

**Current Clinical Information** (Include mental status exam and severity of each symptom/problem.):

**Support System** (Family involvement in treatment):

(Continued on next page.)
**Measurable Goals for CTT** (Include findings from EPSDT if appropriate [under 21].):

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**SUBSTANCE ABUSE HISTORY:**

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If substance abuse is current, specify how this will be/is being addressed in current treatment?

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**Medical history:**

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**TREATMENT PLAN COORDINATION**

I have requested permission from the member to release information to the PCP. ☐ Yes ☐ No

If no, rationale why this is inappropriate: _____

Was the treatment plan discussed with the member? ☐ Yes ☐ No

Does the member understand and agree to treatment plan goals? ☐ Yes ☐ No

If no, explain:

Discharge plan (include specific services):

Projected discharge date: ___

**SUBMISSION DOCUMENTS (optional)**

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Certification for CTT (Must check one box for each item.)

C. Both of the following criteria must be met:
   3. Does the member have Primary DSM-IV TR diagnosis? ☐ Yes ☐ No
   4. Does the member meet the criteria for priority enrollee? ☐ Yes ☐ No

D. One of the following criteria must be met:
   6. Is the member at risk of hospitalization in an acute psychiatric setting, or did the member have a history of being hospitalized in an acute psychiatric setting within the past six months? ☐ Yes ☐ No
   7. Was there a major time-limited weakening of the member’s support system or major change in other social factors and decrease in ability to function independently or within the current support system? ☐ Yes ☐ No
   8. Was there documentation within the preceding six months of inability to meet identified service goals while in traditional case management? ☐ Yes ☐ No

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**Treating Practitioner Certification:**

As the *treating practitioner, I certify that the above criteria (Items A1 and A2; AND either B1, B2 or B3) have been met and that this member is appropriate for CTT services.

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### Current Clinical Information (Include mental status exam and severity of each symptom/problem.):

### Support System (Family involvement in treatment):

### Measurable Goals for CTT (Include findings from EPSDT if appropriate.):

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</tbody>
</table>

If substance abuse is current, specify how this will be/is being addressed in current treatment.

Medical history:

### MEDICATIONS

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Compliant</th>
</tr>
</thead>
<tbody>
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<td>[ ] Yes  [ ] No</td>
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<td>[ ] Yes  [ ] No</td>
</tr>
</tbody>
</table>

### OUTPATIENT TREATMENT INFORMATION

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<tr>
<th>Psychiatrist:</th>
<th>Number of visits:</th>
<th>Frequency:</th>
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<table>
<thead>
<tr>
<th>Therapist (PhD, LPC, LCSW):</th>
<th>Number of visits:</th>
<th>Frequency:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PCP (name and contact number):

Name of other mental health providers:

### TREATMENT PLAN COORDINATION

I have requested permission from the member to release information to the PCP. [ ] Yes [ ] No

If no, rationale why this is inappropriate:

The treatment plan was discussed with the member. [ ] Yes [ ] No

The member understands and agrees to the treatment plan goals. [ ] Yes [ ] No

If no, explain:

(Continued on next page.)
Discharge plan (include specific services):

Projected discharge date:

**SUBMISSION DOCUMENTS (optional)**

<table>
<thead>
<tr>
<th>Document</th>
<th>Document Included?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric evaluation (within 60 days):</td>
<td></td>
</tr>
<tr>
<td>Psychosocial evaluation (within 60 days):</td>
<td></td>
</tr>
<tr>
<td>All treating provider notes (for the last 30 days):</td>
<td></td>
</tr>
<tr>
<td>Other (list):</td>
<td></td>
</tr>
</tbody>
</table>

Certification for CTT

**E. Both of the following criteria must be met:**

1. Does the member have primary DSM-IV TR diagnosis?
   - Yes
   - No

2. Does the member meet the criteria of the Priority Enrollee\(^3\) definition?
   - Yes
   - No

**F. One of the following criteria must be met:**

9. Is the member at risk of hospitalization in an acute psychiatric setting, or has the member had a history of being hospitalized in an acute psychiatric setting within the past six months?
   - Yes
   - No

10. Has there been a major time-limited weakening of the child’s/adolescent’s support system and ability to function independently or within the current support system?
    - Yes
    - No

11. Has there been documentation within the preceding six months of the inability to meet identified service goals while in traditional case management?
    - Yes
    - No

(Continued on next page.)

---

\(^3\) Priority Enrollee: An enrollee who has been identified as a priority enrollee by the Division of TennCare by using specified diagnoses. Priority identification occurs when the Division receives claims information from its contracted Managed Care Contractors (MCCs). A claim must be received that includes a diagnosis designated as priority in order for the member to remain a priority member. A member only becomes nonpriority if the Division does not receive a claim with a diagnosis from the priority list during the following 13 months. If a member is deemed priority and a claim is received during the following 13 months with a nonpriority diagnosis, the member will not automatically be reclassified as nonpriority. Designation as a priority enrollee is applicable to all age groups with a priority diagnosis. Priority diagnoses are available via the provider web site at https://providers.realsolutions.com/pages/home.aspx or upon request.
**Treating Practitioner Certification:**
As the *treating practitioner, I certify that this member meets CTT level of care.

(*Treating provider/practitioner is defined as a member of the treatment team who has direct knowledge of the member’s clinical needs and progress AND who can sufficiently participate in peer-to-peer reviews when additional clinical information is needed to determine medical necessity.)

________________________________________________________________________
Treating Practitioner’s Signature             Date

________________________________________________________________________
Print Treating Practitioner’s Name             Date

Authorization indicates that Amerigroup determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon member eligibility and benefit limitations at the time services are rendered.

FOR AMERIGROUP USE ONLY:
Authorization #________________________
Request for Supported Housing Services Form

**Review Type:** Precertification [ ] Concurrent [ ]

*(Please note: Failure to complete this form in its entirety with all information necessary to make medical necessity determination may result in delay or denial of services. Additional information attached is considered supplemental.)*

<table>
<thead>
<tr>
<th>Fax:</th>
<th>1-888-881-6287</th>
<th>Phone:</th>
<th>1-800-454-3730 or 615-316-2400</th>
<th>Address:</th>
<th>Behavioral Health Unit, 22 Century Blvd., Suite 310 Nashville, TN 37214</th>
</tr>
</thead>
</table>

**REQUESTING PROVIDER INFORMATION**

<table>
<thead>
<tr>
<th>Treating provider *Name/title:</th>
<th>Phone #:</th>
<th>Fax #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility/program (referral source):</td>
<td>Phone #:</td>
<td></td>
</tr>
<tr>
<td>Medicaid ID:</td>
<td>Tax ID:</td>
<td>Provider ID:</td>
</tr>
</tbody>
</table>

 If currently enrolled in lower level of care, list service type and current length of stay:

<table>
<thead>
<tr>
<th>Currently in hospital?</th>
<th>Yes [ ] No [ ]</th>
</tr>
</thead>
</table>

 If yes, list facility name/service type:

**MEMBER INFORMATION**

<table>
<thead>
<tr>
<th>Member’s name:</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amerigroup #:</td>
<td>SSN:</td>
</tr>
<tr>
<td>Member’s address:</td>
<td>City/state:</td>
</tr>
<tr>
<td>Member’s phone #:</td>
<td>Alternate phone #:</td>
</tr>
<tr>
<td>Legal guardian/conservator name:</td>
<td></td>
</tr>
</tbody>
</table>

**AUTHORIZATION REQUEST INFORMATION**

<table>
<thead>
<tr>
<th>Start date requested (dd/mm/yy):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last authorized date (concurrent review ONLY):</td>
</tr>
<tr>
<td>Number of units/days requested:</td>
</tr>
</tbody>
</table>

**DSM-IV TR DIAGNOSIS**

<table>
<thead>
<tr>
<th>Axis I</th>
<th>Axis II</th>
<th>Axis III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis IV</td>
<td>Axis V</td>
<td>Highest in past year:</td>
</tr>
</tbody>
</table>

*(Continued on next page.)*
### TREATMENT HISTORY

**Substance Abuse Treatment** (List all prior treatment episodes—most recent first.):

<table>
<thead>
<tr>
<th>Date of Admission</th>
<th>Date of Discharge</th>
<th>Facility Name</th>
<th>Level of Care Episodes (ER, crisis services, INPT, PHP, IOP, home-based treatment, other pertinent clinical treatment)</th>
<th>Was treatment effective?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>Yes □ No □</td>
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<td>Yes □ No □</td>
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</tbody>
</table>

**Mental Health Treatment** (List all prior treatment episodes—most recent first.):

<table>
<thead>
<tr>
<th>Date of Admission</th>
<th>Date of Discharge</th>
<th>Facility Name</th>
<th>Level of Care Episodes (ER, crisis services, INPT, PHP, IOP, home-based treatment, other pertinent clinical treatment)</th>
<th>Was treatment effective?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>Yes □ No □</td>
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<td>Yes □ No □</td>
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</tbody>
</table>

**Reason for Referral** (List specific precipitant including factors contributing to need for service—precertification ONLY.):

(Continued on next page.)
### Progress Since Last Review (Concurrent Review ONLY):

<table>
<thead>
<tr>
<th>Continued Service Criteria</th>
<th>Was treatment effective?</th>
<th>If yes, provide summary of member specific status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals.</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>Member is not yet making progress but has the capacity to resolve his or her problems. He or she is actively working toward the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the member to continue to work toward his or her treatment goals.</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the member’s new problems can be addressed effectively.</td>
<td>☐ Yes ☐ No</td>
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</tbody>
</table>

**Current Clinical Information** (Include mental status exam and severity of each symptom/problem.):

<table>
<thead>
<tr>
<th>Current Risk Factors:</th>
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</table>

**Support System** (Family involvement in treatment):

(Continued on next page.)
### Activities of Daily Living

<table>
<thead>
<tr>
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<th>Consistent, significant impairment?</th>
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<tbody>
<tr>
<td></td>
<td>(You must check one box for each area.)</td>
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<tr>
<td>Health care:</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Personal hygiene:</td>
<td>□ Yes □ No</td>
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<tr>
<td>Finances:</td>
<td>□ Yes □ No</td>
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<tr>
<td>Healthy diet/food preparation:</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Maintaining a home:</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Community service needs (legal, transportation, housing, etc.):</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Mobility limitations:</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Physical limitations:</td>
<td>□ Yes □ No</td>
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<tr>
<td>Other (List):</td>
<td>□ Yes □ No</td>
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<tr>
<td>Other (List):</td>
<td>□ Yes □ No</td>
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</tbody>
</table>

### SUBSTANCE ABUSE HISTORY

<table>
<thead>
<tr>
<th>Drug</th>
<th>Date of onset/age</th>
<th>Method/route</th>
<th>Amount</th>
<th>Frequency</th>
<th>Date of last use</th>
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If substance abuse is current, specify how this will be/is being addressed in current treatment?

Measurable goals for supported housing:

Medical history:

### MEDICATIONS

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<tr>
<th>Name</th>
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<th>Frequency</th>
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(Continued on next page.)
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<td>Number of visits:</td>
<td>Frequency:</td>
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<tr>
<td>PCP (name and contact #):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of other mental health providers:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## TREATMENT PLAN COORDINATION

- **I have requested permission from the member to release information to the PCP.**
  - [ ] Yes [ ] No
  - If no, rationale why this is inappropriate: 

- **The treatment plan was discussed with the member.**
  - [ ] Yes [ ] No

- **The member understands and agrees to treatment plan goals.**
  - [ ] Yes [ ] No
  - If no, explain:

- **Discharge plan (include specific services):**

- **Projected discharge date:**

## SUBMISSION DOCUMENTS (optional)

<table>
<thead>
<tr>
<th>Document</th>
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<tbody>
<tr>
<td>Psychiatric evaluation (within 60 days):</td>
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<td>[ ] Yes [ ] No</td>
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<tr>
<td>All treating provider notes (for the last 30 days):</td>
<td>[ ] Yes [ ] No (Concurrent reviews only)</td>
</tr>
<tr>
<td>Other (list):</td>
<td>[ ] Yes [ ] No</td>
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</tbody>
</table>

(Continued on next page.)
## Certification for Supported Housing

(Must check one box for each item.)

<table>
<thead>
<tr>
<th>G. All of the following criteria must be met:</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Does the member have primary DSM IV TR diagnosis?</td>
</tr>
<tr>
<td>6. Does the member meet criteria for being a priority enrollee?</td>
</tr>
<tr>
<td>7. Does the member have referral from a treating behavioral health clinician?</td>
</tr>
<tr>
<td>8. Is the member either actively involved in outpatient treatment or reasonably expected to participate in such treatment?</td>
</tr>
<tr>
<td>9. Does the service plan, as per TennCare, meet approved Amerigroup Supported Housing Guidelines?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>H. One of the following criteria must be met:</th>
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<tbody>
<tr>
<td>12. Is the member at risk of hospitalization in an acute psychiatric setting, or has the member had a history of being hospitalized in an acute psychiatric setting within the past six months?</td>
</tr>
<tr>
<td>13. Has the member had a major time-limited weakening of his or her support system, or has the member had a major change in other social factors and a decrease in the ability to function independently or within the current support system resulting in the member having difficulty in sustaining housing or maintaining a safe living environment?</td>
</tr>
<tr>
<td>14. Has the member had consistent and significant difficulty independently managing activities of daily living?</td>
</tr>
</tbody>
</table>

**Treating Practitioner Certification:**

As the *treating practitioner, I certify that the above criteria (Items A1, A2, A3, A4 and A5; AND either B1, B2 or B3) have been met and that it is appropriate for this member to have supported housing services.

(*Treating provider/practitioner is defined as a member of the treatment team who has direct knowledge of the member’s clinical needs and progress AND who can sufficiently participate in peer-to-peer reviews when additional clinical information is needed to determine medical necessity.)

______________________________
Treating Practitioner’s Signature

______________________________
Date

______________________________
Print Treating Practitioner’s Name

______________________________
Date

Authorization indicates that Amerigroup determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon member eligibility and benefit limitations at the time services are rendered.

**FOR AMERIGROUP USE ONLY:**

Authorization #________________________

---

4 Priority Enrollee: An enrollee who has been identified as a priority enrollee by the Division of TennCare by using specified diagnoses. Priority identification occurs when the Division receives claims information from its contracted Managed Care Contractors (MCCs). A claim must be received that includes a diagnosis designated as priority in order for the member to remain a priority member. A member only becomes nonpriority if the Division does not receive a claim with a diagnosis from the priority list during the following 13 months. If a member is deemed priority and a claim is received during the following 13 months with a nonpriority diagnosis, the member will not automatically be reclassified as nonpriority. Designation as a priority enrollee is applicable to all age groups with a priority diagnosis. Priority diagnoses are available via the provider website at https://providers.realsolutions.com/pages/home.aspx or upon request.
# Request for Residential Treatment Center Services Form

## Review type:
- Precertification [ ]
- Concurrent [ ]

Please note: Failure to complete this form in its entirety, including all information required to make medical necessity determination, may result in delay or denial of services. Additional information attached is considered supplemental.

<table>
<thead>
<tr>
<th>Fax</th>
<th>Phone</th>
<th>Medicaid ID</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-888-881-6309</td>
<td></td>
<td>1-800-454-3730</td>
<td>Behavioral Health Unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicaid: 1-866-805-4589 or 615-316-2400</td>
<td>22 Century Blvd., Suite 310</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nashville, TN 37214</td>
</tr>
</tbody>
</table>

## Requesting Provider Information

<table>
<thead>
<tr>
<th>Treating provider name/title</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility/program (referral source)</td>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>Medicaid ID</td>
<td>Tax ID</td>
<td>Provider ID</td>
</tr>
</tbody>
</table>

If currently enrolled in lower-level care, list service type and current length of stay.

<table>
<thead>
<tr>
<th>Currently in hospital:</th>
<th>Yes</th>
<th>No</th>
<th>If yes, list facility name or service type:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

## Member Information

<table>
<thead>
<tr>
<th>Member name</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amerigroup ID</td>
<td>Social Security number</td>
</tr>
<tr>
<td>Member address</td>
<td>City, state</td>
</tr>
<tr>
<td>Member phone</td>
<td>Alternate phone</td>
</tr>
<tr>
<td>Legal guardian/conservator name</td>
<td></td>
</tr>
</tbody>
</table>

## Recommended Facility Information (Precertification Only)

<table>
<thead>
<tr>
<th>Facility name</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid ID</td>
<td>Tax ID</td>
<td>Provider ID</td>
</tr>
<tr>
<td>Contact name</td>
<td>Phone</td>
<td>Fax</td>
</tr>
</tbody>
</table>

## Authorization Request Information

| Start date requested (dd/mm/yy) | |
|--------------------------------||
| Last authorized date (concurrent review only) | |
| Number of units/days requested | |
### DSM-IV Treatment Diagnosis

<table>
<thead>
<tr>
<th>Axis I</th>
<th>Axis II</th>
<th>Axis III</th>
<th>Axis IV</th>
<th>Axis V</th>
<th>Highest in past year</th>
</tr>
</thead>
</table>

### Treatment History

**Substance abuse treatment (list all prior treatment episodes, most recent first):**

<table>
<thead>
<tr>
<th>Date of admission</th>
<th>Date of discharge</th>
<th>Facility name</th>
<th>Level of care episode(s) (e.g., emergency room, crisis services, inpatient, partial hospitalization, intensive outpatient, home-based or other pertinent clinical treatment)</th>
<th>Was treatment effective?</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Yes          No</td>
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<td>Yes          No</td>
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<td>Yes          No</td>
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</tbody>
</table>

**Mental health treatment (list all prior treatment episodes, most recent first):**

<table>
<thead>
<tr>
<th>Date of admission</th>
<th>Date of discharge</th>
<th>Facility name</th>
<th>Level of care episode(s) (e.g., emergency room, crisis services, inpatient, partial hospitalization, intensive outpatient, home-based or other pertinent clinical treatment)</th>
<th>Was treatment effective?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes          No</td>
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<td>Yes          No</td>
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<td>Yes          No</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td>Yes          No</td>
</tr>
</tbody>
</table>

### Reason for referral (list specific precipitant, including factors contributing to imminent risk):

### Current clinical information (include mental status exam and severity of each symptom and/or problem):
Support system (indicate family involvement in treatment):

Complex treatment issues:

<table>
<thead>
<tr>
<th>Substance Abuse History</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drug</strong></td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
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<td></td>
</tr>
</tbody>
</table>

If substance abuse is current, specify how this will be or is being addressed in current treatment:

<table>
<thead>
<tr>
<th>Measurable goals for residential treatment (indicate the appropriate review period and outline goals for that period):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precertification</td>
</tr>
<tr>
<td><strong>Goals:</strong></td>
</tr>
<tr>
<td>Medications</td>
</tr>
<tr>
<td>-------------</td>
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</tr>
</tbody>
</table>

| Outpatient Treatment Information | | | |
|----------------------------------|------------------|
| Psychiatrist                     | Number of visits | Frequency |
| Therapist (PhD, LPC, LCSW)       | Number of visits | Frequency |
| Primary Care Provider (PCP)      | (name and contact phone) | |
| Name(s) of other mental health provider(s) | |

| Treatment Plan Coordination | | | |
|-----------------------------|------------------|
| I have requested permission from the member to release information to the PCP. | Yes  | No  |
| If no, provide rationale: | |
| The treatment plan was discussed with the member. | Yes  | No  |
| The family understands and agrees to at least weekly contact with the member or facility during the member’s stay. | Yes  | No  |
| If no, explain: | |

| Discharge plan (include specific services): | |

| Projected discharge date: | |

<table>
<thead>
<tr>
<th>Discharge planner name/title (concurrent review only)</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
</table>
Required Submission Documents
Please verify that you have included each document.

<table>
<thead>
<tr>
<th>Document</th>
<th>Document included?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric evaluation (within 60 days)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Psychosocial evaluation (within 60 days)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Psychological evaluation (within two years)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Psychosexual evaluation (within two years, if applicable)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>All treating provider notes (for the last 30 days)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Recommendation letter for residential treatment care placement from treating provider</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Other (list):</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

Treating Provider* Certification
As the treating provider, I certify this member is appropriate for residential treatment because he or she is deemed at imminent risk of harm to self or others and cannot be safely maintained in a lower level of care.

__________________________________________________________________________

Treating provider’s signature

Date

Printed name

* Treating provider is defined as a member of the treatment team who has direct knowledge of the member’s clinical needs and progress and who can sufficiently participate in peer-to-peer reviews when additional clinical information is needed to determine medical necessity.

Note: Authorization indicates Amerigroup determined medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon member eligibility and benefit limitations at the time services are rendered.

For Amerigroup use only.

Authorization number: ________________________

Member Name: ________________  Member DOB: __________________________
Authorization to Release Information

Instructions: This form Allows the Release of Information about a Recipient of Services under Title 33, Tennessee Code Annotated, and the Privacy Notice required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. I understand that this Authorization is Voluntary, and that if the Person or Organization Authorized to Receive the Information is Not a Health Plan or Health Care Provider, the Released Information May No Longer Be Protected by Federal Privacy Regulations (HIPAA).

I,______________________________________________________/____________________________________, authorize

(Print name of service recipient) / (Print date of birth)

(Print name of agency/program making disclosure) and (Mailing address of agency/program making disclosure)

To disclose to_____________________________________________ /______________________________________________

(Print name of person(s) or organization to which disclosure is to be made, and their mailing address)

The following information: ___________________________________________

____________________________________

(Describe the specific information to be used or disclosed)

_____________________________________________________________________________________________________

The purpose of the authorized disclosure is to: ______________________________________________________________

(Specific purpose/use of the disclosure)

I understand that I Am Not Required to Sign this Authorization, and that my treatment, payment, enrollment, or eligibility for benefits, is Not Conditioned on my Execution of this Authorization. I may Revoke this Consent in Writing at Any Time, Except to the extent that Action has been Taken in Reliance on it, and that, in any event, this Consent Expires Automatically as follows:

_____________________________________________________________________________

(Specify the date, event, or condition of expiration)

X_________________________________________________________ ____________________

(Signature of service recipient who is 16 years of age or older) (Date)

(All blanks must be filled in before signing)

*Signature of individual acting on behalf of the service recipient if the individual is: (1) the parent, legal guardian, or legal custodian of a service recipient who is under 18 years of age; (2) the conservator or guardian for the service recipient; (3) the guardian-ad-litem of the service recipient but only for the purposes of the litigation in which the guardian-ad-litem serves; (4) the attorney-in-fact under a power of attorney who has the right to make disclosures under the power for the service recipient; (5) the executor, administrator, or personal representative on behalf of a deceased recipient; and (6) the treatment review committee, acting within the authority and scope of §33-6-107, Tennessee Code Annotated. The signature of any individual other than a parent of a child is insufficient to permit release of information unless the individual intending to act on behalf of the individual produces proof of her or his authority to act on behalf of the service recipient.

X_________________________________________________________ ____________________

*(Signature of individual acting on behalf of the service recipient) (Date)

(All blanks must be filled in before signing)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

**If a service recipient gives oral consent or signs with an X, the form must be signed by two (2) witnesses:

X_____________________/________________________ 

**(Witness) (Date) X_____________________/________________________ 

**(Witness) (Date)

MHDD-5025 Revised 03-06
SECTION A—Behavioral Health Notification of Initial Outpatient Treatment

Fax Number: 1-800-505-1193  Telephone Number: 1-800-454-3730
Address: Behavioral Health Unit, P.O. Box 62509, Virginia Beach, VA 23466-2509

INSTRUCTIONS
1. Complete Section A for the initial 10 sessions.
2. Complete Section B for additional requested sessions.
3. Fax or mail the form to the above number or address. You will receive a confirmation number by fax.

MEMBER INFORMATION

PATIENT'S NAME:  DOB:  AMERIGROUP #:  

PATIENT'S ADDRESS:  STATE:  ZIP:  

PROVIDER INFORMATION

PROVIDER NAME:  PHONE#:  FAX#:  

TAX ID #:  

NAME OF PCP:  NAME OF OTHER MENTAL HEALTH PROVIDER:  

SERVICES BEING PROVIDED

PROCEDURE CODE:  NUMBER OF VISITS:  FREQUENCY:  

PROCEDURE CODE:  NUMBER OF VISITS:  FREQUENCY:  

SECTION B—Behavioral Health Additional Request for Outpatient Treatment

DSM-IV TR DIAGNOSIS

AXIS I:  AXIS II:  AXIS III:  

DATE FIRST SEEN:  ANTICIPATED # OF SESSIONS TO COMPLETION OF TREATMENT:  

TREATMENT REPORT

CURRENT CLINICAL INFORMATION:  

COMPLEX TREATMENT ISSUES:  

GOALS FOR CONTINUED TREATMENT:  

MEDICATIONS (OPTIONAL FOR NON-PHYSICIANS)

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
</thead>
</table>

REQUESTED SERVICES

PROCEDURE CODE:  NUMBER OF VISITS:  FREQUENCY:  

PROCEDURE CODE:  NUMBER OF VISITS:  FREQUENCY:  

TREATMENT PLAN COORDINATION

I have requested permission from the member to release information to the PCP.  Yes  No

If no, rationale why this is inappropriate:  

Treatment plan was discussed with patient.  Yes  No  

PROVIDER'S SIGNATURE:  DATE:  

PRINT PROVIDER'S NAME:  DATE:  

Authorization indicates that AMERIGROUP determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is at the discretion of the member's health plan, subject to any member eligibility and benefit limitations at the time services are rendered.

For AMERIGROUP Use Only Authorization #:  

TN-PM-0034-18 - 255 -
Declaration for Mental Health Treatment Form

A Document to Help People Make Choices about Their Mental Health Treatment

The Tennessee Department of Mental Health and Developmental Disabilities developed this form based on Tennessee Code Annotated Title 33, Chapter 6, Part 10.

Introduction

The Tennessee mental health and developmental disability law gives the right to individuals 16 years of age and over to be involved in decisions about their mental health treatment. The law also recognizes that, at times, some individuals are unable to make treatment decisions. A Declaration for Mental Health Treatment allows persons receiving services to plan ahead; it may also assist service providers in giving appropriate treatment.

The Declaration for Mental Health Treatment form describes what a service recipient wants to occur when he/she receives mental health treatment. It describes mental health services that a service recipient might consider, the conditions under which the Declaration may be acted upon, and directions on how a service recipient can revoke a Declaration.

For example, completion of a Declaration for Mental Health Treatment form allows you to state:

- Conditions or symptoms that might cause the Declaration to be acted upon
- Medications you are willing to take and medications you are not willing to take
- Specific instructions for or against electroconvulsive or other convulsive treatment
- Mental health facilities and mental health providers which you prefer
- Treatments or actions which you will allow or those which you refuse to permit
- Any other matter pertaining to your mental health treatment which you wish to make known

Instructions

1. Please read the form carefully. See https://www.tn.gov/content/dam/tn/mentalhealth/documents/Declaration_for_Mental_Health_Treatment-Form.pdf.

2. Where there are places on the form that ask you to choose between two or more items, you must choose at least one. For example, the following statement from the form requires you to choose one of the options.

   “If I am unable to make mental health treatment decisions, my wishes regarding psychoactive and other medications are as follows:
   □ I do not have a preference regarding medications.
   □ I do not consent to the administration of the following medications.”

3. Be as specific as possible when identifying your preferences.

4. Be sure to initial and date at the bottom of each page.

5. You must sign the form in front of two adult witnesses who know you.

6. You must discuss the contents of this form with the witnesses required to sign it.

7. It is highly recommended that you discuss the contents of this form with the significant persons in your life and your mental health service providers.
Declaration for Mental Health Treatment
for _____________________________________________________________________________

Print Full Name

This Declaration states my wishes for the provision of mental health treatment when I am unable to make informed decisions about my mental health treatment. It is authorized by Tennessee Code Annotated Title 33, Chapter 6, Part 10.

I understand that I may become unable to make informed decisions about my mental health treatment due to symptoms of a diagnosed mental disorder. These symptoms may include:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

I recognize that I am able to state my treatment preferences in the following areas: psychoactive and other medications, electroconvulsive and other convulsive therapies, and psychiatric hospitalization for a maximum of fifteen (15) days. This Declaration may include consent to, or refusal to, permit mental health treatment and other instructions and information for mental health service providers.

Psychoactive and Other Medications

If I am unable to make mental health treatment decisions, my wishes regarding psychoactive and other medications are as follows:

You must check one.

☐ I do not have a preference regarding medications.
☐ I do not consent to the administration of the following medications.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Reason for Not Consenting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

The following medications have worked for me.

<table>
<thead>
<tr>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Conditions or Limitations: ____________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Admission to and Remaining in a Hospital for Mental Health Treatment*

If I am unable to make informed mental health treatment decisions, my wishes regarding admission to, or remaining in, a hospital are as follows:
You must check one.

☐ I do not have a preference regarding admission to a hospital for mental health treatment.
☐ I consent to being admitted to a hospital for mental health treatment.
☐ I do not consent to voluntary admission to a hospital.

If I am admitted to a hospital for mental health treatment:

You must check one.

☐ I consent to remain voluntarily in the hospital for mental health treatment.
☐ I do not consent to remain voluntarily in the hospital for mental health treatment.

Conditions or Limitations: ________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

*Authorization under a Declaration is limited to 15 days for psychiatric hospitalization.

Admission to and Continuation of Mental Health Services from Other Facilities

If I am unable to make informed mental health treatment decisions, my wishes about receiving mental health services, or continuation of services, are as follows:

You must check one.

☐ I do not have a preference about receiving mental health services from a facility, which is not a hospital.
☐ I consent to receiving services from a facility, which is not a hospital.
☐ I do not consent to receiving mental health services from a facility, which is not a hospital.

