Amerigroup STAR+PLUS MMP
(Medicare-Medicaid Plan)
Provider Manual

Provider Services • 1-855-878-1785
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CHAPTER 1: INTRODUCTION

Welcome to the Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan)

Welcome to the Amerigroup STAR+PLUS MMP network of dedicated physicians and providers. We were selected by the State of Texas Health and Human Services Commission (HHSC) to integrate care for dual-eligible individuals, or those who are eligible for both Medicare and Medicaid. By consolidating the responsibility for all the covered services into a single plan, we see improved quality of care for the members; maximize the member’s ability to remain safely in their homes and communities; and improve continuity of care across acute care, long-term care, behavioral health and home- and community-based services using a patient-centered approach.

At Amerigroup STAR+PLUS MMP, our goals are to assist you in providing unequaled care to your patients while making the practice of medicine more rewarding in terms of better patient outcomes, better practice economics and diminished practice difficulties. By furnishing the means to accomplish these ends and by helping you and your patients access them, we are confident you will be proud to have joined us.

Service Area

A service area is the geographic area approved by CMS and the State of Texas Health and Human Services Commission in which a person must live to become or remain a member of Amerigroup STAR+PLUS MMP. Members who temporarily (as defined by CMS as six months or less) move outside of the service area are eligible to receive emergency and urgently-needed services outside the service area.

The service area for Amerigroup STAR+PLUS MMP consists of the following counties:
- Bexar
- El Paso
- Harris
- Tarrant

Using This Manual

Designed for Amerigroup STAR+PLUS MMP physicians, hospitals, long-term services and supports (LTSS) providers and ancillary providers who are participating in the Amerigroup STAR+PLUS MMP network, this manual is a useful reference guide for you and your office staff. We recognize that managing our members’ health can be a complex undertaking. It requires familiarity with the rules and requirements of a system that encompasses a wide array of health care services and responsibilities. We want to help you navigate our managed health care plan to find the most reliable, responsible, timely and cost-effective ways to deliver quality health care to our members.

This manual is available on our website at https://providers.amerigroup.com/TX. Providers may view it online, download it to their desktop or print it out from the site. If you have questions about the manual, please contact our Provider Services team at 1-855-878-1785.
We understand some of the information in this manual may need to be revised or changed. To that end, Amerigroup STAR+PLUS MMP may update or make changes to this manual periodically.

**Provider Self-Service Website**

Amerigroup STAR+PLUS MMP provides access to a website, [https://providers.amerigroup.com/TX](https://providers.amerigroup.com/TX), which contains the full complement of online provider resources. The website features an online provider inquiry tool to reduce unnecessary telephone calls by enabling easy access at your convenience to the following resources:

- Online support services, such as:
  - New user registration and activation, login help, and user name and password reset.
  - Forms to update provider demographics and information such as tax ID or group affiliation changes.

- Interactive look-up tools and reference materials, such as:
  - Provider/referral directories.
  - Precertification lookup tool.
  - Claims status/submission tool.
  - Reimbursement policies.

Provider Manuals are available via the provider website or through your local Provider Relations representative.

**Legal and Administrative Requirements**

**Disclaimer**

The information provided in this manual is intended to be informative and to assist providers in navigating the various aspects of participation with Amerigroup STAR+PLUS MMP. Unless otherwise specified in the Provider Agreement, the information contained in this manual is not binding upon Amerigroup STAR+PLUS MMP and is subject to change. Amerigroup STAR+PLUS MMP will make reasonable efforts to notify providers of changes to the content of this manual. This manual, as part of your Provider Agreement and related Addendums, may be updated at any time and is subject to change. In the event of an inconsistency between information contained in this manual and the Provider Agreement between you or your facility and Amerigroup STAR+PLUS MMP, the Agreement shall govern.

In the event of a material change to the Provider Manual, Amerigroup STAR+PLUS MMP will make all reasonable efforts to notify you in advance of such changes through newsletter communications and other mailings. In such cases, the most recently published information shall supersede all previous information and be considered the current directive. The manual is not intended to be a complete statement of all Amerigroup STAR+PLUS MMP program policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially targeted communications. These communications include, but are not limited to letters, bulletins and newsletters.
Throughout this manual, there are instances where information is provided as a sample or example. This information is meant for illustration purposes only and is not intended to be used or relied upon in any circumstance or instance.

This manual does not contain legal, tax or medical advice. Please consult other advisors for such advice.

**Third-Party Websites**
The Amerigroup STAR+PLUS MMP website and this manual may contain links and references to internet sites owned and maintained by third-party entities. Neither Amerigroup STAR+PLUS MMP nor its related affiliated companies operate or control in any respect any information, products or services on these third-party sites. Such information, products, services and related materials are provided as is without warranties of any kind, either express or implied, to the fullest extent permitted under applicable laws. Amerigroup STAR+PLUS MMP disclaims all warranties, express or implied, including but not limited to implied warranties of merchantability and fitness. Amerigroup STAR+PLUS MMP does not warrant or make any representations regarding the use or results of the use of third-party materials in terms of their correctness, accuracy, timeliness, reliability or otherwise.

**Privacy and Security Statements**
Amerigroup STAR+PLUS MMP privacy and security statements related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) can be found on the Amerigroup STAR+PLUS MMP website at [https://providers.amerigroup.com/TX](https://providers.amerigroup.com/TX).

Please be aware that when you travel from the Amerigroup STAR+PLUS MMP website to another website, whether through links provided by Amerigroup STAR+PLUS MMP or otherwise, you will be subject to the privacy policies (or lack thereof) of the other sites. We caution you to determine the privacy policy of such websites before providing any personal information.

**Misrouted Protected Health Information**
Providers and facilities are required to review all member information received from Amerigroup STAR+PLUS MMP to ensure no misrouted protected health information (PHI) is included. Misrouted PHI includes information about members that a provider or facility is not treating or are not enrolled in the practice. PHI can be misrouted to providers and facilities by mail, fax, email or electronic remittance advice. Providers and facilities are required to destroy immediately any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or re-disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please contact Provider Services at 1-855-878-1785.

**Collection of Personal and Clinical Information**
Amerigroup STAR+PLUS MMP will collect and release all personal and clinical information related to members in keeping with Texas and federal laws, including HIPAA, court orders or
subpoenas. Release of records according to valid court orders or subpoenas is subject to the provisions of that court order or subpoena.

The person or entity that is seeking to obtain medical information must obtain the authorization from the member and is to use that information only for the purpose it was requested and retain it only for the duration needed. The individual physician, provider, person or entity may not intentionally share, sell or otherwise use any medical information for any purpose deemed not necessary to provide health care services to the member.

Only necessary information shall be collected and maintained. Reasons for collecting medical information may include but are not limited to:
- Reviewing for medical necessity of care.
- Performing quality management, utilization management and credentialing/re-credentialing functions.
- Determining the appropriate payment under the benefit for covered services.
- Analyzing aggregate data for benefit rating, quality improvement and oversight activities.
- Complying with statutory and regulatory requirements.

**Maintenance of Confidential Information**
Amerigroup STAR+PLUS MMP maintains confidential information as follows:
- Clinical information received verbally may be documented in the Amerigroup STAR+PLUS MMP database. This database includes a secured system restricting access to only those with authorized entry. Computers, workstations and laptops are protected by a password known only to the user assigned to that computer. Devices displaying member or provider information shall not be left on and unattended.
- Electronic, facsimile or written clinical information received is secured, with limited access to employees to facilitate appropriate participant care and reimbursement for such care. No confidential information or documents shall be unattended (i.e., open carts, bins or trays at any time). Hard copies of all documents are not visible at any workstation during an employee’s breaks, lunch or time spent away from desks.
- Written clinical information is stamped *Confidential* with a warning cautioning that its release is subject to state and federal law.
- Confidential information is stored in a secure area with access limited to specified employees, and clinical information is disposed of in a manner that maintains confidentiality (i.e., paper shredding and destroying of recycle bin materials).
- Any confidential information used in reporting to other departments or to conduct training activities, which may include unauthorized staff, will be “sanitized” (i.e., all identifying information blacked out), to prevent the disclosure of confidential information.

Any records related to Quality of Care, unexpected incidence investigations or other Peer Review matters are privileged communications. As such, these records are considered as confidential. Such records are labeled *Confidential* with a warning that its release is subject to State and Federal Law. Information is maintained in locked files.

**Member Consent**
Member authorization is not required for treatment, payment and health care operations. Direct treatment relationships (i.e., the provision and/or coordination of health care by providers) require member consent.

**Member Access to Medical Records**
Members may access their medical records upon proper request. Upon reviewed and approved requests to the Amerigroup STAR+PLUS MMP compliance office, the member may provide a written amendment to their records if they believe that the records are incomplete or inaccurate.

No written request is required for information/documents to which a member would normally have access, such as copies of claims, etc. Amerigroup STAR+PLUS MMP verifies the identity of the individual member (i.e., subscriber number, date of service, etc.) before releasing any information.

A written request signed by a member or the member’s authorized representative is required to release medical records. An initial *consent to treat* may be signed at the point of entry into services prior to the provision of those services, but does not allow records to be released for any reasons other than those delineated in that original consent (i.e., payment and specialty referral authorization processes).

Amerigroup STAR+PLUS MMP will assist members who have difficulty obtaining requested medical records.

**Release of Confidential Information**
For members considered incompetent or lacking the legal capacity to give consent to medical treatment; incompetent members include:

- A member/conservatee who has been declared incompetent to consent to treatment by a court.
- A member/conservatee who has not been declared incompetent to consent to treatment, but whom the treating physician determines lacks the capacity to consent.
- A member who is not capable of understanding the nature and effect of the proposed treatment.

Amerigroup STAR+PLUS MMP will consult with legal counsel as appropriate. The durable power of attorney or letters of conservatorship may need to be reviewed by legal counsel to determine who may consent to the release of member information.

**Release to Providers**
Provider requests may be honored if the request pertains to that provider’s services. All other requests require the member’s or member representative’s signed release for the information. Electronic, facsimile or written clinical information sent is secured with limited access to those employees who are facilitating appropriate patient care and reimbursement for such care.

**Release of Outpatient Psychotherapy Records**
Anyone requesting member outpatient psychotherapy records must submit a written request except when the patient has signed a written letter or form waiving notification to the member and treating provider. The request must be sent to the member within 30 days of the receipt of the records except when the member has signed a written letter or form waiving notification. The written request must be signed by the requestor and must identify:

- What information is requested.
- The purpose of the request.
- The length of time the information will be kept.

A person or entity may extend the time frame provided the person or entity notifies the practitioner of the extension. Any notification of the extension will include:

- The specific reason for the extension.
- The intended use or uses of the information during the extended time.
- The expected date of the destruction of the information.

The request must specifically include the following:

- Statement that the information will not be used for any purpose other than its intended use.
- Statement that the person or entity requesting the information will destroy the information when it is no longer needed.
- Specifics on how the information will be destroyed, or specify that the person or entity will return the information and all copies of it before or immediately after the length of time indicated in the request.
- Specific criteria and process for confidentially faxing and copying outpatient psychotherapy records.

**Release of Records Pursuant to a Subpoena**

Member information will only be released in compliance with a *subpoena duces tecum* received by Amerigroup STAR+PLUS MMP as follows:

- The subpoena is to be accepted, dated and timed by the above person or designee.
- The subpoena should give Amerigroup STAR+PLUS MMP at least 20 days from the date the subpoena is issued to allow a reasonable time for the member to object to the subpoena and/or preparation and travel to the designated stated location.
- All subpoenas must be accompanied by either a written authorization for the release of medical records or a “proof of service” demonstrating the member has been “served” with a copy of the subpoena.
- Alcohol or substance abuse records are protected by both Federal and State law (42 CFR § 2.1 et seq.) and may not be released unless there is also a court order for release which complies with the specific requirements.
- Only the requested information will be submitted (HIV and AIDS information is excluded). HIV and AIDS or AIDS-related information require a specific subpoena (Va. Code Ann. Section 32.1-127.1:03.D and Va. Code Ann Section 32.1-36.1)
Should a notice contesting the subpoena be received prior to the required date, records will not be released without a court order requiring so. If no notice is received, records will be released at the end of the 20-day period.

The record will be sent through the U.S. Postal Service by registered receipt or certified mail.

**Archived Files/Medical Records**
All medical records are retained by Amerigroup STAR+PLUS MMP and/or the delegated/contracted medical groups as well as individual practitioner offices, according to the following criteria:
- Adult patient charts — 10 years
- X-rays — 10 years
# CHAPTER 2: CONTACTS

## Overview

<table>
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<th>Quick Reference Information</th>
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<tr>
<td><strong>Provider Services</strong></td>
<td>Contact Provider Services at 1-855-878-1785 for member eligibility, 24-Hour Nurse HelpLine and Pharmacy Services.</td>
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<tr>
<td><strong>Member Services</strong></td>
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<tr>
<td>• Telephone: 1-855-878-1784</td>
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<tr>
<td>• TTY: 711</td>
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<tr>
<td><strong>TTY</strong></td>
<td>Members should call 711</td>
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<td><strong>Medical Notification/Precertification</strong></td>
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<td>Precertification request:</td>
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<tr>
<td>• Fax: 1-888-235-8468</td>
<td></td>
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<tr>
<td>• Telephone: 1-855-878-1785</td>
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<td><strong>Claims Submission:</strong></td>
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<td><strong>Paper</strong></td>
<td>Submit paper claims to:</td>
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<td>Claims</td>
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<td>Amerigroup STAR+PLUS MMP</td>
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<td>P.O. Box 61010</td>
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<td>Virginia Beach, VA 23466-1010</td>
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<td><strong>Claims Submission:</strong></td>
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<td><strong>Electronic</strong></td>
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<td><strong>Clearinghouse</strong></td>
<td><strong>Payer Number</strong></td>
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<td>Availity</td>
<td>26375</td>
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<tr>
<td>Capario</td>
<td>28804</td>
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<tr>
<td>Emdeon</td>
<td>27514</td>
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<tr>
<td>Smart Data Solutions</td>
<td>81273</td>
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For help, call the Amerigroup STAR+PLUS MMP Electronic Data Interchange Hotline at 1-800-470-9630.

Timely filing is governed by the terms of the Provider Agreement.

- Amerigroup STAR+PLUS MMP provides an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status and precertification status at [https://providers.amerigroup.com/TX](https://providers.amerigroup.com/TX).
- If you are unable to access the internet, you may receive claims, eligibility and precertification status over the telephone at any time by calling our automated Provider Services number toll free at 1-855-878-1785.

| **Dental Services** | DentaQuest: 1-855-418-1621 |
| National Provider Identifier (NPI) | National Provider Identifier (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 STAR+PLUS MMP participating providers must have an NPI number, with the exception of atypical providers.  

Atypical providers are those individuals or businesses that are not health care providers and don’t meet the definition of health care providers according to the NPI rules. Therefore, these types of providers do not require an NPI number.  

The NPI is a 10-digit intelligence-free numeric identifier. Intelligence-free means 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 an application:  
- Online at [https://nppes.cms.hhs.gov](https://nppes.cms.hhs.gov) (Estimated time to complete the NPI application is 20 minutes).  
- By calling 1-800-465-3203 and requesting an application. |
| --- | --- |
| Provider Payment Disputes | Appeals are determined by the liable party not by the initiator. The time frame to review your request will commence once your appeal is received. Please refer to the denial letter or Explanation of Payment (EOP) issued to determine the correct appeals process.  

Payment disputes must be filed within 120 calendar days of the initial Amerigroup STAR+PLUS MMP decision. Send payment disputes to:  

Provider Payment Disputes  
Amerigroup STAR+PLUS MMP  
P.O. Box 61599  
Virginia Beach, VA 23466-1599 |
| Member Liability Appeals | A member liability appeal is the type of request made when the member wants Amerigroup STAR+PLUS MMP to reconsider and change an initial coverage/organization determination (by Amerigroup STAR+PLUS MMP or a provider) about what services, benefits or prescription drugs are necessary or covered or whether Amerigroup STAR+PLUS MMP will reimburse for a service, a benefit or a prescription drug.  

A member, or provider on the member’s behalf, may appeal:  
- An adverse initial organization determination by Amerigroup STAR+PLUS MMP or a provider concerning authorization for or termination of coverage of a health care service.  
- An adverse initial organization determination by Amerigroup |
Quick Reference Information

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<thead>
<tr>
<th>STAR+PLUS MMP concerning reimbursement for a health care service.</th>
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<tr>
<td>• An adverse initial organization determination by Amerigroup</td>
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<tr>
<td>STAR+PLUS MMP concerning a refusal to reimburse for a health</td>
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<tr>
<td>service already received if the refusal would result in the member</td>
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<td>being financially liable for the service.</td>
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<tr>
<td>• An adverse coverage determination by Amerigroup STAR+PLUS MMP</td>
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<td>or a provider concerning authorization for prescription drugs.</td>
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Appeals must be filed within 60 days of the Amerigroup STAR+PLUS MMP notification of the denial. The request may be made telephonically or in writing.

If the member or physician believes that waiting the normal time period for an appeal could seriously jeopardize the member’s life, health or ability to regain maximum function (the same expedited criteria used in initial decisions), the member or the member’s physician can request an expedited appeal. Such appeals generally are resolved within 72 hours, unless it is in the member’s interest to extend this time period. If a physician requests the expedited appeal and indicates the case meets the expedited criteria, Amerigroup STAR+PLUS MMP will automatically expedite the appeal.

Appeals should be sent to:

Complaints, Appeals and Grievances Department  
Amerigroup STAR+PLUS MMP  
Mailstop: OH0205-A537  
4361 Irwin Simpson Road  
Mason, OH 45040  
Phone: 1-855-817-5787  
Fax: 1-888-458-1406

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<tr>
<th>Nonemergent Transportation</th>
<th>Access2Care: 1-844-300-3631</th>
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<tr>
<td>Provider Service</td>
<td>For more information, contact Provider Services at 1-855-878-1785 or your local Provider Relations representative.</td>
</tr>
<tr>
<td>Translation/Interpreter Services</td>
<td>For assistance with translation services for your Amerigroup STAR+PLUS MMP patients, contact Provider Services at 1-855-878-1785.</td>
</tr>
<tr>
<td>Vision Services</td>
<td>Superior Vision Provider Services: 1-800-879-6901</td>
</tr>
<tr>
<td></td>
<td><strong>Claims Submission:</strong></td>
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</table>
|                          | Claims Department  
Superior Vision  
939 Elkridge Landing Road, Suite 200  
Linthicum, MD 21090 |
Quick Reference Information

<table>
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<tr>
<th>Pharmacy Prior Authorization</th>
<th>Contact Provider Services at 1-855-878-1785 or fax 1-800-359-5781.</th>
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| AIM Specialty Health (hi-tech radiology precertification) | 1-800-714-0040  
www.aimspecialtyhealth.com/goweb |
| OrthoNet (Physical and Occupational Therapy Precertification) | Physical and Occupational Therapy  
Fax: 1-844-340-6419  
Phone: 1-844-340-6418  
Spine and Back Pain Management procedures  
Fax: 1-844-788-4806  
Phone: 1-844-788-4805 |

Ongoing Provider Communications and Feedback

To ensure providers are up-to-date with information required to work effectively with Amerigroup STAR+PLUS MMP 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. As per Amerigroup STAR+PLUS MMP policy, we also provide orientation and training to providers, which will include the state-mandated minimum number of hours and topics of training to ensure awareness of the procedures as part of the Dual Demonstration program. The training will be consistent with the requirements contained in the contract between the health plan, state and CMS and provide resources and access information for the disability-competent care population.

CHAPTER 3: PARTICIPATING PROVIDER INFORMATION
The Amerigroup STAR+PLUS MMP Provider Network

Amerigroup STAR+PLUS MMP members obtain covered services by choosing a PCP who is part of the Amerigroup STAR+PLUS MMP network to assist and coordinate their care. Members are encouraged to coordinate with their PCP before seeking care from a specialist, except in the case of specified services (such as women’s routine and preventive care and behavioral health care).

Note: Some services provided by a specialist may require precertification or a referral. When referring a member to a specialist, it’s critical to select a participating provider within our network to maximize the member’s benefit. If you need help finding a participating provider, call Provider Services at 1-855-878-1785.

The Primary Care Provider Role

The PCP is a network physician who has responsibility for the complete care of his or her members, whether providing it himself or herself or by referral to the appropriate provider of care within the network.

Members are asked to select a PCP when enrolling in Amerigroup STAR+PLUS MMP and may change their selected PCP at any time. Amerigroup STAR+PLUS MMP contracts with certain physicians that members may choose as their PCPs and may be individual practitioners associated with a contracted medical group or an independent practice association. The PCP is responsible for referring or obtaining precertification for covered services for members. Participating PCPs are generally physicians of internal medicine, family practitioners, general practitioners, pediatricians, obstetricians/gynecologists or geriatricians. Federally qualified health centers (FQHCs) and rural health clinics (RHCs) may be included as PCPs.

Each member has a service coordinator and a service coordination team (SCT) assigned to assist with developing care plans, collaborating with other team members and providing recommendations for the management of the member’s care.

When coordinating member care, the PCP should refer the member to a participating provider within the Amerigroup STAR+PLUS MMP network. To assist the specialty care provider, the PCP should provide the specialist with the following clinical information:

- Member name
- Referring PCP
- Reason for the consultation
- History of the present illness
- Diagnostic procedures and results
- Pertinent past medical history
- Current medications and treatments
- Problem list and diagnosis
- Specific request of the specialist
Any referral to a nonparticipating provider will require precertification from Amerigroup STAR+PLUS MMP, or the services may not be covered. Contact Provider Services at 1-855-878-1785 for questions or more information.

**Health Risk Assessments**

Amerigroup STAR+PLUS MMP believes that quality primary care and active care coordination are essential components to providing high-quality and cost-effective health care to our members. This philosophy supports the relationship between our contracted PCPs and other health care professionals who coordinate the medical needs of our members. The goal is to ensure each member receives appropriate care, and all of his or her providers are in communication with one another so that the member achieves healthier outcomes.

A health risk assessment (HRA) is a comprehensive questionnaire used by Amerigroup STAR+PLUS MMP to obtain basic health information from members.

A physician health risk assessment (PHRA) is a questionnaire used to obtain basic health information from members that supplements the HRA performed by Amerigroup STAR+PLUS MMP. PCPs complete the PHRA during a visit with an Amerigroup STAR+PLUS MMP member and record the results on the form. The PHRA supplements the comprehensive HRA performed by Amerigroup STAR+PLUS MMP.

To successfully complete the PHRA, the following fields must be legibly documented for processing and claims reimbursement:

- Patient name and Amerigroup STAR+PLUS MMP ID number
- Physician name and NPI
- Date of assessment
- Physician signature included on each page

The PHRA will then be forwarded to the service coordination team to assist in the development and implementation of the member’s plan of care (POC). To obtain a copy of the PHRA form, please access our website at [https://providers.amerigroup.com/TX](https://providers.amerigroup.com/TX).

**The Specialist’s Role**

A specialist is any licensed provider (as defined by Medicare) providing specialty medical services to members. A PCP may refer a member to a specialist when medically necessary. Specialists must obtain authorization from Amerigroup STAR+PLUS MMP before performing certain procedures or when referring members to noncontracted providers. You can review precertification requirements online at [https://providers.amerigroup.com/TX](https://providers.amerigroup.com/TX) or call Provider Services at 1-855-878-1785.

After performing the initial consultation with a member, a specialist should:

- Communicate the member’s condition and recommendations for treatment or follow-up care with the PCP.
Send the PCP the consultation report, including medical findings, test results, assessment, treatment plan and any other pertinent information.

If the specialist needs to refer a member to another provider, the referral should be to another Amerigroup STAR+PLUS MMP provider. Any referral to a nonparticipating provider will require precertification from Amerigroup STAR+PLUS MMP.

Specialist Acting as a PCP

In some cases, a specialist, physician assistant, nurse practitioner or certified nurse midwife under physician supervision may be a PCP. This must be authorized by our Case Management department. If you have any questions, contact MMP Provider Services. To download a copy of the Specialist as a PCP Form, visit https://providers.amerigroup.com/TX.

Participating Provider Responsibilities

- Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers, providing coordination necessary for services provided by specialists and ancillary providers (both in and out-of-network) and maintaining a medical record meeting Amerigroup STAR+PLUS MMP standards.
- Provide coverage 24 hours a day, 7 days a week; regular hours of operation should be clearly defined and communicated to members.
- Provide all services ethically, legally and in a culturally competent manner and meet the unique needs of members with special health care needs.
- Participate in systems established by Amerigroup STAR+PLUS MMP to facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements.
- Make provisions to communicate in the language or fashion primarily used by his or her assigned members.
- Provide hearing interpreter services upon request to members who are deaf or hard of hearing.
- Participate in and cooperate with Amerigroup STAR+PLUS MMP in any reasonable internal and external quality assurance, utilization review, continuing education, and other similar programs established by Amerigroup STAR+PLUS MMP.
- Comply with Medicare, Texas State Health and Human Services Commission (HHSC) laws, regulations, and CMS instructions; agree to audits and inspections by CMS and/or its designees; cooperate, assist and provide information as requested; and maintain records for a minimum of 10 years.
- Participate in and cooperate with the Amerigroup STAR+PLUS MMP appeal and grievance procedures.
- Agree to not balance bill members for monies that are not their responsibility.
- Continue care in progress during and after termination of a provider’s contract for up to 90 days, or such longer period of time (up to six months) as required by state laws and regulations, until a continuity of service plan is in place to transition the member to another network provider.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records.
• Develop and have an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens.
• Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act of 1990 (ADA).
• Support, cooperate and comply with Amerigroup STAR+PLUS MMP Quality Improvement program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner.
• Inform Amerigroup STAR+PLUS MMP if a member objects to the provisions of any counseling, treatments or referral services for religious reasons.
• Treat all members with respect and dignity, provide appropriate privacy, and treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release.
• Provide members complete information concerning their diagnosis, evaluation, treatment and prognosis and give them the opportunity to participate in decisions involving their health care, except when contraindicated for medical reasons.
• Advise members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program and advise them 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 high-quality patient care.
• Agree any notation in a member’s clinical record indicating diagnostic or therapeutic intervention as part of the clinical research will be clearly contrasted with entries regarding the provision of non-research-related care.
• If a member self-refers or a provider is referring to another provider, that provider is responsible for checking the Amerigroup STAR+PLUS MMP provider directory to ensure the specialist is in the network. Referrals to Amerigroup STAR+PLUS MMP contracted specialists do not require precertification. Some procedures performed by specialist physicians may require precertification. Please refer to the Summary of Benefits document or Member Handbook for procedures that require precertification or call Provider Services at 1-855-878-1785. If you cannot locate a provider in the Amerigroup STAR+PLUS MMP network, you should contact Provider Services at 1-855-878-1785. You must obtain authorization from Amerigroup STAR+PLUS MMP before referring members to noncontracted providers. Additionally, certain services/procedures require precertification from Amerigroup STAR+PLUS MMP.
• Agree to use any laboratory designated by Amerigroup STAR+PLUS MMP for our members. Amerigroup STAR+PLUS MMP will reimburse for a limited list of lab services when performed in provider’s office.