Conditions or Limitations: __________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Treatment Provider or Facility

If I am unable to make informed mental health treatment decisions, my wishes regarding treatment providers or treatment facilities are as follows:

Check each that applies.

☐ I do not have a preference of providers or treatment facilities.
☐ I do not consent to receiving treatment by the listed providers or treatment facilities.
☐ I do prefer the following:

<table>
<thead>
<tr>
<th>Providers</th>
<th>Do not consent</th>
<th>Prefer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Facility</th>
<th>Do not consent</th>
<th>Prefer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Conditions or Limitations: ______________________________________________________________________
___________________________________________________________________________________________

Electroconvulsive and Other Convulsive Therapies

If I am unable to make informed mental health treatment decisions, my wishes regarding electroconvulsive and other convulsive therapies are as follows:

**You must check one.**

- [ ] I do not have a preference regarding electroconvulsive or other convulsive therapies.
- [ ] I do not consent to the administration of electroconvulsive or other convulsive therapies.
- [ ] I consent to electroconvulsive or other convulsive therapies, under the following conditions:

Conditions or Limitations: ______________________________________________________________________
___________________________________________________________________________________________

Other Preferences

If I am unable to make informed mental health treatment decisions, my wishes regarding other information or preferences are listed below:

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

If I am unable to make informed mental health treatment decisions, please inform one of the following:

Name __________________________________ Area Code and Phone Number __________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

My Affirmation

I am sixteen (16) years of age or older. I am capable of making informed mental health treatment decisions. I make this Declaration for Mental Health Treatment to be followed, if I become unable to make informed mental health treatment decisions. The determination that I am unable to make an informed decision about my mental health treatment must be made by (1) a court in a conservatorship or guardianship proceeding, or (2) two physicians, or (3) a physician with expertise in psychiatry and a doctoral level psychologist with health service provider designation.

I know that I may cancel this Declaration at any time, orally or in writing, when I am able to make informed treatment decisions.

This Declaration will expire two years from the day it is signed by me and the two witnesses or a shorter period specified by this date: ________________________.

I affirm that the preferences expressed in this document were made after due consideration and without coercion.

I affirm that I have discussed this document with the witnesses.
Print Name __________________________________________________________________________________
Signature ____________________________________________________ Date __________________________
Address __________________________________________________________________________________
___________________________________________________________________________________________
Area Code and Phone Number __________________________________________________________________
Date of Birth ______________________________________

Affirmation of First Witness

I affirm that ________________________________ is personally known to me; that he/she signed this Declaration for Mental Health Treatment in my presence; that he/she talked to me about the document and its contents and the reasons for preparing and wanting the document to be effective. He/she appears to be able to make informed mental health treatment decisions and is not under duress, fraud or undue influence. The Declaration was not signed on the premises of a mental health service provider.

I affirm that I am an adult and that I am not:
   The service recipient’s mental health service provider; or
   An employee of the service recipient’s mental health service provider; or
   The operator of a mental health facility; or
   An employee of a mental health facility.

YOU MUST CHECK ONE
   Yes ❑   No ❑ I am a relative by blood, marriage, or adoption.*

YOU MUST CHECK ONE
   Yes ❑   No ❑ I am likely to be entitled to a portion of this person’s estate in the event of his/her death.**

Signature _____________________________________________ Date _________________________________
Address _____________________________________________________________________________________
Area Code and Phone Number _______________________________________________________________

*Only one of the two witnesses can be a relative by blood, marriage, or adoption.

**Only one of the two witnesses can be a person likely to benefit from the death of the person completing the Declaration.

Affirmation of Second Witness

I affirm that ________________________________ is personally known to me; that he/she signed this Declaration for Mental Health Treatment in my presence; that he/she talked to me about the document and its contents and the reasons for preparing and wanting the document to be effective. He/she appears to be able to make informed mental health treatment decisions and is not under duress, fraud or undue influence. The Declaration was not signed on the premises of a mental health service provider.

I affirm that I am an adult and that I am not:
   The service recipient’s mental health service provider; or
   An employee of the service recipient’s mental health service provider; or
   The operator of a mental health facility; or
   An employee of a mental health facility.

YOU MUST CHECK ONE
   Yes ❑   No ❑ I am a relative by blood, marriage, or adoption.*
YOU MUST CHECK ONE

Yes ❑  No ❑  I am likely to be entitled to a portion of this person’s estate in the event of his/her
death.**

Signature ________________________________________________ Date ____________________________

Address _____________________________________________________________________________________

Area Code and Phone Number __________________________________________________________________

*Only one of the two witnesses can be a relative by blood, marriage, or adoption.

**Only one of the two witnesses can be a person likely to benefit from the death of the person completing the
Declaration.

Declaration for Mental Health Treatment

Tennessee Department of Mental Health. Authorization No. 339408, 10,000 copies, November 2001. This
document was promulgated at a cost of $0.15 per copy.

Additional copies of this form may be obtained from the Tennessee Department of Mental Health website at
www.tn.gov/mental.

For additional information contact the Tennessee Department of Mental Health Office of Consumer Affairs 1-800-

The Tennessee Department of Mental Health is committed to the principles of equal opportunity, equal access,
and affirmative action. Contact the Department’s EEO/AA Coordinator at (615) 532-6580, the Title VI Coordinator
at (615) 532-6700 or the ADA Coordinator at (615) 532-6700 for further information. Persons with hearing
impairments call (615) 532-6612.
Formal psychological testing is not clinically indicated for routine screening or assessment of behavioral health disorders. Nor is psychological testing indicated for the administration of brief behavior rating scales and inventories. Such scales and inventories are an expected part of a routine and complete diagnostic process. Other than in exceptional cases, a diagnostic interview and relevant rating scales should be completed by the psychologist prior to submission of requests for psychological testing authorization. Requests for educational testing or learning disabilities assessment for educational purposes should be referred to the public school system.

**Clinical Assessment**

Indicate which of the following assessments have been completed:

- Psychiatric and medical history
- Clinical interview with patient
- Structured developmental and psychosocial history
- Direct observation of parent-child interactions
- Family history pertinent to testing request
- Interview with family member(s)
- Consultation with school/other important persons
- Medical evaluation
- Consultation with patient’s physician
- Brief inventories and/or rating scales

**Clinical Information**

Presenting problems, symptoms indicating need for testing:

- Inattention
- Mood liability
- Disorganization
- Anxiety
- Irritability
- Lethargy
- Low motivation
- Poor attention span
- Disorganization
- Impulsivity
- Depression
- Acting out behavior
- Attention seeking
- Hallucinations
- Low frustration tolerance
- Delusions
- Other Symptoms ___________________________________________________________________________

Duration of symptoms: □ 0 – 3 Months □ 3 – 6 Months □ 6 – 12 Months □ Over 12 Months

Please list any other pertinent history or clinical information relevant to the request for psychological testing authorization:
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Date(s) of Diagnostic Interview(s): ____________________. Please identify any behavior rating scales or self-report measures (e.g., depression or anxiety scale, parent or teacher questionnaires, MAST, etc.) that were
administered as part of the diagnostic interview and cite the results (percentiles, T-scores or standard scores):

Current possible DSM-IV TR diagnosis under evaluation:
Axis I: ____________________________________  Axis IV: ____________________________________
Axis II: ____________________________________  Axis V: ____________________________________
Axis III: ____________________________________ (current/highest in 12 months)

Has this patient had previous psychological testing? ☐ Yes ☐ No. If yes, date of testing __________. What were
the results and reasons for retesting?

What are the specific questions to be answered by psychological testing that cannot be determined through other
means, such as a comprehensive clinical assessment, history taking, family assessment, referral for psychiatric
assessment, review of pertinent records, a medication review, chemical dependency assessment, referral for
psycho-educational testing and/or use of observational rating scales?

Specifically, how will the proposed testing impact treatment decisions?

Possible tests requested:

☐ Rorschach Test  ☐ Sentence Completion  ☐ Anxiety Scale
☐ Conner’s continuous performance test  ☐ Bender Gestalt  ☐ MMPI
☐ Personality inventory for children  ☐ Wechsler Scales  ☐ Depression Scale
☐ Personality Assessment Inventory  ☐ WRAT-4  ☐ Millon Inventories
Other:

Total time requested in hours: ____________

Provider Signature/Credentials  Date submitted
Amerigroup USE ONLY

Date received: __________  Auth from: __________  Auth to: __________
Reference #: __________
96101 ______ hrs  96118 ______ hrs  Other: ________
96102 ______ hrs  96119 ______ hrs
96103 ______ hrs  96120 ______ hrs
96116 ______ hrs

Authorization for routine outpatient care (90801, 90806, 90846, 90847) is not required for network providers
treating eligible Amerigroup members.

NOTE: We are unable to process illegible or incomplete requests.
**Request For Authorization — Neuropsychological Testing**

Amerigroup Community Care — Behavioral Health Services  
Telephone: 1-800-454-3730  Fax: 1-800-505-1193

**REQUEST FOR AUTHORIZATION — NEUROPSYCHOLOGICAL TESTING**

### General Information

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>Date of Birth</th>
<th>Age:</th>
<th>Member’s Amerigroup ID:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Psychologist:</th>
<th>Amerigroup Provider #:</th>
<th>Phone:</th>
<th>Fax:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Provider NPI#:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referral Source:</th>
<th>Specialty:</th>
<th>Address:</th>
<th>Phone:</th>
</tr>
</thead>
</table>

Neuropsychological testing may be medically necessary for assessment of neurocognitive functioning following traumatic brain injury, stroke or neurosurgery. It also may be useful for monitoring the progression of cognitive impairment secondary to neurological disorders, to assist in the development of rehabilitation strategies for persons with neurological disorders, and to aid in differential diagnosis between psychogenic and neurogenic syndromes. Formal psychological or neuropsychological testing beyond structured interviews and direct, structured behavioral observation is rarely considered medically necessary for the diagnosis of attention-deficit/hyperactivity disorder or pervasive development disorders. Neither is it considered to be medically necessary for diagnosing learning disorders in the absence of verified brain injury.

### Clinical Information

<table>
<thead>
<tr>
<th>Check any that apply:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Traumatic brain injury, date:</td>
<td>☐ Encephalitis, date:</td>
</tr>
<tr>
<td>☐ Anoxic/hypoxic brain injury, date:</td>
<td>☐ CVA, date:</td>
</tr>
<tr>
<td>☐ History of intracranial surgery, date:</td>
<td>☐ Brain tumor in remission with slow progression</td>
</tr>
<tr>
<td>☐ Confirmed neurotoxin exposure, date:</td>
<td>☐ Dementia suspected</td>
</tr>
</tbody>
</table>

Duration of symptoms: ☐ 0 – 3 Months ☐ 3 – 6 Months ☐ 6 – 12 Months ☐ Over 12 Months

Other pertinent history or clinical information relevant to request for neuropsychological testing authorization:
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Current possible DSM-IV TR diagnosis under evaluation:

- Axis I: ________________________________  
- Axis II: ________________________________  
- Axis III: ________________________________  
- Axis IV: ________________________________  
- Axis V: ________________________________  
- Axis: ________________________________  

(current/highest in 12 months)
Has this patient had previous psychological/neuropsychological testing? □ Yes □ No
If yes, date of testing ____ / ____ / _____. What were the results and reasons for retesting?
_____________________________________________________________________________________
_____________________________________________________________________________________

Is patient taking medications? Yes □ No □. If Yes, please list:
_____________________________________________________________________________________
_____________________________________________________________________________________

Have drug effects been ruled out as a cause of cognitive impairment? Yes □ No □

Substance abuse history to date:
_____________________________________________________________________________________
_____________________________________________________________________________________

**Clinical Assessment**

Indicate which of the following assessments have been completed:

- □ Clinical interview with patient, date:
- □ Psychiatric evaluation, date:
- □ Structured developmental and psychosocial history, date:
- □ EEG, date:
- □ Neurological exam, date:
- □ Interview with family member(s), date:
- □ Consultation with school or other important persons, date:
- □ Medical evaluation, date:
- □ Consultation with PCP, date:
- □ Brief inventories and/or rating scales
- □ Neuro-imaging (CT, MRI, PET, etc.), date:

What are the specific questions to be answered by neuropsychological testing that cannot be determined from the above services? How will the test results impact this patient’s treatment?
_____________________________________________________________________________________
_____________________________________________________________________________________

**Possible tests requested:**

- □ Wechsler intelligence scale
- □ MMPI
- □ WRAT-4
- □ Halstead-Reitan Neuropsychological Battery
- □ Other (List):
- □ Luria-Nebraska
- □ Bender Gestalt
- □ Wechsler Memory Scale
- □ Reitan-Indiana Neuropsychological Test Battery

**Total time requested in hours:** __________

**Provider Signature/Credentials**

**Date submitted**

**Amerigroup USE ONLY**

Date received: __________
Reference #: ___________________________
96101 _____ hrs 96102 _____ hrs 96103 _____ hrs
96116 _____ hrs 96118 _____ hrs 96119 _____ hrs
96120 _____ hrs

Authorization for routine outpatient care (90801, 90806, 90846, 90847) is not required for network providers treating eligible Amerigroup members.

**NOTE:** We are unable to process illegible or incomplete requests
Outpatient Treatment Report Form C for BH: The behavioral health provider may use this form instead of calling Amerigroup to precertify outpatient behavioral health services.

### FILL OUT COMPLETELY TO AVOID DELAYS

#### IDENTIFYING DATA

<table>
<thead>
<tr>
<th>PATIENT'S NAME</th>
<th>MEDICAID #:</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT'S ADDRESS</td>
<td>STATE:</td>
<td>ZIP CODE:</td>
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</table>

#### PROVIDER INFORMATION

<table>
<thead>
<tr>
<th>PROVIDER NAME</th>
<th>TAX ID NUMBER</th>
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<tbody>
<tr>
<td>PHONE #:</td>
<td>FAX #:</td>
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<tr>
<td>PCP NAME</td>
<td>NAME OF OTHER BEHAVIORAL HEALTH PROVIDER(S):</td>
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#### DSM-IV TR DIAGNOSIS

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<thead>
<tr>
<th>AXIS I</th>
<th>AXIS II</th>
<th>AXIS III</th>
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</thead>
<tbody>
<tr>
<td>AXIS IV</td>
<td>AXIS V CURRENT</td>
<td>HIGHEST IN PAST YEAR</td>
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#### CURRENT CLINICAL INFORMATION

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<tr>
<th>Symptoms/Problems</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
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<td>Obsessions/compulsions</td>
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<td>Generalized anxiety</td>
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<tr>
<td>Panic attacks</td>
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<td>Phobias</td>
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<td>Impaired concentration</td>
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<td>Impaired memory</td>
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<tr>
<td>Psychomotor retardation</td>
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<td>Sexual issues</td>
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<td>Irritability</td>
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<td>Agitation</td>
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<td>Sleep disturbance</td>
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<td>Grandiosity</td>
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<td>Pressured speech</td>
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<td>Racing thoughts/thought of ideas</td>
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<tr>
<td>Poor judgment/impulsiveness</td>
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<th></th>
<th>Mild</th>
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<th>Severe</th>
<th>Acute</th>
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<tr>
<td>Psychotic disorders</td>
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<tr>
<td>Delusions/paranoia</td>
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<tr>
<td>Self-care issues</td>
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<tr>
<td>Hallucinations</td>
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<tr>
<td>Disorganized thought process</td>
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<tr>
<td>Loosen associations</td>
<td></td>
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<tr>
<td>Substance abuse</td>
<td></td>
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<tr>
<td>Loss of control of dosage</td>
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<tr>
<td>Amnestic episodes</td>
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<tr>
<td>Legal problems</td>
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<td>Alcohol abuse</td>
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<td>Opiate abuse</td>
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<td>Prescription medication abuse</td>
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<td>Oddness/eccentricities</td>
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<td>Disregard for law</td>
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<td>Recurring self-injuries</td>
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<td>Dependency</td>
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<tr>
<td>Enduring traits of:</td>
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</table>
PATIENT NAME:

PATIENT'S TREATMENT HISTORY INCLUDING ALL LEVELS OF CARE:

<table>
<thead>
<tr>
<th>Level of care</th>
<th>Number of distinct episodes/sessions of</th>
<th>Date of last episode/session</th>
<th>Level of care</th>
<th>Number of distinct episodes/ sessions of</th>
<th>Date of last episode/ session</th>
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<td>Inpatient – psych RTC</td>
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<tr>
<td>IOP</td>
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<td></td>
<td>Inpatient – substance abuse</td>
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</tbody>
</table>

TREATMENT GOALS:

1.
2.
3.

OBJECTIVE OUTCOME CRITERIA BY WHICH GOAL ACHIEVEMENT IS MEASURED:

1.
2.
3.

DISCHARGE PLAN AND ESTIMATED DISCHARGE DATE:

EXPECTED OUTCOME AND PROGNOSIS:

☐ Return to normal functioning
☐ Expect improvement, anticipate less than normal functioning
☐ Relieve acute symptoms, return to baseline functioning
☐ Maintain current status, prevent deterioration

RISK HISTORY:

Explain any significant history of suicidal, homicidal, impulse control or any behavior that may impact patient’s level of functioning:

REQUESTED AUTHORIZATION:

<table>
<thead>
<tr>
<th>Procedure Code:</th>
<th>Number of Units:</th>
<th>Frequency:</th>
<th>Units Approved:</th>
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<tr>
<td>Procedure Code:</td>
<td>Number of Units:</td>
<td>Frequency:</td>
<td>Units Approved:</td>
</tr>
</tbody>
</table>

☐ Approved – Auth’d #:

PROVIDER'S SIGNATURE: 

DATE: 

Disclaimer: Authorization indicates that AMERIGROUP determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the eligibility and benefit limitations at the time services are rendered.
TennCare Medical Appeal Form

The TennCare Medical Appeal Form is located at:

Having problems getting health care or medicine in TennCare?

Use this page only to file a TennCare Medical Appeal.

Need help filing a medical appeal? ☐ Call 1-800-878-3192 for free.

Fill out both pages. These are facts we must have to work your appeal. If you don’t tell us all the facts we need, we may not be able to decide your appeal. You may not get a fair hearing. Need help understanding what facts we need? Call us for free at 1-800-878-3192. If you call, we can also take your appeal by phone.

---

1. Who is the person that wants to appeal?

Full name ______________________ Date of birth ___/___/

Social Security Number ______-____-______ Or number on their TennCare card ______________________

Current mailing address __________________________________________

City________________________ State ______ Zip Code _____________

The name of the person we should call if we have questions about this appeal: ______________________________

A daytime phone number for that person (_____) ____-__________

2. Who filled out this form?

If not the person that wants to appeal, tell us your name.

Are you a: ______ Parent, relative, or friend ______ Advocate or attorney ______ Doctor or health care provider

3. What is the appeal for? (Place an X beside the right answer below.)

____ Want to change health plans. (Fill out Part A on page 2.)

____ Need care or medicine. (Fill out Part B on page 2.)

____ Have bills or paid for care or medicine you think TennCare should pay. (Fill out Part C on page 2.)

4. Do you think you have an emergency?

Usually your appeal is decided within 90 days after you file it. But, if you have an emergency, you may be able to get an expedited appeal. An expedited appeal must be decided in 3 business days. An emergency means that if you don’t get a decision on your appeal within 3 business days, it could SERIOUSLY JEOPARDIZE...

- your life;
- your physical health;
- your mental health; or
- your ability to attain, regain, or maintain full function.

Do you still think you have an emergency? If so, you can ask TennCare for an expedited appeal. Your health plan will decide if your appeal should be expedited because you have an emergency. If so, your appeal will be decided in three business days from the date TennCare receives your appeal. However, if your health plan decides that your appeal should not be expedited, then you will get a hearing within 90 days.

Additionally, if your PROVIDER thinks you need an expedited appeal, your provider can visit http://tn.gov/tenncare/topic/miscellaneous-provider-forms to fill out a certificate. You provider should return the certificate to 1-866-211-7228. Your health plan will review the provider’s certificate and make a decision about your appeal. If your health plan decides that your appeal should be expedited after reviewing your provider’s certificate then your appeal will be decided in three business days from then. However, if your health plan decides your appeal should not be expedited after reviewing your provider’s certificate then you will get a hearing within 90 days from the date you filed your appeal.

Rev: 01Jan17   Keep reading. There is 1 more page for you to fill out.
5. **Tell us why you want to appeal** this problem. Include any mistake you think TennCare made. And, send copies of any papers that you think may help us understand your problem.

---

To see which Part(s) you should fill out below, look at number 3 on page 1.

**Part A. Want to change health plans.** Name of health plan you want ________

**Part B. Need care or medicine.** What kind - be specific

What’s the problem?  
____ Can’t get the care or medicine at all.  
____ Can’t get as much of the care or medicine as I need.  
____ The care or medicine is being cut or stopped.  
____ Waiting too long to get the care or medicine.

Did your doctor prescribe the care or medicine?  
____ Yes  
____ No  
If yes, doctor’s name __________

Have you asked your health plan for this care or medicine?  
____ Yes  
____ No  
If yes, when? __________

What did they say? __________

Did you get a letter about this problem?  
____ Yes  
____ No  
If yes, the date of the letter __________

Who was the letter from? __________

**Are you getting this care or medicine from TennCare now?**  
____ Yes  
____ No

Do you want to see if you can keep getting it during your appeal?  
____ Yes  
____ No

Does your doctor say you still need it?  
____ Yes  
____ No  
If yes, doctor’s name __________

If you keep getting care or medicine during your appeal and you lose, you may have to pay TennCare back.

**Part C. Bills for care or medicine you think TennCare should pay for**

The date you got the care or medicine ________
Name of doctor, drug store, or other place that gave you the care or medicine ________
Their phone number (____) ____-_______

Their address ________

Did you pay for the care or medicine and want to be paid back?  
____ Yes  
____ No

If yes, you must send a copy of a receipt that proves you paid for the care or medicine.

If you didn’t pay, **are you getting a bill?**  
____ Yes  
____ No  
If yes, and you think TennCare should pay, you must send a copy of a bill. Tell us the date you first got a bill (if you know). ________

---

**How to file your medical appeal**

Make a copy of the completed pages to keep.

Then, **mail** these pages and other facts to:  
TennCare Solutions  
P.O. Box 593  
Nashville, TN 37202-0593

Or, **fax** it (toll-free) to 1-888-345-5575. **Keep a copy** of the page that shows your fax went through.

To appeal by **phone**, call 1-800-878-3192 for free.
Have speech or hearing problems? Call our TTY/TDD line for free at 1-866-771-7043.

**We do not allow unfair treatment in TennCare.**

No one is treated in a different way because of race, color, birthplace, language, sex, age, religion, or disability.  
If you think you’ve been treated unfairly, call the Tennessee Health Connection for free at 1-855-259-0701.

Rev. 01Jan17
Expedited TennCare Appeal Form
The Expedited TennCare Appeal Form is located at: http://tn.gov/tenncare/topic/miscellaneous-provider-forms.

Treating Provider’s Certificate: Expedited TennCare Appeal

An expedited appeal is an administrative appeal for a medical service that must be either approved or denied within three (3) business days, as opposed to up to ninety (90) days, because of the patient’s health. An appeal will only be expedited if waiting up to ninety (90) days for a decision, “could seriously jeopardize the enrollee’s life, physical health, or mental health or their ability to attain, regain, or maintain full function.”

To request an expedited appeal for your patient:

1. Read the statement below. If you agree, indicate your certification and sign and date in the spaces provided.

   □ I certify that I am the treating clinician of the patient named below, and that the acute presentation of this medical condition is of sufficient severity that the absence of a decision within three business days could seriously jeopardize the enrollee’s life, physical health, or mental health or their ability to attain, regain, or maintain full function.

   Provider’s Signature: ___________________________ Date: ________________

2. Identify the desired service: __________________________

3. Identify the patient.

   (Name) ___________________________ (SS#/ or (date of birth)

4. At your discretion, please attach a narrative and/or medical records that support this request.

Fax this completed form and any accompanying documentation to the Bureau of TennCare at 866-211-7228. (NOTICE: If your patient has already requested this expedited appeal from TennCare, please submit this certificate and documentation as soon as possible.)

TC0181 (Rev. 28Dec.2016) RDA 2045
Provider Appeals Form

Appeal Form

Thank you for contacting Amerigroup. All nonexpedited appeals must be submitted in writing to the Amerigroup Centralized Appeals Team. This form will help ensure that your appeal is processed as efficiently and effectively as possible. Please fill out the form completely.

Note: Per Federal Privacy Regulations (HIPAA), Amerigroup can only accept an appeal from a provider appealing on behalf of a member if the member has issued a written statement naming that provider as his/her designated representative.

Member Information

Last Name: ___________________________________ First Name: ___________________________________
Member Number: __________________________________________________________________________
Address: _________________________________________________________________________________
City: ___________________________________ State: ___________________ ZIP: ________________

Provider Information

Last Name: ___________________________________ First Name: ___________________________________
Facility  ___________________________________________________________________________________
TIN:  ___________________________________ Provider Number: _______________________
Address: __________________________________________________________________________________
City: ___________________________________ State: ___________________ ZIP: ________________

Claim Data (If Applicable)

Claim Number: ________________________________ Authorization Number: ______________________
Date Service Started: _________________________ Date Service Ended: _________________________
Please provide an explanation of the appeal reason. Attach a separate sheet if additional space is needed:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Please place a check mark next to the items being submitted with the appeal.

___Copy of original claim  ___Copy of the Amerigroup EOP  ___Contract rate sheets indicating evidence of payment rates
___EOP or EOB from another carrier  ___Evidence of previous appeal submission or timely filing
___Evidence of eligibility verification  ___Letter from member designating provider as his/her designated representative
___Medical records  ___Approved referral and authorization forms from Amerigroup indicating the authorization number

Appeals forms and supporting documentation should be addressed to:
Amerigroup Centralized Appeal Team
P.O. Box 61599
Virginia Beach, VA 23466-1599

TN-PM-0034-18 - 272 -
Independent Review Forms
There are three different forms available to request an independent review:


2. The Request to Commissioner of Commerce & Insurance for Independent Review of Disputed TennCare Claim form on the following page is a traditional form that can be printed and completed by the provider.

3. The Request to Commissioner for Independent Review of Disputed TennCare Episode of Care Cycle Provider Gain/Risk Share Total form, which is specific to requests related to disputes regarding the annual provider Episode of Care report, can be electronically completed on the state’s website at https://www.tn.gov/commerce/tenncare-oversight/mco-dispute-resolution/independent-review-process.html.
REQUEST to COMMISSIONER of COMMERCE & INSURANCE for INDEPENDENT REVIEW of DISPUTED TENNCARE CLAIM

TO: Compliance Officer, TennCare Division, Tenn. Dept. of Commerce & Insurance
   500 James Robertson Parkway, 11th Floor, Nashville, TN 37243-1169
   Telephone: (615) 741-2677 or Fax: (615) 401-6834

FROM: Provider Contact Person: ____________________________
      Mailing Address: ____________________________________________
      City, State, Zip Code: _______________________________________
      Telephone: (_____) ___________________ Fax Number: (_____) ___________________
      E-mail Address: ____________________________________________

Fill out this form completely or it may be returned as ineligible. Read the attached Instruction Sheet for completing this form. (Submit a separate request form for each claim unless claims will be aggregated. See #14 below.)

1. Provider Name: ____________________________________________ NPI#: ______________________
2. TennCare MCO that denied claim: _____________________________
3. Date(s) of Service(s): ____________________________
4. Enrolee Name & ID #: ____________________________
5. Claim(s) Amount: ____________________________
6. Initial claim(s) submission date: ____________________________
7. Attach submitted claim(s): ____________________________
8. Date MCO partially or totally denied payment of claim(s): ____________________________
9. Attach MCO written denial(s). [Claim(s) must be submitted to Independent Review within 365 days of the MCO’s 1st denial.]
10. Date Provider requested reconsideration in writing: ____________________________. (Reconsideration request is required, regardless of whether a denial was received.)
11. Attach copy of dated written reconsideration request.
12. Attach MCO’s response to your reconsideration request if you received one.
13. Briefly describe disputed claim. Description may include, but not limited to: reason given for denial and your position explaining why the MCO should pay the claim ____________________________

14. Do you want your claims aggregated?   ____ Yes   ____ No. Only claims involving a common question of fact or law may be aggregated. The fact that a claim is not paid does not create a common question of fact or law. If you wish to aggregate your claims, explain the common question of fact or law: ____________________________

Only claims which meet ALL of the requirements set forth in T.C.A. § 56-32-126(b)(2)(A) thru (D) are eligible for Independent Review. Claims payment disputes involved in litigation, arbitration or not associated with a TennCare member are not eligible.

ACKNOWLEDGEMENT OF FEE OBLIGATION
By my signature below, I hereby request independent review of the above claim, pursuant to T.C.A. §§ 56-32-126(b) or 71-5-2314. I also confirm that the above mentioned disputed claim will not be raised as an issue in litigation or arbitration until the reviewer issues his decision. Any provider who brings a lawsuit or institutes arbitration involving a claims payment dispute raised in an independent review request before the independent reviewer renders a decision, must ultimately pay the independent reviewer’s fee. Any provider who initiates independent review for a non-TennCare claim is ultimately responsible for paying the reviewer’s fee. I also understand that there is a mandatory fee of $750.00 per claim and if I have a contract with the MCO, the MCO is initially responsible for paying the fee. I further understand that if the reviewer determines the MCO correctly denied payment of this disputed claim(s), then I must reimburse the MCO for the reviewer’s fee as established by the Selection Panel for TennCare Reviewers.

15. Are you a contracted provider with the MCO?   ____ Yes   ____ No
16. Attach evidence of contract. (A copy of the signature page from the provider contract is sufficient.)
17. If you do not have a contract with the MCO, you must submit the reviewer’s fee with your request. (Per claim, attach check for $750 made payable to the Department of Commerce and Insurance).
18. Amount of check sent to TN Dept. of Commerce and insurance for the reviewer’s fee: ____________________________

Signature (Name & Title) ____________________________ Date ____________

(Type or Print Name & Title) ____________________________ Revised July 2015
Disclosure for Provider Entities

This information is required during the provider registration on the TennCare Web portal at https://www.tn.gov/tenncare/providers/provider-registration.html.
Practitioner Attestation Form

Practitioner Attestation:

I certify and attest that the following is true and correct. I understand that factual misrepresentation may result in my nonselection, or if discovered after selection, my termination, as an Amerigroup Community Care practitioner for the TENNCARE MANAGED CARE Program.

TennCare Rule 1200-13-1-05 (1.a.3.) requires that I disclose whether (i) I am under a federal Drug Enforcement Agency (DEA) restriction of my prescribing and/or dispensing certification for scheduled drugs, or (ii) I have been convicted of a criminal offense in any program under the Medicare, Medicaid, or the Federal Title XX services program since the inception of those programs. Pursuant to Chapter 42 CFR Part 455, Subpart B State plans require disclosure of information regarding a provider’s owners and other persons convicted of criminal offenses against Medicare, Medicaid, and the Title XX Programs.

Amerigroup Community Care is required to disclose to TENNCARE, the Comptroller General and CMS full and complete information regarding persons convicted of criminal activity related to Medicare, Medicaid, or Federal Title XX programs in accordance with federal and State requirements, including Public Chapter 379 of the Acts of 1999.

I, _______________________________, hereby certify and attest that I have not been convicted of fraud, or any other criminal offense in connection with obtaining or attempting to obtain, or performing a public (federal, State, or Local) transaction or grant under a public transaction, a violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property, nor have I had a civil judgment rendered against me for commission of any of the above offenses. I am not under a federal Drug Enforcement Agency (DEA) restriction of my prescribing and/or dispensing certification for scheduled drugs, and I have not been convicted of a criminal offense in any program under Medicare, Medicaid, or the Federal Title XX services program since the inception of those programs.

By: ________________________________

Please Type or write name

________________________________________
Signature

________________________________________
Date

________________________________________
Title-Position

________________________________________
Practice-Facility-Affiliation

________________________________________
Tax Identification Number
How to complete the Provider Payment Dispute Form

Provider Payment Dispute and Correspondence - Submission Form
This form should be completed by Tennessee Providers for Payment Disputes and Claim Correspondence only.

Member First/Last Name ___________________________ Member DOB ___________________________

AMERIGROUP, Medicaid or Medicare (circle one) Member # ___________________________

Provider First/Last Name ___________________________ Provider # ___________________________

Provider Contact First/Last Name ___________________________ Contact Phone (____) ________

☐ Participating
☐ Non-Participating: If filing for a Medicare member and the member has potential financial liability, you must include a completed CMS Waiver of Liability form.

Provider Street Address ______________________________________________________________________

City ___________________________ State ___________________________ Zip ___________________________ Phone (____) ________

Claim # ___________________________ Billed Amount $ ___________________________ Amount Received $ ___________________________

Start Date of Service ___________________________ End Date of Service ___________________________

In accordance with Tennessee regulation T.C.A 56:32:126, providers have an external independent review process available if you continue to disagree with a payment decision after receiving a decision from a health plan’s internal dispute process. For specific instructions and requirements for this process, please review the Tennessee regulation. A form for filing is located at http://www.tn.gov/tncoversight/PCIR.shtml. Please be aware there is a fee associated with each claim requested for review that must be paid by the provider if the external reviewer upholds our determination. Please note this process is not applicable to Medicare member’s liability denials.

PAYMENT DISPUTE
A payment dispute is defined as a dispute between the provider and AMERIGROUP in reference to a claim determination where the member cannot be held financially liable. All disputes with member liability must follow the applicable appeals process. Please refer to the explanation of payment to ensure you are following the correct process. Clearly and completely indicate the payment dispute reason(s). You may attach an additional sheet if necessary. Please include appropriate medical records.

CLAIM CORRESPONDENCE: Check (✓) appropriate box below.
Claim correspondence is defined as a request for additional/needed information in order for a claim to be considered clean, to be processed correctly or for a payment determination to be made.
☐ Itemized Bill/Medical Records (In response to an AMERIGROUP claim denial or request)
☐ Corrected Claim ☐ Other Insurance/Third-Party Liability Information ☐ Other Correspondence

Clearly and completely indicate the reason(s) for your correspondence. You may attach an additional sheet if necessary.

Mail this form and supporting documentation to:

AMERIGROUP Community Care
Payment Disputes
PO Box 61599
Virginia Beach, VA 23466-1599
Use the Provider Payment Dispute Form to request payment reconsideration for any claim(s) that have been previously denied or underpaid by Amerigroup Community Care.

1) Insert **Member Name** for claim(s) in dispute
2) Insert **Member Date of Birth** for claim(s) in dispute
3) Insert **Amerigroup Medicaid or Medicare Member number** for claim(s) in dispute. Circle type of ID applicable for member
4) Insert **Provider First and Last Name** disputing the claim(s)
5) Insert **Provider Number** for provider disputing the claim(s)
6) Insert **Contact First and Last Name** who is familiar with the disputed claim(s) and should receive correspondence regarding the dispute being submitted
7) Insert **Contact Phone Number** to be reached between the hours of 8:00 a.m. – 5:00 p.m. Monday – Friday
8) Check applicable box indicating whether Provider disputing claim(s) is Par (In Network) or Non-Par (Out of Network)
9) (a-e) Insert **Provider Street Address, City, State, ZIP Code and Phone Number**
10) Insert the **Claim(s) Number** of claim(s) in dispute — Attach a separate sheet if additional claim(s) with the same issue are being disputed
11) Insert **Billed Amount** for claim(s) in dispute
12) Insert **Amount Received** (Paid Amount) for claim(s) in dispute
13) Insert the **Start Date of Service** (Earliest date shown from the claim(s) in dispute)
14) Insert the **End Date of Service** (Latest date shown from the claim(s) in dispute)
15) Insert the **Authorization Number** the disputed claim(s) falls under if applicable
16) Check applicable box indicating if this is a **First Level or Second Level** payment dispute.
   (1) First Level – Claim(s) have never been submitted for dispute.
   (2) Second Level – Claim(s) sent for First Level Dispute was denied and the provider received a First Level Dispute determination letter; Second Level Dispute is being submitted for reconsideration.
17) Indicate a **brief description of the reason(s) claim(s) is being disputed.** Attach an additional page if necessary. Also, include appropriate medical records
18) Check applicable box indicating what **type of correspondence** is being submitted
19) Indicate **reason(s) for the correspondence** clearly and completely. Attach an additional page if necessary
20) **Mail Provider Dispute Form** and all supporting documentation to address given
Adverse Occurrence Reporting Form

**TENNCARE BEHAVIORAL HEALTH ADVERSE OCCURRENCE REPORT**

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Consumer Name: (Last, First)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Reporting Person:</td>
<td>Address:</td>
</tr>
<tr>
<td>Name/Title of Person Submitting Report:</td>
<td>SSN:</td>
</tr>
<tr>
<td>Contact Number:</td>
<td>DOB:</td>
</tr>
<tr>
<td>Date Reported:</td>
<td>Date of Incident:</td>
</tr>
</tbody>
</table>

MCO: □ UHCCP □ AmeriGroup □ BlueCare □ TennCare Select

<table>
<thead>
<tr>
<th>Persons Involved (Check all that apply)</th>
<th>Location of Incident</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Clients</td>
<td>Residential</td>
</tr>
<tr>
<td>□ Staff</td>
<td>Inpatient</td>
</tr>
<tr>
<td>□ Persons Not Associated with Facility</td>
<td>Crisis Stabilization Unit (CSU)</td>
</tr>
<tr>
<td>□ Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Behavioral Health Adverse Occurrence (Check One)</th>
<th>Location of Incident</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Suicide Death</td>
<td></td>
</tr>
<tr>
<td>□ Non-Suicide Death</td>
<td></td>
</tr>
<tr>
<td>□ Death-Cause Unknown</td>
<td></td>
</tr>
<tr>
<td>□ Homicide</td>
<td></td>
</tr>
<tr>
<td>□ Homicide Attempt w/significant medical intervention</td>
<td></td>
</tr>
<tr>
<td>□ Suicide Attempt w/significant medical intervention</td>
<td></td>
</tr>
<tr>
<td>□ Allegation of Abuse/Neglect-Including Peer to Peer (Physical, Sexual, Verbal)</td>
<td></td>
</tr>
<tr>
<td>□ Medical Emergency (i.e., heart attack, medically unstable, etc.)</td>
<td></td>
</tr>
<tr>
<td>□ Accidental Injury w/significant medical intervention</td>
<td></td>
</tr>
<tr>
<td>□ Use of Restraints/Seclusion (Physical, Chemical, Mechanical) requiring significant medical intervention</td>
<td></td>
</tr>
<tr>
<td>□ Treatment Complications (medications errors and adverse medication reaction) requiring significant medical intervention</td>
<td></td>
</tr>
<tr>
<td>□ Elopement</td>
<td></td>
</tr>
</tbody>
</table>

Summary of Adverse Occurrence: (Be specific, precise and as detailed as possible)

<table>
<thead>
<tr>
<th>Summary of Action Taken by Facility/Provider:</th>
<th>Notified Parents or Next of Kin</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Notified 911</td>
<td>□ Reported to DHS</td>
</tr>
<tr>
<td>□ Taken to Physician</td>
<td>□ Reported to DCS</td>
</tr>
<tr>
<td>□ Taken to Hospital</td>
<td>□ Other</td>
</tr>
<tr>
<td>□ Notified Fire Department</td>
<td></td>
</tr>
</tbody>
</table>
MCO USE ONLY
Summary of MCO follow up actions to address reported adverse occurrence: (Please be specific, precise and detailed as possible)

FAX TO:
UnitedHealthcare Community Plan 1-888-785-1434
AmeriGroup 1-877-423-9976
BlueCare/TCS 1-866-259-0203
Medicaid Reclamation Claim Refund Form

AMERIGROUP MEDICAID RECLAMATION REFUND REQUEST FORM

This form should be used by a provider to obtain payment for services rendered when:

- Amerigroup obtained payment from the Third Party Liability (TPL),
- Amerigroup subsequently recouped payments from the provider, and
- The above actions resulted in the denial of payment to the provider from the TPL, leaving the provider without payment.

**General Information:**

Provider Name/Contact ____________________________________________________________

Contact Number ___________________________________________________________________

Provider ID _________________________ Provider Tax ID ________________________________

Subscriber ID _____________________________________________________________________

Member Name ________________________________________________________________

Member Account Number __________________________________________________________

**Primary Insurance Information:** (Provide as much information as possible to expedite processing.)

Primary Insurance Name ____________________________ Member ID# ______________________

Amount Paid to Amerigroup $______________ Check # __________ Check Date ___/___/____

Total Check Amount $______________ Date Check Cleared _____/____/____

(Attach copy of check if able to obtain from the TPL Carrier)

**Refund Information:**

Amerigroup Claim Number ________________________________

Total Billed Charges $______________ Date of Service _____/____/____

Dollar Amount Due Provider to be refunded by Amerigroup $__________________________

Brief Description of Situation: ____________________________________________________

_____________________________________________________________________________

I hereby certify that the information provided above is correct and that Provider is due amount indicated.

Signature __________________________________________ Date _____/____/____

**Mail to:** [Amerigroup Community Care

P.O. Box 933657

Atlanta, GA 31193-3657]

This form is not to be used to obtain additional payments from Amerigroup to satisfy the provider’s contracted rate with the other carrier. Any payments made to Amerigroup by the other carrier greater than Amerigroup’s original payment to the provider will be repaid to the other carrier, not the provider.
TENNCARE DISCRIMINATION COMPLAINT

Federal and State laws do not allow the TennCare Program to treat you differently because of your race, color, birthplace, disability/handicap, age, sex, religion, or any other group protected by law. Do you think you have been treated differently for these reasons? Use these pages to report a complaint to TennCare.

The information marked with a star (*) must be answered. If you need more room to tell us what happened, use other sheets of paper and mail them with your complaint.

1. * Write your name and address.

Name:

__________________________________________

Address: _________________________________________________________

__________________________________________ Zip __________

Telephone: Home: (____) __________ Work or Cell: (____) __________

Email Address: __________________________________________

Name of MCC/Health Plan: _______________________________

2. * Are you reporting this complaint for someone else? Yes: ______ No: _______

If Yes, who do you think was treated differently because of their race, color, birthplace, disability/handicap, age, sex, religion, or any other group protected by law?

Name: _________________________________________________________

Address: _________________________________________________________

__________________________________________ Zip __________

Telephone: Home: (____) __________ Work or Cell: (____) __________

How are you connected to this person (wife, brother, friend)?

__________________________________________________________

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Name of this person’s MCO/Health Plan:

3.* Which part of the TennCare Program do you think treated you in a different way:
Medical Services____ Dental Services____ Pharmacy Services____
Long-Term Services & Supports____ Eligibility Services____ Appeals____

4.* How do you think you were you treated in a different way? Was it your
Race____ Birthplace____ Color____ Sex____ Age____
Disability/Handicap____ Religion____ Other__________________________

5. What is the best time to talk to you about this complaint?

______________________________________________________________

6.* When did this happen to you? Do you know the date?
Date it started: _________________
Date of the last time it happened: _________________

7. Complaints must be reported by 6 months from the date you think you were treated in a
different way. You may have more than 6 months to report your complaint if there is a good
reason (like a death in your family or an illness) why you waited.

______________________________________________________________

______________________________________________________________
8. **What happened?** How and why do you think it happened? Who did it? Do you think anyone else was treated in a different way? You can write on more paper and send it in with these pages if you need more room.

9. **Did anyone see you being treated differently?** If so, please tell us their:

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Telephone</th>
</tr>
</thead>
</table>

10. **Do you have more information you want to tell us about?**

11. **We cannot take a complaint that is not signed.** Please write your name and the date on the line below. Are you the Authorized Representative of the person who thinks they were treated differently? Please sign your name below. As the Authorized Representative, you must have proof that you can act for this person. If the patient is less than 18 years old, a parent or guardian should sign for the minor. **Declaration:** *I agree that the information in this complaint is true and correct and give my OK for TennCare to investigate my complaint.*

(Sign your name here if you are the person this complaint is for)  (Date)

(Sign here if you are the Authorized Representative)  (Date)

Are you reporting this complaint for someone else but you are **not** the person’s Authorized Representative? Please sign your name below. **The person you are reporting this complaint for must sign above or must tell his/her health plan or TennCare that it is okay for them to sign for him/her. Declaration:** *I agree that the information in this complaint is true and correct and give my OK for TennCare to contact me about this complaint.*

(Sign here if you reporting this for someone else)  (Date)

Are you a helper from TennCare or the MCO/Health Plan assisting the member in good faith with the completion of the complaint? If so, please sign below:
are either a helper from TennCare or the MCO/Health Plan) (Date)

It is okay to report a complaint to your MCO/Health Plan or TennCare. Information in this complaint is treated privately. Names or other information about people used in this complaint are shared only when needed. Please mail a signed Agreement to Release Information page with your complaint. If you are filing this complaint on behalf of someone else, have that person sign the Agreement to Release Information page and mail it with this complaint. Keep a copy of everything you send. Please mail or email the completed, signed Complaint and the signed Agreement to Release Information pages to us at:

HCFA, Office of Civil Rights Compliance
310 Great Circle Road; Floor 3W • Nashville, TN 37243
615-507-6474 or for free at 855-857-1673
Free / gratis TRS Call / llame 711 Ask / pregunt e 855-857-1673
HCFA.fairtreatment@tn.gov

You can also call us if you need help with this information.
TennCare Agreement to Release Information

To investigate your complaint, TennCare and your MCO/Health Plan may need to tell other persons or agencies important to this complaint your name or other information about you.

To speed up the investigation of your complaint, read, sign, and mail one copy of this Agreement to Release Information with your complaint. Please keep one copy for yourself.

• I understand that during of the investigation of my complaint TennCare and ______________________ (write name of your MCO/Health Plan on the line) may need to tell people my name or other information about me to other persons or agencies. For example, if I report that my doctor treated me in a different way because of my color, my MCO/Health Plan may need to talk to my doctor.

• You do not have to agree to release your name or other information. It is not always needed to investigate your complaint. If you do not sign the release, we will still try to investigate your complaint. But, if you don’t agree to let us use your name or other details, it may limit or stop the investigation of your complaint. And, we may have to close your case. However, before we close your case if your complaint can no longer be investigated because you did not sign the release, we may contact you to find out if you want to sign a release so the investigation can continue.

If you are filing this complaint for someone else, we need that person to sign the Agreement to Release Information. Are you signing this as an Authorized Representative? Then you must also give us a copy of the documents appointing you as the Authorized Representative.

By signing this Agreement to Release Information, I agree that I have read and understand my rights written above. I agree to TennCare telling people my name or other information about me to other persons or agencies important to this complaint during the investigation and outcome.

By signing this Agreement to Release Information, I agree that I have read and understand my rights written above. I agree to my MCO/Health Plan telling people my name or other information about me to other persons or agencies important to this complaint during the investigation and outcome.

This Agreement to Release Information is in place until the final outcome of your complaint. You may cancel your agreement at any time by calling or writing to TennCare or to your MCO/Health Plan without canceling your complaint. If you cancel your agreement, information already shared cannot be made unknown.

Signature: ___________________________ Date: ___________________________

Name (Please print): ___________________________

Address: ___________________________

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Telephone: 

Need help? Want to report a complaint? Please contact or mail a completed, signed Complaint and a signed Agreement to Release Information form:

HCFA OCRC Phone: 1-615-507-6474 or for free at 1-855-857-1673
310 Great Circle Road, 3W For free TRS dial/llamar al 711 and ask for 855-857-1673
Nashville, TN 37243 Email: HCFA.fairtreatment@tn.gov

**Do you need free help with this letter?**

If you speak a language other than English, help in your language is available for free. This page tells you how to get help in a language other than English. It also tells you about other help that’s available.

**Spanish:**


**Kurdish:**

بەژمەنییەیە: ئەگەر چەکەیەت، خەڵکی زەمانەکانی یارەکەیەنەی زەمانەکان، بەهەمانەیە، تەنەبەیەتەکەی، یەکەیە لەسەر TTY (1-800-848-0298) 1-855-259-0701

**Arabic:**

ملاحظة: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجانية. اتصل بقم 1-855-857-1673 (TTY 1-800-848-0298.)

**Chinese:**

注意：如果您使用繁体中文，您可以免费获得语言援助服务。请致电 1-855-259-0701
(TTY 1-800-848-0298).

**Vietnamese:**


**Korean:**


**French:**


**Amharic:**

አማርኛ: የሚመራውን ከማይነት ከማይበሻ ከርሱ የሚመራው ከፋዳር ይርጫው። በፋዳር ይርጫውፋዳር ይርጫውፋዳር ይርጫውፋዳር ይርጫ ይርጫውፋዳር ይርጫውፋዳር ይርጫውፋዳር ይርጫ ከፋዳር ይርጫውፋዳር ይርጫውፋዳር ይርጫ ይርጫ 1-855-259-0701 (መክስ ይርጫ ይርጫ ይርጫ ይርጫ ይርጫ ይርጫ 1-800-848-0298).

**Gujarati:**

સુસમાન: જે તમે ગુજરાતી બોલતા હો, તો નિશ્ચત કરાશે સફળ સેવાઓ તમારા માટે ઉપલબ્ધ છે. કોલ કરો 1-855-259-0701 (TTY: 1-800-848-0298).
<table>
<thead>
<tr>
<th>Language</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laotian</td>
<td>អាសយដ្ឋាន ដុំ និង នាយ ស្រស់ នៃ ទិន្នន័យ, ទូរស័ព្ទ និង សម្រាប់ការ ស្វែងរក និង បំបែក ដំណើរការ, លេខទូរស័ព្ទ ខ្មែរ និង លេខទូរស័ព្ទ ក្នុងតំបន់ ជាច្រើន ទៀត ។ ដូរឈ្នះ 1-855-259-0701 (TTY: 1-800-848-0298).</td>
</tr>
<tr>
<td>Hindi</td>
<td>व्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में माया ग्राहकता सेवाएं उपलब्ध हैं। 1-855-259-0701 (TTY: 1-800-848-0298) पर कॉल करें।</td>
</tr>
<tr>
<td>Nepali</td>
<td>नेपाली व्यान दें: नेपाली बोलनेवाले भवन तपाईले नेपाली भाषा सहायता सेवाहरू लिने। युवा रूपमा उपलब्ध छ। 1-855-259-0701 (टिडिवाइड़: 1-800-848-0298)।</td>
</tr>
</tbody>
</table>

- Do you need help talking with us or reading what we send you?
- Do you have a disability and need help getting care or taking part in one of our programs or services?
- Or do you have more questions about your health care?

Call us for free at 1-855-259-0701. We can connect you with the free help or service you need.
(For TTY call: 1-800-848-0298)
TENNCARE QUEJA DE DISCRIMINACIÓN

Las leyes federales y estatales no permiten que el Programa TennCare lo trate de manera diferente debido a su raza, color de la piel, lugar de nacimiento, discapacidad, edad, sexo, religión o cualquier otro grupo protegido por la ley. ¿Piensa que ha sido tratado de manera diferente por estas razones? Use estas hojas para presentar una queja a TennCare.

Es obligatorio proporcionar la información marcada con un asterisco (*). Si necesita más espacio para decírnos lo que pasó, use otras hojas de papel y envíelas con su queja.

1.* Escriba su nombre y dirección.

Nombre: ________________________________

Dirección: ________________________________

_______________________________ Código postal _________________

Teléfono: Hogar: (____) ___________________ Trabajo o Celular: (____) ___________________

Dirección de correo electrónico: ________________________________

Nombre del MCO/plan de seguro médico: ________________________________

2.* ¿ Está usted presentando esta queja en nombre de otra persona? Sí: ______  No: ______

Si respondió Sí, ¿quién piensa usted que fue tratado de manera diferente debido a su raza, color de la piel, lugar de nacimiento, discapacidad, edad, sexo, religión o cualquier otro grupo protegido por la ley?

Nombre: ________________________________

Dirección: ________________________________

_______________________________ Código postal _________________

Teléfono: Hogar: (____) ___________________ Trabajo o Celular: (____) ___________________
¿Qué relación tiene usted con esta persona (cónyuge, hermano, amigo)?

Nombre del MCO/plan de seguro médico de esa persona:

3. ¿Cuál parte del Programa TennCare cree que lo trató de una manera diferente?
   Servicios médicos ______ Servicios dentales ______ Servicios de farmacia ______
   Servicios y apoyos de largo plazo ______ Servicios de elegibilidad ______ Apelaciones ______

4. ¿Por qué cree que lo trataron de una manera diferente? Fue a causa de su
   Raza ______ Lugar de nacimiento ______ Color de la piel ______ Sexo ______ Edad ______
   Discapacidad ______ Religión ______ Otra cosa ____________________________

5. ¿Cuál es la mejor hora para llamarlo acerca de esta queja?

6. ¿Cuándo sucedió esto? ¿Sabe la fecha?
   Fecha en que comenzó: __________________
   Última fecha en que sucedió: __________________

7. Las quejas deben reportarse no más de 6 meses de la fecha en que piensa que fue tratado
de una manera diferente. Si tiene una causa justificada (como enfermedad o fallecimiento en la
familia), puede reportar su queja más de 6 meses después.

   ____________________________________________

   ____________________________________________

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8. ¿Qué sucedió? ¿Cómo y por qué piensa que pasó? ¿Quién lo hizo? ¿Piensa que alguna otra persona también fue tratada de una manera diferente? Si necesita más lugar, puede escribir en otra(s) hoja(s) y enviarlas con estas hojas.

9. ¿Alguien vio cómo lo trataban de una manera diferente? Si es así, por favor, proporcione la siguiente información sobre esa persona:

<table>
<thead>
<tr>
<th>Nombre</th>
<th>Dirección</th>
<th>Teléfono</th>
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</table>

10. ¿Tiene usted más información que nos desee dar?

11. *No podemos aceptar ninguna queja que no esté firmada.* Por favor, escriba su nombre y la fecha en la línea de abajo. ¿Es usted el Representante Autorizado de la persona que piensa que fue tratada de manera diferente? Firmé abajo. Como el Representante Autorizado, usted debe tener un comprobante de que puede actuar en nombre de esta persona. Si el paciente es menor de 18 años de edad, uno de los padres o tutor debe firmar en su nombre. **Declaración:** Declaro que la información presentada en esta queja es verídica y correcta y doy mi autorización para que TennCare investigue mi queja.

(Firme aquí si usted es la persona de quien trata esta queja)  
(Firme aquí si usted es el Representante Autorizado)  

¿Está usted reportando esta queja en nombre de otra persona pero usted no es el Representante Autorizado de la persona? Firmé abajo. La **persona para quien usted está reportando esta queja debe firmar arriba o debe decirle a su plan de seguro médico o a TennCare que está bien que él/ella firme en su lugar.** **Declaración:** Afirmo que la información contenida en esta
queja es verdadera y correcta y doy mi permiso para que TennCare se comunique contigo acerca de esta queja.

(Firme aquí si está reportando en nombre de otra persona)  (Fecha)

¿Es usted ayudante de TennCare o del MCO/plan de seguro médico y está ayudando al miembro de buena fe a presentar la queja? Si es así, por favor firme abajo:

(Firme aquí si usted es ayudante de TennCare o del MCO/plan de seguro médico)  (Fecha)

Está bien que reporte una queja a su MCO/plan de seguro médico o a TennCare. La información contenida en esta queja se trata de manera privada. Los nombres y otros datos sobre las personas que aparecen en esta queja sólo se divulgan cuando es necesario. Por favor, envíe una hoja de Autorización para Divulgar Información con su queja. Si está presentando esta queja en nombre de otra persona, pídale a la persona que firme la hoja de Autorización para Divulgar Información y envíela por correo con esta queja. Conserve una copia de todo lo que envíe. Envíe las hojas firmadas de la Queja y la Autorización para Divulgar Información a:

HCFA OCRC
310 Great Circle Road, 3rd Floor
Nashville, TN 37243
Teléfono: 1-615-507-6474 o gratis en el 1-855-857-1673
Para TTY gratis, marque el 711 y pida el 1-855-857-1673
Correo electrónico: HCFA.fairtreatment@tn.gov

También puede llamarnos si necesita ayuda con esta información.
TennCare Autorización para Divulgar Información

Para investigar su queja, es posible que TennCare y su MCO/plan de seguro médico tengan que divulgar su nombre u otra información sobre usted a otras personas o agencias importantes en esta queja.

Para acelerar la investigación de su queja, lea, firme y envíe por correo una copia de esta Autorización para Divulgar Información, con su queja. Por favor, conserve una copia para usted.

• Entiendo que durante la investigación de mi queja TennCare y
  (escriba en la línea el nombre de su MCO/plan de seguro médico) posiblemente tengan que dar mi nombre u otra información sobre mí a otras personas o agencias. Por ejemplo, si reporto que mi doctor me trató de manera diferente debido al color de mi piel, es posible que mi MCO/plan de seguro médico tenga que hablar con mi doctor.

• Usted no tiene que estar de acuerdo en divulgar su nombre u otra información. No siempre se necesita para investigar una queja. Aunque no firme la autorización trataremos de investigar su queja. Pero, si usted no está de acuerdo en permitirnos usar su nombre u otros detalles, eso podría limitar o detener la investigación de su queja. Y, tal vez tengamos que cerrar su caso. Sin embargo, antes de cerrar su caso, si no podemos seguir investigando su queja porque usted no firmó la autorización, podríamos comunicarnos con usted para preguntarle si quiere firmar una autorización para que la investigación pueda continuar.

Si usted está presentando esta queja para otra persona, necesitamos que esa persona firme la Autorización para Divulgar Información. ¿Está firmando esto en la capacidad de Representante Autorizado? Si es así, también debe darnos una copia de los documentos que lo nombran como Representante Autorizado.

Al firmar esta Autorización para Divulgar Información, acepto que he leído y entiendo mis derechos dispuestos anteriormente. Yo autorizo a TennCare para que dé mi nombre u otra información sobre mí a otras personas o agencias importantes en esta queja durante la investigación y el resultado.

Al firmar esta Autorización para Divulgar Información, acepto que he leído y entiendo mis derechos dispuestos anteriormente. Yo autorizo a mi MCO/plan de seguro médico que dé mi nombre u otra información sobre mí a otras personas o agencias importantes en esta queja durante la investigación y el resultado.

TC 0136 (REV. 4-15)

RDA-11078
Esta Autorización para Divulgar Información tiene vigencia hasta el resultado final de su queja. Usted puede cancelar su autorización en cualquier momento llamando o escribiendo a TennCare o a su MCO/plan de seguro médico sin cancelar su queja. Si cancela su autorización, la información ya divulgada no se puede hacer desconocer.

Firma: __________________________ Fecha: __________________________

Nombre (en letra de imprenta): ______________________________________

Dirección: ________________________________________________________

Teléfono: _________________________________________________________

¿Necesita ayuda? ¿Quieres reportar una queja? Por favor llame o envíe una queja y una Autorización para Divulgar Información completadas y firmadas a:

HCFA OCRC Teléfono: 1-615-507-6474 o gratis en el 1-855-857-1673
310 Great Circle Road, 3rd Floor Para TTY gratis, marque el 711 y pida el 855-857-1673
Nashville, TN 37243 Correo electrónico: HCFA.fairtreatment@tn.gov

¿Necesita ayuda gratuita con esta carta?