Note: Amerigroup STAR+PLUS MMP does not cover the use of any experimental procedures or experimental medications, except under certain circumstances.
**Provider Responsibilities in the Management of Transitions in Care**

A transition in care for a member is defined as a point at which the member’s care is transferred from one provider to another or from a facility to another level of care. Examples of transitions in care include a referral from a PCP to a specialist, an admission to a hospital or a discharge from a hospital to home care or a skilled nursing facility.

When a member experiences a transition in care, it is the responsibility of the transferring provider to do the following:

- Notify the member in advance of a planned transition.
- Provide documentation of the care plan to the receiving institution or provider within one business day of the transition.
- Communicate with the member about the transition process.
- Communicate with the member about his or her health status and plan of care.
- Notify the member’s usual practitioner of the transition within three business days after notification of the transition.
- Provide a treatment plan/discharge instructions to the member prior to discharge.
- Notify the member’s service coordinator at Amerigroup STAR+PLUS MMP.

The provider is an integral part of effectively managing transitions. Communication is the key with both the member and other treating providers. To prevent duplicate testing and provide critical information about the member, the following processes should be followed:

- The referring physician or provider should provide the relevant patient history to the receiving provider.
- Any pertinent diagnostic results should be forwarded to the receiving provider.
- The receiving provider should communicate a treatment plan back to the referring provider.
- Any diagnostic test results ordered by the receiving provider should be communicated to the referring provider.

**Enrollment and Eligibility Verification**

All health care providers are responsible for verifying enrollment and eligibility before services are rendered, except in the case of an emergency. In general, eligibility should be verified at the time of service and at least once monthly for ongoing services. In an emergency, eligibility should be determined as soon as possible after the member’s condition is stabilized.

When a patient presents as a member, providers must verify eligibility, enrollment and coverage by performing the following steps:

1. Request the member’s Amerigroup STAR+PLUS MMP card; if there are questions regarding the information, call Provider Services at 1-855-878-1785 or visit [https://www.availity.com](https://www.availity.com) to verify eligibility and other benefit information.
2. Copy both sides of the member’s Amerigroup STAR+PLUS MMP card and place the copies in the member’s medical record.
3. Copy the member’s driver’s license (if applicable) to ensure the member’s information matches their Amerigroup STAR+PLUS MMP card and place the copies in the member’s medical record.

4. If you are a PCP, check your Amerigroup STAR+PLUS MMP member panel listing to ensure you are the member’s doctor.

5. If the patient does not have an identification card, visit https://www.availity.com to verify eligibility or call Provider Services at 1-855-878-1785.

Identification Card for Amerigroup STAR+PLUS MMP

The member will have a single ID card for Amerigroup STAR+PLUS MMP.

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 STAR+PLUS MMP requires providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling. 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 appointments without rescheduling may need additional education in appropriate methods of accessing care. In these cases, please call Provider Services at 1-855-878-1785 to address the situation. Amerigroup STAR+PLUS MMP staff will contact the member and provide more extensive education and/or case management as appropriate. Our goal is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCP.

Noncompliant Amerigroup STAR+PLUS MMP Members

Amerigroup STAR+PLUS MMP recognizes providers may need help in managing nonadherent members. If you have an issue with a member regarding behavior, treatment cooperation, completion of treatment and/or making or appearing for appointments, call Provider Services at 1-855-878-1785. A Member Services or 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 the outcome of any counseling efforts to you.
**Second Medical or Surgical Opinion**

At the member’s request, Amerigroup STAR+PLUS MMP will provide a second opinion from a qualified health care professional within the Amerigroup STAR+PLUS MMP network. If there’s no provider in the Amerigroup STAR+PLUS MMP network who can render a second opinion, Amerigroup STAR+PLUS MMP will arrange for the member to obtain one outside the network at no cost to the member.

**Access and Availability**

Participating Amerigroup STAR+PLUS MMP providers must:

- Offer hours of operation that are no less than the hours of operations offered to their other patients (e.g., commercial or public fee for service insured).
- Provide coverage for members 24 hours a day, 7 days a week.
- Ensure another on-call Amerigroup STAR+PLUS MMP provider is available to administer care when the PCP is not available.
- Not substitute hospital emergency rooms or urgent care centers for covering providers.
- See members within 30 minutes of a scheduled appointment or inform them of the reason for delay (e.g., emergency cases) and offer an alternative appointment.
- Provide an after-hours telephone service to ensure a response to emergency phone calls within 30 minutes and a response to urgent phone calls within one hour; individuals who believe they have an emergency medical condition should be directed to immediately seek emergency services from the nearest emergency facility.

**Access and Availability Standards Table**

<table>
<thead>
<tr>
<th>Type of Appointment (Medical)*</th>
<th>Availability Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient visit with new PCP</td>
<td>Within 30 calendar days</td>
</tr>
<tr>
<td>Routine follow-up or preventive care</td>
<td>As soon as possible but within 30 calendar days</td>
</tr>
<tr>
<td>Routine/symptomatic</td>
<td>Within 7 days</td>
</tr>
<tr>
<td>Nonurgent care</td>
<td>Within 7 days</td>
</tr>
<tr>
<td>Urgently needed services</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Emergency</td>
<td>Immediately</td>
</tr>
</tbody>
</table>

* See the Behavioral Health Chapter for specific behavioral health access standards.

Amerigroup STAR+PLUS MMP monitors adherence to appointment availability standards through office visits, long-term care visits, and tracking of complaints and grievances related to access and/or discrimination. Deviations from the policy are reviewed by the medical director for educational and/or counseling opportunities and tracked for provider recredentialing. All providers and hospitals are expected to treat Amerigroup STAR+PLUS MMP members with the same dignity and consideration as afforded to their non-Amerigroup STAR+PLUS MMP patients.
Continuity of Care
Amerigroup STAR+PLUS MMP will ensure newly enrolled members will continue to have access to medically necessary items, services and prescription drugs as well as medical, behavioral health and LTSS providers for the transition period. Members will be allowed to maintain their current providers for 90 days from the date of enrollment. Members will be allowed to maintain their current LTSS providers for 180 days. Members will also be allowed to maintain their preauthorized services for the duration of the prior authorization or 180 days from enrollment, whichever is sooner.

Amerigroup STAR+PLUS MMP will also advise, in writing, both members and providers when members have received care that would not otherwise be covered at an in-network level. Amerigroup STAR+PLUS MMP will contact noncontracted providers to inform them of the procedure for becoming an in-network provider.

Individuals residing in nursing facilities at the time of program implementation may remain in the facility as long as they continue to meet Texas State Health and Human Services Commission (HHSC) criteria for nursing home care, unless they or their families prefer to move to a different nursing facility or return to the community.

During the transition period referenced above, a change from the existing provider can only occur in the following circumstances:
- The member requests a change.
- The provider chooses to discontinue providing services to a member as currently allowed by Medicare or Medicaid.
- Amerigroup STAR+PLUS MMP, CMS or HHSC identifies provider performance issues that affect a member’s health and welfare.
- The provider is excluded under state or federal exclusion requirements.

Covering Physicians
During a provider’s absence or unavailability, the provider must arrange for coverage for his or her members. The provider will either: 1) make arrangements with one or more Amerigroup STAR+PLUS MMP network providers to provide care for his or her members, or 2) 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 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.

Reporting Changes in Address and/or Practice Status
Any changes in a provider’s address and/or practice status must be submitted in writing on company letterhead and faxed to Amerigroup STAR+PLUS MMP at 804-354-3700.
Plan-Specific Termination Criteria

The occurrence of any of the following is grounds for termination of the Amerigroup STAR+PLUS MMP provider’s participation:

- Loss of reputation among peers due to unethical clinical practice or attitude
- The practice of fraud, waste and/or abuse
- Adverse publicity involving the provider due to acts of omission or commission
- Substance abuse
- Loss of professional office
- Inadequate record keeping
- Unsafe environment in the provider’s office relative to inadequate access or other related issues that might cause a member injury
- An office that is improperly kept or unclean or does not present a proper appearance
- Failure to meet OSHA guidelines
- Failure to meet ADA guidelines
- Failure to meet Clinical Laboratory Improvement Amendments (CLIA) guidelines
- Member satisfaction ratings that drop below pre-established standards as determined by the medical advisory committee (MAC) (includes complaints relative to appearance, behavior, medical care, etc.)
- Repetitive complaints about office staff demeanor, presentation and appearance
- Inclusion on the Debarred Providers Listing of the Office of the Inspector General of the Department of Health and Human Services (see “Sanctioned Providers” section below)
- Unfavorable inpatient- or outpatient-related indicators:
  - Severity-adjusted morbidity and mortality rates above established norms
  - Severity-adjusted length-of-stay above established norms
  - Unfavorable outpatient utilization results
  - Consistent inappropriate referrals to specialists
  - Improper maintenance of high-risk patients, such as those members with diabetes and hypertension
  - Underutilization relative to minimum standards of care established per medical management guidelines and/or accepted clinical practice in the community
  - Unfavorable malpractice-related issues
  - Frequent litigious activity above and beyond what would be expected for a provider in that particular specialty

Amerigroup STAR+PLUS MMP providers have 30 calendar days to appeal a termination. The Amerigroup STAR+PLUS MMP process is designed to comply with all state and federal regulations regarding the termination appeal process.

Incentives and Payment Arrangements

Financial arrangements concerning payment to providers for services to members are set forth in each Provider’s Agreement. Amerigroup STAR+PLUS MMP may also use financial incentives to reward providers for achieving certain quality indicator levels.
Amerigroup STAR+PLUS MMP does not use or employ financial incentives that would directly or indirectly induce providers to limit or reduce medically necessary services furnished to individual enrollees. In cases where Amerigroup STAR+PLUS MMP approves provider subcontracting arrangements, those subcontractors cannot employ any financial incentives inconsistent with this policy or CMS regulations.

**Laws Regarding Federal Funds**

Payments providers receive for furnishing services to members are derived in whole or in part from federal funds. Therefore, providers and any approved subcontractors must comply with certain laws applicable to individuals and entities receiving federal funds, including but not limited to Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

**Prohibition Against Discrimination**

Neither Amerigroup STAR+PLUS MMP nor its contracted providers may deny, limit or condition the coverage or furnishing of services to members on the basis of any factor related to health status, including but not limited to the following:

- Medical condition, including mental as well as physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability

**Closing a Provider Panel**

When closing a provider panel to new Amerigroup STAR+PLUS MMP members or other new patients, providers must:

- Give Amerigroup STAR+PLUS MMP prior written notice the provider panel is closing to new members as of a specific closing date.
- Keep the provider panel open to members who were patients of that practice before the panel closed or before they were enrolled with Amerigroup STAR+PLUS MMP.
- Give Amerigroup STAR+PLUS MMP prior written notice when reopening the provider panel, including a specific reopening date.

**Transferring and Terminating Members from a Provider Panel**

Amerigroup STAR+PLUS MMP will determine reasonable cause for transferring a member based on written request and documentation submitted by the provider. Providers may not transfer a member to another provider due to the costs associated with the member’s covered services.

A provider may request termination of a member due to fraud or disruption of medical services. In such cases, the provider should contact Provider Services at 1-855-878-1785.
**Reporting Obligations**

**Cooperation in Meeting CMS Requirements**

Amerigroup STAR+PLUS MMP is required to provide information to CMS necessary to administer and evaluate the Amerigroup STAR+PLUS MMP program and to establish and facilitate a process for current and prospective members to exercise their choice in obtaining services.

Amerigroup STAR+PLUS MMP provides the following information:

- Plan quality and performance indicators such as disenrollment rates (for beneficiaries enrolled in the plan the previous two years)
- Information on member satisfaction
- Information on health outcomes

Providers must cooperate with Amerigroup STAR+PLUS MMP in its data reporting obligations by providing Amerigroup STAR+PLUS MMP with any information required to meet these obligations in a timely fashion.

**Certification of Diagnostic Data**

Amerigroup STAR+PLUS MMP is required to submit information to CMS necessary to characterize the context and purposes of each encounter between a member and provider, supplier, physician or other practitioner (encounter data). Providers that furnish diagnostic data must certify (to the best of their knowledge, information and belief) the accuracy, completeness and truthfulness of the data.

**Cultural Competency**

Cultural competency is the integration of congruent behaviors, attitudes, structures, policies and procedures that come together in a system or agency or among professionals. Cultural competency assists providers and members to:

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

Cultural competence means understanding those values, beliefs and needs associated with the member’s age, gender identity, sexual orientation, and/or racial, ethnic or religious background. Cultural competence also includes a set of competencies that are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities. A competency is based on the premise of respect for member and cultural differences and an implementation of a trust-promoting method of inquiry and assistance.
The quality of the patient-provider interaction has a profound impact on the ability of a patient to communicate symptoms to his or her provider and to adhere to recommended treatment. Some reasons a provider needs to be culturally competent include but are not limited to:

- The perception that illness and disease and their causes vary by culture.
- The diversity of belief systems related to health, healing and wellness are very diverse.
- The fact that culture influences help-seeking behaviors and attitudes toward health care providers.
- The fact that individual preferences affect traditional and nontraditional approaches to health care.
- The fact that patients must overcome their personal biases within health care systems.
- The fact that health care providers from culturally and linguistically diverse groups are under-represented in the current service delivery system.

Cultural barriers between the provider and member can impact the patient-provider relationship in many ways, including but not limited to:

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

To be culturally competent, Amerigroup STAR+PLUS MMP expects providers serving members within their geographic locations to demonstrate the following:

**Cultural Awareness**

- The ability to recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior
- The ability to modify one’s own behavioral style to respond to the needs of others, while at the same time maintaining one’s objectivity and identity

**Cultural Knowledge**

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

**Cultural Skills**
• The ability to understand the basic similarities and differences between and among the cultures of the persons served
• The ability to recognize the values and strengths of different cultures
• The ability to interpret diverse cultural and nonverbal behavior
• The ability to develop perceptions and understanding of other’s needs, values and preferred means of having those needs met
• The ability to identify and integrate the critical cultural elements of a situation to make culturally consistent inferences and to demonstrate consistency in actions
• The ability to recognize the importance of time and the use of group processes to develop and enhance cross-cultural knowledge and understanding
• The ability to withhold judgment, action or speech in the absence of information about a person’s culture
• The ability to listen with respect
• The ability to formulate culturally competent treatment plans
• The ability to use culturally appropriate community resources
• The ability to know when and how to use interpreters and to understand the limitations of using interpreters
• The ability to treat each person uniquely
• The ability to recognize racial and ethnic differences and know when to respond to culturally based cues
• The ability to seek out information
• The ability to use agency resources
• The capacity to respond flexibly to a range of possible solutions
• The acceptance of ethnic differences among people and the understanding of how these differences affect the treatment process
• The willingness to work with clients of various ethnic minority groups

Marketing
Providers may not develop or use any materials that market Amerigroup STAR+PLUS MMP without our prior written approval. Under program rules, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Texas STAR+PLUS Medicare-Medicaid plan unless the materials meet the CMS marketing guidelines and are first submitted to CMS for review and approval.

Additionally, providers can have plan marketing materials in their office as long as marketing materials for all plans the providers participate in are represented. Providers are allowed to have posters or notifications that show they participate in Amerigroup STAR+PLUS MMP as long as the provider displays posters or notifications from all plans in which they participate.

Americans with Disabilities Act (ADA) Requirements
Amerigroup STAR+PLUS MMP policies and procedures are designed to promote compliance with the ADA. Providers are required to take actions to remove an existing barrier and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes the following:
• Access to an examination room that accommodates a wheelchair
• Access to a lavatory that accommodates a wheelchair
• Elevator or accessible ramp into facilities
• Handicap parking clearly marked unless there is street-side parking
• Street-level access
• Appropriate signage

For more information, please access the ADA website at www.ada.gov.
CHAPTER 4: HEALTH CARE BENEFITS

Member Eligibility
To be eligible to participate in the Texas STAR+PLUS Medicare-Medicaid Plan (MMP) Demonstration, individuals must meet the following criteria:

• Age 21 and older
• Coverage with Medicare Part A, B and D
• Coverage with full Medicaid benefits through the Texas Medicaid STAR+PLUS program
• Reside in one of the Demonstration counties

Voluntary Enrollment
Other eligible individuals may choose to participate or opt to enroll but will not be passively enrolled. These include:

• Those in a Medicare Advantage Plan not operated by an MMP participating in the demonstration.
• Those participating in a Medicare Accountable Care Organization with fewer than 9,000 members.
• Those receiving services through the Program of All-Inclusive Care for the Elderly (PACE).

Individuals who meet at least one of the exclusion criteria listed below will be excluded from the Demonstration as appropriate:

• Dual-eligible children (age 20 and younger)
• Dual-eligible individuals not eligible for STAR+PLUS today, including those receiving services in a community-based intermediate care facility for individuals with intellectual disabilities or related conditions (ICF-IID) or receiving services in the following ICF-IID 1915 (c) waivers:
  o Home and Community-Based Services (HCS)
  o Community Living and Support Services (CLASS)
  o Texas Home Living (TxHmL)
  o Deaf-Blind Multiple Disabilities (DBMD)

The following individuals may receive Medicaid coverage for 1) Medicare monthly premiums for Part A, Part B or both (carved-out payment); 2) coinsurance, copay and deductible for Medicare-allowed services; and 3) Medicaid-covered services, including those that are not covered by Medicare:

• Individuals who are inpatients in state mental hospitals
• Individuals who are residents of state hospitals, ICF/MR facilities, residential treatment facilities or long-stay hospitals defined in Appendix 1
  o Dual-eligible individuals residing in nursing facilities will be enrolled in the Demonstration.
• Individuals who are participating in federal waiver programs for home- and community-based Medicaid coverage other than the EDCD Waiver (e.g., Individual and Family Developmental Disability Support, Intellectual Disabilities, Day Support, Technology-Assisted, and Alzheimer’s Assisted Living Waivers)
• Individuals enrolled in a hospice program
  o Individuals receiving hospice services at the time of enrollment will be excluded from the Demonstration. If an individual enters a hospice program while enrolled in the...
Demonstration, he/she will be disenrolled from the Demonstration. However, plans shall refer these individuals to the EDCD Waiver preadmission screening team for additional LTSS.

- Individuals receiving the end-stage renal disease (ESRD) Medicare benefit at the time of enrollment into the Demonstration
  - However, an individual who develops ESRD while enrolled in the Demonstration will remain in the Demonstration unless he or she opts out. If he or she opts out, the individual cannot opt back into the Demonstration.
- Individuals with other comprehensive group or individual health insurance coverage other than full benefit Medicare, insurance provided to military dependents and any other insurance purchased through the Health Insurance Premium Payment Program (HIPP)
- Individuals who have a Medicaid eligibility period that is less than three months
- Individuals who have a Medicaid eligibility period that is only retroactive
- Individuals enrolled in the Money Follows the Person (MFP) program
- Individuals residing outside of the Demonstration areas
- Individuals enrolled in a Program of All-Inclusive Care for the Elderly (PACE)
  - However, PACE participants may enroll in the Demonstration if they choose to disenroll from their PACE provider.
- Individuals participating in the CMS Independence at Home (IAH) demonstration
  - However, IAH participants may enroll in the Demonstration if they choose to disenroll from IAH.

Role of the Enrollment Broker/Maximus

To support enrollment decisions, the Texas State Health and Human Services Commission (HHSC) will ensure that enrollees are educated on Texas STAR+PLUS Medicare-Medicaid Plan (MMP) benefits, Amerigroup STAR+PLUS MMP networks, and the process for opting out of the Demonstration and for changing MCOs.

HHSC will focus on developing clear and accessible information (ensuring availability in alternative formats and languages) on available MCOs and consumer protections. To help facilitate enrollment choices, HHSC has contracted with Maximus to:

- Help educate enrollees.
- Assist with enrollment and MCO selection.
- Operate a toll-free enrollee helpline.

Summary of Benefits Tables

Notations regarding some benefit categories are listed below. Please note availability and limitations and refer to the appropriate Summary of Benefits for detailed information.

Precertification requirements are described in later sections and in detail on the provider website. All services from noncontracted providers, with the exceptions of urgent and emergent care and out-of-area dialysis, require precertification.

The medical benefits are further explained in the following sections.
<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abdominal aortic aneurysm screening</strong></td>
<td>Amerigroup STAR+PLUS MMP will pay only once for an ultrasound screening for members at risk. A participant is at risk if he or she has a family history of abdominal aortic aneurysms, or he is a man 65-75 years of age and has smoked at least 100 cigarettes in his lifetime. Members must get a doctor’s order for this screening at their “Welcome to Medicare” preventive visit.</td>
</tr>
<tr>
<td><strong>Acupuncture</strong></td>
<td>The plan will pay for up to six visits for acupuncture services per year with no copays or out-of-pocket expense. Prior authorization is not required.</td>
</tr>
</tbody>
</table>
| **Adult day health care**     | Amerigroup STAR+PLUS MMP will pay for adult day health care for members who are functionally impaired, not homebound, and who require certain preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services.  

Adult day health care includes the following services:  
- Medical  
- Nursing  
- Food and nutrition  
- Social services  
- Rehabilitation therapy  
- Leisure time activities, which are a planned program of diverse meaningful activities  
- Dental  
- Pharmaceutical  
- Other ancillary services |
| **AIDS adult day health care** | Coverage includes AIDS adult day health care programs (ADHCP) for members with HIV; ADHCP includes the following services:  
- Individual and group counseling/education provided in a structured program setting  
- Nursing care (including triage/assessment of new symptoms)  
- Medication adherence support  
- Nutritional services (including breakfast and/or lunch)  
- Rehabilitative services  
- Substance abuse services  
- Mental health services  
- HIV risk reduction services |
<table>
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<tr>
<th>Service</th>
<th>Coverage Description</th>
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<tbody>
<tr>
<td>Alcohol misuse screening and counseling</td>
<td>Coverage includes one alcohol-misuse screening (SBIRT) for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women. Members who screen positive for alcohol misuse can get up to four brief, face-to-face counseling sessions each year with a qualified primary care provider or practitioner in a primary care setting.</td>
</tr>
<tr>
<td>Ambulance services</td>
<td>Covered ambulance services include fixed-wing, rotary-wing and ground ambulance services. The ambulance will take member to the nearest place to provide care. The member’s condition must be serious enough that other ways of getting to a place of care could risk the member’s life or health. Ambulance services for other cases must be approved by the participant’s ICT or Amerigroup STAR+PLUS MMP. In cases that are not emergencies, the participant’s ICT or Amerigroup STAR+PLUS MMP may authorize the use of an ambulance. The participant’s condition must be serious enough that other ways of getting to a place of care could risk member’s life or health.</td>
</tr>
<tr>
<td>Ambulatory surgery center services</td>
<td>Amerigroup STAR+PLUS MMP will pay for covered surgical procedures provided at ambulatory surgical centers.</td>
</tr>
<tr>
<td>Assertive community treatment (ACT)</td>
<td>Amerigroup STAR+PLUS MMP will pay for ACT services. ACT is a mobile team-based approach to delivering comprehensive and flexible treatment, rehabilitation, case management and support services to individuals in their natural living setting.</td>
</tr>
</tbody>
</table>
| Assisted living program                      | Amerigroup STAR+PLUS MMP will pay for Assisted Living Program services provided in an adult home or enriched housing setting. Services include:  
  • Personal care  
  • Housekeeping  
  • Supervision  
  • Home health aides  
  • Personal emergency response services  
  • Nursing  
  • Physical, occupational and/or speech therapy  
  • Medical supplies and equipment  
  • Adult day health care  
  • A range of home health services  
  • Case management services of a registered professional nurse |
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<tr>
<th>Service</th>
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</table>
| Assistive technology                         | Amerigroup STAR+PLUS MMP will pay for physical adaptations to the private residence of the participant or the participant’s family. The adaptations must be necessary to ensure the health, welfare, and safety of the participant or enable the participant to function with greater independence in the home. Covered adaptations include:  
  • Installation of ramps and grab bars  
  • Widening of doorways  
  • Modifications of bathrooms  
  • Installation of specialized electric and plumbing systems |
| Bone mass measurement                        | Coverage includes certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. Amerigroup STAR+PLUS MMP will pay for the services once every 24 months or more often if they are medically necessary. Amerigroup STAR+PLUS MMP will also pay for a provider to look at and comment on the results. |
| Breast cancer screening (mammograms)        | Coverage includes the following services:  
  • One baseline mammogram between the ages of 35 and 39  
  • One screening mammogram every 12 months for women age 40 and older  
  • Clinical breast exams once every 24 months |
| Cardiac (heart) rehabilitation services     | Coverage includes cardiac rehabilitation services such as exercise, education and counseling. Members must meet certain conditions with a doctor’s referral. Coverage also includes intensive cardiac rehabilitation programs. |
| Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) | Coverage includes one visit a year with a PCP to help lower risk for heart disease. During this visit, providers may:  
  • Discuss aspirin use.  
  • Check blood pressure.  
  • Provide information to make sure members are eating well. |
<p>| Cardiovascular (heart) disease testing       | Coverage includes blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease. |
| Care management (service coordination)       | Care management is an individually designed intervention that helps the participant get access to needed services. These care management interventions are designed to ensure the participant’s health and welfare and increase the participant’s independence and quality of life. |</p>
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| Cervical and vaginal cancer screening | Coverage includes the following:  
• For all women: Pap tests and pelvic exams once every 24 months  
• For women who are at high risk of cervical cancer: one Pap test every 12 months  
• For women who have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months |
| Chemotherapy                    | Amerigroup STAR+PLUS MMP will pay for chemotherapy for cancer patients. Chemotherapy is covered when it is provided in an inpatient or outpatient unit of a hospital, a provider’s office, or a freestanding clinic. |
| Chiropractic services           | Coverage includes adjustments of the spine to correct alignment.                                                                                                                                                      |
| Colorectal cancer screening     | Amerigroup STAR+PLUS MMP will pay for the following:  
• **Barium enema**: Covered once every 48 months if participant is 50 or over and once every 24 months if participant is at high risk for colorectal cancer, when this test is used instead of a flexible sigmoidoscopy or colonoscopy  
• **Colonoscopy**: Covered once every 24 months if participant is at high risk for colorectal cancer. If participant is not at high risk for colorectal cancer, Medicare covers this test once every 120 months, or 48 months after a previous flexible sigmoidoscopy.  
• **Fecal occult blood test**: Covered once every 12 months if participant is 50 or older  
• **Flexible sigmoidoscopy**: Covered once every 48 months for most members 50 or older. If participant isn’t at high risk, Medicare covers this test 120 months after a previous screening colonoscopy. |
| Community integration counseling | Amerigroup STAR+PLUS MMP will pay for community integration counseling. This is a counseling service provided to members who are coping with altered abilities and skills, a revision of long term expectations, or changes in roles in relation to significant others.  
This service is primarily provided in the provider’s office or the participant’s home. Community integration counseling services are usually provided in one-to-one counseling sessions. However, there are times when it is appropriate to provide this service to the participant in a family counseling or group counseling setting. |
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| **Community transitional services**          | Amerigroup STAR+PLUS MMP will pay for Community Transitional Services (CTS). These services help a participant transition from living in a nursing facility to living in the community. CTS includes:  
  • The cost of moving furniture and other belongings.  
  • Buying certain essential items such as linen and dishes.  
  • Security deposits, including broker’s fees required to obtain a lease on an apartment or home.  
  • Buying essential furnishings.  
  • Set-up fees or deposits for utility or service access (for example, telephone, electricity, or heating).  
  • Health and safety assurances such as pest removal, allergen control, or one time cleaning prior to occupancy.  
  CTS cannot be used to purchase diversional or recreational items, such as televisions, VCRs/DVDs, or music systems. |
| **Consumer-directed personal assistance services (CDPAS)** | Amerigroup STAR+PLUS MMP will pay for CDPAS, which provides services to chronically ill or physically disabled individuals who have a medical need for help with activities of daily living (ADLs) or skilled nursing services. Services can include any of the services provided by a personal care aide (home attendant), home health aide or nurse. Participants who choose CDPAS have flexibility and freedom to choose their caregivers. The participant or the person acting on the participant’s behalf (such as the parent of a disabled or chronically ill child) is responsible for recruiting, hiring, training, supervising, and if necessary, terminating caregivers providing CDPAS services. |
| **Continuing day treatment**                 | Amerigroup STAR+PLUS MMP will pay for continuing day treatment. This service helps members maintain or enhance current levels of functioning and skills, maintain community living, and develop self-awareness and self-esteem. Services include:  
  • Assessment and treatment planning.  
  • Discharge planning.  
  • Medication therapy.  
  • Medication education.  
  • Case management.  
  • Health screening and referral.  
  • Rehabilitative readiness development.  
  • Psychiatric rehabilitative readiness determination and referral.  
  • Symptom management. |
<p>| <strong>Day treatment</strong>                            | Amerigroup STAR+PLUS MMP will pay for six months of day treatment. Day treatment is a combination of diagnostic, treatment and rehabilitative procedures that provide the services of the clinic treatment program as well as social training, task and skill training, and socialization activities. |</p>
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<tr>
<td>Defibrillator (implantable automatic)</td>
<td>Amerigroup STAR+PLUS MMP will pay for defibrillators for certain people diagnosed with heart failure, depending on whether the surgery takes place in a hospital inpatient or outpatient setting.</td>
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<td>Dental services</td>
<td>Coverage includes the following:</td>
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<td>• Oral exams once every six months</td>
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<td>• Cleaning once every six months</td>
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<td>• Dental X-rays once every six months</td>
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<td>• Diagnostic services</td>
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<td>• Restorative services</td>
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<td></td>
<td>• Endodontics, periodontics and extractions</td>
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<td>• Dental prosthetics and orthotic appliances required to alleviate a serious condition, including one that affects a participant’s employability</td>
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<td>• Other oral surgery</td>
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<td></td>
<td>• Dental emergencies</td>
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<td>• Other necessary dental care</td>
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<tr>
<td>Depression screening</td>
<td>Amerigroup STAR+PLUS MMP will pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and recommendations for additional treatments.</td>
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<tr>
<td>Diabetes screening</td>
<td>Coverage includes screening (including fasting glucose tests) if the member has any of the following risk factors:</td>
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<td>• High blood pressure (hypertension)</td>
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<td>• History of abnormal cholesterol and triglyceride levels (dyslipidemia)</td>
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<td></td>
<td>• Obesity</td>
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<td></td>
<td>• History of high blood sugar (glucose)</td>
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<td>Tests may be covered in some other cases, such as if the member is overweight and has a family history of diabetes. Depending on the test results, members may qualify for up to two diabetes screenings every 12 months.</td>
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<td>Service</td>
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| **Diabetic self-management training, services and supplies** | Coverage includes the following services for all members who have diabetes (whether they use insulin or not):  
  - Supplies to monitor blood glucose, including the following:  
    o A blood glucose monitor  
    o Blood glucose test strips  
    o Lancet devices and lancets  
    o Glucose-control solutions for checking the accuracy of test strips and monitors  
  - For members with diabetes who have severe diabetic foot disease, Amerigroup STAR+PLUS MMP covers one of the following:  
    o One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year  
    o One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)  
  Coverage also includes fitting the therapeutic custom-molded shoes or depth shoes and training to help members manage their diabetes in some cases |
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<tr>
<th>Service</th>
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</table>
| Durable medical equipment and related supplies | The following items are covered:  
• Wheelchairs  
• Oxygen equipment  
• Crutches  
• IV infusion pumps  
• Hospital beds  
• Walkers  
• Nebulizers  