Si usted habla un idioma diferente al inglés, existe ayuda gratuita disponible en su idioma. Esta página le indica cómo obtener ayuda en otro idioma. Le indica también sobre otras ayudas disponibles.

Spanish: Español

Kurdish: کوردی
کوردی‌واره‌یی کوردی به زمانی کوردی، خزمه‌گزاری‌های کوردی، بهترین زبان، به‌کاربرد، به‌تو، برده‌سپانه.

Arabic: العربية
تمحور: أنتم تتحدث لغة أخرى، فإن خدمات المساعدة اللغوية توافر لك بالسماح. اتصل برقم 1-855-259-0701 (1-800-848-0298).

Chinese: 繁體中文
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-259-0701 (TTY 1-800-848-0298)。

Vietnamese: Tiếng Việt
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.

Korean: 한국어
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<tr>
<th>Language</th>
<th>Language Name</th>
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<tbody>
<tr>
<td>Gujarati</td>
<td>ગુજરાતી</td>
<td>ગુજરાતી લોકોએ તેમાં માનસિક સંબંધ સામર્થ્ય સેવાઓને તમારા માટે ઉપલબ્ધ છે. તમે 1-855-259-0701 (TTY: 1-800-848-0298).</td>
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<td>Hindi</td>
<td>हिंदी</td>
<td>वर्तमान में यह हिंदी बोलने हैं तो आपके लिए मुफ्त में भाषा सहायता में बनाए उपलब्ध हैं। 1-855-259-0701 (TTY: 1-800-848-0298) पर कॉल करें।</td>
</tr>
<tr>
<td>Russian</td>
<td>Русский</td>
<td>ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-259-0701 (телефон: 1-800-848-0298).</td>
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<tr>
<td>Nepali</td>
<td>नेपाली</td>
<td>ध्यान दिनुहोस्: नेपाली बोलनेले नेपाली लोकहरूनु पनि तपाईंले भने तपाईंलाई भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। फोन 1-855-259-0701 (टिकियाक: 1-800-848-0298).</td>
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TC 0136 (REV. 4-15)    RDA-11078
• ¿Necesita ayuda para hablar con nosotros o para leer lo que le enviamos?
• ¿Tiene alguna discapacidad y necesita ayuda para su cuidado o para tomar parte en uno de nuestros programas o servicios?
• ¿O tiene más preguntas sobre su atención médica?

Llámenos gratis al 1-855-259-0701. Podemos conectarlo con la ayuda o servicio gratuito que necesite.
(Para el sistemaTTY (Para los sordos) llame al: 1-800-848-0298)
APPENDIX B — CLINICAL PRACTICE GUIDELINES

Based on the health care needs of the member population and opportunities for improvement identified through the QM program, clinical practice and preventive health guidelines are adopted by the health plan. These guidelines are reviewed, revised and approved at least every two years using nationally recognized evidenced-based literature and developed through a collaborative review process. This review process involves both board-certified and credentialing network practitioners from appropriate specialties and internal medical directors. The guidelines are available online at https://providers.amerigroup.com/TN.

We continuously look for ways to assist you in improving the care provided to your Amerigroup patients. As the CPGs tend to be updated more frequently than the provider manual, having them available online ensures you will always be able to access the most current information. A full copy of the manual can also be downloaded from the provider website.
APPENDIX C — TENNCARE REGULATORY REQUIREMENTS

Amerigroup will not reimburse providers based on automatic escalators or linkages to other methodologies that escalate, such as current Medicare rates or inflation indexes, unless otherwise allowed by TennCare as specified in Section 2.13.2.2 of the CRA.

Additional provider requirements are set forth in this Appendix. Contracting providers agree to comply with the language requirements set forth in the Medicaid Addendum in addition to the provisions of their Amerigroup Participating Provider Agreement. Required language can be updated by inclusion in the provider manual as referenced in Article II Section 2.2 of the Amerigroup Participating Provider Agreement. If any requirement in this Appendix conflicts with a provision of the Amerigroup Participating Provider Agreement, the terms of the Amerigroup Participating Provider Agreement shall govern, unless the provider manual terms are mandated by a program.

Provider Base Agreement
AMERIGROUP Tennessee, Inc.
d/b/a AMERIGROUP Community Care
PARTICIPATING PROVIDER AGREEMENT

THIS PARTICIPATING PROVIDER AGREEMENT (this "Agreement") is made by and between Amerigroup Tennessee, Inc. d/b/a Amerigroup Community Care ("Amerigroup") and the undersigned Provider ("Provider"), effective as of the date set forth immediately below Amerigroup’s signature (the "Effective Date").

RECITALS:

A. Amerigroup is authorized to arrange for the provision of managed health care services to Covered Persons as more fully set forth in this Agreement.

B. Provider is authorized in the State of Tennessee to provide Covered Services to Covered Persons.

C. Amerigroup and Provider mutually desire to enter into an agreement whereby Provider provides the Covered Services in the selected Programs contemplated herein to Covered Persons pursuant to the terms and conditions contemplated below.

AGREEMENT:

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Amerigroup and Provider agree as follows:

ARTICLE I
DEFINITIONS

The following terms shall have the meanings set forth below pertaining to all Programs:

1.1 Agency. "Agency" means a federal, state or local agency, administration, board or other governing body with jurisdiction over the governance or administration of a Program.

1.2 Behavioral Health Care Services. "Behavioral Health Care Services" means Covered Services rendered for the treatment of mental health or drug and alcohol conditions. These include the diagnosis, evaluation, treatment, residential care, rehabilitation, counseling or supervision of persons who have a mental illness.

1.3 CMS. "CMS" means the Center for Medicare & Medicaid Services, an administrative agency within the United States Department of Health & Human Services ("HHS").

- 1 -

TN 2013 Global Model Private Agreement
Revised JAN 24 2018
1.4 **Clean Claim.** “Clean Claim” means a claim received by Amerigroup for adjudication, in a nationally accepted format in compliance with standard coding guidelines, and which requires no further information, adjustment, or alteration by the Provider of the services in order to be processed and paid by Amerigroup. The following exceptions apply to this definition: (a) a claim for payment of expenses incurred during a period of time for which premiums are delinquent; (b) a claim for which fraud is suspected; and (c) a claim for which a third party resource should be responsible.

1.5 **Covered Person.** “Covered Person” means a person who is an eligible Program beneficiary and who is enrolled as an Amerigroup member in accordance with applicable Program enrollment requirements.

1.6 **Covered Services.** “Covered Services” means those services that a Covered Person is entitled to receive through Amerigroup under the applicable benefit package for the Program in which the Covered Person is enrolled.

1.7 **Emergency Behavioral Health Condition.** “Emergency Behavioral Health Condition” means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine: (a) requires immediate intervention and/or medical attention without which Covered Persons would present an immediate danger to themselves or others, or (b) which renders Covered Persons incapable of controlling, knowing or understanding the consequences of their actions.

1.8 **Emergency Medical Condition.** “Emergency Medical Condition” means a physical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part. This definition of “Emergency Medical Condition includes any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine: (a) requires immediate intervention and/or medical attention without which Covered Persons would present an immediate danger to themselves or others, or (b) which renders Covered Persons incapable of controlling, knowing or understanding the consequences of their actions.

1.9 **Emergency Services.** “Emergency Services” means inpatient and outpatient Covered Services that are (1) furnished by a provider that is qualified to furnish these services; and (2) needed to evaluate or stabilize an Emergency Medical Condition. Emergency Services are Covered Services under this Agreement.

1.10 **Participating Provider.** “Participating Provider” or “Provider” means a person or entity that (a) is party to a participation agreement with Amerigroup to provide Covered Services to Covered Persons, or is an employee or subcontractor of a Participating Provider and will be furnishing Covered Services hereunder; and (b) has met all applicable Amerigroup
credentialing requirements for the services the Participating Provider provides. The definition of “Participating Provider” includes, but is not limited to, Provider.

1.11 Program. “Program” means the terms of coverage under an applicable benefit contract for which an Addendum and Attachment A is incorporated into this Agreement setting forth the Providers’ reimbursement for a respective Program. Subject to the above sentence, “Program” may mean any Medicaid managed care program (“Medicaid”), a state or local Child Health Insurance Program (“CHIP”), a Medicare program (“Medicare”), any successor programs thereto, any dual program, or commercial program, or any other state or federal program (i.e., exchanges) under which Amerigroup has authority to arrange for services for Covered Persons.

1.12 Program Contract. “Program Contract” means the contract between Amerigroup and an applicable party, such as an Agency or a Program beneficiary, which governs the delivery of managed health care services to Program beneficiaries.

1.13 Provider Manual. “Provider Manual” means the Amerigroup provider manual which has been supplied to Provider and which is in effect as of the Effective Date and includes, but is not limited to, procedures regarding Covered Person grievance and appeals, quality improvement and utilization management policies and procedures. “Provider Manual” also includes updates and amendments to the Amerigroup provider manual.

1.14 Regulatory Requirements. Provider shall be familiar with and in compliance with all applicable regulatory requirements. These include, but are not necessarily limited to, enacted statutes, adopted regulations, court orders and Contractor Risk Agreement Provisions and/or CMS contract provisions. Any such Regulatory Requirements are incorporated by reference into the Agreement.

ARTICLE II
AMERIGROUP OBLIGATIONS TO ALL PROGRAMS

2.1 Identification Cards. Amerigroup shall issue each Covered Person an Identification Card reflecting the Covered Person’s name, the Covered Person’s Primary Care Physician, the Covered Person’s Amerigroup identification number, telephone contact information and such other information as required by an Agency. A sample Identification Card will be provided upon request of Provider and is also available in the Provider Manual.

2.2 Provider Manual. Amerigroup shall make available to Provider the applicable Provider Manual(s) referencing Amerigroup’s policies and procedures for each Program. Provider shall comply with the terms of the Provider Manual(s) and all Amerigroup policies and procedures referenced or communicated to Provider by Amerigroup. Amerigroup shall provide Provider with at least thirty (30) days prior written notice of any material modifications to the Provider Manual(s) or other applicable policies and procedures affecting reimbursement, unless otherwise required by a Program. In the event of a conflict between the terms of this
Agreement and the Provider Manual(s), the terms of this Agreement shall govern, unless the Provider Manual terms are mandated by a Program.

2.3 Provider Listing; Marketing/Advertising. Amerigroup shall be entitled to use the name(s), business address (es), and phone number(s) of Provider including any individual Participating Provider employed by or under contract with Provider to provide services hereunder. Amerigroup shall be entitled to use information related to any such individual Participating Provider’s education, specialty, subspecialty, licensure, certification and hospital affiliation for the purposes described above. Provider shall be permitted to use Amerigroup’s name for purposes of identifying Provider as a Participating Provider in Amerigroup’s provider network.

2.4 Credentialing. Amerigroup shall review and approve the credentials of Provider and all Participating Providers providing services hereunder on behalf of Provider in accordance with Amerigroup credentialing and recredentialing criteria. Notwithstanding the execution of this Agreement or the stated Effective Date of this Agreement, Amerigroup must confirm Provider’s compliance with each of Amerigroup’s credentialing requirements applicable to the Providers’ area of practice prior to any individual provider being designated as a Participating Provider in Amerigroup’s provider network, or with respect to recredentialing, maintaining such designation as a Participating Provider. Until such time as Provider or any provider authorized by the terms of this Agreement to furnish services under this Agreement has been determined to have fully met Amerigroup’s credentialing requirements, such Provider or such other providers shall not be entitled to the benefits of participation under this Agreement, including, without limitation, the reimbursement rates set forth in any Attachment A hereto.

2.5 Affiliate Services. Provider acknowledges that Amerigroup is affiliated with health plans that offer similar benefits under similar programs as the Programs covered hereunder (“Affiliates”). The parties acknowledge that Provider is not a Participating Provider for purposes of rendering services to members of Affiliates who are covered pursuant to such programs, but recognize the benefit of a mutual understanding as to the care of such members. In the event that Provider treats a member of an Affiliate, Provider shall accept as payment in full the rates established by the Affiliate or the Affiliate’s state program governing care to those out-of-state members. Such services must be covered services under the applicable Program, and shall require prior authorization, except for emergency services and services for which a member is entitled to self-refer under the applicable Program. Upon request, Amerigroup shall coordinate between Provider and the applicable Affiliate for any member of an Affiliate that receives services from Provider to ensure appropriate payment and to provide Provider with information needed to appropriately render and bill for services under the applicable Program. Provider must be eligible and/or make available any state required documentation in order to be reimbursed from a state agency.
2.6 Representations and Warranties.

(a) Amerigroup Status. Amerigroup hereby represents and warrants that Amerigroup: (i) has the power and authority to enter into this Agreement; (ii) is not in violation of any licensure or accreditation requirement applicable to Amerigroup under Regulatory Requirements; (iii) has not been convicted of bribery or attempted bribery of any official or employee of the jurisdiction in which Amerigroup operates, nor made an admission of guilt of such conduct which is a matter of record; (iv) qualifies to participate in a Program as of the date on which Provider may furnish Covered Services hereunder for such Program; and (v) is not, to Amerigroup’s best knowledge, the subject of an inquiry or investigation that could foreseeably result in Amerigroup failing to comply with the representations in subsections (i) – (iv) above.

(b) Disclosure Reporting. Amerigroup, as well as its subcontractors and providers, whether contract or non-contract shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Agreement shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and TennCare policies and procedures, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, within thirty five (35) days after any change in ownership of the disclosing entity, at least once every three (3) years, and at any time upon request. For providers, this requirement may be satisfied through TENNCARE’s provider registration process.

(c) Amerigroup Screenings. Amerigroup, as well as its subcontractors and providers, whether contracted or not contracted, shall comply with all federal requirements (42 CFR Section 1002) on exclusion and debarment screening. All tax reporting provider entities that bill and/or receive TennCare funds as the result of this Agreement shall screen their owners and employees against the Social Security Master Death File, the General Services Administration (GSA) System for Award Management (SAM) and the HHS-OIG List of Excluded Individuals/Entities (LEIE). Any unallowable funds made to an excluded individual as full or partial wages and/or benefits shall be refunded to and/or returned to the State and/or Amerigroup dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

ARTICLE III
PROVIDER OBLIGATIONS TO ALL PROGRAMS

3.1 Provider Services. Provider shall provide to Covered Persons those Medically Necessary Covered Services within the scope of Provider’s licensure, expertise, and usual and customary range of services pursuant to the terms and conditions of this Agreement, and shall be responsible to Amerigroup for its performance hereunder. (a) If Provider is a Physician: To the extent mandated by Regulatory Requirements, Provider shall ensure that Covered Persons have access to 24 hour-per-day, 7 day-per-week urgent and emergency services. Provider shall
not discriminate in any Program in the acceptance of Amerigroup Covered Persons for treatment, and shall provide to Covered Persons of each Program the same access to services as Provider gives to all other patients. (b) If Provider is a Facility: Provider shall render timely and appropriate Medically Necessary services to treat an Emergency Medical Condition affecting a Covered Person, and shall comply with all applicable law related to the post-stabilization care of a Covered Person after an Emergency Medical Condition has been stabilized. Provider shall use its best efforts to notify Amerigroup at the time of eligibility verification or by the end of the next business day after admission and identification of a Covered Person as an inpatient, or after rendition of emergency outpatient Covered Services to a Covered Person. Notwithstanding any provision contained in this Agreement, no notification to, or coverage verification or pre-authorization from, Amerigroup is required prior to Provider rendering Medically Necessary services to treat an Emergency Medical Condition to a Covered Person. Under such circumstances, if a Covered Person’s condition cannot be treated at Provider in its facilities, Provider shall arrange for the services of an alternate Participating Hospital; provided, however, that in the event obtaining the services of an alternate Participating Hospital is impractical, Provider shall arrange for the services by an appropriate non-participating hospital.

3.2 Licensure and Accreditation. At all times during the term of this Agreement, Provider shall (a) maintain in good standing all applicable licenses, certifications, registrations required for Provider to furnish services hereunder; (b) be certified to the extent required under the applicable Programs; and (c) maintain a National Provider Identification Number ("NPI") if required for Provider by applicable law. Provider shall ensure that each of Provider’s employees is duly licensed, certified or registered as required under a Program and applicable standards of professional ethics and practice. Provider shall have a process in place to screen Provider’s employees on a monthly basis to ensure that such employees are not excluded from participation in any Programs. Provider shall notify Amerigroup immediately following Provider’s receipt of any notice of any restrictions upon, including, but not limited to, any suspension or loss of, any such licensure, certification, registration, or accreditation, or of learning that Provider or Provider’s employee has been excluded from any Program. Provider shall submit to Amerigroup evidence of Provider’s satisfaction of the requirements set forth in this section upon Amerigroup’s request.

3.3 Covered Person Verification. Provider shall establish a Covered Person’s eligibility for services prior to rendering services, except in the case of an Emergency Medical Condition where such verification may not be possible. In the case of an Emergency Medical Condition, Provider shall establish a Covered Person’s eligibility as soon as reasonably practical. Amerigroup shall provide a system for Providers to contact Amerigroup to verify Covered Person eligibility 24 hours a day, 7 days per week. Nothing contained in this Agreement shall, or shall be construed to, require advance notice, coverage verification, or pre-authorization for emergency services provided in accordance with the federal Emergency Medical Treatment and Active Labor Act ("EMTALA") prior to Provider’s rendering such services.
3.4 **Provider Responsibility.** Amerigroup shall not be liable for, nor will it exercise control or direction over, the manner or method by which Provider provides health care services to Covered Persons. Provider acknowledges and agrees that Amerigroup may deny payment for Provider services rendered to a Covered Person which Amerigroup determines are not Medically Necessary, are not Covered Services pursuant to an applicable Program Contract, or are not otherwise provided or billed in accordance with this Agreement. Neither such a denial nor any action taken by Amerigroup pursuant to a utilization review, referral, discharge planning program or claims adjudication shall be construed as a waiver of Provider’s obligation to provide appropriate services to a Covered Person under applicable law and any code of professional responsibility. Nothing in this Agreement shall be construed as prohibiting any Participating Provider from discussing treatment or non-treatment options with Covered Persons, irrespective of whether such treatment options are Covered Services. Nothing in this Agreement shall, or shall be construed to, create any financial incentive for Provider to withhold Medically Necessary Covered Services.

3.5 **Rights of Participating Provider.** Nothing in the Agreement shall be construed as prohibiting any Participating Provider from advising or advocating on behalf of a member who is his or her patient for (a) the member’s health status, medical or behavioral health care, or treatment options, including alternative treatment that may be self-administered; (b) any information the member needs in order to decide among all relevant treatment options; (c) the risks, benefits and consequences of treatment or non-treatment; or (d) the member’s right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions.

3.6 **No Refusal to Provide Services.** Provider may not refuse to provide preventative or Medically Necessary Covered Services to a Covered Person under this Agreement for non-medical reasons. However, Provider shall not be required to accept or continue treatment of a Covered Person if Provider cannot establish and/or maintain a professional relationship with such Covered Person. If Provider has a valid reason he or she cannot establish and/or maintain a professional relationship with a Covered Person, the Provider may request to terminate the relationship in accordance with Amerigroup’s specific policy pertaining thereto.

3.7 **Compliance.** Provider shall participate in Amerigroup utilization management and care management programs designed to facilitate the coordination of health care services as referenced in the Provider Manual(s) for the Program(s). In addition, Provider shall participate and cooperate in any internal and external QM/QI with all Amerigroup, and external, Regulatory Requirements related to monitoring, credentialing, utilization management, quality assurance, grievances, peer review, coordination of benefits and third party liability.

3.8 **Concurrent Review.** Provider agrees to provide electronic, telephonic or direct access, and accommodation to Amerigroup employees and/or its designated agent or a third party contractor to review Covered Persons’ medical records and perform on-site concurrent review.
3.9 Insurance Coverage.

(a) **Coverage Requirements.** At all times during the term of this Agreement, Provider shall maintain professional liability insurance, including maintaining such tail or prior acts coverage necessary to avoid any gap in coverage for claims arising from incidents occurring during the term of this Agreement. Such insurance shall (i) be obtained from a carrier authorized to issue coverage in the jurisdiction in which Provider operates, except for permitted self-insurance; and (ii) maintain minimum policy limits equal to $1,000,000.00 per occurrence and $3,000,000.00 in the aggregate, or such other coverage amounts as prescribed by applicable Regulatory Requirements for a Program and consented to by Amerigroup. Provider shall maintain general liability insurance covering Provider’s premises, insuring Provider against any claim of loss, liability, or damage caused by or arising out of the condition or alleged condition of said premises, or the furniture, fixtures, appliances, or equipment located therein, and if Provider operates motor vehicles in connection with Provider’s services, with liability protection against any loss, liability or damage resulting from the operation of such motor vehicles by Provider, Provider’s employees or agents. Such general liability insurance shall contain commercially reasonable coverage limits, or such limits as prescribed by Regulatory Requirements for a Program. To the extent required by Regulatory Requirements, Provider shall maintain workers’ compensation insurance for Provider’s employees.

(b) **Evidence of Insurance.** Provider shall provide Amerigroup with evidence of Provider’s compliance with the foregoing insurance requirements annually, or as otherwise reasonably requested by Amerigroup. Provider shall provide Amerigroup with at least thirty (30) days prior written notice of any cancellation or non-renewal of any required coverage or any reduction in the amount of Provider’s coverage, and shall secure replacement coverage as needed to meet the requirements above so as to ensure no lapse in coverage. Provider shall furnish Amerigroup with a certificate of insurance evidencing such replacement coverage. Provider shall also furnish a certificate of insurance to a requesting Agency upon request. Provider may maintain professional liability coverage hereunder through a self-funded insurance plan, acceptable to Amerigroup, provided that it maintains actuarially sound reserves related to such self-funded plan and provides on an annual basis an opinion letter from an independent actuarial firm or other proof attesting to the financial adequacy of such reserves.

3.10 **Subcontracted Provider Requirements.** In the event that any Covered Services are performed for or on behalf of Provider by a subcontracted provider, Provider shall be responsible for ensuring that such subcontracted provider complies with all of Provider’s obligations under this Agreement including, without limitation, compliance with all applicable Regulatory Requirements, credentialing, as applicable and required insurance provisions of 42 CFR 438.230(b) and 42 CFR 434.6.

3.11 **Proprietary Information; Confidentiality.**

(a) The parties acknowledge and agree this agreement template, rate sheet template(s), provider manual(s) and provider updates are public records. The parties also
acknowledge and agree that all information related to Amerigroup programs, policies, protocols and procedures, and all information otherwise furnished to Provider in writing by Amerigroup as a result of this Agreement is proprietary. Provider agrees not to use such proprietary information except for the purpose of carrying out its obligations under this Agreement. Provider shall not disclose any proprietary information to any person or entity without Amerigroup’s express written consent, except pursuant to Regulatory Requirements or legal order, in which case Provider shall immediately notify Amerigroup of receipt of any such request for the disclosure, prior to the disclosure, and the extent to which such information is available in the public domain or was acquired by such party from a third party not bound to preserve the confidentiality of such information.

(b) Provider and Amerigroup shall each treat all information which is obtained through its respective performance under the Agreement as confidential information, including without limitation information that is confidential pursuant to 42 C.F.R. §422.118 and 45 C.F.R. Parts 160 and 164, as may be amended from time to time or other applicable law, and shall not use any information obtained except as necessary to the proper discharge of its obligations and securing of its rights hereunder. Provider and Amerigroup shall each have a system in place that meets all applicable Regulatory Requirements to protect all records and all other documents relating to this Agreement which are deemed confidential by law. Any disclosure or transfer of confidential information by Provider or Amerigroup will be in accordance with applicable Regulatory Requirements.

3.12 Representations and Warranties.

(a) Provider Status. Provider hereby represents and warrants that Provider: (i) has the power and authority to enter into this Agreement; (ii) is legally authorized to provide the services contemplated hereunder; (iii) is not in violation of any licensure or accreditation requirement applicable to Provider under Regulatory Requirements; (iv) has not been convicted of bribery or attempted bribery of any official or employee of the jurisdiction in which Provider operates, nor made an admission of guilt of such conduct which is a matter of record; (v) is capable of providing all data related to the services provided hereunder in a timely manner as reasonably required by Amerigroup to satisfy its internal requirements and Regulatory Requirements, including, without limitation, data required under the Health Employer Data and Information Set and National Committee for Quality Assurance requirements; (vi) qualifies to participate in each Program for which an Addendum and Attachment A is attached and incorporated hereto; and (vii) is not, to Provider’s best knowledge, the subject of an inquiry or investigation that could foreseeably result in Provider failing to comply with the representations in subsections (i) – (vi) above.

(b) Provider Information and Documentation. Provider represents and warrants that all information provided to Amerigroup is true and correct as of the date such information is furnished, and Provider is unaware of any undisclosed facts or circumstances that would make such information inaccurate or misleading. Provider shall immediately provide Amerigroup with written notice of any material changes to such information.
(c) Provider Screenings and Background Checks. Provider shall conduct criminal background checks and registry checks, which shall include a check of the Tennessee Abuse Registry, National and Tennessee Sexual Offender Registry, in accordance with state law and TennCare policy. Provider shall conduct a monthly screening of the HHS-OIG List of Excluded Individuals/Entities ("LEIE") and System for Award Management (SAM) to determine if any of its employees, agents, contractors or subcontractors has been excluded from participation in any program including, but not limited to, the Medicare, Medicaid, SCHIP, or other Federal health care program (as defined in Section 1128B(f) of the Social Security Act), or has been convicted of a health care-related criminal act. Provider shall document these in the worker’s employment record or otherwise maintain these records on volunteers, as applicable. Provider shall also verify that any persons required to have background checks, including registry checks, as applicable, who have been employed or have volunteered since direct support staff hired after the last credentialing visit have had criminal background checks, including registry checks, as applicable, performed. Provider shall not employ or contract with any individual or entity that has either been excluded from a program as determined above or who has been convicted of a health-care related criminal act, and shall immediately report its findings and determinations to Amerigroup and TennCare. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare members.

(d) If Provider is a “covered entity” as defined in 45 C.F.R. Section 160.103, Provider is required to comply with requirements regarding protection of certain protected health information in accordance with 45 C.F.R. Parts 160 and 164 as amended from time to time.

3.13 Reporting Fraud and Abuse. Provider shall cooperate with Amerigroup’s anti-fraud and abuse compliance program. If Provider identifies any actual or suspected fraud, abuse or misconduct in connection with the services rendered hereunder in violation of state or federal law, Provider shall immediately report such activity directly to the Chief Compliance Officer of Amerigroup or through the Compliance Hotline in accordance with the Provider Manual. Provider is not limited in any respect in reporting actual or suspected fraud, abuse, or misconduct to Amerigroup.

3.14 Laboratory Services. Provider shall comply with all requirements of the Clinical Laboratory Improvement Act ("CLIA"), regulations promulgated thereunder and any amendments and successor statutes and regulations thereto, and furnish written verification or Provider’s appropriate CLIA certification of registration or waiver and CLIA identification number. Provider shall notify Amerigroup within five (5) business days in writing of any changes in Provider’s CLIA certification status or the certification status of any laboratory facilities with which Provider conducts business related to Covered Persons.

3.15 Lobbying. By signing this Agreement, Provider certifies that federal funds have not been used for lobbying in accordance with 45 CFR Part 93 and 31 USC 1352. (See also TCA 3-6-101 et seq., 3-6-201 et seq., 3-6-301 et seq., and 8-50-505). Provider shall disclose any
lobbying activities using non-federal funds in accordance with and to the extent required by 45 CFR Part 93.

3.16 Business Associate Agreement. In the event Provider is not a "covered entity," as such term is defined in the HIPAA Regulations, a Business Associate Agreement shall be executed and made a part hereof. Provider acknowledges that if it is not a covered entity, Amerigroup is unable to disclose to Provider any protected health information regarding any Covered Person until a Business Associate Agreement is fully effective between the parties hereto.

3.17 Surety Bond Requirement. If Provider provides home health services or durable medical equipment, Provider shall comply with all applicable provisions of Section 4724(b) of the Balanced Budget Act of 1997, including, without limitation, any applicable requirements related to the posting of a surety bond.

ARTICLE IV
SUBMISSION, PROCESSING AND PAYMENT OF CLAIMS

4.1 Claims Submission. Provider shall submit claims in accordance with all applicable Regulatory Requirements and Amerigroup requirements on the applicable claims form set forth on each applicable Attachment A, or the electronic equivalent, as further described and referenced in the Provider Manual(s) of the Program(s). Provider shall submit claims information through electronic data interchange (EDI) that allows for automated processing and adjudication of claims, and shall use Amerigroup electronic interface systems for registration, eligibility and benefit verification and claims processing. Provider will use HIPAA compliant billing codes when billing or submitting encounter data and Amerigroup shall not pay any claims submitted using non-compliant billing codes. When billing codes are updated, Provider is required to use appropriate replacement codes for claims for Covered Services, regardless of whether this Agreement has been amended to reflect changes to standard billing codes. Clean Claims must be submitted within one hundred twenty (120) days following the date service is rendered or may be denied for payment by Amerigroup. Amerigroup will not deny Clean Claims for timely payment if the claims received after one hundred twenty (120) days from the date of service were timely filed with another payer because Provider was unable to determine that the patient was an Amerigroup Covered Person or the Provider believed that the patient was self-pay and subsequently learned that the patient was a Covered Person. In such event, Provider shall have one hundred twenty (120) day(s) to submit the claim to Amerigroup from the date Provider received a denial from the payer to which Provider submitted the claim or learned that the patient was a Covered Person.