Other items *may* be covered. Please refer to the Amerigroup STAR+PLUS MMP list of durable medical equipment to see which is covered. Generally, Amerigroup STAR+PLUS MMP covers any durable medical equipment covered by Medicare and Medicaid from the brands and makers on this list. We will not cover other brands and makers unless the member’s SCT or Amerigroup STAR+PLUS MMP authorizes a doctor or other provider’s request for the brand.  

However, if the member is new to Amerigroup STAR+PLUS MMP, and using a brand of durable medical equipment that is not on our list, we will continue to pay for this brand for up to 90 days. During this time, the member should talk with their service coordinator or SCT to decide what brand is medically right for the member after this 90-day period.  

If the member or their provider does not agree with the SCT or Amerigroup STAR+PLUS MMP decision about paying for the equipment, the participant or their provider may file an appeal. The member can also file an appeal if they do not agree with their provider’s decision about what product or brand is right for the member’s medical condition. |
<table>
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<tr>
<th>Service</th>
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<tbody>
<tr>
<td>Emergency care</td>
<td><em>Emergency care</em> means services that are given by a provider trained to give emergency services and needed to treat a medical emergency or behavioral emergency.</td>
</tr>
<tr>
<td></td>
<td>A <em>medical or behavioral emergency</em> is a condition with severe pain or serious injury. The condition is so serious that, if it doesn’t get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in any of the following:</td>
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<td>• Placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy</td>
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<td>• Serious harm to bodily functions</td>
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<td>• Serious dysfunction of any bodily organ or part</td>
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<td></td>
<td>• In the case of a pregnant woman, an active labor, meaning labor at a time when either of the following would occur:</td>
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<td>o There is not enough time to safely transfer the member to another hospital before delivery.</td>
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<td>o The transfer may pose a threat to the health or safety of the member or unborn child.</td>
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<td><em>Members may get covered emergency care whenever they need it, anywhere in the United States or its territories.</em></td>
</tr>
<tr>
<td>Environmental modifications</td>
<td>Amerigroup STAR+PLUS MMP will pay for internal and external physical adaptations to the home that are necessary to ensure the health, welfare, and safety of the participant. Environmental modifications may include:</td>
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<tr>
<td>and adaptive devices</td>
<td>• Installation of ramps and grab bars.</td>
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<td>• Widening of doorways.</td>
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<td>• Modifications of bathroom facilities.</td>
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<td></td>
<td>• Installation of specialized electrical or plumbing systems to accommodate necessary medical equipment.</td>
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<td>• Any other modification necessary to ensure the participant’s health, welfare or safety.</td>
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<td>Coverage Description</td>
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| **Family planning services**        | Participants may choose any provider for certain family planning services. This includes any doctor, clinic, hospital, pharmacy or family-planning office. Coverage includes the following services:  
  • Family planning exam and medical treatment  
  • Family planning lab and diagnostic tests  
  • Family planning methods (birth control pills, patch, ring, IUD, injections, implants)  
  • Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap)  
  • Counseling and diagnosis of infertility and related services  
  • Counseling and testing for sexually transmitted infections (STIs), AIDS and other HIV-related conditions as part of a family planning visit  
  • Treatment for sexually transmitted infections (STIs)  
  • Voluntary sterilization (members must be age 21 or older, and must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that the member signs the form and the date of surgery.)  
  • Abortion                                                                                                                                               |
| **Freestanding birth center services** | Amerigroup STAR+PLUS MMP will cover all medically necessary services at freestanding birth centers.                                                                                                                          |
| **Health and wellness education programs** | Amerigroup STAR+PLUS MMP will pay for health and wellness education for members and their caregivers, which includes:  
  • Classes, support groups, and workshops.  
  • Educational materials and resources.  
  • Website, email, or mobile application communications.  

These services are provided on topics including but not limited to: heart attack and stroke prevention, asthma, living with chronic conditions, back care, stress management, healthy eating and weight management, oral hygiene, and osteoporosis. This benefit also includes annual preventive care reminders and caregiver resources.  |
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<tr>
<td><strong>Hearing services</strong></td>
<td>Coverage includes hearing and balance tests conducted by the participant’s provider. They are covered as outpatient care when a participant gets them from a physician, audiologist or other qualified provider. Hearing services and products are covered when medically necessary to alleviate disability caused by the loss or impairment of hearing. Services include the following: • Hearing aid selecting, fitting and dispensing • Hearing aid checks following dispensing • Conformity evaluations and hearing aid repairs • Audiology services, including examinations and testing • Hearing aid evaluations and hearing aid prescriptions • Hearing aid products, including hearing aids, ear molds, special fittings, and replacement parts when authorized by an audiologist</td>
</tr>
<tr>
<td><strong>HIV screening</strong></td>
<td>Coverage includes one HIV screening exam every 12 months for members who ask for an HIV screening test or are at increased risk for HIV infection. For women who are pregnant, coverage includes up to three HIV screening tests during a pregnancy.</td>
</tr>
<tr>
<td><strong>Home- and community-support services (HCSS)</strong></td>
<td>Amerigroup STAR+PLUS MMP will pay for HCSS for members: • Who require assistance with personal care services tasks. • Whose health and welfare in the community is at risk because supervision of the participant is required when no personal care task is being performed.</td>
</tr>
<tr>
<td><strong>Home-delivered and congregate meals</strong></td>
<td>Amerigroup STAR+PLUS MMP will pay for congregate and home-delivered meals. This is an individually designed service that provides meals to members who cannot prepare or obtain nutritionally adequate meals for themselves, or when providing such meals will decrease the need for more costly supported in-home meal preparation. This benefit includes three meals a day for 52 weeks a year.</td>
</tr>
<tr>
<td><strong>Home health services</strong></td>
<td>Before members can get home health services, a provider must inform Amerigroup STAR+PLUS MMP of the participant’s need for them and they must be provided by a home health agency. Amerigroup STAR+PLUS MMP will pay for the following services: • Physical therapy, occupational therapy and speech therapy • Medical and social services • Medical equipment and supplies</td>
</tr>
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| **Home health agency care**   | Coverage includes the following services:  
  • Physical therapy, occupational therapy and speech therapy  
  • Medical and social services  
  • Medical equipment and supplies                                                                                                                                                                                                                                                                                                                                                      |
| **Home infusion**             | Amerigroup STAR+PLUS MMP will pay for the administration of home infusion drugs and supplies.                                                                                                                                                                                                                                                                                                                                                                      |
| **Home maintenance services** | Amerigroup STAR+PLUS MMP will pay for home maintenance services. Home maintenance services include household chores and services that are required to maintain an individual’s home environment in a sanitary, safe and viable manner. Chore services are provided on two levels:  
  • Light chores – Cleaning and/or washing of windows, walls and ceilings; snow removal and/or yard work; tacking down loose rugs and/or securing tiles; and cleaning of tile work in bath and/or kitchen. Light chores are provided when needed.  
  • Heavy-duty chores – Limited to one-time-only, intensive cleaning/chore efforts, except in extraordinary situations. Heavy-duty chore services may include (but are not limited to) tasks such as scraping and/or cleaning of floor areas. |
| **Home visits by medical personnel** | Amerigroup STAR+PLUS MMP will cover home visits by medical personnel to provide diagnosis, treatment and wellness monitoring. The purpose of these home visits is to preserve the participant’s functional capacity to remain in the community. Wellness monitoring includes disease prevention, health education and identifying health risks that can be reduced.                                                                 |
| **Immunizations**             | Coverage includes the following services:  
  • Pneumonia vaccine  
  • Flu shots, once a year, in the fall or winter  
  • Hepatitis B vaccine if you the member is at high or intermediate risk of getting hepatitis B  
  • Other vaccines if the member is at risk and they meet Medicare Part B coverage rules  
  
  Coverage also includes other vaccines that meet the Medicare Part D coverage rules.                                                                                                                                                                                                                                                                                                                                                                                                 |

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<tr>
<td><strong>Independent living skills and training</strong></td>
<td>Independent living skills training and development (ILST) services are individually designed to improve or maintain the ability of the participant to live as independently as possible in the community. ILST may be provided in the participant’s residence and in the community. Services may include assessment, training and supervision of or assistance with the following: self-care; medication management; task completion; communication, interpersonal, sensory/motor, community transportation, problem solving, and prevocational skills; socialization; mobility; reduction/elimination of maladaptive behaviors; money management; and ability to maintain a household</td>
</tr>
</tbody>
</table>
| **Inpatient acute hospital care, including substance abuse and rehabilitative services** | Coverage includes the following services:  
- Semi-private room (or a private room if medically necessary)  
- Meals, including special diets  
- Regular nursing services  
- Costs of special care units, such as intensive/coronary care units  
- Drugs and medications  
- Lab tests, X-rays and other radiology services  
- Needed surgical and medical supplies  
- Appliances, such as wheelchairs  
- Operating and recovery room services  
- Physical, occupational and speech therapy  
- Inpatient substance abuse services  
- Blood, including storage and administration  
- Physician services  
- In some cases, the following transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell and intestinal/multi-visceral  

If a member needs a transplant, a Medicare-approved transplant center will review their case and decide whether they are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, the member can get their transplant services locally or at a distant location outside the service area. If Amerigroup STAR+PLUS MMP provides transplant services at a distant location outside the service area and the member chooses to get their transplant there, Amerigroup STAR+PLUS MMP will arrange or pay for lodging and travel costs for the member and one other person. |
<p>| <strong>Inpatient mental health care</strong>             | Coverage includes mental health care services that require a hospital stay, including days in excess of the Medicare 190-day lifetime maximum.                                                                                           |</p>
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<tr>
<td>Inpatient services covered during a non-covered inpatient stay</td>
<td>Inpatient stays that are not reasonable and needed will be denied. However, in some cases Amerigroup STAR+PLUS MMP will pay for services members get while they are in the hospital or a skilled nursing facility (SNF) even if the hospital stay is not covered:</td>
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<td>• Provider services</td>
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<td>• Diagnostic tests, like lab tests</td>
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<td>• X-ray, radium and isotope therapy, including technician materials and services</td>
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<td>• Surgical dressings</td>
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<td>• Splints, casts, and other devices used for fractures and dislocations</td>
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<td>• Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices; these are devices that:</td>
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<td>o Replace all or part of an internal body organ (including contiguous tissue)</td>
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<td></td>
<td>o Replace all or part of the function of an inoperative or malfunctioning internal body organ</td>
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<td></td>
<td>• Leg, arm, back and neck braces, trusses and artificial legs, arms and eyes. This includes adjustments, repairs and replacements needed because of breakage, wear, loss or a change in the patient’s condition</td>
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<tr>
<td></td>
<td>• Physical therapy, speech therapy and occupational therapy</td>
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<tr>
<td>Intensive psychiatric rehabilitation treatment programs</td>
<td>Amerigroup STAR+PLUS MMP will pay for time-limited, active psychiatric rehabilitation designed to:</td>
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<td>• Help a participant form and achieve mutually agreed upon goals in living, learning, working and social environments.</td>
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<td></td>
<td>• Intervene with psychiatric rehabilitative technologies to help a participant overcome functional disabilities.</td>
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<tr>
<td><strong>Kidney disease services and supplies</strong></td>
<td>Coverage includes the following services:</td>
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<td>• Kidney disease education services to teach kidney care and help members make good decisions about their care. Members must have stage IV chronic kidney disease, must refer be referred by their physician. Coverage includes up to six sessions of kidney disease education services.</td>
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<tr>
<td></td>
<td>• Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area</td>
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<td></td>
<td>• Inpatient dialysis treatments if the participant is admitted as an inpatient to a hospital for special care</td>
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<td></td>
<td>• Self-dialysis training, including training for the participant and anyone helping the participant with home dialysis treatments</td>
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<tr>
<td></td>
<td>• Home dialysis equipment and supplies</td>
</tr>
<tr>
<td></td>
<td>• Certain home support services, such as necessary visits by trained dialysis workers to check on home dialysis, to help in emergencies, and to check dialysis equipment and water supply.</td>
</tr>
<tr>
<td><strong>Medical nutrition therapy</strong></td>
<td>This is covered for members with diabetes or kidney disease without dialysis. It is also covered after a kidney transplant when referred by the member’s provider. Coverage includes three hours of one-on-one counseling services during the first year the member receives medical nutrition therapy services under Medicare; this includes our plan, any other Medicare Advantage plan or Medicare. Coverage includes up to two hours of one-on-one counseling services each year after that. If the member’s condition, treatment or diagnosis changes, the member may be able to get more hours of treatment with a provider’s request and approval by the SCT or Amerigroup STAR+PLUS MMP. A provider must prescribe these services and renew the request to the SCT or to Amerigroup STAR+PLUS MMP each year if your treatment is needed in the next calendar year.</td>
</tr>
<tr>
<td><strong>Medical social services</strong></td>
<td>Amerigroup STAR+PLUS MMP will pay for medical social services, which includes the assessment of social and environmental factors related to the participant’s illness and need for care. Services include:</td>
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<tr>
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<td>• Home visits to the individual, family or both.</td>
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<td>• Visits to prepare to transfer the participant to the community.</td>
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<td></td>
<td>• Patient and family counseling, including personal, financial and other forms of counseling services.</td>
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<td>Service</td>
<td>Coverage Description</td>
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<tr>
<td>Medicare Part B prescription drugs</td>
<td>These drugs are covered under Part B of Medicare. Amerigroup STAR+PLUS MMP will pay for the following drugs:</td>
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<td></td>
<td>• Injected or infused while provided by a physician, hospital outpatient, or ambulatory surgery center services</td>
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<td>• Drugs taken using durable medical equipment (such as nebulizers) that were authorized by the plan</td>
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<td></td>
<td>• Clotting factors – self-injection for members with hemophilia</td>
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<td></td>
<td>• Immunosuppressive drugs, if member is enrolled in Medicare Part A at the time of the organ transplant</td>
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<td></td>
<td>• Osteoporosis drugs that are injected. These drugs are paid for if member is homebound, has a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug themselves</td>
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<td></td>
<td>• Antigens</td>
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<td>• Certain oral anti-cancer drugs and anti-nausea drugs</td>
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<td>• Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics and erythropoiesis-stimulating agents (such as Procrit®, Aranesp®)</td>
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<tr>
<td></td>
<td>• IV immune globulin for the home treatment of primary immune deficiency diseases</td>
</tr>
<tr>
<td>Medication therapy management (MTM) services</td>
<td>Amerigroup STAR+PLUS MMP provides medication therapy management (MTM) services for members who take medications for different medical conditions. MTM programs help members and their providers make sure members’ medications are working to improve their health.</td>
</tr>
<tr>
<td>Mobile mental health treatment</td>
<td>Amerigroup STAR+PLUS MMP will pay for mobile mental health treatment, which includes individual therapy provided in the home. This service is available to members who have a medical condition or disability that limits their ability to come into an office for regular outpatient therapy sessions.</td>
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<td>Service</td>
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</table>
| **Moving assistance**                               | Amerigroup STAR+PLUS MMP will pay for moving assistance services. These are individually designed services intended to move a participant’s possessions and furnishings when the participant must be moved from inadequate or unsafe housing to an environment which more adequately meets the participant’s health and welfare needs and reduces the risk of unwanted nursing facility placement.  
Moving assistance does not include items such as security deposits, including broker’s fees required to obtain a lease on an apartment or home; set-up fees or deposits for utility or service access (for example, telephone, electricity, heating); and health and safety assurances such as pest removal, allergen control or cleaning prior to occupancy. |
| **24-Hour Nurse Help Line**                         | Amerigroup STAR+PLUS MMP has a nurse help line, which is a toll-free phone service that members can call 24 hours a day, 7 days a week. Members can call the nurse help line for answers to general health-related questions and for assistance in accessing services through Amerigroup STAR+PLUS MMP.                                                                                                                   |
| **Nursing facility care**                           | Amerigroup STAR+PLUS MMP will pay for nursing facilities for members who need 24-hour nursing care and supervision outside of a hospital.                                                                                                                                                                                                                  |
| **Nutrition (includes nutritional counseling and educational services)** | Amerigroup STAR+PLUS MMP will pay for nutrition services provided by a qualified nutritionist. Services include:  
• Assessment of nutritional needs and food patterns.  
• Planning for providing food and drink appropriate for the individual’s physical and medical needs and environmental conditions.                                                                                                                     |
<p>| <strong>Obesity screening and therapy to keep weight down</strong> | Coverage is available for members with a body mass index of 30 or more and includes counseling to help the member lose weight. Members must get the counseling in a primary care setting and be managed within the member’s full prevention plan.                                                                                                          |
| <strong>Other supportive services the SCT determines are necessary</strong> | Amerigroup STAR+PLUS MMP will pay for additional supportive services or items determined by the participant’s SCT to be necessary for the participant. This is meant to cover items or services that are not traditionally included in the Medicare or Medicaid programs but that are necessary and appropriate for the participant. One example is Amerigroup STAR+PLUS MMP paying for a blender to puree foods for a participant who cannot chew. |</p>
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<tr>
<th>Service</th>
<th>Coverage Description</th>
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<tr>
<td><strong>Outpatient blood services</strong></td>
<td>Blood, including storage and administration, beginning with the first pint you need</td>
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<tr>
<td><strong>Outpatient diagnostic tests and therapeutic services and supplies</strong></td>
<td>Coverage includes the following services:</td>
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<td>• CT scans, MRIs, EKGs and X-rays when a provider orders them as part of treatment for a medical problem</td>
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<td>• Radiation (radium and isotope) therapy, including technician materials and supplies</td>
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<td>• Surgical supplies, such as dressings</td>
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<td>• Splints, casts and other devices used for fractures and dislocations</td>
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<td>• Medically necessary clinical lab services and tests ordered by a provider to help diagnose or rule out a suspected illness or condition</td>
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<tr>
<td></td>
<td>• Blood, including storage and administration</td>
</tr>
<tr>
<td></td>
<td>• Other outpatient diagnostic tests</td>
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<tr>
<td><strong>Outpatient hospital services</strong></td>
<td>Coverage is available for medically needed services available in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Coverage includes the following services:</td>
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<td>• Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery</td>
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<td>• Labs and diagnostic tests billed by the hospital</td>
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<td>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it</td>
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<tr>
<td></td>
<td>• X-rays and other radiology services billed by the hospital</td>
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<td></td>
<td>• Medical supplies, such as splints and casts</td>
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<td></td>
<td>• Some screenings and preventive services</td>
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<td></td>
<td>• Some drugs that members can’t give themselves</td>
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<td>Service</td>
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| **Outpatient mental health care** | Coverage includes mental health services provided by the following:  
• A state-licensed psychiatrist or doctor  
• A clinical psychologist  
• A clinical social worker  
• A clinical nurse specialist  
• A nurse practitioner  
• A physician assistant  
• Any other Medicare-qualified mental health care professional as allowed under applicable state laws  

Coverage includes the following services:  
• Group therapy sessions  
• Clinic services  
• Day treatment  
• Psychosocial rehab services  

Participants may directly access one assessment from a network provider in a 12-month period without getting prior authorization.                                                                                                                                                                                                                                                                 |
| **Outpatient rehabilitation services** | Coverage includes physical therapy (PT), occupational therapy (OT) and speech therapy (ST). Members can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs) and other facilities. OT, PT and ST services are limited to twenty visits per therapy per calendar year, except for individuals with intellectual disabilities, individuals with traumatic brain injury and individuals under age 21.                                                                                                                                                                                                 |
| **Outpatient surgery**         | Coverage is available for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.                                                                                                                                                                                                                   |
| **Palliative care**           | Amerigroup STAR+PLUS MMP covers interdisciplinary end-of-life care and consultation with the participant and his/her family members. These services help to prevent or relieve pain and suffering and to enhance the participant's quality of life. Services include the following:  
• Family palliative care education  
• Pain and symptom management  
• Bereavement services  
• Massage therapy  
• Expressive therapies |
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| Partial hospitalization services             | Partial hospitalization is a structured program of active psychiatric treatment. It is offered in a hospital outpatient setting or by a community mental health center. It is more intense than the care a member gets in their doctor’s or therapist’s office. It can help keep members from having to stay in the hospital. Amerigroup STAR+PLUS MMP will pay for partial hospitalization to serve as an alternative to inpatient hospitalization or to reduce the length of a hospital stay within a medically supervised program. Services include the following:  
  • Assessment and treatment planning  
  • Health screening and referral  
  • Symptom management  
  • Medication therapy  
  • Medication education  
  • Verbal therapy  
  • Case management  
  • Psychiatric rehabilitative readiness determination  
  • Referral and crisis intervention                                                                 |
<p>| Peer-delivered services                      | Amerigroup STAR+PLUS MMP will pay for peer support services provided by a peer support provider. This is a person who assists individuals with their recovery from mental illness and substance abuse disorders.                                                                                                           |
| Peer mentoring                               | Amerigroup STAR+PLUS MMP will pay for peer mentoring for members who have recently transitioned into the community from a nursing facility or during times of crisis. This is an individually designed service intended to improve the participant’s self-sufficiency, self-reliance and ability to access needed services, goods and opportunities in the community. This will be accomplished through education, teaching, instruction, information-sharing and self-advocacy training. |
| Personal care services (PCS)                 | Amerigroup STAR+PLUS MMP will pay for PCS to assist members with activities such as personal hygiene, dressing, feeding and nutritional and environmental support function tasks (meal preparation and housekeeping). PCS must be medically necessary, ordered by the participant’s physician, and provided by a qualified person according to a plan of care.                                                                 |
| Personal emergency response services (PERS)   | Amerigroup STAR+PLUS MMP will pay for PERS, which is an electronic device that enables certain high-risk members to reach out for help during an emergency.                                                                                                                                                                                                 |</p>
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<tr>
<td>Personalized recovery oriented services (PROS)</td>
<td>Amerigroup STAR+PLUS MMP will pay for PROS to assist individuals in recovery from the disabling effects of mental illness. This includes the coordinated delivery of a customized array of rehabilitation, treatment and support services in traditional settings and in off-site locations.</td>
</tr>
<tr>
<td>Pharmacy benefits (outpatient)</td>
<td>Amerigroup STAR+PLUS MMP will pay for certain generic, brand, and nonprescription drugs to treat a participant’s illness or condition.</td>
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<tr>
<td>Physician/provider services, including doctor’s office visits</td>
<td>Coverage includes the following services:</td>
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<td>• Medically necessary health care or surgery services given in places such as:</td>
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<td>o Physician’s office.</td>
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<td></td>
<td>o Certified ambulatory surgical center.</td>
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<td>o Hospital outpatient department.</td>
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<td>• Consultation, diagnosis and treatment by a specialist</td>
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<td>• Basic hearing and balance exams given by a primary care provider or specialist</td>
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<td>• Second opinion before a medical procedure</td>
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<tr>
<td>Podiatry services</td>
<td>Coverage includes the following services:</td>
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<tr>
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<td>• Care for medical conditions affecting lower limbs, including diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs)</td>
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<tr>
<td></td>
<td>• Routine foot care for members with conditions affecting the legs, such as diabetes. Amerigroup STAR+PLUS MMP will pay for four routine foot care visits every year for all members.</td>
</tr>
<tr>
<td>Positive behavioral interventions and support (PBIS)</td>
<td>Amerigroup STAR+PLUS MMP will pay for PBIS for members who have significant behavioral difficulties that jeopardize their ability to remain in the community. The primary focus of this service is to decrease the intensity and/or frequency of the targeted behaviors and to teach safer or more socially appropriate behaviors. Examples of PBIS include:</td>
</tr>
<tr>
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<td>• Comprehensive assessment of the participant.</td>
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<td>• Development and implementation of a holistic structured behavioral treatment plan.</td>
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<td>• Training of family, natural supports and other providers.</td>
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<td></td>
<td>• Regular reassessment of the effectiveness of the participant’s behavioral treatment plan.</td>
</tr>
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<td>Service</td>
<td>Coverage Description</td>
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</tbody>
</table>
| Prescription drug coverage | Amerigroup STAR+PLUS MMP follows this Formulary Tier Structure:  
  • Tier 1 – Medicare Part D preferred brand/generic drugs with $0 copay  
  • Tier 2 – Medicare Part D nonpreferred brand/generic drugs – low income subsidies (LIS) copay applies  
  • Tier 3 – state Medicaid Rx generic drugs and brand name drugs with $0 copay  
  • Tier 4 – state Medicaid over-the-counter (OTC) with $0 copay                                                                                     |
| Prescription drugs      | Prescription drugs are only available by prescription, are used or sold in the United States and must be used for medically accepted indications. Prescription drugs covered by Amerigroup STAR+PLUS MMP are listed in the Amerigroup STAR+PLUS MMP formulary.  
  The formulary includes all generic drugs covered under the program as well as many brand-name drugs, nonpreferred brands and specialty drugs. One can view a copy of the formulary on the Amerigroup STAR+PLUS MMP website at [https://providers.amerigroup.com/TX](https://providers.amerigroup.com/TX) or request a copy from the Provider Relations department. Some of these drugs have precertification or step-therapy requirements or quantity limits. Providers may request authorization for a drug or coverage of a drug not on the formulary by contacting the Pharmacy department at 1-855-817-5786 or via fax at 1-800-359-5781.  
  Amerigroup STAR+PLUS MMP members should obtain covered drugs from a network pharmacy pursuant to a physician’s prescription. Pharmacy claims are processed by Express Scripts Inc. (ESI), the Amerigroup STAR+PLUS MMP pharmacy benefit management vendor. ESI services also include home infusion, specialty pharmacy and mail-order pharmacy. More information on these services can be obtained by contacting the Pharmacy department at the number listed above. |
### Service Coverage Description

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<th>Service</th>
<th>Coverage Description</th>
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<tbody>
<tr>
<td><strong>Prescription drugs by mail order</strong></td>
<td>Members can use the mail-order service to fill prescriptions for maintenance drugs (i.e., drugs taken on a regular basis for a chronic or long-term medical condition). For mail-order prescriptions, the physician must write on the maintenance drug prescription whether it is for a 31-, 62- or 93-day supply. When mailing in a prescription to the mail-order service for the first time, the member should allow up to two weeks for the prescription to be filled. For refills of the same prescription, members should allow up to two weeks for mailing and processing. If a member runs out of a medication before receiving a new supply from the mail-order pharmacy, call Pharmacy at 1-855-878-1785. They will assist with obtaining an emergency supply of the participant’s medication until he or she receives the new mail-order supply. Participants are not required to use mail-order prescription drug services to obtain an extended supply of maintenance medications. Members also have the option of using a retail pharmacy in the Amerigroup STAR+PLUS MMP network to obtain their maintenance medications. Some retail pharmacies may agree to accept the mail-order reimbursement rate for an extended supply of medication, which may result in no out-of-pocket payment difference to the participant.</td>
</tr>
<tr>
<td><strong>Preventive services</strong></td>
<td>Amerigroup STAR+PLUS MMP will pay for all preventive tests and screenings covered by Medicare and Medicaid to help prevent, find or manage a medical problem. This includes but is not limited to all the preventive services listed in this table.</td>
</tr>
<tr>
<td><strong>Private duty nursing services</strong></td>
<td>Amerigroup STAR+PLUS MMP will pay for private duty nursing services covered for continuous or intermittent skilled nursing services. These services are provided in the member’s home and are beyond what a certified home health agency can provide.</td>
</tr>
</tbody>
</table>
| **Prostate cancer screening exams**     | Coverage is for men age 50 and older and includes the following services once every 12 months:  
  - A digital rectal exam  
  - A prostate specific antigen (PSA) test |
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</table>
| **Prosthetic devices and related supplies**  | Coverage includes the following prosthetic devices:  
• Colostomy bags and supplies related to colostomy care  
• Pacemakers  
• Braces  
• Prosthetic shoes  
• Artificial arms and legs  
• Breast prostheses (including a surgical brassiere after a mastectomy)  
• Orthotic appliance and devices  
• Support stockings  
• Orthopedic footwear  

Coverage also includes some supplies related to prosthetic devices, including repair or replacement of prosthetic devices.                                                                                           |
| **Pulmonary rehabilitation services**        | Amerigroup STAR+PLUS MMP will pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). The participant must have an order approved by the ICT or Amerigroup STAR+PLUS MMP for pulmonary rehabilitation from the provider treating the COPD. This service is initially limited to 36 visits over a 12-18 week period but can be renewed. No prior authorization is required for the first course of treatment. Physician authorization is required for additional courses of treatment. |
| **Respiratory care services**                 | Amerigroup STAR+PLUS MMP will pay for respiratory therapy, which is an individually designed service provided in the home. Respiratory therapy includes preventive, maintenance and rehabilitative airway-related techniques and procedures.                                                                                                        |
| **Respite care services**                    | Amerigroup STAR+PLUS MMP will pay for respite care services to provide scheduled relief to nonpaid supports who provide primary care and support to a participant. The service may be provided in a 24-hour block of time as required.  

The primary location for this service is in the participant’s home, but respite services may also be provided in another community dwelling or facility acceptable to the participant. |
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<tr>
<td><strong>Sexually transmitted infections (STIs) screening and counseling</strong></td>
<td>Amerigroup STAR+PLUS MMP will pay for screenings for chlamydia, gonorrhea, syphilis and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A PCP or other primary care practitioner must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. Amerigroup STAR+PLUS MMP will also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20-30 minutes long. Amerigroup STAR+PLUS MMP will pay for these counseling sessions as a preventive service only if they are given by a PCP. The sessions must be in a primary care setting, such as a doctor’s office.</td>
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</table>
| **Skilled nursing facility care**              | Amerigroup STAR+PLUS MMP covers an unlimited number of days of skilled nursing facility care, and there is no prior hospital stay required. Coverage includes the following services:  
• A semi-private room or a private room if it is medically needed  
• Meals, including special diets  
• Nursing services  
• Physical therapy, occupational therapy and speech therapy  
• Drugs that’re part of the member’s plan of care, including substances that are naturally in the body, such as blood-clotting factors  
• Blood, including storage and administration  
• Medical and surgical supplies given by nursing facilities  
• Lab tests given by nursing facilities  
• X-rays and other radiology services given by nursing facilities  
• Appliances, such as wheelchairs, usually given by nursing facilities  
• Physician/provider services  

Members will usually get care from network facilities. However, members may be able to get care from a facility not in our network. Members can get care from the following places if they accept our plan’s amounts for payment:  
• A nursing home or continuing care retirement community where a member lived before they went to the hospital (as long as it provides nursing facility care)  
• A nursing facility where the member’s spouse lives at the time the member leaves the hospital |
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<tr>
<td>Silver Sneakers Fitness Membership</td>
<td>Amerigroup STAR+PLUS MMP provides the Silver Sneakers program as a supplemental benefit. Members are instructed on the use of the contracted fitness center’s equipment and home self-paced exercise programs through an orientation of the program.</td>
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</table>
| Smoking and tobacco cessation (counseling to stop smoking or tobacco use) | If a member uses tobacco but does not have signs or symptoms of tobacco-related disease; uses tobacco and has been diagnosed with a tobacco-related disease; or is taking medicine that may be affected by tobacco:  
  • Amerigroup STAR+PLUS MMP will pay for two counseling quit attempts in a 12-month period as a preventive service. This service is free for the member. Each counseling attempt includes up to four face-to-face visits.  
  • Amerigroup STAR+PLUS MMP will pay for smoking cessation counseling for pregnant women and women up to six months after birth. This smoking cessation counseling is in addition to benefits for prescriptions and over-the-counter smoking cessation products. |
| Social and environmental supports            | Amerigroup STAR+PLUS MMP will pay for services and items to support a member’s medical needs. Services may include:  
  • Home maintenance tasks.  
  • Homemaker/chore services.  
  • Housing improvement.  
  • Respite care. |
<p>| Social day care                              | Amerigroup STAR+PLUS MMP will pay for social day care for functionally impaired members for less than 24 hours per day. The services included in this benefit provide members with socialization, supervision and monitoring, personal care and nutrition in a protective setting. |
| Social day care transportation               | Amerigroup STAR+PLUS MMP will pay for transportation between a member’s home and the social day care facilities. |</p>
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<tr>
<td><strong>Structured day program</strong></td>
<td>Amerigroup STAR+PLUS MMP will pay for structured day program services provided in an outpatient congregate setting or in the community. Services are designed to improve or maintain the participant’s skills and ability to live as independently as possible in the community. Services may include the following: • Assessment • Training and supervision to an individual with self-care • Task completion • Communication skills • Interpersonal skills • Problem-solving skills • Socialization • Sensory/motor skills • Mobility • Community skills • Reduction/elimination of maladaptive behaviors • Money management skills • Ability to maintain a household</td>
</tr>
<tr>
<td><strong>Substance abuse services:</strong> Opioid treatment services</td>
<td>Amerigroup STAR+PLUS MMP will pay for opioid treatment services to help members manage addiction to opiates such as heroin. Opioid treatment programs administer medication, generally methadone by prescription, along with a variety of other clinical services. These programs help members control the physical problems associated with opiate dependence and provide the opportunity for members to make major lifestyle changes over time. This service does not include methadone maintenance, which is available through Medicaid but not through Amerigroup STAR+PLUS MMP.</td>
</tr>
<tr>
<td><strong>Substance abuse services:</strong> Outpatient medically supervised withdrawal</td>
<td>Amerigroup STAR+PLUS MMP will pay for medical supervision of members that are: • Undergoing mild to moderate withdrawal. • At risk of mild to moderate withdrawal. • Experiencing nonacute physical or psychiatric complications associated with their chemical dependence. Services must be provided under the supervision and direction of a licensed physician.</td>
</tr>
<tr>
<td><strong>Substance abuse services:</strong> outpatient substance abuse services</td>
<td>Amerigroup STAR+PLUS MMP will pay for outpatient substance abuse services including individual and group visits. Participants may directly access one assessment from a network provider in a 12-month period without getting prior authorization.</td>
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<td>Service</td>
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<tr>
<td>Substance abuse services: substance abuse program</td>
<td>Amerigroup STAR+PLUS MMP will pay for substance abuse program services to provide individually designed interventions to reduce/eliminate the use of alcohol and/or other substances by the participant, which, if not effectively dealt with, will interfere with the individual’s ability to remain in the community.</td>
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</table>
| Telehealth/telemonitoring and web-phone based technology services | Amerigroup STAR+PLUS MMP will pay for telehealth services for members with conditions that require frequent monitoring and/or the need for frequent physician, skilled nursing, or acute care services to reduce the need for in-office visits.  
Participants eligible for this service include those with the following conditions: congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, polypharmacy, mental or behavioral problems limiting self-management, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding. |
| Transportation services (emergency and nonemergency) | Amerigroup STAR+PLUS MMP will pay for emergency and nonemergency transportation. Transportation is provided for medical appointments and services. Transportation is also available for nonmedical events or services — such as religious services, community activities or supermarkets — through transportation modes including but not limited to the following:  
• Taxi  
• Bus  
• Subway  
• Van  
• Medical transport  
• Ambulance  
• Fixed-wing or airplane transport  
• Invalid coach  
• Livery  
• Other means |
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| **Urgent care** | Urgent care is care given to treat:  
• A nonemergency.  
• A sudden medical illness.  
• An injury.  
• A condition that needs care right away.  

Members requiring urgent care should first try to get it from a network provider. However, they can use out-of-network providers when they cannot get to a network provider.  

Urgent care does not include primary care services or services provided to treat an emergency medical condition. Members may get covered emergency care whenever they need it, anywhere in the United States or its territories. |
| **Vision care** | Amerigroup STAR+PLUS MMP will pay for the diagnosis and treatment of visual defects, eye disease and eye injury. This includes treatment for age-related macular degeneration. Examinations for refraction are limited to one exam every two years unless medically necessary.  

For people at high risk of glaucoma, Amerigroup STAR+PLUS MMP will pay for one glaucoma screening each year. People at high risk of glaucoma include:  
• Participants with a family history of glaucoma  
• Participants with diabetes  
• African-Americans who are age 50 and older |
<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision care: eyeglasses (lenses and frames) and contact lenses</td>
<td>Amerigroup STAR+PLUS MMP will pay for eyeglasses, medically necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services, when authorized by an optometrist or ophthalmologist. Coverage also includes the repair or replacement of parts. Eyeglasses (lenses and frames) and contact lenses are provided once every two years unless it is medically necessary to have them more frequently or unless the glasses or contact lenses are lost, damaged or destroyed. Amerigroup STAR+PLUS MMP will pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. If the member has two separate cataract surgeries, he or she must get one pair of glasses after each surgery. The member cannot get two pairs of glasses after the second surgery, even if he or she did not get a pair of glasses after the first surgery. Amerigroup STAR+PLUS MMP will also pay for corrective lenses, frames and replacements if needed after a cataract removal without a lens implant.</td>
</tr>
<tr>
<td>“Welcome to Medicare” preventive visit</td>
<td>Coverage includes the one-time “Welcome to Medicare” preventive visit. The visit includes: • A review of the member’s health. • Education and counseling about the preventive services a member needs (including screenings and shots). • Referrals for other care if needed. <strong>Important:</strong> We cover the “Welcome to Medicare” preventive visit only during the first 12 months the member has Medicare Part B.</td>
</tr>
<tr>
<td>Wellness counseling</td>
<td>Amerigroup STAR+PLUS MMP will pay for wellness counseling to help medically stable members maintain their optimal health status. A registered professional nurse (RN) works with the member to reinforce or teach healthy habits such as the need for daily exercise, weight control or avoidance of smoking. The RN is also able to offer support for control of diseases or disorders such as high blood pressure, diabetes, morbid obesity, asthma or high cholesterol. The RN can help the member identify signs and symptoms that may require intervention to prevent further complications from the disease or disorder.</td>
</tr>
</tbody>
</table>
Formulary Exceptions

If a prescription drug is not listed in the Amerigroup STAR+PLUS MMP formulary, check the updated formulary on the Amerigroup STAR+PLUS MMP website. The website formulary is updated frequently with any changes. In addition, providers may contact the Amerigroup STAR+PLUS MMP Pharmacy department to be sure a drug is covered. If the Pharmacy department confirms the drug is not on the formulary, there are two options:

- The prescribing physician can prescribe another drug that is covered on the formulary.
- The patient or prescribing physician may ask Amerigroup STAR+PLUS MMP to make an exception (a type of coverage determination) to cover the nonformulary drug. If the member pays out-of-pocket for a nonformulary drug and requests an exception Amerigroup STAR+PLUS MMP approves, Amerigroup STAR+PLUS MMP will reimburse the member. If the exception is not approved, the member may appeal our denial. See the “Participant Liability Appeals” section for more information on requesting exceptions and appeals.

In some cases, Amerigroup STAR+PLUS MMP will contact a member who is taking a drug that is not on the formulary. Amerigroup STAR+PLUS MMP will give the member the names of covered drugs used to treat his or her condition and encourage the member to ask his or her physician if any of those drugs would be appropriate options for treatment. Also, members who recently joined Amerigroup STAR+PLUS MMP may be able to get a temporary supply of a drug they are taking if the drug is not on the Amerigroup STAR+PLUS MMP formulary.

Pharmacy Transition Policy

New Amerigroup STAR+PLUS MMP members may be taking drugs that are not on the formulary or that are subject to certain restrictions, such as precertification or step therapy. Current members may also be affected by changes in the formulary from one year to the next. Members are encouraged to talk to their providers to decide if they should switch to a different drug Amerigroup STAR+PLUS MMP covers or request a formulary exception to get coverage for the drug (as described above).

During the period of time members are talking to their providers to determine the right course of action, Amerigroup STAR+PLUS MMP may provide a temporary supply of the nonformulary drug if those members need a refill for the drug during the first 90 days of new participation in Amerigroup STAR+PLUS MMP. For current members affected by a formulary change from one year to the next, Amerigroup STAR+PLUS MMP will provide a temporary supply of the nonformulary drug for members needing a refill for the drug during the first 90 days of the new plan year.

When a member goes to an Amerigroup STAR+PLUS MMP network pharmacy and we provide a temporary supply of a drug that is not on the formulary or that has coverage restrictions or limits, Amerigroup STAR+PLUS MMP will cover at least a one-time, 31-day supply (unless the prescription is written for fewer days). If necessary, Amerigroup STAR+PLUS MMP will cover more than one refill of these drugs during the first 90 days a member is enrolled in our plan. Amerigroup STAR+PLUS MMP will provide the member with a written notice after it covers a temporary supply. The notice will explain the steps the member can take to request an
exception and the way to work with the prescribing physician to decide if switching to an appropriate formulary drug is feasible.

If a new member is a resident of a long-term care facility (like a nursing home), Amerigroup STAR+PLUS MMP will cover a temporary, 31-day transition supply (unless the prescription is written for fewer days). If necessary, Amerigroup STAR+PLUS MMP will cover more than one refill of these drugs during the first 90 days a member is enrolled in our plan. If the member has been enrolled in the plan for more than 90 days and needs a drug that is not on the formulary or is subject to other restrictions such as step therapy or dosage limits, Amerigroup STAR+PLUS MMP will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new member requests a formulary exception.

This policy also applies to current members who experience a change in the level of their care. For example, if a member leaves the hospital and enters a long-term care facility or leaves hospice status and reverts back to standard care, the member may receive a temporary transition supply of the non-formulary drug for up to 31 days unless the prescription is written for fewer days.
CHAPTER 5: LONG-TERM SERVICES AND SUPPORTS (LTSS)

Overview
Amerigroup STAR+PLUS MMP provides an integrated approach to health care delivery that addresses those services members may require in the acute, behavioral, functional, social and environmental areas. Service coordination is a major feature of Amerigroup STAR+PLUS MMP and involves specialized person-centered thinking for members. Service coordinators provide assistance to members, family members and providers to develop a detailed service plan and provide the following services according to the member’s needs:

- Nursing facility care
- Acute care
- Behavioral health
- Environmental care
- Functional care
- Home- and community-based care

Role of Long-Term Services and Supports Providers
Amerigroup STAR+PLUS MMP long-term services and supports providers are responsible for (but not limited to) the following:

- Contacting us to verify member eligibility
- Obtaining authorizations for services prior to provision of those services
- Coordinating Medicaid/Medicare benefits
- Notifying us of changes in a member’s physical condition or eligibility
- Partnering with our service coordinator in managing a member’s health care
- Managing continuity of care
- Employment Assistance providers must develop and update quarterly a plan for delivering Employment Assistance Services
- Supported Employment providers must develop and update quarterly a plan for delivering Supported Employment Services

Personal Attendant Wage Requirements
Persons providing attendant services that qualify as Personal Assistance Services or Day Activity Health Services in the STAR+PLUS Other Community Care or HCBS STAR+PLUS Waiver programs must be paid at least $7.86 per hour.

Title 40 Texas Administrative Code §§49.71 – 49.73 contains these wage requirements, which apply to personal attendants working as either employees or contractors of a provider, or as employees or contractors of a subcontractor.

Electronic Visit Verification
Electronic visit verification (EVV) is the electronic verification and documentation of visit data, such as the date and time the services begin and end, the name of the attendant and the service recipient, and the services provided. EVV for personal attendant services (PAS) and
home nursing services will be implemented for Amerigroup STAR+PLUS MMP members. This requirement is optional for members who get attendant care services through the consumer-directed services (CDS) model based on the choice of each member.

PAS and home nursing services providers rendering services to Amerigroup STAR+PLUS MMP members under the agency models must have attendants and nursing staff use EVV to record visit information.

Amerigroup STAR+PLUS MMP will ensure that each PAS or home nursing service unit authorized and billed to Amerigroup STAR+PLUS MMP matches the applicable EVV record. The claim and EVV record will be evaluated during claim review.

**Covered Services**

Amerigroup STAR+PLUS MMP includes both residential nursing home care and community-based services.

The HCBS STAR+PLUS Waiver provides community long-term services and supports to Medicaid-eligible adults with disabilities and elderly persons as a cost-effective alternative to living in a nursing facility. These members must be age 21 or older, enrolled in Medicaid or otherwise financially eligible for waiver services.

While eligible members covered under traditional Medicaid have access to these services through the Community Based Alternatives (CBA) program, the STAR+PLUS program provides these services to individuals enrolled in managed care under the HCBS STAR+PLUS Waiver (SPW).

All LTSS services must be precertified. Coverage of these services is limited to members who need assistance with the activities of daily living. Some services are limited to members who meet the nursing home level of care. If you have an Amerigroup STAR+PLUS MMP patient who needs these services, please direct him or her to contact Member Services at 1-855-817-5789 (TTY: 711), 8 a.m.-8 p.m. local time. Our service coordinators will assess the member’s needs and develop a service plan.

**STAR+PLUS Coverage Table**

Amerigroup STAR+PLUS MMP members get benefits for acute care such as doctor visits, hospitalizations, prescriptions and behavioral health services, and they also can get long-term services and supports. A member may not need long-term services and supports right now, but they can get these benefits if needed in the future.
<table>
<thead>
<tr>
<th>Service Types</th>
<th>Dual Eligibles (Medicaid and Medicare coverage) + SPW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical (such as doctor’s visits and hospital services) and Behavioral Health Services</td>
<td>Medicare or Medicare HMO</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Member’s chosen Part D prescription drug vendor</td>
</tr>
<tr>
<td>Medicare Coinsurance and Deductibles</td>
<td>State’s fiscal agent (TMHP) for regular Medicare; Medicare HMO</td>
</tr>
<tr>
<td>Primary Home Care/Personal Assistance Services</td>
<td>Amerigroup STAR+PLUS MMP*</td>
</tr>
<tr>
<td>Day Activity and Health Services (DAHS)</td>
<td>Amerigroup STAR+PLUS MMP*</td>
</tr>
<tr>
<td>Consumer-directed attendant care</td>
<td>Amerigroup STAR+PLUS MMP*</td>
</tr>
<tr>
<td>Nursing services (in home)</td>
<td>Amerigroup STAR+PLUS MMP* or Medicare/ Medicare HMO</td>
</tr>
<tr>
<td>Emergency response services (emergency call button)</td>
<td>Amerigroup STAR+PLUS MMP*</td>
</tr>
<tr>
<td>Dental services</td>
<td>Amerigroup STAR+PLUS MMP*</td>
</tr>
<tr>
<td>Home-delivered meals</td>
<td>Amerigroup STAR+PLUS MMP*</td>
</tr>
<tr>
<td>Minor home modifications</td>
<td>Amerigroup STAR+PLUS MMP*</td>
</tr>
<tr>
<td>Adaptive aids</td>
<td>Amerigroup STAR+PLUS MMP*</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>Amerigroup STAR+PLUS MMP*</td>
</tr>
<tr>
<td>Medical supplies</td>
<td>Amerigroup STAR+PLUS MMP*</td>
</tr>
<tr>
<td>Physical, occupational and speech therapy</td>
<td>Amerigroup STAR+PLUS MMP*</td>
</tr>
<tr>
<td>Adult foster care/personal home care</td>
<td>Amerigroup STAR+PLUS MMP*</td>
</tr>
<tr>
<td>Assisted living</td>
<td>Amerigroup STAR+PLUS MMP*</td>
</tr>
<tr>
<td>Transition assistance services (for members leaving a nursing facility) - $2,500 maximum</td>
<td>Amerigroup STAR+PLUS MMP*</td>
</tr>
<tr>
<td>Respite (with or without self-directed models)</td>
<td>Amerigroup STAR+PLUS MMP*</td>
</tr>
<tr>
<td>Dietitian/Nutritional Assistance</td>
<td>Amerigroup STAR+PLUS MMP*</td>
</tr>
<tr>
<td>Transportation Assistance</td>
<td>Medical Transportation Program (MTP)</td>
</tr>
<tr>
<td>Cognitive Rehabilitation Therapy</td>
<td>Amerigroup STAR+PLUS MMP*</td>
</tr>
<tr>
<td>Financial Management Services</td>
<td>Amerigroup STAR+PLUS MMP*</td>
</tr>
<tr>
<td>Support Consultation</td>
<td>Amerigroup STAR+PLUS MMP*</td>
</tr>
<tr>
<td>Employment Assistance</td>
<td>Amerigroup STAR+PLUS MMP*</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>Amerigroup STAR+PLUS MMP*</td>
</tr>
</tbody>
</table>

* Members should contact a service coordinator or call Member Services to find out if they qualify for services.