4.2 Reimbursement.

(a) Program Reimbursement. Amerigroup shall pay claims for Covered Services for each Program in the amount set forth in the applicable Attachment A as payment in full for the Covered Services provided to Covered Person in the Program.
(b) Adjudication of Clean Claims; Payment of Interest. Amerigroup shall adjudicate a Clean Claim, in accordance with, and within the time frames set forth in the Regulatory Requirements applicable to each Program. If applicable, Amerigroup shall pay Provider interest on all Clean Claims that are not adjudicated within the applicable prompt pay period at the interest rate specified under the applicable Program. Such interest shall not apply if Provider files duplicate claims prior to the expiration of the adjudication timeframe.

4.3 Recoveries from Third Parties. Provider acknowledges and agrees that claims payments made by Amerigroup may be subject to Program requirements regarding third party liability. Provider shall cooperate with Amerigroup’s policies and procedures related to third party liability recovery when claims for services rendered by Provider to a Covered Person are related to an illness or injury for which a third party may be liable; including, without limitation, claims that may be covered by automobile insurance, workers’ compensation, other health insurance, or otherwise give rise to a claim for third party liability, coordination of benefits or subrogation (to the extent permitted by Regulatory Requirements). Provider shall cooperate with Amerigroup in connection with such recoveries, including executing appropriate documents reasonably requested by Amerigroup to enforce such claims or to assign payments to Amerigroup.

4.4 Right of Recoupment and Offset. Amerigroup shall be entitled to offset and recoup an amount equal to any overpayments or improper payments made by Amerigroup to Provider against any payments due and payable by Amerigroup to Provider under this Agreement in conformance with applicable law. Upon determination that any recoupment, improper payment, or overpayment is due from Provider to Amerigroup, Amerigroup shall first give Provider notice of recoupment and request reimbursement via check for such an overpayment. If reimbursement is not received within forty-five (45) days from the date of such notice, Amerigroup shall be entitled to offset such overpayment against other amounts due and payable by Amerigroup to Provider in accordance with applicable law.

Provider shall comply with the Affordable Care Act and TennCare policies and procedures regarding recovery of overpayments, including written notification to the Amerigroup and TennCare Office of Program Integrity (OPI) of overpayments identified by the provider and, when applicable, returning the overpayment to the Amerigroup within sixty (60) days from the date the overpayment is identified. Failure to return overpayment(s) within sixty (60) days from the date the overpayment(s) was identified may be a violation of state or federal law.

4.5 Providers-Preventable Conditions. Provider understands and agrees that no payment will be made to Provider by Amerigroup for any provider-preventable conditions which have been identified by an applicable Agency/Program or pursuant to Regulatory Requirements. In addition, Provider shall identify provider-preventable conditions that are associated with claims for services provided under a Program hereunder or with courses of
treatment furnished to Covered Persons for which payment under a Program would otherwise be available.

4.6 **Hold Harmless.** Provider agrees that in no event, including, but not limited to non-payment by Amerigroup, Amerigroup insolvency, or breach of this Agreement, shall Provider solicit or accept any surety or guarantee of payment from a Covered Person for Covered Services in excess of the amount of the contracted amount. For purposes of this section, “Covered Person” shall include the Covered Person, parent(s), guardian, spouse or any other legally responsible person of the Covered Person being served.

**ARTICLE V**

**RECORDS**

5.1 **Records.** Provider shall maintain medical, financial and administrative records regarding services provided to Covered Persons in accordance with industry standards and Regulatory Requirements, including without limitation applicable federal and state privacy and security provisions. Such records shall be retained by Provider for the period of time required under Regulatory Requirements applicable to each contracted Program more specifically set forth in the applicable Addendum. Provider shall provide Amerigroup and state and federal agencies electronic, telephonic or direct access to review records related to services provided hereunder for off-site review, or on-site at Provider’s facility, in accordance with Regulatory Requirements. Provider shall supply to Amerigroup the records described above at no charge.

5.2 **Record Transfer.** Provider shall cooperate in the transfer of Covered Persons’ medical records to other Participating Providers when required and shall assume the cost associated with the transfer. Following a Covered Person’s request for record transfer, Provider shall transfer such Covered Person’s medical records in Provider’s custody within fourteen (14) days following the request, or such other time period required under applicable Regulatory Requirements.

5.3 **Audits.** Provider shall permit Amerigroup or its designated agent or a third party contractor to audit records in order to determine the appropriateness of Covered Services and/or charges on a specific claim directly related to services provided to Covered Persons, either by providing such records to Amerigroup or to its designated agent for off-site review, electronically or telephonically, or on-site at Provider’s facility, upon reasonable notice from Amerigroup and during regular business hours. Amerigroup reserves the right to use a code editing software to ensure claims adjudication in accordance with industry standards. If applicable, Amerigroup and the Provider agree Amerigroup’s procedures for Provider audits may involve the use of sampling. If sampling is used, Amerigroup, or its agents, will utilize a generally accepted, statistically valid sampling methodology for selecting the sample of claims to be audited. Improper payments or overpayments identified may be calculated through the use of extrapolation techniques based on such sampling.
5.4 Payment for Medical Records. Provider shall supply the records described above upon request and at no charge.

ARTICLE VI
COMPLAINT/DISPUTE RESOLUTION

6.1 Informal Resolution of Disputes.

(a) In the event of a dispute arising out of this Agreement that is not resolved by Amerigroup's grievance and appeals process or by discussions among the Parties, the Parties shall seek good faith informal resolution of the dispute prior to pursuing any external remedies, subject to applicable law. Any party may initiate the informal resolution process by sending a written description of the dispute to the other parties by certified or registered mail or personal delivery. The description shall explain the nature of the dispute in detail and set forth a proposed resolution, including a specific time frame within which the Parties must act. The party receiving the letter must respond in writing within thirty (30) days with a detailed explanation of its position and a response to the proposed resolution. Within thirty (30) days of the initiating party receiving this response, principals of the party who have authority to settle the dispute will meet to discuss the resolution of the dispute. The initiating party shall initiate the scheduling of the meeting.

(b) In the event the parties are unable to resolve the dispute following exhaustion of the grievance and appeal process and the negotiation or mediation, a party shall pursue remedies at law or equity.

ARTICLE VII
TERM; TERMINATION

7.1 Initial Term and Renewal. Subject to the terms and conditions otherwise set forth in this Agreement, this Agreement (including each Program Addendum and Attachment A) shall have an initial term of two (2) years, commencing as of the Effective Date, and shall renew automatically thereafter for successive one (1) year terms, unless either party notifies the other of its intent not to renew at least one hundred twenty (120) days prior to the end of the then current term.

Each Program Addendum and Attachment A will be subject to the same Initial Term and Effective Date, and each may be subject to termination without cause and/or termination with cause WITHOUT requiring that this Agreement be terminated.

7.2 Termination. This Agreement may be terminated in its entirety (or each Program Addendum and Attachment A may be terminated separately) under any of the following circumstances:
(a) by mutual written agreement of the parties, subject to state notice requirements for subcontractor termination;

(b) by either party after the initial term, upon sixty (60) days written notice;

(c) by either party upon sixty (60) days written notice in the event of a material breach of this Agreement by the other party, except that such a termination will not take effect if the breach is cured within the sixty (60) days after notice of the termination; moreover, such termination may be deferred as further described in 6.1 (Informal Resolution of Disputes);

(d) by either party upon ten (10) days written notice in the event the other party loses licensure or other governmental authorization necessary to perform this Agreement, or fails to have insurance as required under Section 3.9 (Insurance Coverage).

7.3 Immediate Termination; Automatic Termination.

(a) Immediate Termination. Upon written notice to Provider, Amerigroup shall be entitled to terminate this Agreement immediately upon Amerigroup’s determination made in good faith and with reasonable belief that: (i) a Covered Person’s health is subject to imminent danger or a provider’s ability to practice medicine is effectively impaired by an action of the Board of Medicine or other governmental agency, (ii) Provider continues a practice or pattern of (1) substantial disregard for the rules and regulations of Amerigroup with respect to patient care, or (2) material deviation from the practice and quality assurance standards adopted by Amerigroup, (iii) Provider’s continued participation could adversely affect the care of Covered Persons, (iv) Provider is indicted or convicted of fraud or other criminal act involving moral turpitude or, following due investigation, Amerigroup determines there is substantial evidence that Provider fraudulently billed Amerigroup for services, (v) upon the filing of a petition in bankruptcy for liquidation or reorganization by or against Provider, if Provider becomes insolvent, or if a receiver is appointed for Provider or its property or (vi) in accordance with Section 3.2 above, and subject to Regulatory Requirements, upon the expiration, termination, surrender, revocation, restriction, or suspension of any accreditation, certification or license of Provider required under this Agreement. In the case of termination under this subsection, the effective date of such termination shall be the date set forth in Amerigroup’s written notice to Provider notifying Provider of such termination.

(b) Automatic Termination. If Provider is terminated, barred, suspended or otherwise excluded from participation in, or has voluntarily withdrawn as the result of a settlement agreement related to, any program under Titles XVIII, XIX or XX of the Social Security Act, this Agreement shall automatically and immediately terminate.

7.4 Continuity of Care. In the event of the termination of this Agreement for any reason except termination of this Agreement for cause by Amerigroup, Provider shall agree to furnish Covered Services to Covered Persons in accordance with Regulatory Requirements. During any such continuation period, Provider agrees to: (i) accept reimbursement from Amerigroup for all Covered Services furnished hereunder which shall be in accordance with this
Agreement and at the rates set forth in the applicable Program Addendum and Attachment A hereto; and (ii) adhere to Amerigroup’s policies and procedures, including but not limited to procedures regarding quality assurance requirements referrals, pre-authorization and treatment planning, or pursuant to other Regulatory Requirements.

ARTICLE VIII
MISCELLANEOUS

8.1 Amendment.

(a) This Agreement may be amended by the mutual agreement of the parties as evidenced in a writing signed by the parties. The Agreement may be amended by adding or deleting any Program Addendum and Attachment A by mutual agreement of the parties.

(b) In addition, Amerigroup shall be entitled to amend this Agreement as follows without the written agreement of Provider upon thirty (30) days prior written notice to Provider, or such other notice period as required by applicable law:

(i) If the amendment is being effected by Amerigroup to comply with a Regulatory Requirement, such amendment shall be effective as of the effective date set forth in the amendment. Amerigroup shall be entitled to amend the Agreement upon less than thirty (30) days prior written notice if a shorter notice period is required in order to comply with such Regulatory Requirement.

(ii) To the extent the amendment is being effected by Amerigroup for a purpose other than compliance with a Regulatory Requirement, Provider shall be entitled to object to the amendment, by written notice provided to Amerigroup within thirty (30) days following Provider’s receipt of such amendment, and it shall take effect at that time if there is no timely objection. If a timely objection is received by Amerigroup, the amendment shall take effect when the parties mutually agree on a resolution to the objection or this Agreement is terminated in accordance with the terms herein.

8.2 Non-Exclusivity: Volume. This Agreement shall not, nor shall it be construed to, limit or restrict Amerigroup in any manner from entering into any other agreements of any nature whatsoever with other persons or entities for the provision of the same or similar services contemplated hereunder. Neither this Agreement, nor anything contained herein, shall guarantee or obligate Amerigroup or any other party to provide any minimum number of referrals to Provider hereunder.

8.3 Assignment.

(a) This Agreement may not be assigned by Provider without the prior written consent of Amerigroup, which consent shall not be unreasonably withheld. Any assignment by Provider without such prior consent shall be void.
(b) Amerigroup may assign this Agreement in whole or in part. In the event of a partial assignment of this Agreement by Amerigroup, the obligations of the Provider shall be performed for Amerigroup with respect to the part retained and shall be performed for Amerigroup’s assignee with respect to the part assigned, and such assignee is solely responsible to perform all obligations of Amerigroup with respect to the part assigned.

(c) The rights and obligations of the parties hereunder shall inure to the benefit of, and shall be binding upon, any permitted successors and assigns of the parties hereto.

8.4 Indemnification.

(a) Provider agrees to indemnify, defend, and hold harmless Amerigroup and its officers, employees and agents from and against any and all liability, loss, claim, damage or expense, including defense costs and legal fees, incurred in connection with (i) Provider’s breach of any representation and warranty made by Provider in this Agreement, and (ii) claims for damages of any nature whatsoever, including, but not limited to, bodily injury, death, personal injury or property damage arising from Provider’s delivery of health care services or Provider’s performance or failure to perform Provider’s obligations hereunder.

(b) Amerigroup agrees to indemnify, defend, and hold harmless Provider and, if Provider is an entity, its officers, employees and agents, from and against any and all liability, loss, claim, damage or expense, including defense costs and legal fees, incurred in connection with (i) Amerigroup’s breach of any representation and warranty made by Amerigroup in this Agreement, and (ii) claims for damages of any nature whatsoever, arising from Amerigroup’s performance or failure to perform its obligations hereunder.

(c) Notwithstanding the foregoing subsections (a) and (b), subsections (a) and (b) shall be null and void to the extent they are interpreted to reduce insurance coverage to which either party is otherwise entitled, by way of any exclusion for contractually assumed liability or otherwise.

8.5 Waiver. Either party’s waiver of any breach or violation of this Agreement by the other party shall not, nor shall it be construed to, constitute a waiver of any subsequent breach or violation of this Agreement by the other party.

8.6 Severability. The invalidity or unenforceability of any provision contained herein shall not affect the validity of any other provisions of this Agreement, and this Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted, or, to the extent permitted by applicable law, such invalid or unenforceable paragraph shall be replaced with another paragraph as similar in terms as may be possible and as may be legal, valid and enforceable.
8.7 **Construction.** This Agreement shall be construed without regard to any presumption or other rule requiring construction against the party causing this Agreement to be drafted.

8.8 **Notice.** Any notice required to be given under this Agreement shall be sent by U.S. first class mail; certified mail, return receipt requested, postage prepaid; hand delivery; overnight prepaid delivery; or confirmed facsimile to the addresses set forth below, or to such other address designated by a party hereto, including without limitation, an email address, by notice to the other party pursuant to the terms of this Agreement:

If to Amerigroup, at the address set forth in the applicable Program Provider Manual.

If to Provider, to the mailing address set forth in the Participation application, which Provider may update according to the application process without amending this Agreement. All notices shall be deemed to have been delivered (a) when delivered by hand, (b) upon confirmation of receipt when transmitted by facsimile transmission or by electronic mail, (c) upon receipt by registered or certified mail, postage prepaid or (d) on the next business day if transmitted by national overnight courier.

8.9 **Independent Contractor Status.** Nothing contained herein shall, or shall be construed to, create a partnership, joint venture or any other relationship between the parties hereto other than that of independent contractors.

8.10 **Captions.** The section headings in this Agreement are for convenience of reference only, shall not define or limit the provisions hereof, and shall have no legal effect whatsoever.

8.11 **Governing Law/Venue.** This Agreement shall be governed by, construed and enforced in accordance with the laws of the State of Tennessee without regard to its conflict of laws rules. Any suit brought hereunder shall be brought in the state or federal courts in the State of Tennessee, or such other jurisdiction mutually agreed upon by the parties. Each of the parties hereto hereby irrevocably waives any and all right to trial by jury in any legal proceeding arising out of or related to this Agreement or the transactions contemplated herein.

8.12 **Counterparts.** This Agreement and any amendment hereto may be executed in two or more counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute one and the same agreement.

8.13 **Force Majeure.** Neither party shall be liable, nor deemed to be in default hereunder, for any delay in performance or failure to perform under this Agreement which results directly or indirectly from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, employee strikes or other work interruptions, earthquakes, floods, failure of transportation, or any cause beyond the reasonable control of such party. Provider acknowledges and agrees that this Agreement and the arrangement contemplated
herein is subject to regulation by state and federal governmental authorities. In the event that any action of any such governmental authority impairs, limits, or delays either party's performance of any obligation hereunder, that party shall be excused from such performance, and party's failure to perform such obligation for such reason shall not constitute a breach of this Agreement.

8.14 **Compliance with Regulatory Requirements.** Amerigroup and Provider shall each comply with all applicable Regulatory Requirements related to this Agreement, including the applicable Program Provider Manual(s). The failure of this Agreement to expressly reference a Regulatory Requirement applicable to either party in connection with their duties and responsibilities shall in no way limit such party's obligation to comply with such Regulatory Requirement.

8.15 **Survivability.** Sections 3.11, 5.1, 3.9 and 8.4 of this Agreement relating to confidentiality, records, insurance, or indemnification shall survive termination or expiration of this Agreement. Additionally, any provisions of this Agreement or of a Program that contemplate performance subsequent to any termination or expiration of this Agreement shall survive any termination or expiration of this Agreement and continue in full force and effect.

8.16 **Entire Agreement.** This Agreement and any exhibits, addenda, attachments or amendments hereto, together with the applicable program provider manual(s), constitute the entire agreement and understanding between the parties with respect to the subject matter hereof, and supersedes any prior understandings and agreement between the parties, whether written or oral, with respect to the subject matter hereof. If any requirement in this Agreement is determined to be in conflict with the Program Contract, such requirement shall be deemed null and void, but all other provisions of this Agreement shall remain in full force and effect.
IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized officers or agents.

Amerigroup:

Amerigroup Tennessee, Inc., d/b/a Amerigroup Community Care, a Tennessee corporation

By: __________________________________________ [Name]
    __________________________________________ [Title]
    __________________________________________ [EffectiveDate]

Provider:

Private agreement

By: __________________________________________ [PrintedName]
    __________________________________________ [Title]
    __________________________________________ [Address]
    __________________________________________ [Telephone]
    __________________________________________ [Date]

LIST the exhibits, addenda, and attachments here (So there is a record on the signature page of what was included in executed agreement)
Government Agreement

Amerigroup Tennessee, Inc.
d/b/a Amerigroup Community Care
PARTICIPATING PROVIDER AGREEMENT

THIS PARTICIPATING PROVIDER AGREEMENT (this "Agreement") is made by and between Amerigroup Tennessee, Inc. d/b/a Amerigroup Community Care ("Amerigroup") and the undersigned Provider ("Provider"). effective as of the date set forth immediately below Amerigroup's signature (the “Effective Date”).

RECITALS:

A. Amerigroup is authorized to arrange for the provision of managed health care services to Covered Persons as more fully set forth in this Agreement.

B. Provider is authorized in the State of Tennessee to provide Covered Services to Covered Persons.

C. Amerigroup and Provider mutually desire to enter into an agreement whereby Provider provides the Covered Services in the selected Programs contemplated herein to Covered Persons pursuant to the terms and conditions contemplated below.

AGREEMENT:

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Amerigroup and Provider agree as follows:

ARTICLE I
DEFINITIONS

The following terms shall have the meanings set forth below pertaining to all Programs:

1.1 Agency. “Agency” means a federal, state or local agency, administration, board or other governing body with jurisdiction over the governance or administration of a Program.

1.2 Behavioral Health Care Services. “Behavioral Health Care Services” means Covered Services rendered for the treatment of mental health or drug and alcohol conditions. These include the diagnosis, evaluation, treatment, residential care, rehabilitation, counseling or supervision of persons who have a mental illness.

1.3 CMS. “CMS” means the Center for Medicare & Medicaid Services, an administrative agency within the United States Department of Health & Human Services ("HHS").
1.4 **Clean Claim.** "Clean Claim" means a claim received by Amerigroup for adjudication, in a nationally accepted format in compliance with standard coding guidelines, and which requires no further information, adjustment, or alteration by the Provider of the services in order to be processed and paid by Amerigroup. The following exceptions apply to this definition: (a) a claim for payment of expenses incurred during a period of time for which premiums are delinquent; (b) a claim for which fraud is suspected; and (c) a claim for which a third party resource should be responsible.

1.5 **Covered Person.** "Covered Person" means a person who is an eligible Program beneficiary and who is enrolled as an Amerigroup member in accordance with applicable Program enrollment requirements.

1.6 **Covered Services.** "Covered Services" means those services that a Covered Person is entitled to receive through Amerigroup under the applicable benefit package for the Program in which the Covered Person is enrolled.

1.7 **Emergency Behavioral Health Condition.** "Emergency Behavioral Health Condition" means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine: (a) requires immediate intervention and/or medical attention without which Covered Persons would present an immediate danger to themselves or others, or (b) which renders Covered Persons incapable of controlling, knowing or understanding the consequences of their actions.

1.8 **Emergency Medical Condition.** "Emergency Medical Condition" means a physical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part. This definition of "Emergency Medical Condition includes any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine: (a) requires immediate intervention and/or medical attention without which Covered Persons would present an immediate danger to themselves or others, or (b) which renders Covered Persons incapable of controlling, knowing or understanding the consequences of their actions.

1.9 **Emergency Services.** "Emergency Services" means inpatient and outpatient Covered Services that are (1) furnished by a provider that is qualified to furnish these services; and (2) needed to evaluate or stabilize an Emergency Medical Condition. Emergency Services are Covered Services under this Agreement.

1.10 **Participating Provider.** "Participating Provider" or "Provider" means a person or entity that (a) is party to a participation agreement with Amerigroup to provide Covered Services to Covered Persons, or is an employee or subcontractor of a Participating Provider and will be furnishing Covered Services hereunder; and (b) has met all applicable Amerigroup
credentialed requirements for the services the Participating Provider provides. The definition of “Participating Provider” includes, but is not limited to, Provider.

1.11 Program. “Program” means the terms of coverage under an applicable benefit contract for which an Addendum and Attachment A is incorporated into this Agreement setting forth the Providers’ reimbursement for a respective Program. Subject to the above sentence, “Program” may mean any Medicaid managed care program (“Medicaid”), a state or local Child Health Insurance Program (“CHIP”), a Medicare program (“Medicare”), any successor programs thereto, any dual program, or commercial program, or any other state or federal program (i.e., exchanges) under which Amerigroup has authority to arrange for services for Covered Persons.

1.12 Program Contract. “Program Contract” means the contract between Amerigroup and an applicable party, such as an Agency or a Program beneficiary, which governs the delivery of managed health care services to Program beneficiaries.

1.13 Provider Manual. “Provider Manual” means the AMERIGROUP provider manual which has been supplied to Provider and which is in effect as of the Effective Date and includes, but is not limited to, procedures regarding Covered Person grievance and appeals, quality improvement and utilization management policies and procedures. “Provider Manual” also includes updates and amendments to the AMERIGROUP provider manual.

1.14 Regulatory Requirements. Provider shall be familiar with and in compliance with all applicable regulatory requirements. These include, but are not necessarily limited to, enacted statutes, adopted regulations, court orders and Contractor Risk Agreement Provisions and/or CMS contract provisions. Any such Regulatory Requirements are incorporated by reference into the Agreement.

ARTICLE II
AMERIGROUP OBLIGATIONS TO ALL PROGRAMS

2.1 Identification Cards. Amerigroup shall issue each Covered Person an Identification Card reflecting the Covered Person’s name, the Covered Person’s Primary Care Physician, the Covered Person’s Amerigroup identification number, telephone contact information and such other information as required by an Agency. A sample Identification Card will be provided upon request of Provider and is also available in the Provider Manual.

2.2 Provider Manual. Amerigroup shall make available to Provider the applicable Provider Manual(s) referencing Amerigroup’s policies and procedures for each Program. Provider shall comply with the terms of the Provider Manual(s) and all Amerigroup policies and procedures referenced or communicated to Provider by Amerigroup. Amerigroup shall provide Provider with at least thirty (30) days prior written notice of any material modifications to the Provider Manual(s) or other applicable policies and procedures affecting reimbursement, unless otherwise required by a Program. In the event of a conflict between the terms of this
Agreement and the Provider Manual(s), the terms of this Agreement shall govern, unless the Provider Manual terms are mandated by a Program.

2.3 Provider Listing: Marketing/Advertising. Amerigroup shall be entitled to use the name(s), business address(es), and phone number(s) of Provider including any individual Participating Provider employed by or under contract with Provider to provide services hereunder. Amerigroup shall be entitled to use information related to any such individual Participating Provider’s education, specialty, subspecialty, licensure, certification and hospital affiliation for the purposes described above. Provider shall be permitted to use Amerigroup’s name for purposes of identifying Provider as a Participating Provider in Amerigroup’s provider network.

2.4 Credentialing. Amerigroup shall review and approve the credentials of Provider and all Participating Providers providing services hereunder on behalf of Provider in accordance with Amerigroup credentialing and recredentialing criteria. Notwithstanding the execution of this Agreement or the stated Effective Date of this Agreement, Amerigroup must confirm Provider’s compliance with each of Amerigroup’s credentialing requirements applicable to the Providers’ area of practice prior to any individual provider being designated as a Participating Provider in Amerigroup’s provider network, or with respect to recredentialing, maintaining such designation as a Participating Provider. Until such time as Provider or any provider authorized by the terms of this Agreement to furnish services under this Agreement has been determined to have fully met Amerigroup’s credentialing requirements, such Provider or such other providers shall not be entitled to the benefits of participation under this Agreement, including, without limitation, the reimbursement rates set forth in any Attachment A hereto.

2.5 Affiliate Services. Provider acknowledges that Amerigroup is affiliated with health plans that offer similar benefits under similar programs as the Programs covered hereunder (“Affiliates”). The parties acknowledge that Provider is not a Participating Provider for purposes of rendering services to members of Affiliates who are covered pursuant to such programs, but recognize the benefit of a mutual understanding as to the care of such members. In the event that Provider treats a member of an Affiliate, Provider shall accept as payment in full the rates established by the Affiliate or the Affiliate’s state program governing care to those out-of-state members. Such services must be covered services under the applicable Program, and shall require prior authorization, except for emergency services and services for which a member is entitled to self-refer under the applicable Program. Upon request, Amerigroup shall coordinate between Provider and the applicable Affiliate for any member of an Affiliate that receives services from Provider to ensure appropriate payment and to provide Provider with information needed to appropriately render and bill for services under the applicable Program. Provider must be eligible and/or make available any state required documentation in order to be reimbursed from a state agency.
2.6 **Representations and Warranties.**

(a) **Amerigroup Status.** Amerigroup hereby represents and warrants that Amerigroup: (i) has the power and authority to enter into this Agreement; (ii) is not in violation of any licensure or accreditation requirement applicable to Amerigroup under Regulatory Requirements; (iii) has not been convicted of bribery or attempted bribery of any official or employee of the jurisdiction in which Amerigroup operates, nor made an admission of guilt of such conduct which is a matter of record; (iv) qualifies to participate in a Program as of the date on which Provider may furnish Covered Services hereunder for such Program; and (v) is not, to Amerigroup's best knowledge, the subject of an inquiry or investigation that could foreseeably result in Amerigroup failing to comply with the representations in subsections (i) – (iv) above.

(b) **Disclosure Reporting.** Amerigroup, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Agreement shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and TennCare policies and procedures, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, within thirty five (35) days after any change in ownership of the disclosing entity, at least once every three (3) years, and at any time upon request. For providers, this requirement may be satisfied through TENNCARE’s provider registration process.

(c) **Amerigroup Screenings.** Amerigroup, as well as its subcontractors and providers, whether contracted or not contracted, shall comply with all federal requirements (42 CFR Section 1002) on exclusion and debarment screening. All tax reporting provider entities that bill and/or receive TennCare funds as the result of this Agreement shall screen their owners and employees against the Social Security Master Death File, the General Services Administration (GSA) System for Award Management (SAM) and the HHS-OIG List of Excluded Individuals/Entities (LEIE). Any unallowable funds made to an excluded individual as full or partial wages and/or benefits shall be refunded to and/or returned to the State and/or Amerigroup dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

**ARTICLE III**

**PROVIDER OBLIGATIONS TO ALL PROGRAMS**

3.1 **Provider Services.** Provider shall provide to Covered Persons those Medically Necessary Covered Services within the scope of Provider’s licensure, expertise, and usual and customary range of services pursuant to the terms and conditions of this Agreement, and shall be responsible to Amerigroup for its performance hereunder. (a) If Provider is a Physician: To the extent mandated by Regulatory Requirements, Provider shall ensure that Covered Persons have access to 24 hour-per-day, 7 day-per-week urgent and emergency services. Provider shall
not discriminate in any Program in the acceptance of Amerigroup Covered Persons for treatment, and shall provide to Covered Persons of each Program the same access to services as Provider gives to all other patients. (b) If Provider is a Facility: Provider shall render timely and appropriate Medically Necessary services to treat an Emergency Medical Condition affecting a Covered Person, and shall comply with all applicable law related to the post-stabilization care of a Covered Person after an Emergency Medical Condition has been stabilized. Provider shall use its best efforts to notify AMERIGROUP at the time of eligibility verification or by the end of the next business day after admission and identification of a Covered Person as an inpatient, or after rendition of emergency outpatient Covered Services to a Covered Person. Notwithstanding any provision contained in this Agreement, no notification to, or coverage verification or pre-authorization from, Amerigroup is required prior to Provider rendering Medically Necessary services to treat an Emergency Medical Condition to a Covered Person. Under such circumstances, if a Covered Person's condition cannot be treated at Provider in its facilities, Provider shall arrange for the services of an alternate Participating Hospital; provided, however, that in the event obtaining the services of an alternate Participating Hospital is impractical, Provider shall arrange for the services by an appropriate non-participating hospital.

3.2 Licensure and Accreditation. At all times during the term of this Agreement, Provider shall (a) maintain in good standing all applicable licenses, certifications, registrations required for Provider to furnish services hereunder; (b) be certified to the extent required under the applicable Programs; and (c) maintain a National Provider Identification Number ("NPI") if required for Provider by applicable law. Provider shall ensure that each of Provider's employees is duly licensed, certified or registered as required under a Program and applicable standards of professional ethics and practice. Provider shall have a process in place to screen Provider's employees on a monthly basis to ensure that such employees are not excluded from participation in any Programs. Provider shall notify Amerigroup immediately following Provider's receipt of any notice of any restrictions upon, including, but not limited to, any suspension or loss of, any such licensure, certification, registration, or accreditation, or of learning that Provider or Provider's employee has been excluded from any Program. Provider shall submit to Amerigroup evidence of Provider's satisfaction of the requirements set forth in this section upon Amerigroup's request.