**Primary Home Care/Personal Assistance Services (PAS)**

Primary home care/personal assistance services (PAS) are available to all Amerigroup STAR+PLUS MMP members based on medical and functional necessity and are provided to members living in their own home and community settings. Services include but are not limited to the following:
• Assisting with the activities of daily living, such as feeding, preparing meals, transferring and toileting
• Assisting with personal maintenance, such as grooming, bathing, dressing and routine care of hair and skin
• Assisting with general household activities and chores necessary to maintain the home in a clean, sanitary and safe environment, such as changing bed linens, housecleaning, laundering, shopping, storing purchased items and washing dishes
• Providing protective supervision
• Providing extension of therapy services
• Providing ambulation and exercise
• Assisting with medications that are normally self-administered
• Performing nursing tasks delegated by registered nurses
• Escorting the member on trips to obtain medical diagnosis, treatment or both

Day Activity and Health Services (DAHS)
All Amerigroup STAR+PLUS MMP members may receive medically and functionally necessary DAHS. DAHS includes nursing and personal care services, physical rehabilitative services, nutrition services, transportation services and other supportive services. These services are provided at facilities licensed or certified by the Texas Department of Aging and Disability Services (DADS).

Adult Foster Care (AFC)
Adult foster care (AFC) is a benefit for Amerigroup STAR+PLUS MMP members that provides a 24-hour living arrangement in a Department of Aging and Disability Services (DADS)-contracted foster home for persons who, because of physical, mental or emotional limitations, are unable to continue independent functioning in their own homes. Services may include meal preparation, housekeeping, personal care, nursing tasks, supervision, companion services, daily living assistance and provision of, or arrangement for, transportation.

The member must reside in a SPW AFC home. Providers of AFC must live in the household and share a common living area with the member. Detached living quarters do not constitute a common living area. The individual enrolled to provide AFC must be the primary caregiver. Providers may serve up to three adult members in a DADS-enrolled AFC home without licensure as a personal care home. Up to four residents may be served in a foster home, though there are limitations as to the number of members at each level who may reside in one home. Members are required to pay for their own room and board costs, and contribute to the cost of their care, if able, through a copay to the AFC provider.

Adaptive Aids and Medical Supplies
Adaptive aids and medical supplies are covered benefits for members when needs for the member to have optimal function, independence and well-being are identified and approved by Amerigroup STAR+PLUS MMP. Adaptive aids and medical supplies are specialized medical equipment and supplies, including devices, controls or appliances specified in the plan of care, that enable individuals to increase their abilities to perform activities of daily living or perceive,
control or communicate with the environment in which they live. Adaptive aids and medical
supplies are reimbursed with the goal of providing individuals a safe alternative to nursing
facility (NF) placement. Items not of direct remedial benefit (providing a remedy to cure or
restore health) or medical benefit to the individual are excluded from reimbursement.

Adaptive aids and medical supplies are limited to the most cost-effective items that can:
• Meet the member's needs.
• Directly aid the member to avoid premature NF placement.
• Provide NF residents an opportunity to return to the community.

The Amerigroup STAR+PLUS MMP program is not intended to provide every member with any
and all adaptive aids or medical supplies the member may receive as an NF resident. Details of
items covered under this category can be found in the DADS STAR+PLUS Handbook at:

**Dental Services**

Dental Services for Amerigroup STAR+PLUS MMP members are services provided by a dentist to
preserve teeth and meet the medical needs of the member. Allowable services include:
• Emergency dental treatment necessary to control bleeding, relieve pain, and eliminate
acute infection.
• Preventative procedures required to prevent the imminent loss of teeth.
• The treatment of injuries to teeth or supporting structures.
• Dentures and the cost of preparation and fitting.
• Routine procedures necessary to maintain good oral health.

Dental services for members are limited to $5,000 per waiver plan year. This limit may be
exceeded upon approval by Amerigroup STAR+PLUS MMP up to an additional $5,000 per
waiver plan year when medically necessary treatment requires the services of an oral surgeon.
Amerigroup STAR+PLUS MMP may also approve other dental services above the $5,000 waiver
plan year limit on a case-by-case basis due to medical necessity, functional necessity, or the
potential for improved health of the member. Amerigroup STAR+PLUS MMP must review and
approve any treatment in excess of the waiver plan year limit prior to services being rendered.

**Cognitive Rehabilitation Therapy**

Cognitive rehabilitation therapy is a service available to members that assists a member in
learning or relearning cognitive skills that have been lost or altered as a result of damage to
brain cells/chemistry in order to enable the member to compensate for the lost cognitive
functions. Cognitive rehabilitation therapy may be provided when an appropriate professional
assesses the member and determines it is medically necessary. Cognitive rehabilitation therapy
is provided in accordance with the plan of care developed by the assessor and includes
reinforcing, strengthening or reestablishing previously learned patterns of behavior, or
establishing new patterns of cognitive activity or compensatory mechanisms for impaired
neurological systems.
Employment Assistance
Employment assistance means assistance provided to a member to help the member locate paid employment in the community. Employment assistance includes:

- Identifying an individual's employment preferences, job skills and requirements for a work setting and work conditions.
- Locating prospective employers offering employment compatible with an individual's identified preferences, skills and requirements.
- Contacting a prospective employer on behalf of a member and negotiating the member's employment.

Employment assistance is not available to members receiving services through a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.

Supported Employment
Supported employment means assistance provided to a member in order to sustain paid employment to a member who, because of a disability, requires intensive, ongoing support to be self-employed, work from home or perform in a work setting at which members without disabilities are employed. Supported employment includes employment adaptations, supervision and training related to a member's diagnosis.

Supported employment is not available to members receiving services through a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.

Financial Management Services
Financial management services (FMS) is assistance provided to members who elect to participate in the consumer-directed services (CDS) option to manage funds associated with services elected for self-direction. The assistance is provided by the CDS agency. This includes initial orientation and ongoing training related to the responsibilities of being an employer and adhering to legal requirements for employers. A monthly administrative fee is authorized on the individual service plan and paid to the CDS agency for FMS.

Support Consultation
Support consultation services are available to members participating in the CDS option. It is an optional service. A member's service planning team may recommend the service when the employer (the individual or legally authorized representative (LAR)) or the designated representative (DR) would benefit from additional support with employer responsibilities.

Support consultation services must not duplicate or replace services to be delivered through a case manager, a service coordinator, the financial management services agency (FMSA) or other sources. A support advisor provides skills-specific training, assistance and supports to the employer or the employer's designated representative (DR) to meet responsibilities of the CDS option.
Examples of services a support advisor may provide include training related to recruiting and screening applicants for employment and verifying employment eligibility, assistance with developing job descriptions, coaching on problem solving and coordinating employee management activities, training on developing and implementing service backup and corrective action plans, and coaching on handling other employer responsibilities.

**Service Coordination**
We provide a single identified person as a service coordinator to all Amerigroup STAR+PLUS MMP members. The member will be notified by letter of the name and direct telephone number of their assigned personal service coordinator.

We will help ensure each Amerigroup STAR+PLUS MMP member has access to a PCP or physician who is responsible for overall clinical direction. The PCP/physician, in conjunction with the service coordinator, serves as a central point of integration and coordination of covered services.

Service coordinators work with members and providers to coordinate all Amerigroup STAR+PLUS MMP covered services and any other applicable services. Our service coordinators collaborate with the member’s PCP/physician regardless of network status.

**Discharge Planning**
We will promptly assess the needs of a member discharged from a hospital, nursing facility, or other care or treatment facility. A service coordinator will work with the member’s PCP, the hospital or nursing facility discharge planner, the attending physician, the member, and the member’s family to assess and plan for the member’s discharge. When long-term services and supports are needed, we will ensure the member’s discharge plan includes arrangements for receiving community-based care whenever possible. The service coordinator will provide information to the member, the member’s family and the member’s PCP regarding all service options available to meet the member’s needs in the community.

**Transition Plan for New Amerigroup STAR+PLUS Members**
We will provide a transition plan for a member newly enrolled with Amerigroup STAR+PLUS MMP who is already receiving long-term services and supports, including nursing facility services. HHSC, or the previous STAR+PLUS MCO, will give us information such as detailed care plans and names of current providers. We will ensure that current providers are paid for medically necessary and functionally necessary covered services that are delivered in accordance with the member’s existing care plan beginning with the member’s date of enrollment with Amerigroup STAR+PLUS MMP until the transition plan is developed and implemented.

The transition planning process will include the following:
- Review of existing care plans prepared by DADS or another STAR+PLUS MCO
• Preparation of a transition plan that ensures continuous care under the member’s existing care plan during the transfer into the Amerigroup STAR+PLUS MMP network while we conduct an appropriate assessment and development of a new plan (if needed)
• If durable medical equipment or supplies had been ordered prior to enrollment but have not been received by the date of enrollment, we will coordinate and follow through to ensure that the member receives the necessary supportive equipment and supplies without undue delay
• Payment to the existing provider of service under any existing authorization for up to six months, until we have completed the assessment and service plan and issued a new authorization

We will review any existing care plan for a new member and develop a transition plan within 30 days of receiving notice of the member’s enrollment. The transition plan will remain in place until we contact the member or the member’s representative and we coordinate modifications to the member’s current care plan. We will ensure that existing services continue and there is no break in services. For the carve-in of nursing facility services effective March 1, 2015, we will honor existing authorizations for the earliest of:
• Six months after the carve-in of nursing facility services.
• Until the expiration date of the existing authorization.
• Until we have evaluated and assessed the member and issued or denied a new authorization.

A transition plan will include the following:
• The member’s history
• A summary of current medical, behavioral health and social needs and concerns
• Short-term and long-term needs and goals
• A list of services required and their frequency
• A description of who will provide the services

The transition plan may include information about services outside the scope of covered services such as how to access affordable, integrated housing. We will ensure the member or the member’s representative is involved in the assessment process and fully informed about options, is included in the development of the transition plan, and is in agreement with the plan when completed.

Precertification
Referral and precertification forms are available at https://providers.amerigroup.com/TX.

All LTSS require authorization before services are rendered. Requests may be submitted via fax, telephone or our website for review and approval. We will send a fax confirmation of the service approval. Authorizations can be submitted at:
• Fax: 1-844-206-3445
• Email: nursingfacility@amerigroup.com
Claims
Timely Filing
Providers must ensure clean claims are submitted and received at Amerigroup STAR+PLUS MMP within 95 calendar days of the date of service and/or date of discharge. In the case of other insurance, submit a clean claim within 95 days of receiving a response from the third-party payer. Clean claims for members whose eligibility has not been added to the state’s system must be received within 95 days from the date the eligibility is added. We must receive clean claims from out-of-network providers rendering services outside of Texas within one year of the date of service and/or date of discharge. Refer to the “Billing and Claims Administration” chapter of this manual for the definition of a clean claim.

Claims can be submitted electronically or by paper at the provider’s preferred frequency (daily, weekly, etc.), but cannot exceed the filing limit deadline. When billing a span of dates on a single outpatient claim, the filing timeline is calculated from the first or earliest service date on the claim. Acute care and outpatient claims should be submitted in accordance with the requirements in the “Billing and Claims Administration” chapter of this manual.

Uniform Billing Code Guidelines
Providers must follow the uniform coding guidelines for LTSS as defined by the Texas Health and Human Services Commission (HHSC). Refer to our website at https://providers.amerigroup.com/TX for the current guidelines. Use only the uniform billing defined code, modifier, type and place of service combinations.

Claim Submission
LTSS providers have three options for submitting claims: our website, Electronic Data Interchange (EDI) or paper.

Website
We provide a free online claim submission tool through https://www.availity.com. Submission via the Availity Portal requires provider registration.

Electronic Data Interchange
Claims may be submitted electronically through the clearinghouses identified below. The guide for EDI claims submission is located on our website at https://providers.amerigroup.com/TX. The EDI claim submission guide includes additional information related to the EDI claim process. To initiate the electronic claims submission process or obtain additional information, please call the EDI Hotline at 1-800-590-5745.

Amerigroup STAR+PLUS MMP payer IDs:

<table>
<thead>
<tr>
<th>Clearinghouse</th>
<th>Payer Number</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availity</td>
<td>26375</td>
<td>1-877-334-8446</td>
</tr>
<tr>
<td>Capario</td>
<td>28804</td>
<td>1-800-792-5256</td>
</tr>
<tr>
<td>Emdeon</td>
<td>27514</td>
<td>1-877-469-3263</td>
</tr>
</tbody>
</table>
Paper Claims
For more effective claims processing, paper claim forms:

- Must be submitted on original claim forms (CMS-1500 or CMS-1450 [UB-04]) with dropout red ink and printed or typed (not handwritten) in a large, dark font.
- Cannot be submitted with alterations to key billing information; we do not accept claims with information that is marked through, handwritten or whited out.

Claims that have been altered are rejected and returned to the provider with an explanation of the reason for the return.

Submit LTSS paper claims to us at:

Long-Term Care Claims
Amerigroup STAR+PLUS MMP
P.O. Box 61010
Virginia Beach, VA 23466-1010

CMS 1500 Claim Form
Noninstitutional providers and suppliers must use the CMS 1500 form.

- You may bill either individual dates of service or bill using a span of dates.
- Example: Claim may be submitted for dates of service from January 1, 2010, to January 15, 2010, on one claim. Box 24 should indicate service dates from January 1, 2010, to January 15, 2010.
- You must include your state-issued LTSS provider ID appropriate for the service being billed. IDs are assigned to specific categories of service. Place the number in Box 33B:
  - Sample ID
  - Statewide = S00000000
  - Facility-based provider (DAHS) = F00000000

This form and instructions are available on the CMS website at https://cms.hhs.gov. See a sample on the following page:
null
Institutional and other selected providers must use the CMS 1450 (UB-04) form. This form and instructions are available on the CMS website at https://cms.hhs.gov. See sample below:

Claim Adjudication and Reimbursement

Our members must not be balance billed for covered services. Additional information can be found in the “Billing and Claims Administration” chapter of this manual.
Clean claims for members are adjudicated within 30 days from the date we receive them. Clean claims not adjudicated within 30 days of receipt by us are subject to interest payments. Adjudication edits are based on the member’s eligibility, benefit plan, authorization status, HIPAA coding compliance and our claim processing guidelines. Claim coding is subject to review using code-editing software.

Claim reimbursement is based on the provider’s contract. We are responsible for paying an enhanced fee to LTSS providers who are part of the Department of Aging and Disability Services (DADS) Attendant Enhancement Payment program. When contracted with us for this program, the fees will be built into the provider’s fee schedule. We are not required to match the DADS program.

**Cost Reporting to HHSC**

LTSS providers must submit periodic cost reports and supplemental reports to HHSC in accordance with 1 T.A.C. Chapter 355, including Subchapter A (Cost Determination Process) and 1 T.A.C. §355.403 (Vendor Hold). If an LTSS provider fails to comply with these requirements, HHSC will notify Amerigroup STAR+PLUS MMP to hold payments to the provider until HHSC instructs us to release the payments.

**Attendant Care Enhancement Payment Program (ACEP)**

The Attendant Care Enhancement Payments (ACEP) is a legislatively mandated program providing additional compensation to long-term care direct care providers. We administer the enhanced payments for direct care providers rendering services to our members.

**Attendant Care Enhancement Payments Program Enrollment**

Providers, including nursing facility providers, are eligible to enroll in the ACEP program for the following services: assisted living/residential care (ALRC), day activity and health services (DAHS), and personal attendant services (PAS).

We allow contracted providers in the DADS attendant care enhancement program to enroll in our ACEP program. The agreement between these providers and us includes language defining the requirements for enhancement payments.

Any provider joining our ACEP program or requesting a change in participation level will be required to demonstrate enrollment in good standing in the DADS program. Acceptable documentation includes either a copy of the DADS letter to the provider indicating the level of participation or the provider’s DADS contract number that can be verified with the DADS participation list. A newly contracted provider’s enrollment into our program will be effective concurrently with the effective date of his or her provider participation agreement/contract. A provider with an existing participation agreement/contract with us may request an amendment for participation in our ACEP program during our annual open enrollment period.
In some cases, LTSS providers in STAR+PLUS-defined counties are no longer afforded the opportunity to hold DADS program contracts, because DADS does not administer a particular program in those counties. In these instances, we will allow new or contracted providers to enroll in our ACEP program. This exception is granted under the following conditions:

- The provider is licensed by DADS.
- The provider has not been sanctioned, disciplined, restricted, prohibited from contracting and/or disenrolled from the DADS program contracts in the previous three fiscal state periods.

**Attendant Care Enhancement Payments Payment Levels**

We will increase our fee schedule rates for those codes included within the enhancement program for contracted providers who enroll. Services eligible for the additional payment under the program are PAS, DAHS and assisted living/residential care. Enhancement levels are available in five tiers. The amount of the fee schedule increase will be determined based on a financial analysis of the historic costs of the enhancement program to the extent these are available. The enhancement payment amount will be added to the provider’s negotiated rate schedule for eligible services. The enhancement payment is made as part of the claim payment. The payment and Explanation of Payment (EOP) issued to the provider will not indicate that the provider was paid at the enhanced rate.

We reserve the right to adjust and amend the ACEP program fee schedule at any time with appropriate notice to program participants. Effective September 1, 2016, the Amerigroup STAR+PLUS MMP ACEP program administers five tiers of payment as defined below:

- Tier B (DADS levels 26-31) = $1.75 per unit
- Tier 1 (DADS levels 16-25) = $1.25 per unit
- Tier 2 (DADS levels 11-15) = $.75 per unit
- Tier 3 (DADS levels 6-10) = $.50 per unit
- Tier 4 (DADS levels 1-5) = $.25 per unit

Tier amounts are subject to change based on the funds available for our attendant care enhancement program. Providers will be notified of rate changes by contract amendment. Participation in the program will renew each contract year unless the provider disenrolls from the DADS program or changes DADS payment levels.

**Attendant Care Enhancement Payments Reporting**

We require each contracted provider participating in the enhancement program to supply a detailed report describing the amount spent and payment distribution. Each provider must submit the required report in the format and by the date required each year by Amerigroup STAR+PLUS MMP. We will send notifications of the requirements to each provider enrolled in the program with Amerigroup STAR+PLUS MMP. Each report submitted by the provider will be reviewed to ensure funds were distributed in accordance with state guidelines. We will conduct detailed audits as we deem necessary.

If a provider fails to distribute the funds appropriately, we will issue a notice of corrective action to that provider. The provider will then have 45 days to ensure funds are distributed
correctly. Should the provider fail to comply with the corrective action, we will take action including, but not limited to:

- Retracting the funds.
- Reporting inappropriate use of funds by the provider to HHSC.
- Suspending or terminating the provider’s participation in the Amerigroup STAR+PLUS MMP enhancement program.
- Terminating the Amerigroup STAR+PLUS MMP Provider Participation Agreement.

**Provider Complaints**

A complaint is a written expression of dissatisfaction regarding any aspect of health care services provided by Amerigroup STAR+PLUS MMP and network providers and/or staff other than a payment appeal. For a description of the provider complaint process, see the “Provider Complaint and Grievance Procedures” chapter of this manual.

**Provider Payment Disputes**

Providers may make the initial attempt to resolve a claim issue by calling Provider Services at 1-855-878-1785. All disputes must be submitted in writing and received by us within 120 calendar days of the printed run date on the EOP. To submit a payment appeal, complete the payment appeal form located online at [https://providers.amerigroup.com/TX](https://providers.amerigroup.com/TX). All appropriate supporting documents (including the EOP, medical records, etc.) must accompany the dispute. Submit the documentation to:

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Provider Payment Disputes
Amerigroup STAR+PLUS MMP
P.O. Box 61599
Virginia Beach, VA 23466-1599
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Providers may also utilize the payment dispute tool on our website. When inquiring on the status of a claim that is considered eligible for dispute due to no or partial payment, a button will display for submission of a dispute. Once this button is clicked, a web form will display for the provider to complete and submit. If all required fields are completed, the provider will receive immediate acknowledgement of his or her submission. When using the online tool, supporting documentation can be uploaded using the attachment feature on the web form. The documentation will attach to the form when submitted.

Resolution should be received within 30 calendar days from our receipt of the written dispute. If the provider disagrees with our determination, he or she may dispute the first level resolution within 30 calendar days of the date of the first level decision letter. Further disagreement must be resolved through the terms of the provider’s participation agreement. Additional information on the payment dispute process (including acute care claims) is located in the “Provider Complaint and Grievance Procedures” chapter of this manual.
Changes and/or errors in CPT codes are not considered payment disputes. Corrected claims should be resubmitted with a notation of corrected claim to:

LTSS Claims
Amerigroup STAR+PLUS MMP
P.O. Box 8668
Virginia Beach, VA 23466-8668
CHAPTER 6: BEHAVIORAL HEALTH SERVICES

Overview
Behavioral health services are covered services for the treatment of mental, emotional or chemical dependency disorders.

We provide coverage of medically necessary behavioral health services that:
• Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain or prevent deterioration of functioning resulting from such a disorder.
• Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care.
• Are furnished in the most appropriate and least restrictive setting in which services can be safely provided.
• Are the most appropriate level or supply of service that can safely be provided.
• Could not be omitted without adversely affecting the member’s mental and/or physical health or the quality of care rendered.
• Are not experimental or investigative.
• Are not primarily for the convenience of the member or provider.

We do not cover behavioral health services that are experimental or investigative. Covered services are not intended primarily for the convenience of the member or the provider. For more information about behavioral health services:
• Providers should call 1-855-878-1784.
• Members should call 1-855-817-5789.

Covered Behavioral Health Services
Medicaid-covered behavioral health services are not subject to the quantitative treatment limitations that apply under traditional, fee-for-service (FFS) Medicaid coverage. The services may be subject to the HMO’s nonquantitative treatment limitations, provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008 behavioral health services, including the following:
• Inpatient mental health services
• Outpatient mental health services
• Psychiatry services
• Counseling services for adults (age 21 and older)
• Outpatient substance use disorder treatment services, including:
  • Assessment
  • Detoxification services
  • Counseling treatment
  • Medication-assisted therapy
• Residential substance use disorder treatment services, including detoxification services
• Substance use disorder treatment, including room and board
• Mental Health Rehabilitative Services
• Targeted Case Management

Mental Health Rehabilitative Services and Targeted Case Management

For members with severe and persistent mental illness (SPMI) or severe emotional disturbance (SED), mental health rehabilitative (MHR) services and targeted case management (TCM) must be available to eligible members.

SPMI is a condition of an adult 18 years of age or older. It is a diagnosable mental, behavioral, or emotional disorder that meets the criteria of DSM-IV-TR and that has resulted in functional impairment which substantially interferes with or limits one or more major life activities.

SED is a condition of a child up to age 18 either currently or at any time during the past year. It is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV-TR and that has resulted in functional impairment which substantially interferes with or limits the child’s role or functioning in family, school, or community activities.

MHR services include training and services that help the member maintain independence in the home and community, such as the following:

• Medication training and support – curriculum-based training and guidance that serves as an initial orientation for the member in understanding the nature of his or her mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and the increased tenure in the community
• Psychosocial rehabilitative services – social, educational, vocational, behavioral, or cognitive interventions to improve the member’s potential for social relationships, occupational or educational achievement, and living skills development
• Skills training and development – skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers, and teachers
• Crisis intervention – intensive community-based one-to-one service provided to members who require services in order to control acute symptoms that place the member at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting
• Day program for acute needs – short-term, intensive, site-based treatment in a group modality to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting or reduce the amount of time spent in the more restrictive setting

TCM services include case management for members who have SPMI (adult, 18 years of age or older).

MHR services and TCM services and any limitations to these services are described in the most current TMPPM, including the Behavioral Health, Rehabilitation, and Case Management Services Handbook. We will authorize these services using the Department of State Health Services (DSHS) Resiliency and Recovery Utilization Management Guidelines (RRUMG), but
Amerigroup STAR+PLUS MMP is not responsible for providing any services listed in the RRUMG that are not covered services.

Texas Resilience and Recovery Utilization Management Guidelines for Adult Mental Health Services can be found at Texas Resilience and Recovery Utilization Management Guidelines—Adult Services (PDF): [www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589981162](www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589981162)

Texas Resilience and Recovery Utilization Management Guidelines for Child and Adolescent Services can be found at Texas Resilience and Recovery Utilization Management Guidelines—Child and Adolescent Services (PDF): [www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589979570](www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589979570)

Providers of MHR services and TCM services must use and be trained and certified to administer the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths (CANS) tools to assess a member’s need for services and recommend a level of care. Providers must use these tools to recommend a level of care to Amerigroup STAR+PLUS MMP by using the current DSHS Clinical Management for Behavioral Health Services (CMBHS) web-based system. Providers must also complete the Mental Health Rehabilitative and Mental Health Targeted Case Management Services Request Form and submit the completed form to Amerigroup STAR+PLUS MMP. A provider entity must attest to Amerigroup STAR+PLUS MMP that the organization has the ability to provide, either directly or through sub-contract, the full array of RRUMG services to members.

**Attention Deficit Hyperactivity Disorder (ADHD)**

Treatment of children diagnosed with ADHD, including follow-up care for children who are prescribed ADHD medication, is covered as outpatient mental health services. Reimbursement for these services will be determined according to the Provider Agreement. Covered benefits are as outlined in the TMPPM.

**Primary and Specialty Services**

Amerigroup STAR+PLUS MMP members have access to the following primary and specialty services:

- Behavioral health clinicians available 24 hours a day, 7 days a week to assist with identifying the most appropriate and nearest behavioral health service
- Routine or regular laboratory and ancillary medical tests or procedures to monitor behavioral health conditions of members; these services are furnished by the ordering provider at a lab located at or near the provider’s office; in most cases, our network of reference labs is conveniently located at or near the provider’s office
- Behavioral health case managers to coordinate with the hospital discharge planner and member to ensure appropriate outpatient services are available
- Support and assistance for network behavioral health care providers in contacting members within 24 hours to reschedule missed appointments
Behavioral Health Care Provider Responsibilities

We maintain a behavioral health provider network, including psychiatrists, psychologists and other behavioral health providers experienced in serving children, adolescents and adults. The network provides accessibility to qualified providers for all eligible individuals in the service area.

PCPs providing behavioral health services must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. Screening and assessment tools to assist with the detection, treatment and referral of behavioral health care services are found on our website.

Providers who furnish routine outpatient behavioral health services must schedule appointments within the earlier of 10 business days or 14 calendar days of a request. Providers who furnish inpatient psychiatric services must schedule outpatient follow-up and/or continuing treatment prior to a patient’s discharge. The outpatient treatment must occur within seven days from the date of discharge. Behavioral health providers must contact members who have missed appointments within 24 hours to reschedule appointments.

PCPs should:
- Educate members with behavioral health conditions about the nature of the condition and its treatment.
- Educate members about the relationship between physical and behavioral health conditions.
- Contact a behavioral health clinician when behavioral health needs go beyond his or her scope of practice.