3.3 Covered Person Verification. Provider shall establish a Covered Person's eligibility for services prior to rendering services, except in the case of an Emergency Medical Condition where such verification may not be possible. In the case of an Emergency Medical Condition, Provider shall establish a Covered Person's eligibility as soon as reasonably practicable. Amerigroup shall provide a system for Providers to contact Amerigroup to verify Covered Person eligibility 24 hours a day, 7 days per week. Nothing contained in this Agreement shall, or shall be construed to, require advance notice, coverage verification, or pre-authorization for emergency services provided in accordance with the federal Emergency Medical Treatment and Active Labor Act ("EMTALA") prior to Provider's rendering such services.
3.4 Provider Responsibility. Amerigroup shall not be liable for, nor will it exercise control or direction over, the manner or method by which Provider provides health care services to Covered Persons. Provider acknowledges and agrees that Amerigroup may deny payment for Provider services rendered to a Covered Person which Amerigroup determines are not Medically Necessary, are not Covered Services pursuant to an applicable Program Contract, or are not otherwise provided or billed in accordance with this Agreement. Neither such a denial nor any action taken by Amerigroup pursuant to a utilization review, referral, discharge planning program or claims adjudication shall be construed as a waiver of Provider's obligation to provide appropriate services to a Covered Person under applicable law and any code of professional responsibility. Nothing in this Agreement shall be construed as prohibiting any Participating Provider from discussing treatment or non-treatment options with Covered Persons, irrespective of whether such treatment options are Covered Services. Nothing in this Agreement shall, or shall be construed to, create any financial incentive for Provider to withhold Medically Necessary Covered Services.

3.5 Rights of Participating Provider. Nothing in the Agreement shall be construed as prohibiting any Participating Provider from advising or advocating on behalf of a member who is his or her patient for (a) the member's health status, medical or behavioral health care, or treatment options, including alternative treatment that may be self-administered; (b) any information the member needs in order to decide among all relevant treatment options; (c) the risks, benefits and consequences of treatment or non-treatment; or (d) the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions.

3.6 No Refusal to Provide Services. Provider may not refuse to provide preventative or Medically Necessary Covered Services to a Covered Person under this Agreement for non-medical reasons. However, Provider shall not be required to accept or continue treatment of a Covered Person if Provider cannot establish and/or maintain a professional relationship with such Covered Person. If Provider has a valid reason he or she cannot establish and/or maintain a professional relationship with a Covered Person, the Provider may request to terminate the relationship in accordance with Amerigroup's specific policy pertaining thereto.

3.7 Compliance. Provider shall participate in Amerigroup utilization management and care management programs designed to facilitate the coordination of health care services as referenced in the Provider Manual(s) for the Program(s). In addition, Provider shall participate and cooperate in any internal and external QM/QI with all Amerigroup, and external, Regulatory Requirements related to monitoring, credentialing, utilization management, quality assurance, grievances, peer review, coordination of benefits and third party liability.

3.8 Concurrent Review. Provider agrees to provide electronic, telephonic or direct access, and accommodation to Amerigroup employees and/or its designated agent or a third party contractor to review Covered Persons' medical records and perform on-site concurrent review.
3.9 **Insurance Coverage.**

(a) If the Provider is State owned and/or operated: The State of Tennessee, including the University of Tennessee, is prohibited by law from agreeing to provide indemnity. In addition, the General Assembly for the State of Tennessee does not authorize the State agencies or employees to provide, carry, or maintain commercial General Liability Insurance or Medical, Professional or Hospital Liability Insurance. Claims against the State of Tennessee, or its employees, for injury, damages, expenses or attorney's fees are heard and determined by the Tennessee Claims Commission or the Tennessee Board of Claims in the manner prescribed by law. See Tenn. Code Ann. §§ 8-42-101 et seq., 9-8-101 et seq., 9-8-301et seq., and 9-8-410 et seq. Provider as a governmental entity is not required to provide workers compensation insurance. It does, however, provide a fully funded injured on duty benefit program for its employees.

(b) If the Provider is a local government owned and operated: The Provider, being a Tennessee local governmental entity (such as a county or municipality), is governed by the provisions of the Tennessee Government Tort Liability Act, Tennessee Code Annotated, Sections 29-20-101 et seq., for causes of action sounding in tort. Further, no contract provision requiring a Tennessee political entity to indemnify or hold harmless the State beyond the liability imposed by law is enforceable because it appropriates public money and nullifies governmental immunity without the authorization of the General Assembly. Provider as a governmental entity is not required to provide workers compensation insurance. If the Provider does not maintain workers compensation insurance it does, however, provide a fully funded injured on duty benefit program for its employees.

(c) If the Provider is a non-profit corporation duly existing and organized under the laws of the State of Tennessee which is a Federally Qualified Health Center as defined in 42 C.F.R. §405.2401, Provider is an entity to which the Federal Tort Claims Act may apply. For so long as Provider qualifies as an “employee” in accordance with Section 224 (g) of the Public Health Service Act ("PHS"), located at 42 U.S.C. § 223(g), as amended, Provider shall have its liability limits defined by Section 224(a) of the Federal Tort Claims Act. As an employee under the PHS, Provider carries no professional liability insurance; however, it is insured for general liability. This general liability insurance is for the benefit of the Provider only and provides no indemnification for any other entity whatsoever. The Provider agrees to produce proof of adequate professional liability insurance for the Provider's professional employees who perform any professional services under this Agreement and are not covered by the Federal Tort Claims Act. To the extent required by Regulatory Requirements, Provider shall maintain workers' compensation insurance for Provider’s employees. In the event that Provider loses its status as an “employee” pursuant to Section 224(g) of the PHS, Provider shall maintain professional liability insurance, including maintaining such tail or prior acts coverage necessary to avoid any gap in coverage for claims arising from incidents occurring during the term of this Agreement. Such insurance shall (i) be obtained from a carrier authorized to issue coverage in the jurisdiction in which Provider operates, except for permitted self-insurance; and (ii) maintain minimum policy limits equal to $1,000,000.00 per occurrence and $3,000,000.00 in...
the aggregate, or such other coverage amounts as prescribed by applicable Regulatory Requirements for a Program and consented to by Amerigroup. Provider shall maintain general liability insurance covering Provider's premises, insuring Provider against any claim of loss, liability, or damage caused by or arising out of the condition or alleged condition of said premises, or the furniture, fixtures, appliances, or equipment located therein, and if Provider operates motor vehicles in connection with Provider's services, with liability protection against any loss, liability or damage resulting from the operation of such motor vehicles by Provider, Provider's employees or agents. Such general liability insurance shall contain commercially reasonable coverage limits, or such limits as prescribed by Regulatory Requirements for a Program.

3.10 **Subcontracted Provider Requirements.** In the event that any Covered Services are performed for or on behalf of Provider by a subcontracted provider, Provider shall be responsible for ensuring that such subcontracted provider complies with all of Provider's obligations under this Agreement including, without limitation, compliance with all applicable Regulatory Requirements, credentialing, as applicable and required insurance provisions of 42 CFR 438.230(b) and 42 CFR 434.6.

3.11 **Proprietary Information; Confidentiality.**

(a) The parties acknowledge and agree this agreement template, rate sheet template(s), provider manual(s) and provider updates are public records. The parties also acknowledge and agree that all information related to Amerigroup programs, policies, protocols and procedures, and all information otherwise furnished to Provider in writing by Amerigroup as a result of this Agreement is proprietary. Provider agrees not to use such proprietary information except for the purpose of carrying out its obligations under this Agreement. Provider shall not disclose any proprietary information to any person or entity without Amerigroup's express written consent, except pursuant to Regulatory Requirements or legal order, in which case Provider shall immediately notify Amerigroup of receipt of any such request for the disclosure, prior to the disclosure, and the extent to which such information is available in the public domain or was acquired by such party from a third party not bound to preserve the confidentiality of such information.

(b) Provider and Amerigroup shall each treat all information which is obtained through its respective performance under the Agreement as confidential information, including without limitation information that is confidential pursuant to 42 C.F.R. §422.118 and 45 C.F.R. Parts 160 and 164, as may be amended from time to time or other applicable law, and shall not use any information obtained except as necessary to the proper discharge of its obligations and securing of its rights hereunder. Provider and Amerigroup shall each have a system in place that meets all applicable Regulatory Requirements to protect all records and all other documents relating to this Agreement which are deemed confidential by law. Any disclosure or transfer of confidential information by Provider or Amerigroup will be in accordance with applicable Regulatory Requirements.
3.12 Representations and Warranties.

(a) Provider Status. Provider hereby represents and warrants that Provider: (i) has the power and authority to enter into this Agreement; (ii) is legally authorized to provide the services contemplated hereunder; (iii) is not in violation of any licensure or accreditation requirement applicable to Provider under Regulatory Requirements; (iv) has not been convicted of bribery or attempted bribery of any official or employee of the jurisdiction in which Provider operates, nor made an admission of guilt of such conduct which is a matter of record; (v) is capable of providing all data related to the services provided hereunder in a timely manner as reasonably required by Amerigroup to satisfy its internal requirements and Regulatory Requirements, including, without limitation, data required under the Health Employer Data and Information Set and National Committee for Quality Assurance requirements; (vi) qualifies to participate in each Program for which an Addendum and Attachment A is attached and incorporated hereto; and (vii) is not, to Provider’s best knowledge, the subject of an inquiry or investigation that could foreseeably result in Provider failing to comply with the representations in subsections (i) – (vi) above.

(b) Provider Information and Documentation. Provider represents and warrants that all information provided to Amerigroup is true and correct as of the date such information is furnished, and Provider is unaware of any undisclosed facts or circumstances that would make such information inaccurate or misleading. Provider shall immediately provide Amerigroup with written notice of any material changes to such information.

(c) Provider Screenings and Background Checks. Provider shall conduct criminal background checks and registry checks, which shall include a check of the Tennessee Abuse Registry, National and Tennessee Sexual Offender Registry, in accordance with state law and TennCare policy. Provider shall conduct a monthly screening of the HHS-OIG List of Excluded Individuals/Entities (“LEIE”) and System for Award Management (SAM) to determine if any of its employees, agents, contractors or subcontractors has been excluded from participation in any program including, but not limited to, the Medicare, Medicaid, SCHIP, or other Federal health care program (as defined in Section 1128B(f) of the Social Security Act), or has been convicted of a health care-related criminal act. Provider shall document these in the worker’s employment record or otherwise maintain these records on volunteers, as applicable. Provider shall also verify that any persons required to have background checks, including registry checks, as applicable, who have been employed or have volunteered since direct support staff hired after the last credentialing visit have had criminal background checks, including registry checks, as applicable, performed. Provider shall not employ or contract with any individual or entity that has either been excluded from a program as determined above or who has been convicted of a health-care related criminal act, and shall immediately report its findings and determinations to Amerigroup and TennCare. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare members.
(d) If Provider is a “covered entity” as defined in 45 C.F.R. Section 160.103, Provider is required to comply with requirements regarding protection of certain protected health information in accordance with 45 C.F.R. Parts 160 and 164 as amended from time to time.

3.13 Reporting Fraud and Abuse. Provider shall cooperate with Amerigroup’s anti-fraud and abuse compliance program. If Provider identifies any actual or suspected fraud, abuse or misconduct in connection with the services rendered hereunder in violation of state or federal law, Provider shall immediately report such activity directly to the Chief Compliance Officer of Amerigroup or through the Compliance Hotline in accordance with the Provider Manual. Provider is not limited in any respect in reporting actual or suspected fraud, abuse, or misconduct to Amerigroup.

3.14 Laboratory Services. Provider shall comply with all requirements of the Clinical Laboratory Improvement Act (“CLIA”), regulations promulgated thereunder and any amendments and successor statutes and regulations thereto, and furnish written verification or Provider’s appropriate CLIA certification of registration or waiver and CLIA identification number. Provider shall notify Amerigroup within five (5) business days in writing of any changes in Provider’s CLIA certification status or the certification status of any laboratory facilities with which Provider conducts business related to Covered Persons.

3.15 Lobbying. By signing this Agreement, Provider certifies that federal funds have not been used for lobbying in accordance with 45 CFR Part 93 and 31 USC 1352. (See also TCA 3-6-101 et seq., 3-6-201 et seq., 3-6-301 et seq., and 8-50-505). Provider shall disclose any lobbying activities using non-federal funds in accordance with and to the extent required by 45 CFR Part 93.

3.16 Business Associate Agreement. In the event Provider is not a “covered entity,” as such term is defined in the HIPAA Regulations, a Business Associate Agreement shall be executed and made a part hereof. Provider acknowledges that if it is not a covered entity, Amerigroup is unable to disclose to Provider any protected health information regarding any Covered Person until a Business Associate Agreement is fully effective between the parties hereto.

3.17 Surety Bond Requirement. If Provider provides home health services or durable medical equipment, Provider shall comply with all applicable provisions of Section 4724(b) of the Balanced Budget Act of 1997, including, without limitation, any applicable requirements related to the posting of a surety bond.

ARTICLE IV
SUBMISSION, PROCESSING AND PAYMENT OF CLAIMS

4.1 Claims Submission. Provider shall submit claims in accordance with all applicable Regulatory Requirements and Amerigroup requirements on the applicable claims.
form set forth on each applicable Attachment A, or the electronic equivalent, as further described and referenced in the Provider Manual(s) of the Program(s). Provider shall submit claims information through electronic data interchange (EDI) that allows for automated processing and adjudication of claims, and shall use Amerigroup electronic interface systems for registration, eligibility and benefit verification and claims processing. Provider will use HIPAA compliant billing codes when billing or submitting encounter data and Amerigroup shall not pay any claims submitted using non-compliant billing codes. When billing codes are updated, Provider is required to use appropriate replacement codes for claims for Covered Services, regardless of whether this Agreement has been amended to reflect changes to standard billing codes. Clean Claims must be submitted within one hundred twenty (120) days following the date service is rendered or may be denied for payment by Amerigroup. Amerigroup will not deny Clean Claims for timely payment if the claims received after one hundred twenty (120) days from the date of service were timely filed with another payer because Provider was unable to determine that the patient was an Amerigroup Covered Person or the Provider believed that the patient was self-pay and subsequently learned that the patient was a Covered Person. In such event, Provider shall have one hundred twenty (120) day[s] to submit the claim to Amerigroup from the date Provider received a denial from the payer to which Provider submitted the claim or learned that the patient was a Covered Person.

4.2 Reimbursement.

(a) Program Reimbursement. Amerigroup shall pay claims for Covered Services for each Program in the amount set forth in the applicable Attachment A as payment in full for the Covered Services provided to Covered Person in the Program.

(b) Adjudication of Clean Claims; Payment of Interest. Amerigroup shall adjudicate a Clean Claim, in accordance with, and within the time frames set forth in the Regulatory Requirements applicable to each Program. If applicable, Amerigroup shall pay Provider interest on all Clean Claims that are not adjudicated within the applicable prompt pay period at the interest rate specified under the applicable Program. Such interest shall not apply if Provider files duplicate claims prior to the expiration of the adjudication timeframe.

4.3 Recoveries from Third Parties. Provider acknowledges and agrees that claims payments made by Amerigroup may be subject to Program requirements regarding third party liability. Provider shall cooperate with Amerigroup's policies and procedures related to third party liability recovery when claims for services rendered by Provider to a Covered Person are related to an illness or injury for which a third party may be liable; including, without limitation, claims that may be covered by automobile insurance, workers' compensation, other health insurance, or otherwise give rise to a claim for third party liability, coordination of benefits or subrogation (to the extent permitted by Regulatory Requirements). Provider shall cooperate with Amerigroup in connection with such recoveries, including executing appropriate documents reasonably requested by Amerigroup to enforce such claims or to assign payments to Amerigroup.
4.4 Right of Recoupment and Offset. Amerigroup shall be entitled to offset and recoup an amount equal to any overpayments or improper payments made by Amerigroup to Provider against any payments due and payable by Amerigroup to Provider under this Agreement in conformance with applicable law. Upon determination that any recoupment, improper payment, or overpayment is due from Provider to Amerigroup, Amerigroup shall first give Provider notice of recoupment and request reimbursement via check for such an overpayment. If reimbursement is not received within forty-five (45) days from the date of such notice, Amerigroup shall be entitled to offset such overpayment against other amounts due and payable by Amerigroup to Provider in accordance with applicable law.

Provider shall comply with the Affordable Care Act and TennCare policies and procedures regarding recovery of overpayments, including written notification to the Amerigroup and TennCare Office of Program Integrity (OPI) of overpayments identified by the provider and, when applicable, returning the overpayment to the Amerigroup within sixty (60) days from the date the overpayment is identified. Failure to return overpayment(s) within sixty (60) days from the date the overpayment(s) was identified may be a violation of state or federal law.

4.5 Providers-Preventable Conditions. Provider understands and agrees that no payment will be made to Provider by Amerigroup for any provider-preventable conditions which have been identified by an applicable Agency/Program or pursuant to Regulatory Requirements. In addition, Provider shall identify provider-preventable conditions that are associated with claims for services provided under a Program hereunder or with courses of treatment furnished to Covered Persons for which payment under a Program would otherwise be available.

4.6 Hold Harmless. Provider agrees that in no event, including, but not limited to non-payment by Amerigroup, Amerigroup insolvency, or breach of this Agreement, shall Provider solicit or accept any surety or guarantee of payment from a Covered Person for Covered Services in excess of the amount of the contracted amount. For purposes of this section, “Covered Person” shall include the Covered Person, parent(s), guardian, spouse or any other legally responsible person of the Covered Person being served.

ARTICLE V
RECORDS

5.1 Records. Provider shall maintain medical, financial and administrative records regarding services provided to Covered Persons in accordance with industry standards and Regulatory Requirements, including without limitation applicable federal and state privacy and security provisions. Such records shall be retained by Provider for the period of time required under Regulatory Requirements applicable to each contracted Program more specifically set forth in the applicable Addendum. Provider shall provide Amerigroup and state and federal agencies electronic, telephonic or direct access to review records related to services provided
hereunder for off-site review, or on-site at Provider’s facility, in accordance with Regulatory Requirements. Provider shall supply to Amerigroup the records described above at no charge.

5.2 Record Transfer. Provider shall cooperate in the transfer of Covered Persons' medical records to other Participating Providers when required and shall assume the cost associated with the transfer. Following a Covered Person’s request for record transfer, Provider shall transfer such Covered Person’s medical records in Provider’s custody within fourteen (14) days following the request, or such other time period required under applicable Regulatory Requirements.

5.3 Audits. Provider shall permit Amerigroup or its designated agent or a third party contractor to audit records in order to determine the appropriateness of Covered Services and/or charges on a specific claim directly related to services provided to Covered Persons, either by providing such records to Amerigroup or to its designated agent for off-site review, electronically or telephonically, or on-site at Provider’s facility, upon reasonable notice from Amerigroup and during regular business hours. Amerigroup reserves the right to use a code editing software to ensure claims adjudication in accordance with industry standards. If applicable, Amerigroup and the Provider agree Amerigroup’s procedures for Provider audits may involve the use of sampling. If sampling is used, Amerigroup, or its agents, will utilize a generally accepted, statistically valid sampling methodology for selecting the sample of claims to be audited. Improper payments or overpayments identified may be calculated through the use of extrapolation techniques based on such sampling.

5.4 Payment for Medical Records. Provider shall supply the records described above upon request and at no charge.

ARTICLE VI
COMPLAINT/DISPUTE RESOLUTION

6.1 Informal Resolution of Disputes.

(a) In the event of a dispute arising out of this Agreement that is not resolved by Amerigroup’s grievance and appeals process or by discussions among the Parties, the Parties shall seek good faith informal resolution of the dispute prior to pursuing any external remedies, subject to applicable law. Any party may initiate the informal resolution process by sending a written description of the dispute to the other parties by certified or registered mail or personal delivery. The description shall explain the nature of the dispute in detail and set forth a proposed resolution, including a specific time frame within which the Parties must act. The party receiving the letter must respond in writing within thirty (30) days with a detailed explanation of its position and a response to the proposed resolution. Within thirty (30) days of the initiating party receiving this response, principals of the party who have authority to settle the dispute will meet to discuss the resolution of the dispute. The initiating party shall initiate the scheduling of the meeting.
(b) In the event the parties are unable to resolve the dispute following exhaustion of the grievance and appeal process and the negotiation or mediation, a party shall pursue remedies at law or equity.

ARTICLE VII
TERM; TERMINATION

7.1 Initial Term and Renewal. Subject to the terms and conditions otherwise set forth in this Agreement, this Agreement (including each Program Addendum and Attachment A) shall have an initial term of two (2) years, commencing as of the Effective Date, and shall renew automatically thereafter for successive one (1) year terms, unless either party notifies the other of its intent not to renew at least one hundred twenty (120) days prior to the end of the then current term.

Each Program Addendum and Attachment A will be subject to the same Initial Term and Effective Date, and each may be subject to termination without cause and/or termination with cause WITHOUT requiring that this Agreement be terminated.

7.2 Termination. This Agreement may be terminated in its entirety (or each Program Addendum and Attachment A may be terminated separately) under any of the following circumstances:

(a) by mutual written agreement of the parties, subject to state notice requirements for subcontractor termination;

(b) by either party after the initial term, upon sixty (60) days written notice;

(c) by either party upon sixty (60) days written notice in the event of a material breach of this Agreement by the other party, except that such a termination will not take effect if the breach is cured within the sixty (60) days after notice of the termination; moreover, such termination may be deferred as further described in 6.1 (Informal Resolution of Disputes);

(d) by either party upon ten (10) days written notice in the event the other party loses licensure or other governmental authorization necessary to perform this Agreement, or fails to have insurance as required under Section 3.9 (Insurance Coverage).

7.3 Immediate Termination; Automatic Termination.

(a) Immediate Termination. Upon written notice to Provider, Amerigroup shall be entitled to terminate this Agreement immediately upon Amerigroup’s determination made in good faith and with reasonable belief that: (i) a Covered Person’s health is subject to imminent danger or a provider’s ability to practice medicine is effectively impaired by an action of the Board of Medicine or other governmental agency, (ii) Provider continues a practice or pattern of (1) substantial disregard for the rules and regulations of Amerigroup with respect to
patient care, or (2) material deviation from the practice and quality assurance standards adopted by Amerigroup, (iii) Provider's continued participation could adversely affect the care of Covered Persons, (iv) Provider is indicted or convicted of fraud or other criminal act involving moral turpitude or, following due investigation, Amerigroup determines there is substantial evidence that Provider fraudulently billed Amerigroup for services, (v) upon the filing of a petition in bankruptcy for liquidation or reorganization by or against Provider, if Provider becomes insolvent, or if a receiver is appointed for Provider or its property or (vi) in accordance with Section 3.2 above, and subject to Regulatory Requirements, upon the expiration, termination, surrender, revocation, restriction, or suspension of any accreditation, certification or license of Provider required under this Agreement. In the case of termination under this subsection, the effective date of such termination shall be the date set forth in Amerigroup's written notice to Provider notifying Provider of such termination.

(b) **Automatic Termination.** If Provider is terminated, barred, suspended or otherwise excluded from participation in, or has voluntarily withdrawn as the result of a settlement agreement related to, any program under Titles XVIII, XIX or XX of the Social Security Act, this Agreement shall automatically and immediately terminate.

7.4 **Continuity of Care.** In the event of the termination of this Agreement for any reason except termination of this Agreement for cause by Amerigroup, Provider shall agree to furnish Covered Services to Covered Persons in accordance with Regulatory Requirements. During any such continuation period, Provider agrees to: (i) accept reimbursement from Amerigroup for all Covered Services furnished hereunder which shall be in accordance with this Agreement and at the rates set forth in the applicable Program Addendum and Attachment A hereto; and (ii) adhere to Amerigroup's policies and procedures, including but not limited to procedures regarding quality assurance requirements referrals, pre-authorization and treatment planning, or pursuant to other Regulatory Requirements.

**ARTICLE VIII**

**MISCELLANEOUS**

8.1 **Amendment.**

(a) This Agreement may be amended by the mutual agreement of the parties as evidenced in a writing signed by the parties. The Agreement may be amended by adding or deleting any Program Addendum and Attachment A by mutual agreement of the parties.

(b) In addition, Amerigroup shall be entitled to amend this Agreement as follows without the written agreement of Provider upon thirty (30) days prior written notice to Provider, or such other notice period as required by applicable law:

(i) If the amendment is being effected by Amerigroup to comply with a Regulatory Requirement, such amendment shall be effective as of the effective date set forth in the amendment. Amerigroup shall be entitled to amend the Agreement upon less than thirty
(30) days prior written notice if a shorter notice period is required in order to comply with such Regulatory Requirement.

(ii) To the extent the amendment is being effected by Amerigroup for a purpose other than compliance with a Regulatory Requirement, Provider shall be entitled to object to the amendment, by written notice provided to Amerigroup within thirty (30) days following Provider’s receipt of such amendment, and it shall take effect at that time if there is no timely objection. If a timely objection is received by Amerigroup, the amendment shall take effect when the parties mutually agree on a resolution to the objection or this Agreement is terminated in accordance with the terms herein.

8.2 Non-Exclusivity: Volume. This Agreement shall not, nor shall it be construed to, limit or restrict Amerigroup in any manner from entering into any other agreements of any nature whatsoever with other persons or entities for the provision of the same or similar services contemplated hereunder. Neither this Agreement, nor anything contained herein, shall guarantee or obligate Amerigroup or any other party to provide any minimum number of referrals to Provider hereunder.

8.3 Assignment.

(a) This Agreement may not be assigned by Provider without the prior written consent of Amerigroup, which consent shall not be unreasonably withheld. Any assignment by Provider without such prior consent shall be void.

(b) Amerigroup may assign this Agreement in whole or in part. In the event of a partial assignment of this Agreement by Amerigroup, the obligations of the Provider shall be performed for Amerigroup with respect to the part retained and shall be performed for Amerigroup’s assignee with respect to the part assigned, and such assignee is solely responsible to perform all obligations of Amerigroup with respect to the part assigned.

(c) The rights and obligations of the parties hereunder shall inure to the benefit of, and shall be binding upon, any permitted successors and assigns of the parties hereto.

8.4 Indemnification.

(a) Provider agrees to indemnify, defend, and hold harmless Amerigroup and its officers, employees and agents from and against any and all liability, loss, claim, damage or expense, including defense costs and legal fees, incurred in connection with (i) Provider’s breach of any representation and warranty made by Provider in this Agreement, and (ii) claims for damages of any nature whatsoever, including, but not limited to, bodily injury, death, personal injury or property damage arising from Provider’s delivery of health care services or Provider’s performance or failure to perform Provider’s obligations hereunder.
(b) Amerigroup agrees to indemnify, defend, and hold harmless Provider and, if Provider is an entity, its officers, employees and agents, from and against any and all liability, loss, claim, damage or expense, including defense costs and legal fees, incurred in connection with (i) Amerigroup’s breach of any representation and warranty made by Amerigroup in this Agreement, and (ii) claims for damages of any nature whatsoever, arising from Amerigroup’s performance or failure to perform its obligations hereunder.

(c) Notwithstanding the foregoing subsections (a) and (b), subsections (a) and (b) shall be null and void to the extent they are interpreted to reduce insurance coverage to which either party is otherwise entitled, by way of any exclusion for contractually assumed liability or otherwise.

8.5 Waiver. Either party’s waiver of any breach or violation of this Agreement by the other party shall not, nor shall it be construed to, constitute a waiver of any subsequent breach or violation of this Agreement by the other party.

8.6 Severability. The invalidity or unenforceability of any provision contained herein shall not affect the validity of any other provisions of this Agreement, and this Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted, or, to the extent permitted by applicable law, such invalid or unenforceable paragraph shall be replaced with another paragraph as similar in terms as may be possible and as may be legal, valid and enforceable.

8.7 Construction. This Agreement shall be construed without regard to any presumption or other rule requiring construction against the party causing this Agreement to be drafted.

8.8 Notice. Any notice required to be given under this Agreement shall be sent by U.S. first class mail; certified mail, return receipt requested, postage prepaid; hand delivery; overnight prepaid delivery; or confirmed facsimile to the addresses set forth below, or to such other address designated by a party hereto, including without limitation, an email address, by notice to the other party pursuant to the terms of this Agreement:

If to Amerigroup, at the address set forth in the applicable Program Provider Manual.

If to Provider, to the mailing address set forth in the Participation application, which Provider may update according to the application process without amending this Agreement. All notices shall be deemed to have been delivered (a) when delivered by hand, (b) upon confirmation of receipt when transmitted by facsimile transmission or by electronic mail, (c) upon receipt by registered or certified mail, postage prepaid or (d) on the next business day if transmitted by national overnight courier.
8.9 **Independent Contractor Status.** Nothing contained herein shall, or shall be construed to, create a partnership, joint venture or any other relationship between the parties hereto other than that of independent contractors.

8.10 **Captions.** The section headings in this Agreement are for convenience of reference only, shall not define or limit the provisions hereof, and shall have no legal effect whatsoever.

8.11 **Governing Law/Venue.** This Agreement shall be governed by, construed and enforced in accordance with the laws of the State of Tennessee without regard to its conflict of laws rules. Any suit brought hereunder shall be brought in the state or federal courts in the State of Tennessee, or such other jurisdiction mutually agreed upon by the parties. Each of the parties hereto hereby irrevocably waives any and all right to trial by jury in any legal proceeding arising out of or related to this Agreement or the transactions contemplated herein.

8.12 **Counterparts.** This Agreement and any amendment hereto may be executed in two or more counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute one and the same agreement.

8.13 **Force Majeure.** Neither party shall be liable, nor deemed to be in default hereunder, for any delay in performance or failure to perform under this Agreement which results directly or indirectly from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, employee strikes or other work interruptions, earthquakes, floods, failure of transportation, or any cause beyond the reasonable control of such party. Provider acknowledges and agrees that this Agreement and the arrangement contemplated herein is subject to regulation by state and federal governmental authorities. In the event that any action of such governmental authority impairs, limits, or delays either party’s performance of any obligation hereunder, that party shall be excused from such performance, and party’s failure to perform such obligation for such reason shall not constitute a breach of this Agreement.

8.14 **Compliance with Regulatory Requirements.** Amerigroup and Provider shall each comply with all applicable Regulatory Requirements related to this Agreement, including the applicable Program Provider Manual(s). The failure of this Agreement to expressly reference a Regulatory Requirement applicable to either party in connection with their duties and responsibilities shall in no way limit such party’s obligation to comply with such Regulatory Requirement.

8.15 **Survivability.** Sections 3.11, 5.1, 3.9 and 8.4 of this Agreement relating to confidentiality, records, insurance, or indemnification shall survive termination or expiration of this Agreement. Additionally, any provisions of this Agreement or of a Program that contemplate performance subsequent to any termination or expiration of this Agreement shall survive any termination or expiration of this Agreement and continue in full force and effect.
8.16 **Entire Agreement.** This Agreement and any exhibits, addenda, attachments or amendments hereto, together with the applicable program provider manual(s), constitute the entire agreement and understanding between the parties with respect to the subject matter hereof, and supersedes any prior understandings and agreement between the parties, whether written or oral, with respect to the subject matter hereof. If any requirement in this Agreement is determined to be in conflict with the Program Contract, such requirement shall be deemed null and void, but all other provisions of this Agreement shall remain in full force and effect.
IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized officers or agents.

Amerigroup:

Amerigroup Tennessee, Inc., d/b/a Amerigroup Community Care, a Tennessee corporation

By: ________________________________ [Name]
______________________________ [Title]
______________________________ [EffectiveDate]

Provider:

Gov Agree

By:

(authorized signature) [PrintedName]
______________________________ [Title]
______________________________ [Address]
______________________________ [Telephone]
______________________________ [Date]

LIST the exhibits, addenda, and attachments here (So there is a record on the signature page of what was included in executed agreement):

Agreement
Medicaid Addendum
Number of Medicaid Attachment A(s): _____
Medicare Addendum
Number of Medicare Attachment A(s): _____
PROVIDER EPISODE-BASED RETROSPECTIVE PAYMENT APPENDIX

AMERIGROUP Tennessee, Inc.

d/b/a AMERIGROUP Community Care

Amerigroup shall implement Payment Reform Initiatives, including retrospective episode based reimbursement, as required by TennCare. Provider types identified by TennCare as Principal Accountable Providers ("PAPs") or "Quarterbacks" (QBs) are required, as a condition of participation in the TennCare Program, to participate in such AMERIGROUP Payment Reform Initiatives for the purposes of furthering quality improvement and reporting processes in accordance with TennCare requirements. Episodes and quality measures defined by TennCare will be provided within the Amerigroup Provider Episode-Based Retrospective Payment Appendix Thresholds Attachment. AMERIGROUP shall provide quarterly performance reports to Provider and Quarterbacks and shall reconcile episode performance annually.

Payment Reform Initiatives. Amerigroup has adopted this Episode-Based Retrospective Payment Program, (this “Program”) as part of the State of Tennessee’s Health Care Innovation Initiative for the purpose of more closely aligning reimbursement with health care quality. Amerigroup shall implement this Program as described in this Episode-Based Retrospective Payment Appendix (this “Appendix”), in accordance with TennCare requirements.

Provider acknowledges the TennCare Program is implementing an Episode of Care payment system for compensation of providers deemed to have the greatest accountability for quality and cost of care for a patient. Providers deemed to have the greatest accountability for the quality and cost of care for a patient are "Principal Accountable Providers" or "PAPs" or "Quarterbacks".

Provider agrees that a Quarterback, as identified by TennCare for each episode of care and as defined herein, is required by the TennCare Program to participate and cooperate with Amerigroup for purposes of furthering quality improvement and reporting processes as developed for this program and described by TennCare. Episodes and quality measures defined by TennCare are identified in the attached Amerigroup Thresholds Attachment, which is incorporated herein.

Amerigroup shall provide quarterly performance reports to the Quarterback and shall reconcile episode performance annually.

Additional episodes will be identified and added as determined by TennCare. Amerigroup will work with TennCare to define the process for adding each additional episode.

SECTION I—Definitions

Acceptable Cost Threshold: The dollar amount, as determined by TennCare, to which the Quarterbacks' risk adjusted average episode cost (calculated in Section II below) for a Program
Episode will be compared. The Acceptable Cost Threshold is used to determine the dollar amount of the Shared Risk Payment from the Quarterback to Amerigroup and can be found on each interim and final Performance Report provided to the Quarterback. See thresholds attachment.

**Commendable Cost Threshold:** The dollar amount, as determined by Amerigroup, to which the Quarterback’s risk adjusted average episode cost for a Program Episode will be compared. If the Quarterback meets all of the quality indicators linked to gain sharing, the commendable cost threshold is then used to determine dollar amount of a shared savings payment from Amerigroup to the Quarterback, subject to the Gain Share Limit. The dollar amount of the commendable cost threshold can be found on each interim and final Performance Report provided to the Quarterback. See thresholds attachment.

**Cost Zones:** Based on the prior quarter average episode costs, as calculated in Section II below, Quarterback Zone, or Commendable Cost Zone.

**Episode or Episode of care:** Episodes are acute or specialized treatments a patient receives for a specified period of time. An Episode will include all the different health care services related to the treatment of one acute or specialized health care event, net of episodes excluded for clinical or operational considerations.

**Episode Measurement Period ("EMP"):** The measurement period for the Quality Certification Component of the program defined as including all episodes ending the 12-month period that begins on the effective date of this Appendix. Subsequently measurement periods will begin as defined by TennCare.

**Episode Provider Stop-loss:** A methodology that will be incorporated into the Total Episode Cost calculation that is designed to limit significant provider risk under the episode of care model. The Episode Provider Stop-loss is not intended to be a regulated stop loss or reinsurance product, but rather is a calculation integrated within the Risk Sharing component of the Program intended to provide protection from the impact of excessive Quarterback penalties.

**Gain Share Limit:** Calculated, as defined by TennCare, as the average of the non-adjusted cost for the five lowest costs for a valid Episode of Care that will be used to calculate any shared savings payment to the Quarterback, if all of the eligibility criteria are met.

**Gain Sharing:** If a Quarterback achieves a risk-adjusted average per-episode cost below the commendable threshold while meeting quality standards, then the Quarterback is eligible for Gain Sharing. Gain Sharing is savings below the commendable threshold with respect to the Gain Share Limit.

**Member:** A member is a Medicaid enrollee assigned to Amerigroup by the state Medicaid program. A member is subject to retroactive disenrollment by the state, in which case such
individual will not be considered a member for any period as of the effective date of such disenrollment.

Performance Report: The interim or final report with respect to a given Episode Measurement Period that shows, on an interim or final basis, the Quarterback's performance results and the other information described in this Appendix.

Principal Accountable Provider ("PAP" or "Quarterback"): The provider deemed to have the greatest accountability for the quality and cost of care for a patient. Quarterbacks are designated for each episode based on the degree of influence they have over clinical decisions and the care delivered.

Quality Certification Component: The program component that measures the quality performance of the Quarterback. The quarterly quality certification is a prerequisite for becoming and remaining eligible for Gain Sharing. The quality certification designation will apply to those Quarterbacks that have a score meeting or exceeding TennCare defined threshold levels for Quality Indicators Linked to Gain Sharing.

Quality Indicators Linked To Gain Sharing: The set of indicators that will be used for determination of quality certification of each episode. These quality indicators will be based on clinically appropriate and evidence-based practice. Applicable quality indicator definitions and measurement specifications will be published with each episode. See thresholds attachment.

Quality Indicators Not Linked To Gain Sharing: The additional set of indicators that will be provided to each Quarterback of each episode for the purpose of quality improvement. These quality indicators will be based on clinically appropriate and evidence-based practice. Applicable quality indicator definitions and measurement specifications will be published with each episode.

Risk Sharing: If a Quarterback's risk adjusted average per-episode cost is more than the acceptable threshold, no gain share payment is earned, and the risk will be shared with Amerigroup. Risk sharing is the cost above the Acceptable Threshold.

Total Episode Cost: The total episode cost is the sum of the amount that reflects the totality of all costs for claims identified for all TennCare Members included in the episode.

Valid Episode of Care: Covered Services provided by one or more providers over a period of time related to a particular condition or procedure, including clinically related services, as pre-defined by TennCare. An episode will include all the different health care services related to the treatment of one acute or specialized health care event, net of episodes excluded for clinical or operational considerations.
Section II - Gain/Risk Share Pay Component

Risk Sharing Amount: If the risk-adjusted average episode cost is more than the acceptable cost threshold, no gain share payment is earned and the risk will be shared with Amerigroup. The Quarterback, without regard to whether the eligibility criteria are met, is required to pay their portion of any deficit to Amerigroup. In the event that the final performance report shows that the provider owes money to Amerigroup, the final report will serve as an invoice to the provider, and the provider will need to issue their payment to Amerigroup within 30 days of the date of this notification. If Amerigroup does not receive payment, Amerigroup reserves the right to offset claim payments for money owed.

Steps for submitting payment:
Checks should be made out to Amerigroup and mailed to the address below. Include as a note on the remit check that this payment is for the Episodes of Care program and the name of the Episode(s) the risk share amount is referencing:
Amerigroup Community Care Attn: Finance Department
22 Century Blvd., Suite 220
Nashville, TN 37214

Gain Sharing Amount: If the risk-adjusted total episode cost is less than the acceptable cost threshold for the episode measurement period, the Quarterback's unadjusted payment by Amerigroup will be calculated according to the specifications below. The delivery date for checks to providers is within 30 days of the date of this notification. Providers who will receive a gain-share payment will receive a paper check. This check will be sent to the remittance address on file with Amerigroup and/or the requested mailing address of the provider.

Total Episode Cost = All associated claims submitted and paid during an episode measurement period.

Total # of valid episodes = Net of episodes excluded for clinical or operational considerations

\[
\text{Avg. episode cost (non adj.)} = \frac{\text{Raw claims average}}{\text{Total episode cost}} \div \text{total # of valid episodes}
\]

Risk adjustment factor (avg.) =
The adjustment needed to insure that the average risk score across all episodes for Amerigroup is equal to 1.00
Average adjustment to raw claims to account for clinical variability

\[
\text{Avg. episode cost (risk adj.)} = \frac{\text{Adjusted cost per episode}}{\text{Average episode cost non-adjusted}} \div \text{the risk adjustment factor}
\]

Total Gain Sharing generated =

---

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Total difference in adjusted cost vs. commendable cost =
Difference between average episode cost risk-adjusted and commendable cost × total # of valid episodes

Total Risk Sharing penalty =
Total difference in adjusted cost vs. not acceptable cost =
Difference between acceptable cost and average episode cost risk-adjusted × total # of valid episodes

SECTION III – Notification
Amerigroup shall notify Quarterbacks to the availability of their quarterly performance and/or preview EOC reports via email, fax, or letter. The Quarterback will be asked to respond to Amerigroup confirming receipt of the notification, confirming their preferred delivery method, and contact person. Quarterbacks must provide their most up-to-date contact information as this is essential in order for providers to receive alerts about any changes to EOC reports or newly released reports in a timely manner. In the initial communication to Quarterbacks, Amerigroup shall provide 1) instructions on how to access full reports, and 2) how to share and update electronic contact information.

Section IV - Reporting Component
The Quarterback’s performance will be measured for each episode in reports. Average episode cost (risk adjusted) will be compared with pre-determined thresholds. Based on performance, Amerigroup will then reconcile total payment with each Quarterback. This performance summary will provide a detailed picture of the quality indicators of a Quarterback that go into the Quarterback’s quality outcomes and how the Quarterback is performing relative to other Quarterbacks in this episode.

Cost ranges for commendable, acceptable and unacceptable costs will also be included in the report. If the Quarterback’s costs are considered unacceptable, the Quarterback will be subject to risk sharing. If the Quarterback’s costs are in the acceptable range, there will be neither gain nor risk sharing. If the Quarterback’s costs are within the commendable range, the Quarterback will be eligible for gain sharing as long as the Quarterback met required quality metrics.

Section V - Eligibility - Quality Certification
A. Amerigroup will make available to the Quarterback an interim performance report on a quarterly basis. This report is designed to provide a summary and to list those members that are included in any of the quality indicators measurements for each valid episode. This report will detail the quality indicators linked to gain/risk sharing.

B. Quarterbacks who do not meet the benchmarks for quality indicators linked to Gain Sharing are ineligible for Gain Sharing. In addition, Quarterbacks whose average episode costs fall above the acceptable threshold are responsible for a portion of those costs. Quarterbacks
whose average cost falls between the commendable and acceptable thresholds receive no gain share and pay no risk share.

All Quarterbacks involved in an episode of care will be paid in accordance with their Agreement for services rendered.

Section VI - Quarterly Reconciliations and Payments

Quarterly performance reports are for informational purposes, and only the final performance report for a given performance period will be used to determine any shared gain/risk payments.

A. **Risk Share Payment**: Payment equal to 50% of the total Risk Shared. See Section II for calculations.

B. **Gain Share Payment**: Payment equal to 50% of the total Gain Shared. See Section II for calculations.

C. **Shared Risk Payment Due Date**: Amerigroup or Quarterback, as applicable, will pay to the other party the shared risk payment, if any, within a predetermined, agreed upon number of days after Amerigroup provides the final Quarterback Performance Report.

Section VII - Regulatory Requirements

A. The parties acknowledge and agree that: (i) the compensation set forth in the Agreement, including this Appendix, does not reward Quarterbacks for limiting the provision of any medically necessary services to any patients; and (ii) nothing contained in the Agreement, including this Appendix, will be construed in any manner as creating an obligation or inducement to limit the provision of any medically necessary services to be provided by Quarterbacks. Provider, on behalf of itself and/or its assigned Quarterbacks, covenants and agrees that Quarterbacks will immediately report to Amerigroup any physician, health care professional or facility whom a Quarterback believes, or has reason to believe, may have limited or denied, or attempted to limit or deny, medically necessary or clinically appropriate care to one or more Members. Any such limitation, denial, or attempt, as determined by Amerigroup in its sole discretion, will be grounds for immediate termination of this Appendix and will be deemed a material breach under the Agreement for purposes of termination of the Agreement; and notwithstanding anything in this Appendix to the contrary, no further payments will be made under this Appendix in the event of such termination. In its sole discretion, Amerigroup may elect instead to exclude the individual physician, health care professional or facility from participating under this Appendix immediately upon written notice to such Quarterback. Provider acknowledges and agrees that Amerigroup is relying upon the foregoing representations and covenants of Quarterback in connection with Quarterback's participation in the Program described in this Appendix.
B. Provider, on behalf of itself and/or its assigned Quarterbacks, represents and warrants that, to the extent the Provider distributes any portion of any incentive payments to or from Amerigroup under this Appendix to PCPs, Quarterback (i) will make such distribution(s) in compliance with CMS rules and regulations and (ii) will make any such distributions on a per capita basis to all professionals who have been PCPs for at least one year, and shall not limit distributions to any particular group of individual physicians or professionals; and (iii) will limit each such payment so that no PCP receives an amount that would result in substantial financial risk as defined by the PIP Regulations. If requested by Amerigroup, Quarterbacks will provide Amerigroup with a description of their physician compensation arrangements and such other information related to such payments as needed to demonstrate the Quarterback’s compliance with CMS and other applicable rules and regulations and this Section.

C. If this Appendix is required to be filed with one or more federal, state or local governmental authorities, Amerigroup will be responsible for each such filing. If, following any such filing, the governmental authority requests changes to this Appendix, Provider, on behalf of itself and/or its Quarterbacks, agrees to cooperate with Amerigroup in preparing the response to the governmental authority.

Section VIII - Reconsideration
Regarding quarterly and performance EOC reports, if there are any concerns with data in either of these partial year reports, please contact your EOC Provider Representative within 30 days of the report notification or email agpeepisode.reporting@amerigroup.com. Amerigroup will then work with you to investigate the reported concerns and determine the best course of action to address the issue. This is an informal process and not part of the final report reconsideration process.

There are two levels of reconsideration for the EOC program. The first step is with Amerigroup. The second step is with the Tennessee Department of Commerce and Insurance (TDCI). After receiving the Final Performance Report in August and in the event that a Quarterback has concerns regarding the program provider payment and/or metrics accuracy of the final performance report, the Quarterback will submit a formal Reconsideration request as detailed below:

Within 30 business days following the date of the final performance report notification, providers have the right to submit a written request for reconsideration to Amerigroup. Amerigroup will review and respond within 30 business days of receipt of the reconsideration. Steps for submitting a written reconsideration request:
Reconsideration requests need to be sent in writing to Amerigroup via mail or email: Mail: Amerigroup Community Care
Attn: Provider Relations — Episodes of Care 22 Century Blvd., Suite 220
Nashville, TN 37214
Email: agpeepisode.reporting@amerigroup.com
Please provide a detailed rationale to support the reconsideration request to include:
• Identification of each performance result (payment and metrics) to be reconsidered

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TN-Episode Payment 3.1.2018
Identification of the contested result calculated
A detailed explanation of why the provider believes the determination is incorrect
Any other relevant information to support the provider's reconsideration request

If the Quarterback does not object in writing to a final reconsideration within 30 days following the receipt of Amerigroup's reconciliation report, the Quarterback will be deemed to have accepted such reconciliation.

If a provider is dissatisfied with the result of the reconsideration process or if Amerigroup fails to respond to the reconsideration request within 30 days from the received date of the payment dispute, the provider may submit a Provider Complaint about specific claims or an episode directly to TDCl. This is an option instead of starting the independent review process which is detailed below. To submit a provider complaint to TDCl the Provider will access the Provider Complaint Form: TennCare Program Episode of Care Cycle, Provider Gain/Risk Share Total Complaint. Instructions for completing the form can be obtained on the State website, https://www.tn.gov/content/dam/tn/commerce/documents/tcoversight/forms/PROVIDER_CO MPLAINT_EOC_FORM_111416.pdf. TDCl will process the complaint within a few days of receipt and allow Amerigroup 30 calendar days to investigate and respond accordingly. This process is estimated to take no longer than 40 days. However, please note that unlike the independent review protocol, this process is informal and not binding for either party.

The provider may also submit concerns to the Commissioner of the Department of Commerce and Insurance for an independent review of the disputed claims as set forth in T.C.A. 56-32-126. The Independent Review Process is available to providers to resolve episodes of care disputes. It is understood that in the event providers file a request with the Commissioner for independent review the dispute, shall be governed by T.C.A. 56-32-126(b).

The request to the Commissioner for Independent Review of Disputed TennCare Claim form and instructions for completing the form, sample copies of requests to the commissioner for independent review, and FAQ developed by the State of Tennessee Department of Commerce and Insurance can be obtained on the State website (tn.gov/commerce>Our Divisions>TennCare Oversight>MCO Dispute Resolution>Independent Review Process).

Section IX - Program Changes
Amerigroup will review program components as defined by TennCare and update them as necessary. Amerigroup will modify or amend the Program as determined by TennCare with 30-days' written notice to the Provider.

Section X - Cooperation and Review
Provider, on behalf of itself and/or its Quarterbacks, agrees to cooperate with Amerigroup in all ways which affect TennCare's Payment Reform Initiatives. Provider shall be responsible for promptly reviewing any and all reports provided to Quarterbacks by Amerigroup hereunder. Provider and/or Quarterbacks shall, within 30 days of receipt of such reports, notify Amerigroup in writing of any discrepancies or inaccuracies in such reports.

TN-Episode Payment 3.1.2018
Section XI – Business Associate Agreement
In the event Provider is not a “covered entity”, as such term is defined in the HIPAA Regulations; a Business Associate Agreement shall be executed and made a part thereof. Provider acknowledges that if it is not a covered entity, Amerigroup is unable to disclose to Provider any protected health information regarding any Covered Person until a Business Associate Agreement is fully effective between the parties hereto.
## AMERIGROUP PROVIDER EPISODE-BASED RETROSPECTIVE PAYMENT: THRESHOLDS ATTACHMENT

<table>
<thead>
<tr>
<th>Episodes</th>
<th>Threshold for Quality Indicators Linked To Gain Sharing</th>
<th>Acceptable Threshold</th>
<th>Commendable Threshold</th>
<th>Gain Share Limit</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>1. Follow-up with physician 30%</td>
<td>($1,394)</td>
<td>($883)</td>
<td>($183)</td>
<td>Jan-18</td>
</tr>
<tr>
<td></td>
<td>2. Patient on appropriate medication 60%</td>
<td></td>
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<tr>
<td>Perinatal</td>
<td>1. C-section Rate 41%</td>
<td>($8,213)</td>
<td>($6,553)</td>
<td>($2,934)</td>
<td>Jan-18</td>
</tr>
<tr>
<td></td>
<td>2. Group B strep screening rate 85%</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. HIV screening rate 85%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Joint Replacement</td>
<td>No quality metrics linked to gain sharing</td>
<td>($19,843)</td>
<td>($9,776)</td>
<td>($8,783)</td>
<td>Jan-18</td>
</tr>
<tr>
<td>COPD Acute Exacerbation</td>
<td>Patient visits to other practitioner during the post-trigger window 40%</td>
<td>($3,300)</td>
<td>($2,164)</td>
<td>($281)</td>
<td>Jan-18</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>Percent of valid episodes performed in a facility participating in a Qualified Clinical Data Registry (QCDR) 25%</td>
<td>($1,325)</td>
<td>($619)</td>
<td>($290)</td>
<td>Jan-18</td>
</tr>
<tr>
<td>Cholecystectomy</td>
<td>Hospital admission in the post-trigger window</td>
<td>($6,312)</td>
<td>($3,624)</td>
<td>($2,122)</td>
<td>Jan-18</td>
</tr>
<tr>
<td>Acute PCI</td>
<td>Hospital admission in the post-trigger window</td>
<td>($13,384)</td>
<td>($8,782)</td>
<td>($3,448)</td>
<td>Jan-18</td>
</tr>
<tr>
<td>Non-acute PCI</td>
<td>Hospital admission in the post-trigger window</td>
<td>($11,596)</td>
<td>($8,064)</td>
<td>($3,532)</td>
<td>Jan-18</td>
</tr>
<tr>
<td>GI Hemorrhage (G1H)</td>
<td>Follow-up care within the post-trigger window</td>
<td>($6,028)</td>
<td>($2,607)</td>
<td>($236)</td>
<td>Jan-18</td>
</tr>
<tr>
<td>Upper GI endoscopy (EGD)</td>
<td>Percent of valid episodes performed in a facility participating in a Qualified Clinical Data Registry (QCDR) 25%</td>
<td>($1,769)</td>
<td>($988)</td>
<td>($383)</td>
<td>Jan-18</td>
</tr>
<tr>
<td>Respiratory Infection</td>
<td>No quality metrics linked to gain sharing</td>
<td>($172)</td>
<td>($109)</td>
<td>($20)</td>
<td>Jan-18</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Follow-up care within the post-trigger window</td>
<td>($2,192)</td>
<td>($898)</td>
<td>($134)</td>
<td>Jan-18</td>
</tr>
<tr>
<td>Urinary Tract Infection (UTI)-Outpatient</td>
<td>Admission within the trigger window for ED triggered episodes 5%</td>
<td>($228)</td>
<td>($118)</td>
<td>($19)</td>
<td>Jan-18</td>
</tr>
<tr>
<td>Urinary Tract Infection (UTI) Inpatient</td>
<td>Admission within the trigger window for non-ED triggered episodes 5%</td>
<td>($5,834)</td>
<td>($4,269)</td>
<td>($923)</td>
<td>Jan-18</td>
</tr>
<tr>
<td>Episodes</td>
<td>Threshold for Quality Indicators Linked to Gain Sharing</td>
<td>Acceptable Threshold</td>
<td>Commendable Threshold</td>
<td>Gain Share Limit</td>
<td>Effective Date</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------------------</td>
<td>----------------------</td>
<td>-----------------------</td>
<td>-----------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Attention Deficit and Hyperactivity Disorder (ADHD)</td>
<td>Minimum Care requirement (5 visits/claims) during the episode window</td>
<td>70%</td>
<td>($2,048)</td>
<td>($1,112)</td>
<td>($73)</td>
</tr>
<tr>
<td></td>
<td>Long-acting stimulants for members aged 4 and 5</td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Long-acting stimulants for members aged 6 to 11</td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Long-acting stimulants for members aged 12 to 20</td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Utilization of therapy for members aged 4 and 5</td>
<td>1 Visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barrett’s Surgery</td>
<td>Follow-up care within the post-coagulation window</td>
<td>30%</td>
<td>($10,468)</td>
<td>($8,945)</td>
<td>($6,880)</td>
</tr>
<tr>
<td></td>
<td>Coronary Artery Bypass Graft (CABG)</td>
<td>Follow-up care within the post-coagulation window</td>
<td>90%</td>
<td>($44,428)</td>
<td>($30,499)</td>
</tr>
<tr>
<td></td>
<td>Congestive Heart Failure (CHF) Acute Exacerbation</td>
<td>Follow-up care within the post-coagulation window</td>
<td>60%</td>
<td>($9,334)</td>
<td>($5,003)</td>
</tr>
<tr>
<td></td>
<td>Oppositional Defiant Disorder (ODD)</td>
<td>Minimum Care requirement (6 therapy and/or level 1 case management visits) during the episode window</td>
<td>30%</td>
<td>($2,199)</td>
<td>($1,847)</td>
</tr>
<tr>
<td></td>
<td>Value repair and replacement</td>
<td>Follow-up care within the post-coagulation window</td>
<td>90%</td>
<td>($84,095)</td>
<td>($33,899)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Minimum care requirement</td>
<td>25%</td>
<td>($924)</td>
<td>($381)</td>
<td>($79)</td>
</tr>
<tr>
<td></td>
<td>Utilization of benzodiazepines in children</td>
<td>5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Biopsy</td>
<td>Appropriate diagnostic workup rate</td>
<td>90%</td>
<td>($2,721)</td>
<td>($1,167)</td>
<td>($537)</td>
</tr>
<tr>
<td></td>
<td>Core needle biopsy rate</td>
<td>85%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-emergent Depression</td>
<td>Minimum care requirement</td>
<td>60%</td>
<td>($2,797)</td>
<td>($416)</td>
<td>($67)</td>
</tr>
<tr>
<td></td>
<td>Utilization of benzodiazepines in children</td>
<td>5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tonsillectomy</td>
<td>Bleeding up to two days following the procedure</td>
<td>10%</td>
<td>($3,926)</td>
<td>($2,345)</td>
<td>($58)</td>
</tr>
<tr>
<td>Otitis Media</td>
<td>OME episodes without antibiotics filled</td>
<td>25%</td>
<td>($316)</td>
<td>($160)</td>
<td>($28)</td>
</tr>
<tr>
<td></td>
<td>Non-OME episode with antibiotics filled</td>
<td>60%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSTI</td>
<td>Bacterial cultures when I&amp;O performed</td>
<td>50%</td>
<td>($439)</td>
<td>($183)</td>
<td>($20)</td>
</tr>
<tr>
<td></td>
<td>SSTI episodes with a first line antibiotic</td>
<td>85%</td>
<td>($5,377)</td>
<td>($3,727)</td>
<td>($304)</td>
</tr>
<tr>
<td>HIV</td>
<td>Periodic ART refill</td>
<td>85%</td>
<td>($8,837)</td>
<td>($8,714)</td>
<td>($1,025)</td>
</tr>
<tr>
<td></td>
<td>Pancreatitis</td>
<td>Follow-up care within 14 days</td>
<td>30%</td>
<td>($8,836)</td>
<td>($8,244)</td>
</tr>
<tr>
<td>Diabetes Acute Exacerbation</td>
<td>Follow-up care within the first 14 days</td>
<td>30%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Change in quality metric threshold from 2017 CY.

Acceptable Cost Threshold: The dollar amount, as determined by TENNCARE, to which the PAP’s or QB’s risk adjusted average episode cost (calculated in Section II below) for a Program Episode will be compared. The Acceptable Cost Threshold is used to determine the dollar amount of the Shared Risk Payment from the QB to Amerigroup and can be found on each interim and final Performance Report provided to the QB.
Commendable Cost Threshold: The dollar amount, as determined by Amerigroup, to which the QB's average episode cost for a Program Episode will be compared. If the QB meets all of the quality indicators linked to gain sharing, the commendable cost threshold is then used to determine the dollar amount of a shared risk payment from Amerigroup to the QB, subject to the Gain Share Limit. The dollar amount of the commendable cost threshold can be found on each interim and final Performance Report provided to the QB.

Additional episodes will be identified as determined by TENNCARE and added to this attachment prior to the beginning of each performance period.
Employment Community First Provider Addendum
To
AMERIGROUP Tennessee, Inc.
d/b/a Amerigroup Community Care
PARTICIPATING PROVIDER AGREEMENT

THIS ADDENDUM is made effective as of the effective date of that certain Participating Provider Agreement, as hereinafter defined, by and between (“Provider”) and AMERIGROUP Tennessee, Inc. d/b/a AMERIGROUP Community Care (“AMERIGROUP”).

RECITALS:

A. AMERIGROUP and Provider are parties to that certain Participating Provider Agreement of even date herewith (the “Agreement”).

B. In the event of a conflict between the Addendum and the Agreement, the Addendum shall control.

AGREEMENT:

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows.