PCPs can offer behavioral health services when:
- Clinically appropriate and within the scope of his or her practice.
- The member’s current condition is not so severe, confounding or complex as to warrant a referral to a behavioral health provider.
- The member is willing to be treated by the PCP.
- The services rendered are within the scope of the benefit plan.

Behavioral health providers:
- Must refer members with known or suspected physical health problems or disorders to the PCP for examination and treatment.
- Must utilize the most current DSM multi-axial classification when assessing members; network providers must document DSM and assessment/outcome information in the member’s medical record.
- May only provide physical health care services if licensed to do so.
- Must send initial and quarterly summary reports of a member’s behavioral health status to the PCP with the member’s consent.
Care Continuity and Coordination Guidelines

PCPs and behavioral health care providers are responsible for actively coordinating and communicating continuity of care. Appropriate and timely sharing of information is essential when the member is receiving psychotropic medications or has a new or ongoing medical condition. The exchange of information facilitates behavioral and medical health care strategies.

Our care continuity and coordination guidelines for PCPs and behavioral health providers include:

- Coordinating medical and behavioral health services with the local mental health authority (LMHA) and state psychiatric facilities regarding admission and discharge planning for members with serious emotional disorders (SED) and serious mental illness (SMI), if applicable.
- Completing and sending the member’s consent for information release to the collaborating provider.
- Using the release as necessary for the administration and provision of care.
- Noting contacts and collaboration in the member’s chart.
- Responding to requests for collaboration within one week or immediately if an emergency is indicated.
- Sending a copy of a completed Coordination of Care/Treatment Summary form to us and the member’s PCP when the member has seen a behavioral health provider; the form can be found on our website.
- Sending initial and quarterly (or more frequently, if clinically indicated) summary reports of a member’s behavioral health status from the behavioral health provider to the member’s PCP.
- Contacting the PCP when a behavioral health provider changes the behavioral health treatment plan.
- Contacting the behavioral health provider when the PCP determines the member’s medical condition could reasonably be expected to affect the member’s mental health treatment planning or outcome and documenting the information on the coordination of care/treatment summary.

Emergency Behavioral Health Services

An emergency behavioral health condition means any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson possessing an average knowledge of health and medicine requires immediate intervention and/or medical attention. And in an emergency and without immediate intervention and/or medical attention, the member would present an immediate danger to himself, herself or others or would be rendered incapable of controlling, knowing or understanding the consequences of his or her actions.

In the event of a behavioral health emergency, the safety of the member and others is paramount. The member should be instructed to seek immediate attention at an emergency room or other behavioral health crisis service. An emergency dispatch service or 911 should be
contacted if the member is a danger to self or others and is unable to go to an emergency care facility.

A behavioral health emergency occurs when the member is:
• Suicidal.
• Homicidal.
• Violent towards others.
• Suffering a precipitous decline in functional impairment and is unable to take care of activities of daily living.
• Alcohol or drug dependent with signs of severe withdrawal.

We do not require precertification or notification of emergency services, including emergency room and ambulance services.

**Urgent Behavioral Services**

An urgent behavioral health situation is defined as a condition that requires attention and assessment within 24 hours. In an urgent situation, the member is not an immediate danger to himself or herself or others and is able to cooperate with treatment.

Care for non-life-threatening emergencies should be within six hours.

**Precertification and Referrals for Behavioral Health**

Members may self-refer to any Amerigroup STAR+PLUS MMP network behavioral health services provider by calling Member Services at 1-855-817-5789. No precertification or referral is required from the PCP. Providers may refer members for services by:
• Calling Provider Services at 1-855-878-1785.
• Faxing referral information to our dedicated behavioral health fax lines at 1-877-434-7578 for inpatient services and 1-866-877-5229 for outpatient services.

Our staff is available 24 hours a day, 7 days a week, 365 days a year for crisis or emergency calls and authorization requests. We are responsible for authorized inpatient hospital services, including freestanding psychiatric facilities for Amerigroup STAR+PLUS MMP members.
CHAPTER 7: CREDENTIALING AND RECredentialing

Overview
To be reimbursed for services rendered to Amerigroup STAR+PLUS MMP members, providers must be enrolled in Texas Medicaid. Providers are not considered participating with us until they have enrolled in Texas Medicaid and have been credentialed with a duly executed contract with us.

We adhere to NCQA standards and state requirements for credentialing and recredentialing. In accordance with these standards, providers must submit all requested information necessary to complete the credentialing or recredentialing process. Each provider must cooperate with us as necessary to conduct credentialing and recredentialing pursuant to our policies and procedures.

As an applicant for participation in our network, each provider has the right to review information obtained from other sources during the credentialing process. Upon notification from us of a discrepancy, the provider has the right to explain information obtained from another party that may vary substantially from the information provided in the application and to submit corrections to the facts in dispute. The provider must submit a written explanation or appear before the credentialing committee if deemed necessary.

We will complete the initial credentialing process and our claims system will be able to recognize a newly contracted provider no later than 90 calendar days after receipt of a complete application. If an application does not include required information, we will send the applicant written notice of all missing information no later than five business days after receipt of the application.

If a provider qualifies for expedited credentialing under Texas Insurance Code 1452, Subchapters C, D and E, regarding providers joining established medical groups or professional practices that are already contracted with us, our claims system will be able to process claims from the provider as if the provider was fully contracted, no later than 30 days after receipt of a complete application, even if we have not yet completed the credentialing process.

The recredentialing process will occur at least every three years. The process will take into consideration provider performance data including member complaints and appeals, quality of care and utilization management.

Providers are required to notify us of a change in address or practice status within 10 days of the effective date of the change. Practice status is defined as a change in office hours, panel status, etc. The inclusion of a new address on a recredentialing application is not an acceptable form of notification. A notice of termination must adhere to the advance notice time lines stated in the provider’s agreement.

Submit changes to:
Credentialing Decision Appeal Process

In the event of a decision by the credentialing committee to limit or restrict the credentials or terminate the participation of a provider in the Amerigroup STAR+PLUS MMP network as part of the recredentialing process, the provider will be notified in writing of a 30-calendar-day time frame in which the provider may appeal the decision. We have a two-level appeal process.

The request from the provider for an appeal must set forth in detail those matters the provider believes were improperly determined by the credentialing committee and/or medical director and the specific reasons why the provider believes the decision to be improper. The provider may include any statement, documents, or other materials the provider would like the credentialing appeals committee (first-level appeals) or credentialing hearing committee (second-level appeals), or appointed hearing officer to consider prior to rendering a final decision. If the provider does not submit a written appeal within the 30-calendar-day time frame, the appeal right expires and the initial determination will stand.

If the credentialing appeals committee does not render a favorable decision to a provider in a first-level recredentialing appeal, the provider may request a second-level appeal. The provider must request the additional appeal in writing within 30 days of the date of the denial notification letter. When we receive the provider’s request for a second-level appeal, an acknowledgment letter will be sent to the provider, which sets forth the next steps in the appeal process.

The second-level appeal is reviewed by the credentialing hearing committee led by a hearing officer. The provider may participate by phone or appear in person and has the right to be represented by an attorney or other representative. The hearing will take place within 30 days of the date of the provider’s letter requesting the second-level appeal. We will send a letter to the provider 14 days in advance of the hearing, which will state the date, time, and place of the hearing. The provider will receive an evidence packet that will be used for reference by the credentialing hearing committee. During the hearing, the provider may call, examine and cross-examine any witnesses. The provider may also submit a written statement at the close of the hearing.

The credentialing hearing committee will consist of individuals who 1) are participating licensed practitioners; 2) are not in direct economic competition with the provider; 3) are not in business with the provider; and 4) have not previously made a recommendation or decision regarding the provider’s participation in our network.

The outcome of the second-level appeal may be to reinstate the provider, establish a provisional reinstatement subject to certain conditions, or uphold the decision of the
credentialing appeals committee. The provider will be notified in writing of the committee’s decision within 15 days of the meeting. The findings of the credentialing hearing committee are final. If a determination to terminate is upheld, termination will be effective the first day of the month following 30 days from the date of the letter detailing the credentialing hearing committee’s second-level appeal decision.

**Practitioner Office Site Quality**

We establish standards and thresholds for office site criteria and medical/treatment record-keeping practices. This applies to all practitioners within the scope of credentialing. To protect the health and safety of our members, we developed a process for evaluating a physician office site for one or more of the following reasons:

- Receipt of a member complaint concerning physical accessibility, physical appearance, adequacy of waiting or examining room space, or adequacy of medical/treatment records
- Receipt of a member complaint determined to be severe enough to potentially endanger or which endangers members’ health and well-being
- When a pattern related to the quality of the site is identified
- At the time of initial credentialing and/or recredentialing as outlined by contractual requirement
- To complete the open investigation of any quality or quality of service issue

All physicians/practitioners are required to meet standards set forth by us and to comply with state and federal regulations.

If we identify a physician/practitioner office site receiving three or more complaints within a six-month period related to the following components (with the exception of physical accessibility for which the complaint threshold is one), a Practitioner Office Site Quality Assessment will be conducted that will include a review of the following:

- Physical accessibility
- Physical appearance
- Adequacy of waiting or examining room space
- Adequacy of medical/treatment record-keeping practices

The Amerigroup STAR+PLUS MMP Practitioner Office Site Evaluation form is used to score the office site quality measurements. A minimum threshold of 80 percent or greater in each component is considered a passing audit score. The acceptable performance for on-site visits for each office location and medical record reviews for the applicant is a minimum passing score of 80 percent in each of the four designated components outlined above. Any exception to the minimum passing score is at the discretion of the health plan credentialing committee and must be based on compelling circumstances.
<table>
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<tr>
<th><strong>Practitioner Office Site Assessment Criteria</strong></th>
<th><strong>Scoring</strong></th>
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<tbody>
<tr>
<td><strong>Physical Accessibility</strong></td>
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<tr>
<td><strong>1.</strong> Is there accessibility for people with disabilities? If not, does staff have an alternative plan of action?</td>
<td>Must have first-floor ramp or elevator access. Bathroom and hallways must accommodate a wheelchair. If yes, 2 points; if no, 0 points.</td>
</tr>
<tr>
<td><strong>2.</strong> Is accessible parking clearly marked?</td>
<td>Off-street accessible parking is identified by a sign or a painted symbol on the pavement. Score as N/A if street-side parking only is available. If yes, 1 point; if no, 0 points.</td>
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<tr>
<td><strong>3.</strong> Are doorways and stairways that provide access free from obstructions at all times, and do they allow easy access by wheelchair or stretcher?</td>
<td>There should be no boxes, furniture, etc. blocking doorways or stairways. If yes, 2 points; if no, 0 points.</td>
</tr>
<tr>
<td><strong>4.</strong> Are exits clearly marked, and is there emergency lighting in instances of power failure?</td>
<td>Exits are marked with appropriate chevrons and emergency powered in case of power outage. There is a posted evacuation plan by either staff design or building management. If yes, 2 points; if no, 0 points.</td>
</tr>
<tr>
<td><strong>5.</strong> Are building and office suite clearly identifiable (clearly marked office sign)?</td>
<td>The sign identifying the office is clearly posted. If yes, 1 point; if no, 0 points</td>
</tr>
<tr>
<td><strong>Physical Appearance</strong></td>
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<tr>
<td><strong>1.</strong> Is the office clean, well-kept and smoke-free?</td>
<td>Mark yes if there are no significant spills on furniture or floor, the trash is confined, and the office and waiting area appears neat. Does the office prevent hazards that might lead to slipping, falling, electrical shock, burns, poisoning, and other trauma? If yes, 2 points; if no, 0 points</td>
</tr>
<tr>
<td><strong>2.</strong> Is treatment area clean and well kept? (No significant spills on floors, counters or furnishings, no trash on floor)</td>
<td>Mark yes if there are no significant spills on furniture or floor, the trash is confined, the treatment area appears neat. If yes, 2 points; if no, 0 points</td>
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<tr>
<td><strong>3.</strong> Does office have smoke detector(s)?</td>
<td>Smoke detectors should be in place and tested twice yearly. How does the office log the twice-yearly check? Is the office a smoke-free facility? If yes, 2 points; if no, 0 points</td>
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| 4 | Is there easy access to a clean, supplied bathroom?) | • Soap, toilet paper, and hand towels are available.  
• Hand washing instructions are posted.  
• Lavatory is clean; toilet is functioning.  
If yes, 1 point; if no, 0 points |
| 5 | Is the waiting room well lit? | Is there adequate lighting and comfort level for reading?  
If yes, 1 point; if no, 0 points |
| 6 | Are fire extinguishers clearly present and fully charged with a current inspection (even if the office has a sprinkler system)? | Fire extinguisher tag is dated within the last year. There should be an adequate number of fire extinguishers for the square footage placed at opposite ends of office.  
If yes, 1 point; if no, 0 points |

### Adequacy of Waiting/Examining Room Space

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| 1 | Is there adequate seating in the waiting area (based on the number of physicians/practitioners)? | 1 provider = 6 seats, 2 providers = 8 seats, 3 providers = 11 seats, 4 providers = 14 seats, 5 providers = 17 seats  
If yes, 1 point; if no, 0 points |
| 2 | Does the staff provide extra seating when the waiting room is full? | Ask the staff where patients go when waiting area is full.  
If yes, 1 point; if no, 0 points |
| 3 | Is there a minimum of two exam rooms per scheduled provider? (two consultation rooms for BH providers) | Count exam/consultation rooms and compare against provider schedule.  
If yes, 1 point; if no, 0 points |
| 4 | Is there privacy in exam/consultation rooms? | There must be door or curtain closures, exam/consultation rooms cannot be seen from waiting room.  
If yes, 1 point; if no, 0 points |

### Adequacy of Waiting/Examining Room Space (cont.)

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| 5 | Are exam/consultation rooms reasonably sound proof to ensure patient privacy during interviews/examinations? | Conversations cannot be heard from waiting room or other exam/consultation rooms.  
If yes, 2 points; if no, 0 points |
| 6 | Is an otoscope, an ophthalmoscope, a blood pressure cuff and a scale readily accessible? | Applies to all physicians/practitioners except BH providers.  
If yes, 1 point; if no, 0 points |
| 7 | 7a - For OB/GYNs only or any physician/practitioner providing OB care:  
7b – Is a fetalscope (DeLee and/or Dopler) and a measuring tape for fundal height measurement readily accessible  
- Supplies for dipstick urine analysis (glucose, protein)? | Score 7a and 7b as N/A if provider does not provide OB services.  
If yes, 1 point for each; if no, 0 points |
|---|---|
| Adequacy of Medical Records | 1 | Are there individual patient records?  
Each patient has an individual record.  
There should be no family charts.  
If yes, 2 points; if no, 0 points |
| 2 | Are records stored in a manner that ensures confidentiality? Who is the designated person in charge of clinical records? (provide name)  
Records are maintained in locations not easily accessible to patients and office visitors.  
If yes, 2 points; if no, 0 points |
| 3 | Are all items secured in the chart?  
All patient medical information must be secured within the chart.  
If yes, 2 points; if no, 0 points |
| 4 | Are medical records readily available?  
Medical records should be available within 15 minutes of request. Providers with more than one office location must have a mechanism to assure the medical record is available for reference if a patient is seen at an alternate site to the usual office.  
If yes, 2 points; if no, 0 points |
| 5 | Medical recordkeeping practices:  
We are only determining there is a place within a blank chart to document the information in 5a thru 5f. Due to HIPAA regulations and other reasons related to the legal right to access, we must not ask to review an actual patient chart for providers in the initial credentialing process. We may only review charts of those Amerigroup STAR+PLUS MMP members actually assigned or currently being seen by the providers/practitioners. There would be none for initial providers. When medical records are retired, what is the procedure for storage and final destruction? |
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<tr>
<td>5a</td>
<td>Is there a place to document allergies?</td>
<td>Allergies or the absence of allergies, along with the reactions, should be prominently displayed in or on the medical record. The absence of medicine sensitivities should also be noted. If yes, 2 points; if no, 0 points</td>
</tr>
<tr>
<td>5b</td>
<td>Is there a place to document a current medication list?</td>
<td>All medications, both prescription and over-the-counter/herbal medications, should be documented in the chart along with the dosages. A notation should also include No Medications to attest that the inquiry was made. If yes, 2 points; if no, 0 points</td>
</tr>
<tr>
<td>5c</td>
<td>Is there a place to document current chronic problems list?</td>
<td>A problem list would be generated as part of each visit’s assessment. If yes, 2 points; if no, 0 points</td>
</tr>
<tr>
<td>5d</td>
<td>Is there an immunization record on pediatric charts? N/A for BH providers</td>
<td>The immunization record should be completed to the age the child has reached at the time of the last encounter. If shots were completed prior to the first encounter with the current physician/practitioner, the notation <em>Immunizations are up-to-date</em> is acceptable. If yes, 2 points; if no, 0 points</td>
</tr>
<tr>
<td>5e</td>
<td>Is there a growth chart on pediatric charts? N/A for BH providers</td>
<td>Height and weight are documented annually; head circumference is documented until age 2. If yes, 2 points; if no, 0 points</td>
</tr>
<tr>
<td>5f</td>
<td>Is there a place to document presence/absence and discussion of a patient self-determination/advance directive?</td>
<td>There is a place for documentation that an advance directive has been executed or that the physician/practitioner has inquired as to whether the patient has a written advance directive. If yes, 2 points; if no, 0 points Score as N/A if patient is &lt; 21 years old.</td>
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**Appointment Availability**

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<tbody>
<tr>
<td>1</td>
<td>Please see specific appointment availability requirements</td>
<td>If yes, 1 point for each; if no, 0 points</td>
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**Documentation Evaluation**
<table>
<thead>
<tr>
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<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>1</td>
<td>Is there a no-show follow-up procedure/policy?</td>
<td>A written policy should be available. If not, the staff should verbally describe the follow-up process. Staff should be encouraged to adapt policy into a written format. If yes, 2 points; if no, 0 points</td>
</tr>
<tr>
<td>2</td>
<td>Is there a chaperone policy? May not apply to some specific BH situations – ask for clarification and document same on form.</td>
<td>A written policy should be available. If a written policy is not in place, the staff should verbally describe the process and provide a statement on the office letterhead stating a chaperone will be in the exam room. Staff should be encouraged to adapt the policy into a written format. <strong>The provider must have this element in place to pass the site evaluation and participate with Amerigroup STAR+PLUS MMP.</strong> If yes, 2 points; if no, 0 points</td>
</tr>
<tr>
<td>3</td>
<td>Is the Patient Bill of Rights posted? Are copies available upon request?</td>
<td>A notice should be posted in a prominent location, and copies should be available upon request. If yes, 1 point; if no, 0 points</td>
</tr>
<tr>
<td>4</td>
<td>Is a medical license/occupational license displayed? Are the hours of operation posted?</td>
<td>Licensures and hours of operation should be posted within the office. If yes, 1 point; if no, 0 points</td>
</tr>
<tr>
<td>5</td>
<td>Is there a notice of member complaint process?</td>
<td>A notice should be posted in a prominent location. If yes, 1 points; if no, 0 points</td>
</tr>
</tbody>
</table>
| 6 | Is there a written policy for hand washing, gloved procedures, and disposal of sharps? May not be applicable for BH providers in private practice setting. | A written policy for hand washing should be available (1 point)  
A written policy for sharp disposal should be available (1 point). Sharps should be disposed of immediately. Reusable containers must not be opened, emptied, or cleaned manually. Policies may be located in the office OSHA manual. If yes, 2 points; if no, 0 points |
| 7 | Is there a written OSHA exposure control plan that includes universal precautions and blood-borne pathogen exposure procedures for staff? | A written policy should be in place detailing the process to protect staff from exposure to hazardous waste materials and the cleanup/disposal of same. Are MSDS sheets available?  
If yes, 2 points; if no, 0 points |
|---|---|---|
| 8 | Is a copy of the Clinical Laboratory Improvement Amendments (CLIA) certificate or certificate of waiver if applicable posted? If the PCP provides Texas Health Steps services, must have CLIA/waiver or lab services within the same building. | If the provider offers laboratory services that require a CLIA or certificate of waiver, the current notice should be posted and a copy obtained and attached to the site visit form.  
If yes, 1 point; if no, 0 points |
| 9 | Is there a copy of the current radiology services certification or licensure if applicable posted? | If the provider offers radiology services, current licensure and/or certification must be posted and copy obtained and attached to the site visit form. Are pregnancy signs posted?  
If yes, 1 point; if no, 0 points |
| 10 | If provider employs nurse practitioners, physicians’ assistants, or other mid-level providers that will assess health care needs of members, do they have written policies describing the duties and supervision of such providers? | A written policy should be available describing the level/type of care provided by the mid-level practitioners within the physician’s/practitioner’s office and the level/type of supervision of same.  
If yes, 2 points; if no, 0 points |
| HIPAA Requirements/Regulations | | |
| 1 | Is there a written policy and procedure addressing permitted uses/disclosures and required disclosures of patient Personal Health Information (PHI)/Individually Identifiable Health Information (IIHI)? | There should be a written policy and procedure addressing permitted uses and disclosures as well as required disclosures of patient PHI/IIHI, as required by HIPAA regulations. Providers should have appropriate forms available for members and patients  
If yes, 2 points; if no, 0 points |
| 2 | Does the provider have authorization forms available to designate personal representative(s) to which PHI/IIHI may be released and/or disclosed? | Does the provider have an authorization form for disclosure of PHI/IIHI, as required by HIPAA regulations? Form should include an expiration date. Should also include description of how members/patients may revoke authorization in writing.  
If yes, 2 points; if no, 0 points |
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<th>Question</th>
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<tr>
<td>3</td>
<td>Are there physical safeguards in place to protect the privacy of patient PHI/IIHI?</td>
<td>There should be no papers with PHI in areas accessible to other patients. Examples: All patient information is securely placed in locked cabinet. No confidential information is left out in the open for other patients or staff members to see (e.g., patient sign-in sheet). Is there a shredding machine and policy on storage and disposal of medical records? Computer has safeguards in place: security codes for access, safety. If yes, 2 points; if no, 0 points.</td>
</tr>
<tr>
<td>4</td>
<td>Is there a designated compliance and privacy person?</td>
<td>You must include the name of the individual in the space provided on the site evaluation form. If yes, 2 points; if no, 0 points.</td>
</tr>
<tr>
<td></td>
<td><strong>Office Evaluation</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Is there an approved process for biohazardous disposal?</td>
<td>There is a written policy for biohazardous waste disposal in a manner that protects employees from occupational exposure. Biohazardous waste includes liquid or semi-liquid blood or other potentially infectious materials. Biohazardous items include contaminated items that would release blood if compressed, items caked with blood, contaminated sharps, and pathological and microbiological waste. If yes, 2 points; if no, 0 points.</td>
</tr>
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</table>
| 2 | Are pharmaceutical supplies and medication stored in a locked area that is not readily accessible to patients?                             | - Medications are in a locked area, including samples.  
- Prescription pads are kept in a secured location away from patient access; pads should not be found in exam rooms or left on countertops unsupervised by office staff. If yes, 2 points; if no, 0 points. |
<p>| 3 | Is there a plan/procedure for narcotic inventory, control and disposal?                                                                      | There is a plan to randomly check that sample medications are current and there is a procedure for disposing of expired medications – wasting of medications. If yes, 1 point; if no, 0 points. |</p>
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<tr>
<td>4</td>
<td>Are vaccines and other biologicals refrigerated as appropriate?</td>
<td>If refrigeration is required for medication, there is a separate space provided. There should be no other items – including food and biological specimens – on the same shelf as medication (preferably these are in a separate refrigerator). Look for Penny Test in freezer to document power outages. If yes, 1 point; if no, 0 points</td>
</tr>
<tr>
<td>5</td>
<td>Is emergency equipment available? If not, note how the staff accommodates emergency situations.</td>
<td>The minimum requirement is an oral airway and Ambu bag (for children and/or adults based on age range) If the office has an emergency kit or cart, check for routine inspections and expired supplies or medications. If yes, 1 point; if no, 0 points</td>
</tr>
<tr>
<td>6</td>
<td>Observe 2-3 office staff interactions: Are they professional and helpful? Is CPR-trained staff in the office at all times when patients are present?</td>
<td>If yes, 2 points; if no, 0 points</td>
</tr>
</tbody>
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CHAPTER 8: PERFORMANCE AND TERMINATION

Performance Standards and Compliance

All providers must meet specific performance standards and compliance obligations. When evaluating a provider’s performance and compliance, Amerigroup STAR+PLUS MMP reviews a number of clinical and administrative practice dimensions including:

- Quality of care — measured by clinical data related to the appropriateness of care and outcomes.
- Efficiency of care — measured by clinical and financial data related to health care costs.
- Member satisfaction — measured by the members’ reports regarding accessibility, quality of health care, member/provider relations and the comfort of the office setting.
- Administrative requirements — measured by the provider’s methods and systems for keeping records and transmitting information.
- Participation in clinical standards — measured by the provider’s involvement with panels used to monitor quality of care standards.

Providers must:

- Comply with all applicable laws and licensing requirements.
- Furnish covered services in a manner consistent with professionally recognized standards of medical and surgical practice generally accepted in the professional community at the time of treatment.
- Comply with Amerigroup STAR+PLUS MMP standards, including:
  - Guidelines established by the Centers for Disease Control and Prevention (or any successor entity)
  - Federal, state and local laws regarding professional conduct
    - Comply with Amerigroup STAR+PLUS MMP policies and procedures regarding the following:
      - Participating on committees and clinical task forces to improve the quality and cost of care
      - Prenotification and/or precertification requirements and time frames
      - Provider credentialing requirements
      - Referral policies
      - Case Management Program referrals
      - Appropriately releasing inpatient and outpatient utilization and outcomes information
      - Providing accessibility of member medical record information to fulfill Amerigroup STAR+PLUS MMP business and clinical needs as well as member needs
      - Cooperating with efforts to assure appropriate levels of care
      - Maintaining a collegial and professional relationship with Amerigroup STAR+PLUS MMP personnel and fellow providers
      - Providing equal access and treatment to all Amerigroup STAR+PLUS MMP members

The following types of noncompliance issues are key areas of concern:

- Member complaints and grievances filed against the provider
• Underutilization, overutilization or inappropriate referrals
• Inappropriate billing practices, such as balance billing of Amerigroup STAR+PLUS MMP members for amounts that are not their responsibility
• Unnecessary out-of-network referrals and utilization (which require precertification)
• Failure to provide advance notice of admissions or precertification of discharges from inpatient facilities, comprehensive outpatient rehabilitation facilities or home health care services
• Nonsupportive actions and/or attitude

Provider noncompliance is tracked on a calendar year basis. Corrective actions are taken as appropriate.

**Physician-Patient Communications**

Providers acting within the lawful scope of practice are encouraged to advise Amerigroup STAR+PLUS MMP members of the following:

• Health status, medical care or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options
• Risks, benefits and consequences of treatment or nontreatment
• Opportunity for the individual to refuse treatment and to express preferences about future treatment decisions

Physician and patient communications are a necessary component of standard medical practice. Although coverage under this program is determined by Amerigroup STAR+PLUS MMP, the provider along with the member remains responsible for all treatment decisions related to the Amerigroup STAR+PLUS MMP member.

**Provider Participation Decisions: Appeals Process**

Upon a denial, suspension, termination or nonrenewal of a provider’s participation in the Amerigroup STAR+PLUS MMP provider network, Amerigroup STAR+PLUS MMP acts as follows:

• The affected physician is given a written notice of the reasons for the action, including if relevant the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by Amerigroup STAR+PLUS MMP.
• The physician is allowed to appeal the action to a hearing panel.
• The physician is provided written notice of the right to a hearing and the process and timing for requesting a hearing.
• Amerigroup STAR+PLUS MMP ensures the majority of the hearing panel members are peers of the affected physician.
• Amerigroup STAR+PLUS MMP notifies the National Practitioner Data Bank, the appropriate state licensing agency, and any other applicable licensing or disciplinary body to the extent required by law if a suspension or termination is the result of quality of care deficiencies.
• Subcontracted physician groups must ensure these procedures apply equally to physicians within those subcontracted groups.
• Amerigroup STAR+PLUS MMP notifies CMS and HHSC within seven calendar days, via the CMT, when it terminates, suspends, or declines a provider from its network because of fraud, integrity or quality.

Amerigroup STAR+PLUS MMP decisions subject to an appeal include decisions regarding reduction, suspension or termination of a provider’s participation resulting from quality deficiencies. Amerigroup STAR+PLUS MMP notifies the National Practitioner Data Bank, the appropriate state licensing agency and any other applicable licensing or disciplinary body to the extent required by law. Written communication to the provider details the deficiencies and informs him or her of the right to appeal.

Notification to Members of Provider Termination
Amerigroup STAR+PLUS MMP makes a good faith effort to provide notice to each member who received his or her care from the provider or was seen on a regular basis by the provider within 15 calendar days of receipt or issuance of the termination notice. Amerigroup STAR+PLUS MMP may provide member notification in less than 15 days’ notice as a result of a provider’s death or exclusion from the federal health programs.

When a termination involves a PCP or any medical, behavioral health or long-term services and supports provider, all members who are patients of that provider are notified of the termination.

For members who are receiving treatment for a chronic or ongoing medical condition or LTSS, Amerigroup STAR+PLUS MMP will ensure there is no disruption in services provided.
CHAPTER 9: QUALITY MANAGEMENT

Overview
Amerigroup STAR+PLUS MMP maintains a comprehensive Quality Management (QM) program to objectively and systematically monitor and evaluate care and service provided to members. The scope and content of the program reflects the demographic, epidemiologic, medical and behavioral health needs of the population served. Key components of the program include but are not limited to the following:

- Quality of member care and service
- Accessibility and availability of services
- Member safety and prevention
- Continuity and coordination of care
- Appropriateness of service utilization
- Cultural competency
- Member outcomes
- Member and provider satisfaction
- Regulatory and accreditation standards

Members and providers have opportunities to participate in quality management and make recommendations for areas of improvement through complaints, grievances, appeals, satisfaction or other surveys, committee participation where applicable, quality initiatives/projects, and calls to the health plans. QM program goals and outcomes are available to providers and members upon request.

Quality activities are planned across the continuum of care and service with ongoing proactive evaluation and refinement of the program.

The Amerigroup STAR+PLUS MMP QM program tracks and trends quality of care issues and service concerns identified for all care settings. QM staff review member complaints, grievances, reported adverse events and other information to evaluate the quality of service and care provided to our members.

Centers for Medicare & Medicaid Services (CMS)
CMS evaluates all Medicare-Medicaid Plans through the use of Healthcare Effectiveness Data and Information Set (HEDIS®) metrics. Many of the measures included in the CMS evaluation are measures of preventive care management. Some of these are listed below and are subject to change:

- Staying healthy — screening, tests and vaccines:
  - Breast cancer screening
  - Colorectal cancer screening
  - Cholesterol screening for cardiovascular and diabetes care
  - Annual flu vaccine
  - Improving and maintaining physical and mental health
• Monitoring physical activity
• Adult body mass index assessment

Managing chronic conditions:
• Care for the older adult: medication review, functional status assessment and pain screening
• Managing osteoporosis in women who had a fracture
• Obtaining diabetes care for eye exams, kidney disease monitoring, and blood sugar and cholesterol control
• Controlling blood pressure
• Managing rheumatoid arthritis
• Improving bladder control
• Reducing the risk of falling
• Plan all-cause readmissions
• Medication adherence and management (oral diabetics, hypertension and cholesterol medications)

With the growing focus on quality health care and plan member satisfaction, CMS and the state assess plan performance. One of the assessment tools used is the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. Members who receive health care services through the Texas STAR+PLUS Medicare-Medicaid Plan will receive CAHPS surveys each year through the mail in late February.

The survey asks the Texas STAR+PLUS Medicare-Medicaid Plan member to assess his or her health and the care received from his or her primary care providers and specialists over the past six months. The survey includes questions regarding providers’ communication skills and the member’s perception about his or her access to needed health care services. The survey questions ask the member to report his or her opinion about access to care and the health plan’s customer service. It also asks the member to rate the communication received from his or her providers.

A second assessment tool used by CMS is the Health Outcomes Survey (HOS) to evaluate all managed care organizations’ ability to maintain or improve the physical and mental health functioning of its Medicare beneficiaries over a two-year period of time. The survey is used as a way of measuring how the care provided by the health plan is affecting the functional status of their enrollees. CMS includes the HOS in their performance assessment program.

This survey is sent out in two cohorts. The first cohort records baseline data. If a member answers the first survey, they are sent a second survey in two years, and these results become part of the effectiveness of care ratings for the health plan.

Amerigroup STAR+PLUS MMP encourages participating providers to help improve member satisfaction by:

• Ensuring members receive appointments within acceptable time frames as outlined in the “Access and Availability Standards Table” in this manual.
• Educating members and talking to them during each visit about their preventive health care needs.
• Ensuring providers answer any questions members have regarding newly prescribed medications.
• Ensuring members know to bring all medications and medical histories to their specialists and know the purpose of a specialist referral.
• Allowing time during the appointment to validate members’ understanding of their health conditions and the services required for maintaining a healthy lifestyle.
• Referring members to the Member Services department and speaking to a case manager.

Committee Structure
Amerigroup STAR+PLUS MMP maintains a comprehensive quality management committee structure as noted below with program oversight by the board of directors.

Quality Improvement Committee
The purpose of the quality improvement committee is to provide leadership and oversight of the health plan quality management programs, improve safety and quality of care and services, improve customer service, and improve operating efficiencies.

Responsibilities include the following:
• Review and approval of the program descriptions
• Work plans and annual evaluations for quality management, utilization management, health promotion, credentialing, case management and pharmacy
• Review and approval reporting of complaints, appeals and Service Level Agreements (SLAs)
• Review of regular standardized reports (at least semi-annually) delineating progress towards goals of the program, actions taken, improvements made, focused study results and follow-up actions on identified opportunities
• Evaluation of resource adequacy to ensure effective implementation of the programs and ongoing effectiveness
• Recommending policy decisions
• Instituting needed actions and ensure completion
• Ensuring practitioner participation

Quality Management Committee
The purpose of our quality management committee (QMC) is to maintain quality as a cornerstone of Amerigroup STAR+PLUS MMP culture and to be an instrument of change through demonstrable improvement in care and service.

The QMC’s responsibilities are to:
• Review regular standardized reports, at least semi-annually, delineating progress towards clinical goals, actions taken and improvements.
• Establish processes and structure that ensure CMS compliance.
• Analyze, review and make recommendations regarding the planning, implementation, measurement, and outcomes of the clinical/service quality improvement projects (QIP).
• Coordinate communication of quality management activities throughout the health plan.
• Review CMS Stars, HEDIS, HOS and CAHPS data and action plans for improvement.
• Review, monitor and evaluate program compliance against the health plan, state, federal and CMS standards.
• Review of LTSS credentialing issues as applicable.
• Review and approve the annual Quality Management Program Description and Work Plan and the QM Program Evaluation.
• Evaluate the overall effectiveness of the SNP Model of Care including regular reports, performance outcomes and satisfaction, barrier analysis, effectiveness of interventions and adequacy of resources.
• Oversee the compliance of delegated services and delegation oversight activities.
• Assure inter-departmental collaboration, coordination and communication of quality improvement activities.
• Measure compliance to medical and behavioral health practice guidelines.
• Monitor continuity of care between medical and behavioral health services.
• Monitor accessibility and availability.
• Publicly make information available to enrollees and practitioners about the network hospital’s action to improve patient safety.
• Make information available about the QM program to enrollees and practitioners.
CHAPTER 10: HEALTH CARE MANAGEMENT SERVICES

Overview
Amerigroup STAR+PLUS MMP continuously seeks to improve the quality of care provided to its members. We encourage and expect our providers to participate in health promotion programs. Providers are encouraged to collaborate with Amerigroup STAR+PLUS MMP in efforts to promote healthy lifestyles through member education and information sharing.

Providers must fully comply with:
- Health care management services policies and procedures.
- Quality improvement and other performance improvement programs.
- All regulatory requirements.

The health care delivery system is a gatekeeper model that supports the role and relationship of the PCP. The model includes direct contracts with PCPs, hospitals, specialty physicians and other providers, as required, to deliver Medicare and Medicaid benefits for members with complex medical needs. All contracted providers are available to Amerigroup STAR+PLUS MMP members by PCP or self-referral for the services identified below.

The gatekeeper model requires all members to select a PCP upon joining the plan. Members who do not choose a PCP are assigned one. Amerigroup STAR+PLUS MMP works with the member, the physician and the member’s representative, as appropriate, to ensure the PCP is suitable to meet the member’s individual needs. Members must have access to their PCP or a covering physician 24 hours a day, 7 days a week.

Self-Referral Guidelines
Amerigroup STAR+PLUS MMP members may self-refer for the following services:
- Screening mammograms
- Behavioral health
- Influenza and pneumococcal vaccinations
- Routine physical examinations, prostate screening and preventive women’s health services (e.g., Pap smears)

Except for emergent or out-of-area urgent care and dialysis services, in general, members must obtain services within the Amerigroup STAR+PLUS MMP network or obtain a precertification for covered services outside the network.

Referral Guidelines
PCPs may only refer members to Amerigroup STAR+PLUS MMP-contracted network specialists to ensure the specialist receives appropriate clinical background data and is aware of the member’s ongoing primary care relationship. If a member wants to receive care from a different specialist or the required specialty is not available within the contracted network, the
PCP should contact Provider Services at 1-855-878-1785. PCPs must obtain precertification from Amerigroup STAR+PLUS MMP before referring members to nonparticipating providers.

**Authorization/Precertification**

Certain services/procedures require precertification from Amerigroup STAR+PLUS MMP for participating and nonparticipating PCPs and specialists and other providers. Please refer to the list below or the Precertification Lookup Tool Online or call Provider Services at 1-855-878-1785 for more information. You can also access information concerning precertification requirements on our website at [https://providers.amerigroup.com/TX](https://providers.amerigroup.com/TX).

The following are examples of services requiring precertification before providing the following nonemergent or urgent care services:

- Inpatient mental health services
- Behavioral health partial hospitalization
- Skilled nursing facility (SNF)
- Home health care
- Diagnostic tests including but not limited to MRI, MRA, PET scans, etc.
- Hospital or ambulatory care center-based outpatient surgeries for certain procedures
- Elective inpatient admissions
- Transplant evaluation and services
- Any nonemergency service from or referral to a noncontracted provider
- Durable medical equipment (DME)
- Outpatient IV infusion or injectable medications
- Prosthetics
- Certain reconstructive procedures
- Occupational, speech and physical therapy services
- Long-term services and supports (LTSS)

**Radiology Services**

Amerigroup STAR+PLUS MMP collaborates with AIM Specialty Health® (AIM) to provide certain outpatient imaging utilization management services for Amerigroup STAR+PLUS MMP members. The ordering provider is responsible for obtaining prior authorization for the following services:

- Computer tomography (CT/CTA) scans
- Stress echocardiography (SE)
- Echocardiogram (Echo)
- Resting transthoracic echocardiography (TTE)
- Magnetic resonance (MRI/MRA)
- Positron emission tomography (PET) scans
- Transesophageal echocardiography (TEE)
- Nuclear cardiology

Authorization review requests can be initiated by visiting [www.aimspecialtyhealth.com/goweb](http://www.aimspecialtyhealth.com/goweb) or calling AIM at 1-800-714-0040, Monday-Friday, 8 a.m.-5 p.m.
Physical and Occupational Therapy
Amerigroup STAR+PLUS MMP collaborates with OrthoNet, LLC, to conduct medical necessity reviews for physical therapy, occupational therapy, spine and back pain management procedures for our members.

The following procedures must be reviewed by OrthoNet for prior authorization:
- Physical therapy
- Occupational therapy
- Spine and back pain management procedures:
  - Epidurals
  - Facet blocks
  - Pain pumps
  - Neurostimulators
  - Spinal fusion
  - Spinal decompression
  - Vertebro/kyphoplasty

In addition, OrthoNet will conduct post service prepayment coding review of professional services, including:
- Orthopedic surgery
- Plastic surgery
- Neurosurgery
- Sports medicine
- Podiatry
- Hand surgery
- Neurology
- Pain management
- Psychiatry/physical medicine and rehabilitation (PM&R)
- ENT
- General surgery
- Dermatology
- Cardiology
- Urology
- Percutaneous coronary intervention (PCI)

Please submit all required clinical information at least three business days before the requested procedure to allow a thorough clinical analysis. For institutional admissions, all facilities must notify us within 24 hours or the next business day ( whichever is earlier) after admission. In an urgent or emergent situation, the above time frames will be waived. Please provide notice to the plan as soon as possible.

You may request prior authorization by submitting completed clinical information to OrthoNet physical therapy/occupational therapy, pain management, and spinal surgery by:

**Physical and occupational therapy**
Fax: 1-844-340-6419
Phone: 1-844-340-6418

**Spine and back pain management procedures**
Fax: 1-844-788-4806
Phone: 1-844-788-4805
**Medically Necessary Services and Medical Criteria**

Medically necessary services are medical services determined by Amerigroup STAR+PLUS MMP to be:

- Rendered for the diagnosis or treatment of an injury or illness.
- Appropriate for the symptoms, consistent with diagnosis and otherwise in accordance with sufficient scientific evidence and professionally recognized standards.
- Not furnished primarily for the convenience of the member, the attending provider or other provider of service.

Medical necessity decisions are objective, based on medical evidence and applied according to the individual needs of the member and an assessment of the local delivery system. Amerigroup STAR+PLUS MMP makes utilization management criteria available to practitioners upon request. If a medical necessity decision results in a denial, practitioners are welcome to discuss the denial decision with the medical director. All denial decisions are made by appropriately licensed and qualified physicians. Practitioners can obtain utilization management criteria or speak to a medical director by calling Provider Services at 1-855-878-1785.

Amerigroup STAR+PLUS MMP makes determinations of medical necessity based on CMS national coverage determinations (NCD), local coverage determinations (LCD), other coverage guidelines and instructions issued by CMS and the state and legislative changes in benefits. In coverage situations where there is no NCD, LCD, or guidance on coverage in original Medicare or Medicaid manuals, Amerigroup STAR+PLUS MMP will make a determination on medical necessity based on authoritative evidence as documented by Milliman, CMS and state guidelines and Amerigroup STAR+PLUS MMP policies as a guideline.

In some instances, Amerigroup STAR+PLUS MMP may develop its own coverage policies. In these instances, 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 objective, based on medical evidence, review of market practice, national standards and 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 when and how often the criteria will be evaluated and updated.
- The criteria cannot be more restrictive or limiting than CMS or state guidelines or requirements.

These guidelines are communicated to providers through Amerigroup STAR+PLUS MMP blast fax notices, letters and newsletters. Communications are posted to the Amerigroup STAR+PLUS MMP website at [https://providers.amerigroup.com/TX](https://providers.amerigroup.com/TX).
CHAPTER 11: MEDICAL MANAGEMENT

Requirements Overview
Amerigroup STAR+PLUS MMP providers must maintain permanent medical records that are:

- Current, detailed and organized; permit effective, confidential patient care; and allow quality reviews.
- In conformity with good professional medical practice and appropriate health management.
- Located at the primary care site for every Amerigroup STAR+PLUS MMP member.
- Kept in accordance with Amerigroup STAR+PLUS MMP and state standards as described in this manual.
- Retained for 10 years from the final date of the contract or from the date of completion of any audit.
- Accessible upon request to Amerigroup STAR+PLUS MMP, any state agency and the federal government.

Amerigroup STAR+PLUS MMP will:

- Systematically review medical records to ensure compliance with standards. The health plan’s MAC oversees and directs Amerigroup STAR+PLUS MMP in formalizing, adopting and monitoring guidelines.
- Institute actions for improvement when standards are not met.
- Maintain a record-keeping system that is designed to collect all pertinent medical management information for each member.
- Make information readily available to appropriate health professionals and appropriate state agencies.
- Use nationally recognized standards of care and work with providers to develop clinical policies and guidelines of care for members.

Case Management
The Amerigroup STAR+PLUS MMP Case Management Solutions Program is a member-centric, integrated continuum of care model that strives to address the totality of each member’s physical, behavioral, cognitive, functional and social needs.

The scope of the Case Management Solutions Program includes but is not limited to:

- Member identification using a prospective approach that is designed to focus case management resources for members expected to be at the highest risk for poor health outcomes.
- Initial and ongoing assessment.
- Problem-based, comprehensive care planning to include measurable goals and interventions tailored to the complexity level of the member as determined by initial and ongoing assessments.
- Coordination of care with PCPs and specialty providers.
- Member education.
- Member empowerment using motivational interviewing techniques.
- Facilitation of effective member and provider communications.
• Program monitoring and evaluation using quantitative and qualitative analysis of data.
• Satisfaction and quality of life measurement.

Using a prospective systematic approach, members with a risk of poor health outcomes are identified and targeted for case management services that are tailored to their condition and risks. This continuous case finding system evaluates members of a given population based on disease factors and claims history with the goal of improving quality of life through proper utilization of necessary services and a reduction in the use of unnecessary services.

Case management member candidate lists are updated monthly and prioritized to identify members with the highest expected needs for service. Case management resources are focused on meeting listed members’ needs by using a combination of standardized and individualized approaches.

A core feature of the Amerigroup STAR+PLUS MMP Case Management Solutions Program is the emphasis on an integrated approach to meeting the needs of members. The program considers the whole person, including the full range of each member’s physical, behavioral, cognitive, functional and social needs. The role of the case manager is to engage members of identified risk populations and to follow them across health care settings, to collaborate with other health care team members to determine goals and to provide access to resources and monitor utilization of resources. The case manager works with the member to identify specific needs and interfaces with the member’s providers with the goal of facilitating access to quality, necessary, cost-effective care.

Using information gathered through the assessment process, including a review of the relevant evidence-based clinical guidelines, the case manager develops a goal-based care plan that includes identified interventions for each diagnosis, short- and long-term goals, interventions designed to assist the member in achieving these goals and identification of barriers to meeting goals or complying with the care plan.

Assessment information, including feedback from members, family/caregivers and in some cases providers, provides the basis for identification of problems. Areas identified during the assessment that may warrant intervention include but are not limited to the following:
• Conditions that compromise member safety
• History of high service utilization
• Use of inappropriate services
• Current treatment plan that has been ineffective
• Permanent or temporary loss of function
• Comorbid conditions
• Medical/psychological/functional complications
• Health education deficits
• Poor or inconsistent treatment/medication adherence
• Inadequate social support
• Lack of financial resources to meet health or other basic needs
• Identification of barriers or potential barriers to meeting goals or complying with the care plan

Preparation of the care plan includes an evaluation of the member’s optimal care path as well as the member’s wishes, values and degree of motivation to take responsibility for meeting each of the care plan goals. Wherever possible, the case manager encourages the member to suggest his or her own goals and interventions, as this may increase their investment in their successful completion.

Our case managers work closely with the member and providers to develop and implement the plan of care. As a provider, you may receive a call from the case manager or a copy of the member’s care plan may be sent to you.

**Model of Care**

Amerigroup STAR+PLUS MMP has developed an evidenced-based model of care that offers coordinated care delivered by a network of providers with expertise to meet the needs of the specialized population. The effectiveness of the model of care is measured annually as part of our Quality Management Program. We have designed a care system to meet the intentions of Amerigroup STAR+PLUS MMP, a coordinated, integrated person-centered system of care that assures high quality and an excellent member experience.

The model of care is a comprehensive care management and care coordination program that incorporates our experience and the goals of Amerigroup STAR+PLUS MMP, which are to:

- Improve the quality of care for members.
- Maximize the ability of members to remain safely in their homes and communities with appropriate services and supports, in lieu of institutional care.
- Coordinate Medicare and Medicaid benefits across health care settings and improve continuity of care across acute care, long-term care, behavioral health, and home and community-based services settings by using a person-centered approach.
- Promote a system that is both sustainable and person- and family-centered, and enables members to attain or maintain personal health goals by providing timely access to appropriate, coordinated health care services and community resources, including home-and community-based services and mental health and substance use disorder services.
- Increase the availability and access to LTSS including HCBS.
- Improve transitions of care across health care settings, providers and HCBS.
- Preserve and enhance the ability for members to self-direct their care and receive high quality care.
- Optimize the use of Medicare, Medicaid and other state/county resources.

Each member has a service coordination team (SCT) assigned to assist with developing care plans, collaborating with other team members and providing recommendations for the management of the member’s care. The representative of the team and the mode of communication are determined by the needs of the member. Typically the team can be made up of the member and/or his or her designee, assigned service coordinator, primary care
The member is an important part of the team and is involved in the planning process. The member’s participation is voluntary and they can choose to decline at any time. The service coordinator is the coordinator of the team and reaches out to providers and other team members to coordinate the needs of the member. Important information about the member including the assessment and care plan details are available to you through the secured provider portal. Health care practitioners and providers of care in the home or community are also very important members of the team and help to establish and execute the care plan. All case management and SCT are person-centered and built on the member’s specific preferences and needs, ensuring transparency, individualism, accessibility, respect, linguistic and cultural competency and dignity.

The figure above demonstrates the person-centricity of the model. Depending on member conditions, needs and desires, a team comprised of experts in physical health, behavioral health, LTSS and social work works with the member, their representative (if desired) and the PCP and specialists as required. Communication among all the constituents is critical and is supported by Amerigroup STAR+PLUS MMP systems.
**Member Medical Records Standards**

We require medical records to be current, detailed and organized for effective, confidential patient care and quarterly review. Your medical records must conform to good professional medical practice and be permanently maintained at the primary care site.

Members are entitled to one copy of their medical record each year provided, at no cost. Members or their representatives should have access to these records.

**Our medical records standards include the following:**

- Patient identification information — patient name or ID number must be shown on each page or electronic file
- Personal/biographical data — age, sex, address, employer, home and work telephone numbers, and marital status
- Date and corroboration — dated and identified by the author
- Legibility — if someone other than the author judges it illegible, a second reviewer must evaluate it
- Allergies — must note prominently:
  - Medication allergies
  - Adverse reactions
  - No Known Allergies (NKA)
- Past medical history — for patients seen three or more times. Include serious accidents, operations, illnesses and prenatal care of mother and birth for children
- Immunizations — a complete immunization record for pediatric members age 20 and younger with vaccines and dates of administration
- Diagnostic information
- Significant illnesses and chronic and recurrent medical conditions are indicated in the problem list on all member medical records
- Report contributory and/or chronic conditions if they are monitored, evaluated, addressed or treated at the visit and impact of the care.
- All diagnoses reported on the claim should be fully documented in the medical record, and each diagnosis noted in the medical record should be reported in the claim corresponding to that encounter.
- Medical information, including medication(s) and instruction to patient
- Identification of current problems
  - Serious illnesses
  - Medical and behavioral conditions
  - Health maintenance concerns
- Instructions including evidence the patient was provided basic teaching and instruction for physical or behavioral health condition
- Smoking/alcohol/substance abuse — notation required for patients age 12 and older and seen three or more times
- Consultations, referrals and specialist reports — consultation, lab and X-ray reports must have the ordering physician’s initials or other documentation signifying review; any consultation or abnormal lab and imaging study results must have an explicit notation
• Emergencies — all emergency care and hospital discharge summaries for all admissions must be noted
• Hospital discharge summaries — must be included for all admissions while enrolled and prior admissions when appropriate
• Advance Directives — must document whether the patient has executed an advance directive such as a living will or durable power of attorney
• All documentation required by the State for existing programs

Documentation Standards for an Episode of Care
When we request clinical documentation from you to support claims payments for services, you must ensure the information provided to us:
• Identifies the member.
• Is legible.
• Reflects all aspects of care.

To be considered complete, documentation for episodes of care will include, at a minimum, the following elements:
• Patient identifying information
• Consent forms
• Health history, including applicable drug allergies
• Types and dates of physical examinations
• Diagnoses and treatment plans for individual episodes of care
• Physician orders
• Face-to-face evaluations
• Progress notes
• Referrals
• Consultation reports
• Laboratory reports
• Imaging reports (including X-ray)
• Surgical reports
• Admission and discharge dates and instructions
• Preventive services provided or offered appropriate to the member’s age and health status
• Evidence of coordination of care between primary and specialty physicians

Refer to the standard data elements to be included for specific episodes of care as established by The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A single episode of care refers to continuous care or a series of intervals of brief separations from care to a member by a provider or facility for the same specific medical problem or condition.

Documentation for all episodes of care must meet the following criteria:
• Is legible
• Contains information that identifies the member on each page in the medical record
• Contains entries in the medical record that are dated and include author identification (e.g., handwritten signatures, unique electronic identifiers or initials)
**Other Documentation Not Directly Related to the Member**

Records should contain information relevant to support clinical practice and used to support documentation regarding episodes of care, including:

- Policies, procedures and protocols.
- Critical incident/occupational health and safety reports.
- Statistical and research data.
- Clinical assessments.
- Published reports/data.

Amerigroup STAR+PLUS MMP may request that you submit additional documentation, including medical records or other documentation not directly related to the member, to support claims you submit. If documentation is not provided following the request or notification or if documentation does not support the services billed for the episode of care, we may:

- Deny the claim.
- Recover and/or recoup monies previously paid on the claim.