1.1 Insurance Coverage.

(a) Coverage Requirements. At all times during the term of this Agreement, Provider shall maintain professional liability insurance, including maintaining such tail or prior acts coverage necessary to avoid any gap in coverage for claims arising from incidents occurring during the term of this Agreement. Such insurance shall (i) be obtained from a carrier authorized to issue coverage in the jurisdiction in which Provider operates, except for permitted self-insurance; and (ii) maintain minimum policy limits equal to $500,000.00 in the aggregate, or such other coverage amounts as prescribed by applicable Regulatory Requirements for a Program and consented to by Amerigroup. Provider shall maintain general liability insurance covering Provider’s premises, insuring Provider against any claim of loss, liability, or damage caused by or arising out of the condition or alleged condition of said premises, or the furniture, fixtures, appliances, or equipment located therein, and if Provider operates motor vehicles in connection with Provider’s services, with liability protection against any loss, liability or damage resulting from the operation of such motor vehicles by Provider, Provider’s employees or agents. Such general liability insurance shall contain commercially reasonable coverage limits, or such limits as prescribed by Regulatory Requirements for a
Program. To the extent required by Regulatory Requirements, Provider shall maintain workers’ compensation insurance for Provider’s employees.

(b) **Evidence of Insurance.** Provider shall provide Amerigroup with evidence of Provider’s compliance with the foregoing insurance requirements annually, or as otherwise reasonably requested by Amerigroup. Provider shall provide Amerigroup with at least thirty (30) days prior written notice of any cancellation or non-renewal of any required coverage or any reduction in the amount of Provider’s coverage, and shall secure replacement coverage as needed to meet the requirements above so as to ensure no lapse in coverage. Provider shall furnish Amerigroup with a certificate of insurance evidencing such replacement coverage. Provider shall also furnish a certificate of insurance to a requesting Agency upon request. Provider may maintain professional liability coverage hereunder through a self-funded insurance plan, acceptable to Amerigroup, provided that it maintains actuarially sound reserves related to such self-funded plan and provides on an annual basis an opinion letter from an independent actuarial firm or other proof attesting to the financial adequacy of such reserves.

(c) **Community Living Supports (“CLS”) and Community Living Supports-Family Model (“CLS-FM”) Providers Insurance Requirements.** If Provider provides CLS and CLS-FM services, the following additional insurance requirements will apply for the provision of such service:

(i) **Workers’ Compensation/ Employers’ Liability (including all States’ coverage) with a limit not less than seven hundred fifty thousand dollars ($750,000.00) per occurrence for employers’ liability. Comprehensive Commercial General Liability (including personal injury & property damage, premises/operations, independent Provider, contractual liability and completed operations/products coverage) with bodily injury/property damage combined single limit not less than seven hundred fifty thousand dollars ($750,000.00) per occurrence and one million, five hundred thousand dollars ($1,500,000.00) aggregate. Automobile Coverage (including owned, leased, hired, and non-owned vehicles coverage) with a bodily injury/property damage combined single limits not less than one million, five hundred thousand dollars ($1,500,000.00).**

1.2 **Adult and Children Protective Services.** Provider agrees to report suspected abuse, neglect, and exploitation of adults in accordance with TCA 71-6-103 to the Tennessee Department of Human Services and to report suspected brutality, abuse, or neglect of children in accordance with TCA 37-1-403 and TCA 37-1-605 to the Tennessee Department of Children’s Services.

1.3 **Member Support Coordinator Notification.** Provider shall notify a member’s support coordinator of any significant changes in the member’s needs or care, hospitalizations, emergency room visits or recommendations for additional services. AMERIGROUP will notify the Provider in writing of all assigned support coordinators for each member assigned to them.
1.4 Reportable Event and Management. Providers shall comply with applicable TennCare Rules and Regulations related to Reportable Event Management for Employment and Community First ("ECF") Providers.

1.5 Criminal Background and Registry Checks. In accordance with applicable Regulatory Requirements, Provider shall perform criminal background checks and registry checks for all employed or contracted individuals providing services under this Agreement.

1.6 Program Contract Requirements.

(a) Provider agrees to notify AMERIGROUP in writing at least thirty (30) days advance notice to AMERIGROUP when the provider is no longer willing or able to provide services to a member, including the reason for the decision, and to cooperate with the member’s support coordinator to facilitate a seamless transition to alternate providers.

(b) In the event that a Provider change is initiated for a member, regardless of any other provision in the Provider agreement, Provider shall continue to provide services to the member in accordance with the member’s person-centered support plan, as appropriate until the member has been transitioned to a new provider, as determined by AMERIGROUP, unless otherwise directed by AMERIGROUP; which may exceed thirty (30) days from the date of notice to AMERIGROUP unless the member is in immediate jeopardy or the member’s health and welfare would be otherwise at risk by remaining with the current provider, or if continuing to provide services is reasonably expected to place staff that would deliver services at imminent risk of harm;

(c) Provider agrees that reimbursement of a Provider shall be contingent upon the satisfactory provision of services to an eligible member in accordance with applicable federal and state requirements and the member’s person-centered support plan, as appropriate and as authorized by AMERIGROUP, and must be supported by detailed documentation of service delivery to support the amount of services billed, including at a minimum, the date, time and location of service, the specific service provided, the name of the member receiving the service, the name of the staff person who delivered the service, the detailed tasks and functions performed as a component of each service, notes for other caregivers (whether paid or unpaid) regarding the member or his/her needs (as applicable), and the initials or signature of the staff person who delivered the service;

(d) Provider shall immediately report any deviations from a member’s service schedule that would affect service authorizations to the member’s support coordinator;

(e) Provider shall use, as applicable, the electronic visit verification system specified by the AMERIGROUP in accordance with AMERIGROUP requirements;

(i) Amerigroup shall require that all Providers utilizing the electronic visit verification system ensure that all employees complete and submit worker surveys upon logging out of each visit using a format and in a manner prior approved by TENNCARE.
(f) Upon acceptance to provide approved services to a member as indicated in
the member’s person-centered support plan, as appropriate, the Provider shall ensure that it
has staff sufficient to provide the service(s) authorized by AMERIGROUP in accordance with the
member’s or person-centered support plan, as appropriate, including the amount, frequency,
duration and scope of each service in accordance with the member’s service schedule.

(g) Provider shall provide backup for their own staff if they are unable to fulfill
their assignment for any reason and ensure that backup staff meet the qualifications for the
authorized service; and

(h) Provider shall not require a member to choose the Provider as a provider of
multiple services as a condition of providing any service to the member.

(i) Prohibit Provider from soliciting members to receive services from the
provider including;

(j) Referring an individual for Provider screening and intake with the
expectation that Provider enrollment occur. The provider will be selected by the member as the
service provider; or

(k) Communicating with existing Provider members via telephone, face-to-face
or written communication for the purpose of petitioning the member to change providers;

(l) Communicating with hospitals, discharge planners or other institutions for
the purposes of soliciting potential members that should instead be referred to AMERIGROUP
or Area Agency on Aging and Disability (AAAD), or Department of Intellectual and
Developmental Disabilities (DIDD) as applicable;

(m) Providers shall screen their employees and contractors initially and on an
ongoing monthly basis to determine whether any of them has been excluded from participation
in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section
1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that
has been excluded. The provider shall be required to immediately report to AMERIGROUP any
exclusion information discovered. The provider shall be informed that civil monetary penalties
may be imposed against providers who employ or enter into contracts with excluded
individuals or entities to provide items or services to TennCare members.

(n) Prohibit providers from altering in any manner official Program or Money
Follows the Person (MFP) brochures or other Program or MFP materials unless AMERIGROUP
has submitted a request to do so to TENNCARE and obtained prior written approval from
TENNCARE in accordance with Section 2.17 of the Contract Risk Agreement.
(o) Prohibit providers from reproducing for its own use the Program or MFP logos unless AMERIGROUP has submitted a request to do so to TENNCARE and obtained prior written approval from TENNCARE in accordance with Section 2.17 of the Contract Risk Agreement.

(p) Provider agrees to maintain compliance with the HCBS Settings Rule detailed in 42 C.F.R. § 441.301(c)(4)-(5).

(q) Prior to executing the Agreement with Provider seeking Medicaid reimbursement for HCBS, AMERIGROUP shall verify that the Provider is compliant with the HCBS Settings Rule detailed in 42 C.F.R. § 441.301(c)(4)-(5).

(r) All ECF CHOICES Provider agreements shall specify that the Provider shall comply with any and all policies and requirements applicable to services provided under the Section 1915(c) HCBS waivers as set forth in DIDD policy and/or the DIDD Provider and/or modified by TENNCARE for the ECF CHOICES program.

(s) When there is a change of ownership with any ECF CHOICES providers, the new legal entity shall provide to TENNCARE a bill of sale (or equivalent) and documentation from the appropriate State licensing entity stating that the new legal entity is allowed to operate under the existing license until such time as a new license is issued. TENNCARE shall issue a new Medicaid ID based on this provider-submitted documentation, and AMERIGROUP shall reimburse the new legal entity based on rates provided by TENNCARE to AMERIGROUP on the next weekly rate file following TENNCARE’s receipt of the new legal entity’s documentation.

1.7 Community Living Supports (“CLS”) and Community Living Supports-Family Model (“CLS-FM”) Provider Requirements.

(a) Residential providers shall develop and maintain policies concerning fire evacuation and natural disasters, including ensuring staff are knowledgeable about evacuation procedures and any available safety equipment (e.g., fire extinguishers).

(b) Providers shall routinely monitor the maintenance of a sanitary and comfortable living environment and/or program site, and shall develop and maintain policies for staff to identify and report any individual or systemic problems identified. Additionally, all CLS-FM providers must complete a DIDD-compliant home study and a current DIDD Family Model Residential Supports Initial Site Survey prior to member placement.

(c) Providers with Provider-owned vehicles (including employee-owned vehicles used to transport members) shall develop and maintain policies to routinely inspect such vehicles, including adaptive equipment used in such vehicles, and report and resolve any deficiencies with these vehicles.
(d) Providers shall designate a staff member as an Incident Management Coordinator who shall be trained on critical incident processes by Amerigroup as prescribed by TENNCARE. Such staff member shall be the Provider’s lead for critical incidents, be primarily responsible for tracking and analyzing critical incidents and Amerigroup’s main point of contact at the provider agency for critical incidents.

(e) Providers shall develop and maintain a crisis intervention policy that is consistent with TennCare requirements and approved by Amerigroup. As applicable, policies shall include instructions for the use of psychotropic medications and behavioral safety interventions.

(f) Providers shall develop and maintain a complaint resolution process, which includes, but is not limited to: designation of a staff member as the complaint contact person; maintenance of a complaint log; and documentation and trending of complaint activity. The provider’s policies and procedures concerning the complaint resolution process shall be available to Amerigroup upon request.

(g) As applicable, Providers providing assistance to members with medication administration shall develop and maintain policies to ensure any medications are provided and administered by trained and qualified staff consistent with a physician’s orders. Such Providers shall ensure that medication administration records are properly maintained, and that all medication is properly stored and accessible to members when needed. Such Providers shall also develop and maintain policies to track and trend medication variance and omission incidents to analyze trends and implement prevention strategies.

(h) Providers shall develop and maintain policies approved by Amerigroup that ensure members are treated with dignity and respect, including training staff on person-centered practices. Such policies shall include, but are not limited to:

(i) Ensuring members/representatives and family are given the opportunity to participate in the selection and evaluation of their direct support staff, if applicable;

(ii) Soliciting member/representative and family feedback on provider services;

(iii) Ensuring the member/representative has information to make informed choices about available services;

(iv) Ensuring members are allowed to exercise personal control and choice related to their possessions;

(v) Supporting members in exercising their rights;
(vi) Periodically reviewing members’ day services and promoting meaningful day activities, if applicable;

(vii) Supporting the member in pursuing employment goals; and

(viii) Only restricting members’ rights as provided in the member’s person-centered support plan.

(i) Residential Providers shall develop and maintain policies to ensure that members have good nutrition while being allowed to exercise personal choice and that members’ dietary and nutritional needs are met.

(j) Providers shall ensure that staff have appropriate, job-specific qualifications and shall verify prior to and routinely during employment that provider staff have all required licensure and certification. Additionally, all providers shall ensure that staff receive ongoing supervision consistent with staff job functions.

(k) Providers shall ensure that the composition of the provider board of directors or community advisor group, as applicable, reflects the diversity of the community that the provider serves and is representative of the people served.

(l) Residential Providers shall have policies and procedures to manage and protect members’ personal funds that comport with all applicable TennCare policies, procedures and protocols.

(m) Providers shall agree to carry adequate liability and other appropriate forms of insurance as stated in section 1.1 (c) above.

(n) All provider agreements for CLS and CLS-FM providers shall include a requirement that such Providers allow DIDD staff access to pertinent CHOICES member documentation as specified in TennCare protocol during DIDD critical incident investigations in CLS and CLS-FM blended residences in instances where the critical incident may impact all residents of the home (for example, staff misconduct). For the purpose of this Contract, a CLS or CLS-FM blended residence is one in which at least one (1) CHOICES member and one (1) DIDD waiver participant receive services in the same CLS or CLS-FM residence.

(o) Provider shall require that all direct support staff (i.e., provider staff working directly with people in ECF CHOICES) complete required training as prescribed by TENNCARE within thirty (30) days of hire and prior to providing direct support to members.
AMERIGROUP TENNESSEE, Inc.
d/b/a AMERIGROUP Community Care
MEDICARE Addendum

THIS MEDICARE ADDENDUM is made effective as of the effective date of that certain Participating Provider Agreement, as hereinafter defined, by and between Gov Agree ("Provider") and AMERIGROUP Tennessee, Inc. d/b/a AMERIGROUP Community Care ("AMERIGROUP").

RECITALS:

A. AMERIGROUP and Provider are parties to that certain Participating Provider Agreement of even date herewith (the “Agreement”).

B. Provider desires to furnish services under the Medicare Program, including without limitation, the Amerivantage Classic + Rx plan, which includes copays for most services, and Amerivantage Specialty + Rx plan to beneficiaries who are eligible for both Medicare and Medicaid benefits (dual-eligible) and enrolled in the following Medicare Savings Programs: Qualified Medicare Beneficiaries (QMB) and QMB Plus, and AMERIGROUP desires that Provider furnish these services in accordance with the terms and conditions set forth in this Medicare Addendum (the “Addendum”).

AGREEMENT:

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows.

ARTICLE I
DEFINITIONS

1.1 “Downstream Entity(ies)” means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare benefit, below the level of the arrangement between Amerigroup and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

1.2 “First Tier Entity(ies)” means any party that enters into a written agreement, acceptable to CMS, with Amerigroup to provide administrative services or health care services for a Medicare eligible Covered Person under the Medicare Program.

1.3 “Medically Necessary” or "Medical Necessity" means care which CMS determines is reasonable and necessary under Medicare for services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of Covered Person's medical condition and meet accepted standards of medical practice.
1.4 "Related Entity(ies)" means any entity that is related to Amerigroup by common ownership or control and (1) performs some of Amerigroup’s management functions under contract or delegation; (2) furnishes services to Covered Person under an oral or written agreement; or (3) leases real property or sells materials to Amerigroup at a cost of more than twenty-five hundred dollars ($2,500) during a contract period.

ARTICLE II
OBLIGATIONS OF PARTIES

2.1 Conformance with Law.

(a) Pursuant to 42 C.F.R. §§ 422.504(i)(4)(v) Amerigroup, Provider, and any First Tier, Downstream or Related Entity, contractor or subcontractor will comply with all applicable Medicare Regulatory Requirements and CMS instructions.

(b) Provider agrees to comply with all Regulatory Requirements that apply to all persons receiving state and federal funds, including without limitation, all applicable Medicare Regulatory Requirements and CMS instructions.

(c) Provider acknowledges and agrees that, in connection with the Medicare Program, Provider’s failure to report potential fraud or abuse to CMS may result in sanctions, cancellation of contract, or exclusion from participation in the

2.2 Hold Harmless. Provider agrees that in no event, including but not limited to non-payment by Amerigroup, insolvency of Amerigroup or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or any person acting on behalf of the Covered Person, other than Amerigroup, for Covered Services provided pursuant to this Agreement.

(a) Medicare Non-Covered Services. Notwithstanding any other provision in this Agreement applicable to non-Covered Services, Provider is not prohibited from the collection of amounts due for Medicare services that have been correctly identified in advance as a non-Covered Service, subject to medical coverage criteria, with appropriate disclosure to the Covered Person of his/her financial obligation. This advance notice must be provided in accordance with the CMS regulations for Medicare Advantage organizations. CMS regulations require that a coverage determination be made with a standard denial notice (Notice of Denial of Medical Coverage (or Payment)/CMS-10003) for a non-Covered Service or item when such service or item is typically not covered, but could be covered under specific conditions. If prior to rendering the service or item, Provider obtains, or instructs the Covered Person to obtain, a coverage determination of a non-Covered Service or item, the Covered Person can be held financially responsible for such non-Covered Services or items. However, if a service or item is never covered by Amerigroup, such as a statutory exclusion, and the Covered Person’s Evidence
of Coverage (EOC) clearly specifies that the service or item is never covered, Provider does not have to seek a coverage determination from Amerigroup in order to hold the Covered Person responsible for the full cost of the service or item. Additional information, related requirements and the process to request a coverage determination can be found in the Provider Manual. Both parties agree that failure to follow the CMS regulations can result in Provider’s financial liability.

2.3 Continuity of Care. Provider agrees that, upon termination of this Agreement for any reason (other than termination of Provider for reasons of medical competence or professional behavior), Provider shall continue to furnish Covered Services to all Medicare Covered Persons hospitalized as of the date of such termination up through the discharge of such Covered Persons. Amerigroup shall pay Provider for such Covered Services in accordance with terms applicable to the Medicare reimbursement set forth on Attachment A. In addition, Provider agrees that in the event of Amerigroup’s insolvency, termination of the CMS contract or other cessation of operations, Covered Services to Covered Persons will continue through the period for which the premium has been paid to Amerigroup, and services to Covered Persons confined in an inpatient hospital on the date of termination of the CMS contract or on the date of insolvency or other cessation of operations will continue until their discharge.

2.4 Delegation.

(a) Obligations.

(i) In accordance with 42 C.F.R. §422.504(i)(3)(iii), any services or other activity performed by a First Tier, Downstream or Related Entity, contractor, or subcontractor of Provider in accordance with a contract or written agreement shall be consistent and comply with Amerigroup’s contractual obligations with CMS.

(ii) Provider shall comply with the requirements of 42 C.F.R. §422.504(i)(4) if any of Amerigroup’s activities or responsibilities under its contract with CMS are delegated to other parties.

(iii) In addition to other requirements as set forth herein, if Amerigroup has delegated activities to Provider, then Amerigroup will provide the following information to Provider and Provider shall provide such information to any of its subcontracted entities: (1) A list of delegated activities and reporting responsibilities; (2) arrangements for the revocation of delegated activities; (3) notification that the performance of the contracted and subcontracted entities will be monitored by Amerigroup; (4) notification that the credentialing process must be approved and monitored by Amerigroup; and (5) notification that all contracted and subcontracted entities must comply with all applicable Medicare Regulatory Requirements and CMS instructions.

(iv) In addition to other requirements as set forth herein, Provider agrees that if Provider enters into subcontracts to perform services under the terms of this
Agreement, Provider’s subcontracts shall include: (1) an agreement by the subcontractor to comply with all of Provider’s obligations in this Agreement; (2) a prompt payment provision as negotiated by Provider and the subcontractor; (3) a provision setting forth the term of the subcontract (preferably one (1) year or longer); and (4) dated signatures of all the parties to the subcontract.

(b) Accountability.

(i) In accordance with 42 C.F.R. 422.504(i), Amerigroup shall oversee and be ultimately responsible to CMS for all responsibilities described in this Agreement.

(ii) In accordance with 42 C.F.R. §422.504(i)(3)(ii), Provider may only delegate activities or functions to a provider, First Tier, Downstream or Related Entity, contractor, or subcontractor in a manner consistent with the requirements set forth in 42 C.F.R. §422.504(i)(4).

(iii) In addition to the responsibilities for delegated activities as set forth herein, to the extent that Amerigroup has delegated selection of providers, contractors, or subcontractor to Provider, Amerigroup retains the right to revoke, approve, suspend, or terminate any such arrangement.

(c) Executive Order 13496. This provision is applicable to Providers who participate in Amerigroup’s Medicare Program under Medicare Parts C and D and receive at least $10,000 or more in payments from such Amerigroup Medicare Program. Provider shall comply with the requirements of Executive Order 13496, 29 CFR 471, Appendix A to Subpart A.

2.5 Inspection of Books and Records.

Provider acknowledges that Amerigroup, Health and Human Services department (HHS), the Comptroller General, or their designees have the right to timely access to inspect, evaluate and audit any books, contracts, medical records, patient care documentation, and other records of Amerigroup and Provider, or his/her/its First Tier, Downstream and Related Entities, including but not limited to subcontractors or transferees involving transactions related to Amerigroup’s Medicare Advantage contract through ten (10) years from the final date of the contract period or from the date of the completion of any audit, or for such longer period provided for in 42 CFR § 422.504(e)(4) or other applicable law, whichever is later. For the purposes specified in this section, Provider and Amerigroup agree to make available their premises, physical facilities and equipment, records relating to Amerigroup’s Covered Persons, including access to Provider’s computer and electronic systems and any additional relevant information that CMS may require.

In accordance with 42 C.F.R. Section 420.205, Provider further agrees to furnish to AMERIGROUP, the Secretary of Health and Human Services (the “Secretary”) or CMS on
request, information related to business transactions, within 35 days of the date on a request by the Secretary or an Agency, full and complete information about:

(1) The ownership of any Contracted Provider with whom Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

(2) Any significant business transactions between Provider and any wholly owned supplier, or between Provider and any Contracted Provider, during the 5-year period ending on the date of the request.

(3) The names of managing employees of the subcontractors;

(4) The identity of any other entities to which payment may be made by Medicare, which a person with an ownership or control interest or a managing employee in the subcontractor has or has had an ownership or control interest in the 3–year period preceding disclosure; and

(5) Any penalties, assessments, or exclusions under sections 1128, 1128A and 1128B of the Act incurred by the subcontractor, its owners, managing employees or those with a controlling interest in the subcontract.

2.6 Confidentiality. Provider shall comply with Regulatory Requirements relating to confidentiality and Covered Person record accuracy, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Regulatory Requirements, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by Covered Person to the records and information that pertain to them.

2.7 Risk Adjustment Data Validation Audits.

(a) Amerigroup and Provider are required in accordance with 42 CFR § 422.310(e) to submit a sample of medical records for Covered Persons for the purpose of validation of risk adjustment data. Accordingly, Amerigroup, or its designee, shall have the right to obtain copies of such documentation on at least an annual basis. Provider agrees to provide the requested medical records to Amerigroup, or its designee, within fourteen (14) calendar days from Amerigroup's, or its designee's, written request. Such records shall be provided to Amerigroup, or its designee, at no additional cost.

(b) Data Reporting Submissions. Provider agrees to provide to Amerigroup all information necessary for Amerigroup to meet its data reporting and submission obligations to CMS, including but not limited to, data necessary to characterize the context and purpose of each encounter between a Covered Person and the Provider ("Risk Adjustment Data"), and data necessary for Amerigroup to meet its reporting obligations under 42 CFR §§ 422.516 and
422.310. In accordance with the CMS requirements, Amerigroup reserves the right to assess Provider for any penalties resulting from Provider’s submission of false data.

(c) **Risk Adjustment Data.** Provider’s Risk Adjustment Data shall include all information necessary for Amerigroup to submit such data to CMS as set forth in 42 CFR § 422.310 or any subsequent or additional regulatory provisions. If Provider fails to submit his/her/its Risk Adjustment Data accurately, completely and truthfully, in the format described in the 42 CFR § 422.310 or any subsequent or additional regulatory provisions, then this will result in denials and/or delays in payment of Provider’s claims.

(d) **Accuracy of Risk Adjustment Data.** Provider further agrees to certify the accuracy, completeness, and truthfulness of Provider generated Risk Adjustment Data that Amerigroup is obligated to submit to CMS. Within thirty (30) days after the beginning of every fiscal year or as required by CMS while Provider participates in the Amerigroup Medicare Program pursuant to the Agreement, Provider agrees to provide Amerigroup with Risk Adjustment Data that is true, complete and correct, in a format that Amerigroup specifies.

2.8 **Cultural Competency.** Provider shall ensure that Covered Services rendered to Covered Persons, both clinical and non-clinical, are accessible to all Covered Persons, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, the homeless, and Covered Persons with physical and mental disabilities. Provider must provide information regarding treatment options in a cultural-competent manner, including the option of no treatment. Provider must ensure that Covered Persons with disabilities have effective communications with participants throughout the health system in making decisions regarding treatment options.

2.9 **No Payment Outside the U.S.** Provider agrees that Amerigroup shall not provide any payments for items or services provided under the Agreement to any financial institution or entity located outside the United States of America except for Medicare covered emergency services provided outside of the United States. Furthermore, Provider is prohibited to transfer TennCare member data or TennCare confidential information in any form via any medium to any third party beyond the boundaries and jurisdiction of the United States without the prior written consent of TennCare.

**ARTICLE III**

**REIMBURSEMENT**

3.1 **Reimbursement.** Attachment A is incorporated into this Agreement setting forth the Provider’s reimbursement for furnishing services under the Medicare Program, including without limitation, the Amerivantage Classic + Rx plan, which includes copays for most services, and Amerivantage Specialty + Rx plan to beneficiaries who are eligible for both Medicare and Medicaid benefits (dual-eligible) and enrolled in the following Medicare Savings Programs: Qualified Medicare Beneficiaries (QMB) and QMB Plus, and AMERIGROUP desires that Provider
furnish these services in accordance with the terms and conditions set forth in this Medicare Addendum (the “Addendum”).

3.2 Medicare Co-payments and Deductibles: Limitations of Billing.

(a) In connection with the Medicare Program, except for costs associated with non-Covered Services provided to a Covered Person, applicable co-payments and deductibles as permitted under the Medicare Program and set forth in the Amerigroup Provider Manual or in the schedule of benefits for the Medicare Program are the only amounts that Provider may collect from a Medicare-eligible Covered Person in connection with Covered Services. Provider acknowledges that Medicaid cost-sharing requirements may preclude Provider’s collection of co-payments or deductibles from dual eligible Medicare and Medicaid Covered Persons.

(b) Provider shall be responsible for collecting any applicable co-payments or permitted deductibles at the time of service in accordance with the policies and procedures set forth in the Amerigroup Provider Manual.

(c) Provider understands that if Provider initiates any actions to collect payment from any Medicare-eligible Covered Person over and above allowable co-payments, excluding payment for services not covered under the Medicare Program, Amerigroup will initiate and maintain such necessary actions to stop Provider or Provider’s employee, agent, assign, trustee, or successor in interest from maintaining such action against such Medicare-eligible Covered Person.

(d) Dual Eligibles. Provider further agrees that for Covered Persons who are dual eligible beneficiaries for Medicare and Medicaid, that Provider will not bill the Covered Person for cost-sharing that is not the Covered Member’s responsibility and such Covered Person will not be held liable for Medicare Parts A and B cost-sharing when the State is liable for the cost-sharing. In addition, Provider agrees to accept Amerigroup payment as payment in full or Provider should bill the appropriate State source.

3.3 Billing. For the purposes of the Medicare Program, Provider understands and agrees that Provider shall submit claims in accordance with all CMS requirements including, without limitation, requirements for electronic transactions in standard formats. In connection with the Medicare Program, Provider may, and is encouraged to, submit claims information through electronic data interchange (EDI) that allows for automated processing and adjudication of claims. Provider shall submit claims on the appropriate claim form for all Covered Services within one hundred twenty (120) days of the date those services are rendered. Claims received after this one hundred twenty (120) day period may be denied for payment. Provider shall submit claims to the location described in the Provider Manual.

3.4 Clean Claims. For the purposes of the Medicare Program, a “Clean Claim” is defined as a claim that has no defect, impropriety, lack of any required substantiating documentation, including substantiating documentation needed to meet CMS requirements for
encounter data, or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare. Amerigroup shall pay Clean Claims within thirty (30) days of receipt in accordance with terms applicable to Medicare reimbursement set forth on Attachment A and as may be specified in the Agreement or Provider Manual.

ARTICLE IV
MISCELLANEOUS

4.1 Non-Discrimination. Provider shall abide by the federal Civil Rights Act of 1964, the Federal Rehabilitation Act of 1973, and all other applicable statutes, regulations and orders (including, without limitation, Executive Orders 11246 and 11375, “Equal Employment Opportunities”) as amended, and any and all successor statutes, regulations and related orders. Provider shall not exclude any Covered Person from participation in any aid, care, service or other benefit, or deny any Covered Person such services on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin or any other classifications protected under federal or state laws, or be denied benefits of, or be otherwise subjected to discrimination in the performance of provider’s obligation under its agreement with AMERIGROUP or in the employment practices of the Provider. Provider will cooperate with TENNCARE and/or CMS, and Amerigroup, as applicable, during discrimination complaint investigations and report discrimination complaints and allegations to Amerigroup including allegations of discrimination as set forth in the CRA, i.e., any instance of disrespectful or inappropriate communication, e.g., humiliation, harassment, threats of punishment or deprivation, intimidation or demeaning or derogatory communication (vocal, written, gestures) or any other acts pertaining to a person supported that is not directed to or within eyesight or audible range of the person supported and that does not meet the definition of emotional or psychological abuse. The provider will assist any Covered Person in obtaining discrimination complaint forms and contact information for Amerigroup’s Nondiscrimination Office. The provider shall upon request show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees, TennCare applicants, and enrollees.