Amerigroup STAR+PLUS MMP is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

**Patient Visit Data Records Standards**

You must provide:

- A history and physical exam with both subjective and objective data for presenting complaints
- Behavioral health treatment, including at-risk factors:
  - Danger to self/others
  - Ability to care for self
  - Affect
  - Perpetual disorders
  - Cognitive functioning
  - Significant social health
- Admission or initial assessment must include:
  - Current support systems
  - Lack of support systems
- Documented assessment at each visit for client status and symptoms, indicating:
  - Decreased
  - Increased
  - Unchanged
  - A plan of treatment, including:
    - Activities
    - Therapies
    - Goals to be carried out
    - Diagnostic tests
    - Evidence of family involvement in therapy sessions and/or treatment
• Follow-up care encounter forms or notes indicating follow-up care, call or visit in weeks, months or PRN
• Referrals and results of all other aspects of patient care and ancillary services

We systematically review medical records to ensure compliance and institute actions for improvement when our standards are not met.

We maintain a professional recordkeeping system for services to our members. We make all medical management information available to health professionals and state agencies and retain these records for seven years from the date of service.

**Medical Record Review**
Federal regulations require MCOs and their agents review medical records to avoid over- or under-payment and verify documentation to support of diagnostic conditions. Additionally, health plan leadership for quality management and the quality management committee conduct medical record audits periodically and use the results in the provider recredentialing process.

**Risk Adjustment Data Validation**
Participation in risk adjustment data validation is required of all providers, and it is important that you are aware that medical records may be requested from your office. Data validation through a review of medical record documentation ensures the accuracy of risk-adjusted payments. These medical record reviews verify the accuracy of claim and encounter data and identify additional conditions not captured through this mechanism.

Amerigroup STAR+PLUS MMP may contract with a third-party vendor to acquire medical records or conduct onsite reviews. Under CFR 164.502 (HIPAA implementation), providers are permitted to disclose requested data for the purpose of health care operations after they have obtained the general consent of the member. A general consent form should be an integral part of your medical record file.

More information related to risk adjustment can be found at [www.cms.gov](http://www.cms.gov).

**Clinical Practice Guidelines**
Using nationally recognized standards of care, Amerigroup STAR+PLUS MMP works with providers to develop clinical policies and guidelines for the care of its membership. The medical advisory committee (MAC) oversees and directs Amerigroup STAR+PLUS MMP in formulating, adopting and monitoring guidelines.

Amerigroup STAR+PLUS MMP selects at least four evidence-based Clinical Practice Guidelines (CPGs) relevant to the member population for analysis. The guidelines are reviewed and revised by the Amerigroup STAR+PLUS MMP quality improvement council at least every two years, or whenever the guidelines change.
The Amerigroup STAR+PLUS MMP CPGs are located online at https://providers.amerigroup.com/TX. To access the CPGs, log in to the secure site with your user name and password and select the Clinical Practice Guidelines link from the Clinical Policy and Guidelines section on the top navigation menu. A copy of the guidelines can be printed from the website.

**Patient360**

Patient360 is a read-only dashboard available through our secure provider self-service website that gives you instant access to detailed information about your Amerigroup STAR+PLUS MMP patients. By clicking on each tab in the dashboard, you can drill down to specific items in a patient’s medical record:

- Demographic information – member eligibility, other health insurance, assigned PCP and assigned case managers
- Care summaries – emergency department visit history, lab results, immunization history, and due or overdue preventive care screenings
- Claims details – status, assigned diagnoses and services rendered
- Authorization details – status, assigned diagnoses and assigned services
- Pharmacy information – prescription history, prescriber, pharmacy and quantity
- Care management-related activities – assessment, care plans and care goals

To access Patient360:
1. Log in to our secure provider self-service website at https://providers.amerigroup.com/TX.
2. Select Member Information from the left navigation.
4. Enter a specific Amerigroup STAR+PLUS MMP member’s information.

**Advance Directives**

Advance directives are written instructions that:

- Give direction to health care providers as to the provision of health care.
- Provide for treatment choices when a person is incapacitated.
- Are recognized under state law when signed by a competent person.

There are three types of advance directives:

- A durable power of attorney for health care (durable power) allows the member to name a patient advocate to act on behalf of the member.
- A living will allows the member to state his or her wishes in writing but does not name a patient advocate.
- A declaration for mental health treatment gives instructions about a member’s future mental health treatment if the member becomes unable to make those decisions. The instructions state whether the member agrees or refuses to have the treatments described in the declaration with or without conditions and limitations.
Amerigroup STAR+PLUS MMP advance directives policies include the following:

- Respecting the rights of the member to control decisions relating to his or her own medical care, including the decision to have provided, withheld or withdrawn the medical or surgical means or procedures calculated to prolong his or her life; 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
- Adhering to the Patient Self-Determination Act and maintaining written policies and procedures regarding advance directives; providers must adhere to this Act and to all state and federal standards as specified in SSA 1902(a)(57), 1903(m)(1)(A), 42 CFR 438.6(i) and 42 CFR 489 subpart I
- Advising members of their right to self-determination regarding advance directives
- Encouraging members to request an advance directives form and education from their PCP at their first appointment
- Assisting members with questions about an advance directives; no Amerigroup STAR+PLUS MMP employee may serve as witness to an advance directives or as a member’s authorized agent or representative
- While members have the right to formulate an advance directives, an Amerigroup STAR+PLUS MMP associate, a facility or a provider may conscientiously object to an advance directives within certain limited circumstances if allowed by state law
- Having Member Services, Health Promotion, Provider Relations and/or Health Care Management Services staff review and update advance directives notices and education materials for members on a regular basis
- Member materials will contain information, as applicable, regarding provisions for conscience objection. Materials explain the differences between institution-wide objections based on conscience and those that may be raised by individual physicians
- Amerigroup STAR+PLUS MMP or the practitioner must issue a clear and precise written statement of this limitation to CMS and request a conscience protection waiver. The conscientious objection will be stated clearly and describes the following:
  - Describes the range of medical conditions or procedures affected by the conscience objection
  - Identifies the state legal authority permitting such objection
- Noting the presence of advance directives in the medical records when conducting medical chart audits

Providers must do the following:

- Comply with the Patient Self-Determination Act requirements
- Make sure the first point of contact in the PCP’s office asks the member if he or she has executed an advance directive
- Document in the member’s medical record his or her response to an offer to execute any advance directive in a prominent place, including a do-not-resuscitate directive or the provider and member’s discussion and action regarding the execution or non-execution of an advance directive
- Ask members who have executed an advance directive to bring a copy of the advance directive(s) to the PCP/provider at the first point of contact
• Make an advance directive part of the member’s medical record and put it in a prominent place
  o The physician discusses potential medical emergencies with the member and/or family/significant other and with the referring physician if applicable
  o If an advance directive has not been executed, the first point of contact at the PCP/provider’s office will ask the member if he or she would like advance directive information. If the member desires further information, member advance directive education will be provided
• Not discriminate or retaliate against a member based on whether he or she has executed an advance directive

A specific advance directive, which meets compliance with the state of Texas, can be located at: [www.dads.state.tx.us/news_info/publications/handbooks/advancedirectives.html](http://www.dads.state.tx.us/news_info/publications/handbooks/advancedirectives.html)

Psychiatric advance directive information can be found at: [www.nrc-pad.org/content/view/41/25](http://www.nrc-pad.org/content/view/41/25).
Overview

Amerigroup STAR+PLUS MMP 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 the Amerigroup STAR+PLUS MMP Health Care Management Services 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 STAR+PLUS MMP to verify benefits and process the precertification request. For services that require precertification, Amerigroup STAR+PLUS MMP makes case-by-case determinations that consider an individual’s health care needs and medical history in conjunction with nationally recognized standards of care.

The hospital can confirm a precertification is on file by calling Provider Services at 1-855-878-1785 (see the Amerigroup STAR+PLUS MMP website and the Provider Inquiry Line section of this manual for instructions on use of the Provider Inquiry Line). If coverage of an admission has not been approved, the facility should call Provider Services at 1-855-878-1785. Amerigroup STAR+PLUS MMP will contact the referring physician directly to resolve the issue.

Amerigroup STAR+PLUS MMP 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 nationally recognized standards of care, an Amerigroup STAR+PLUS MMP reference number will be issued to the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member’s needs and medical history.

If medical necessity criteria for the admission are not met on the initial review, the medical director will contact the requesting physician to discuss the case. If the precertification documentation is incomplete or inadequate, the precertification nurse will notify the referring provider to submit the additional necessary documentation. If the medical director denies coverage of the request, the appropriate denial letter, including the appropriate appeal rights, will be mailed to the member and provider.
Providers will be held liable for all other inpatient denials issued. Any subsequent appeals should follow the correct process as outlined in the denial letter.

**Emergent Admission Notification Requirements**

Amerigroup STAR+PLUS MMP prefers immediate notification by network hospitals of emergent admissions. Network hospitals must notify Amerigroup STAR+PLUS MMP of emergent admissions within one business day. Amerigroup STAR+PLUS MMP Health Care Management Services staff will verify eligibility and determine benefit coverage.

Amerigroup STAR+PLUS MMP is available 24 hours a day, 7 days a week to accept emergent admission notification via the provider portal or by contacting the Provider Services line at 1-855-878-1785.

Coverage of emergent admissions is authorized based on review by a concurrent review nurse. When the clinical information received meets nationally recognized standards of care, an Amerigroup STAR+PLUS MMP reference number will be issued to the hospital.

If the notification documentation provided is incomplete or inadequate, Amerigroup STAR+PLUS MMP will not approve coverage of the request but will notify the hospital to submit the additional necessary documentation.

If the medical director denies coverage of the request, the appropriate denial letter will be mailed to the member and/or provider, including the appropriate appeal rights depending on the nature of the denial.

**Nonemergent Outpatient and Ancillary Services – Precertification and Notification Requirements**

Amerigroup STAR+PLUS MMP requires precertification for coverage of selected nonemergent outpatient and ancillary services. Requests for precertification with all supporting documentation should be submitted immediately upon identifying the need for the request or at least 72 hours prior to the scheduled service.

To ensure timeliness of the decision, the following must be provided:

- Member name and ID number
- Name, telephone number and fax number of physician performing the elective service
- Name of the facility and telephone number where the service is to be performed
- Date of service
- Member diagnosis
- Name of elective procedure to be performed with CPT-4 code
- Medical information to support requested services (medical information includes current signs/symptoms, past and current treatment plans, response to treatment plans and medications)
Inpatient Admission Reviews

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

Affirmative Statement About Incentives

Amerigroup STAR+PLUS MMP requires associates who make Utilization Management (UM) decisions to adhere to the following principles:

• UM decision-making is based only on the appropriateness of care and service and existence of coverage.
• Amerigroup STAR+PLUS MMP does not reward practitioners or other individuals for issuing denials of coverage or service.
• Financial incentives for Amerigroup STAR+PLUS MMP UM decision makers do not encourage decisions that result in underutilization.

Discharge Planning

Discharge planning is designed to assist the provider in the coordination of a member’s discharge when acute care (hospitalization) is no longer necessary. The Amerigroup STAR+PLUS MMP concurrent review nurse or case manager (working with the Amerigroup STAR+PLUS MMP medical director) will assist providers and hospitals with the discharge planning process in accordance with Amerigroup STAR+PLUS MMP requirements. At the time of admission and during the hospitalization, the Amerigroup STAR+PLUS MMP case manager will discuss discharge planning with the provider, ICT, member and/or member advocate.

When the provider and/or SCT identifies medically necessary and appropriate services for the member, Amerigroup STAR+PLUS MMP will assist the provider and the discharge planner in providing a timely and effective transfer to the next appropriate level of care or coordination of services.

The nurse or case manager will also assist the member and/or member advocate with:

• Notification and participation of the member’s SCT in discharge planning, coordination and reassessment as needed.
• Identification of nonclinical supports and the role they serve in the member’s treatment and aftercare plans.
• Scheduling of discharge/aftercare appointments in accordance with the access and availability standards.
• Identification of barriers to aftercare and the strategies developed to address such barriers.
• Assurance that inpatient and 24-hour diversionary behavioral health providers provide a discharge plan following any behavioral health admission to SCT members.
• Ensuring members who require medication monitoring will have access to such services within fourteen (14) business days of discharge from a behavioral health inpatient setting.
• Making best efforts to ensure a smooth transition to the next service or to the community.
• Documenting all efforts related to these activities, including the member’s active participation in discharge planning.

During the transition period referenced above, Amerigroup STAR+PLUS MMP may change a member’s existing provider only in the following circumstances:
• Member requests a change.
• The provider chooses to discontinue providing services to a member as currently allowed by Medicare and Medicaid.
• Amerigroup STAR+PLUS MMP, CMS or HHSC identify provider performance issues that affect a member’s health and welfare.
• The provider is excluded under state or federal exclusion requirements.

Confidentiality Statement
Members have the right to privacy and confidentiality regarding their health care records and information in accordance with Amerigroup STAR+PLUS MMP and provisions of HIPAA concerning members’ rights with respect to their protected health information and obligations of covered entities.

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

Providers must comply with all state and federal laws concerning privacy, confidentiality, accuracy and timely maintenance of health and other member information. Providers must have policies and procedures regarding use and disclosure of health information and comply with applicable laws.

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

Amerigroup STAR+PLUS MMP does not discourage members from using the 911 emergency system nor does Amerigroup STAR+PLUS MMP deny access to emergency services. Emergency services are provided to members without requiring precertification. Any hospital or provider calling for precertification for emergency services will be granted one immediately upon
request. Emergency services coverage includes services 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: 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; and/or 3) serious dysfunction of any bodily organ or part; or 4) with respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.

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

When a member seeks emergency services at a hospital, the determination as to whether the need for those services exists will be made for purposes of treatment by a physician licensed to practice medicine or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine. The physician or other appropriate personnel will indicate in the member’s chart the results of the emergency medical screening examination. Amerigroup STAR+PLUS MMP will compensate the provider for the screening, evaluations and examinations that are reasonable and calculated to assist the health care provider to 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 STAR+PLUS MMP. If the emergency department is unable to stabilize and release the member, Amerigroup STAR+PLUS MMP will assist in coordination of the inpatient admission regardless of whether the hospital is network or non-network. 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, the Amerigroup STAR+PLUS MMP concurrent review nurse will implement the concurrent review process to ensure coordination of care.
Post-Stabilization Care Services
Post-stabilization care services are covered services related to an emergency condition provided after a patient is stabilized to maintain the stabilized condition or improve or resolve the patient’s condition. Precertification is not required for emergency services in or out of the network. All emergency services are reimbursed at least at the Medicare network rate. Amerigroup STAR+PLUS MMP will cover emergency and post-stabilization care services that are medically necessary until the emergency condition is stabilized and maintained.

Nonemergency Services
For routine, symptomatic, beneficiary-initiated outpatient appointments for primary preventive medical care, the request-to-appointment time must be no greater than 30 days unless the member requests a later time. For routine, symptomatic, beneficiary-initiated outpatient appointments for nonurgent primary medical care, the request-to-appointment time must be no greater than 30 calendar days unless the member requests a later time.

Primary medical urgent care, including dental care outpatient appointments for urgent conditions, must be available within 24 hours. For specialty outpatient referral and/or consultation appointments, the request-to-appointment time must be consistent with the clinical urgency, but no greater than 21 days unless the member requests a later time. For outpatient scheduled appointments, the time the member is seen must not be more than 30 minutes after the scheduled time unless the member is late.

For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time must be consistent with the clinical urgency, but no greater than seven days unless the member requests a later time. For urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability will be consistent with the clinical urgency but no greater than 24 hours. The timing of scheduled follow-up outpatient visits with practitioners must be consistent with the clinical need.

Urgent Care
Amerigroup STAR+PLUS MMP requests its members to contact their PCP in situations when urgent, unscheduled care is necessary. Precertification with Amerigroup STAR+PLUS MMP is not required for a member to access a network urgent care center.
CHAPTER 13: MEMBER MANAGEMENT SUPPORT

Welcome Call
As part of our member management strategy, Amerigroup STAR+PLUS MMP offers a welcome call to new members. Additionally, Member Services representatives offer to assist members with any current needs, such as scheduling an initial checkup.

Appointment Scheduling
Through our participating providers, Amerigroup STAR+PLUS MMP ensures 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 a member’s needs and requests in a timely manner. The PCP should make every effort to schedule members for appointments using the PCP access and availability guidelines.

24-Hour Nurse HelpLine
The Amerigroup STAR+PLUS MMP 24-Hour Nurse HelpLine is a service designed to support the provider by offering information and education about medical conditions, health care and prevention to members after normal physician practice hours. The 24-Hour Nurse HelpLine provides triage services and helps direct members to appropriate levels of care. The phone number is 1-855-878-1785 and is listed on the member’s ID card. This ensures members have an additional avenue of access to health care information when needed.

Features of the 24-Hour Nurse HelpLine include:
• Availability 24 hours a day, 7 days a week for crisis and triage services.
• Information based upon nationally recognized and accepted guidelines.
• Free translation services for over 200 different languages and for members with difficulty hearing.
• Education for members about appropriate alternatives for handling nonemergent medical conditions.
• Member assessment reports faxed to providers’ offices within 24 hours of the call.

Care Management Support
Amerigroup STAR+PLUS MMP Care Management Support is a service designed to support the provider as well as the member. Providers can speak with a service coordinator about a specific member’s care plan or general questions concerning care management. Members have access to information regarding all covered services. Amerigroup STAR+PLUS MMP Care Management Support is available 24 hours a day, 7 days a week at 1-855-878-1785.

Interpreter Services
Amerigroup STAR+PLUS MMP provides your office with interpreter services for your Amerigroup STAR+PLUS MMP members. Services are available 24 hours a day, 7 days a week and include over 200 languages, as well as services for members who are deaf or hard of
Health Promotion
Amerigroup STAR+PLUS MMP 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 contracted with Amerigroup STAR+PLUS MMP.

Amerigroup STAR+PLUS MMP manages projects that offer our members education and information regarding their health. Ongoing projects include:

- Creation and distribution of health education tools used to inform members of health promotion issues and topics.
- Health Tips on Hold (educational telephone messages while the member is on hold).
- Health education programs offered to members.
- Development of health education curricula and procurement of other health education tools (e.g., breast self-exam cards).
- Relationship development with community-based organizations to enhance opportunities for members.

Member Satisfaction
Amerigroup STAR+PLUS MMP periodically surveys members to measure overall customer satisfaction, including satisfaction with the care received from providers. Amerigroup STAR+PLUS MMP reviews survey information and shares the results with network providers.

Members are also surveyed by CMS twice a year through the CAHPS and HOS surveys. The results of both CMS surveys are part of the Amerigroup STAR+PLUS MMP HEDIS and Star ratings. Participating providers should encourage members to actively participate in their health care, to receive preventive services timely and to improve their quality of life by following the provider’s treatment plan.
CHAPTER 14: CLAIMS SUBMISSION and ADJUDICATION PROCEDURES

Claims- Billing and Reimbursement

Clean claims for members are generally adjudicated within 30 calendar days from the date Amerigroup STAR+PLUS MMP receives the claim. However, clean claims from providers of Medicaid covered services (e.g., nursing facilities, long-term services and supports, community behavioral health) will be processed within 10 days of receipt of the clean claim. Pharmacy nonelectronic claims will be processed within 21 days and pharmacy electronic claims within 18 days.

Amerigroup STAR+PLUS MMP will pay interest charges on claims in compliance with requirements set forth in the Demonstration between CMS, the state and the Amerigroup STAR+PLUS MMP contract as applicable.

For nonclean claims, the provider receives written notification identifying the claim number, the reason the claim could not be processed, the date the claim was received by Amerigroup STAR+PLUS MMP and the information required from the provider in order to adjudicate the claim. Amerigroup STAR+PLUS MMP produces and mails an Explanation of Payment (EOP) on a twice weekly basis. The EOP delineates for the provider the status of each claim that has been paid or denied during the previous week.

Reimbursement by Amerigroup STAR+PLUS MMP constitutes payment in full. Balance billing the Amerigroup STAR+PLUS MMP member is prohibited per the participating Provider Agreement and, for LTSS providers only, the Attachment A rate sheet.

Amerigroup STAR+PLUS MMP follows Strategic National Implementation Process (SNIP) level 1-6 editing for all claims received in accordance with HIPAA. Providers must bill all electronic and paper submitted claims and use HIPAA-compliant billing codes. When billing codes are updated, the provider is required to use appropriate replacement codes for submitting claims for covered services. An amendment to the participating Provider Agreement will not be required to replace such billing codes. Amerigroup STAR+PLUS MMP will not reimburse any claims submitted using noncompliant billing or SNIP codes.

Providers resubmitting claims for corrections must clearly mark the claim “Corrected Claim.” Failure to mark the claim appropriately may result in denial of the claim as a duplicate. Corrected claims must be received within the applicable timely filing requirements of the originally submitted claim.

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 health care 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.

**Claims Status**

Providers should visit the Availity website at https://www.availity.com or call the automated Provider Services line at 1-855-878-1785 to check claims status.

Providers are encouraged to review EDI reports from their EDI vendors and address any issues with claims submissions such as rejected claims.

**Provider Claims**

Providers should submit claims to Amerigroup STAR+PLUS MMP as soon as possible after service is rendered. Providers are encouraged to submit their claims electronically as the preferred method for claims submission. Providers must submit electronic claims using the 837I (Institutional) or 837P (Professional) standard format. Provider must use the industry standard claim form CMS-1450, also known as the UB-04, or CMS-1500 (02-12) for all paper submissions.

**CMS-1500 (08-05)**

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<td>d. INSURANCE PLAN NAME OR PROGRAM NAME</td>
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Hospitals
CMS-1450, also known as the UB-04

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<tr>
<td>Availity</td>
<td>26375</td>
<td>1-877-334-8446</td>
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<tr>
<td>Capario</td>
<td>28804</td>
<td>1-800-792-5256</td>
</tr>
<tr>
<td>Emdeon</td>
<td>27514</td>
<td>1-877-469-3263</td>
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Coordination of Benefits
Amerigroup STAR+PLUS MMP will coordinate and process the claim upon initial submission from the provider.

Electronic Claims
Claims may be submitted electronically through the clearinghouses identified below. The guide for EDI claims submission is located on our website at https://providers.amerigroup.com. The EDI claim submission guide includes additional information related to the EDI claim process. To initiate the electronic claims submission process or obtain additional information, please call the Amerigroup STAR+PLUS MMP EDI Hotline at 1-800-590-5745.

Paper Claim Submission
Providers also have the option of submitting paper claims. Amerigroup STAR+PLUS MMP uses optical character recognition (OCR) technology as part of its front-end claims processing procedures. The benefits include the following:
- Faster turnaround times and adjudication
- Claims status availability within five days of receipt
- Immediate image retrieval by Amerigroup STAR+PLUS MMP staff for claims information, allowing more timely and accurate response to provider inquiries

To use OCR technology, claims must be submitted on original red claim forms (not black and white or photocopied forms) and laser printed or typed (not handwritten) in a large, dark font. Providers must submit a properly completed UB-04 or CMS-1500 (08-05) within 95 days (365 days for nursing facilities other than nursing facility add-on services) from the date of discharge for inpatient services or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date the third party documents resolution of the claim.
In accordance with the implementation timelines set by CMS and NUCC, Amerigroup STAR+PLUS MMP requires the use of the new CMS-1500 (08-05) for the purposes of accommodating the National Provider Identifier (NPI).

In accordance with the implementation timelines set by CMS and NUBC, Amerigroup STAR+PLUS MMP requires the use of the new UB-04 CMS-1450 for the purposes of accommodating the NPI.

CMS-1500 (08-05) and UB-04 CMS-1450 must include the following information (HIPAA-compliant where applicable):

- Patient’s ID number
- Patient’s name
- Patient’s date of birth
- ICD-10 diagnosis codes/revenue codes
- Date of service
- Place of service
- Description of services rendered CPT-4 codes/HCPCS codes/DRGs
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- Amerigroup STAR+PLUS MMP provider number
- NPI of billing provider when applicable
- Name of ordering physician
- NPI of ordering physician when applicable
- Name of performing physician
- NPI of performing provider when applicable
- State Medicaid ID number
- Coordination of Benefits/other insurance information
- Authorization/precertification number or copy of authorization/precertification
- Name of referring physician
- NPI of referring physician when applicable
- Any other state-required data

Amerigroup STAR+PLUS MMP cannot accept claims with alterations to billing information. Claims that have been altered will be returned to the provider with an explanation of the reason for the return. Amerigroup STAR+PLUS MMP will not accept handwritten claims.

Paper claims must be submitted within the timely filing limit of 95 days from the date of service (365 days for nursing facilities other than nursing facility add-on services). Submit paper claims to:

Amerigroup STAR+PLUS MMP
P.O. Box 61010
Virginia Beach, VA 23466-101
Encounter Data

Amerigroup STAR+PLUS MMP has 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 STAR+PLUS MMP for each member encounter. Encounter data can be submitted through EDI submission methods or on a CMS-1500 (08-05) or a UB-04 claim form, unless other arrangements are approved by Amerigroup STAR+PLUS MMP. Data will be submitted in a timely manner but no later 95 days (365 days for nursing facilities other than nursing facility add-on services) from the date of service.

The encounter data will include the following:

- Amerigroup STAR+PLUS MMP member ID number
- Amerigroup STAR+PLUS MMP member name (first and last name)
- Amerigroup STAR+PLUS MMP member date of birth
- Provider name according to contract
- NPI 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 address provided on the previous page. Through claims and encounter data submissions, HEDIS information is collected. This includes but is not limited to the following:

- Preventive services (e.g., childhood immunization, mammography, Pap smears)
- Prenatal care (e.g., low birth weight, general first trimester care)
- Acute and chronic illness (e.g., ambulatory follow-up and hospitalization for major disorders)

Compliance is monitored by Amerigroup STAR+PLUS MMP 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 termination.

Claims Adjudication

Amerigroup STAR+PLUS MMP is dedicated to providing timely adjudication of provider claims for services rendered to members. All network and non-network provider claims submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by the CPT-4 and ICD-10 manuals. Institutional claims should be submitted using EDI submission methods or a CMS-1450 (UB-04) and provider claims using the CMS-1500.

Providers must use HIPAA-compliant billing codes when billing Amerigroup STAR+PLUS MMP. 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 STAR+PLUS MMP will not pay any claims submitted using noncompliant billing codes.

Amerigroup STAR+PLUS MMP reserves the right to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure. The automated claims auditing system verifies the coding accuracy of claims for CPT and HCPCS procedures. This system ensures the same auditing criteria are applied across all claims. Editing decisions are supported by online medical coding policy statements published by CMS as a part of the National Correct Coding Initiative (NCCI, also known as CCI).

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

- Submit claims within the number of days specified from the date the service is rendered, or for inpatient claims filed by a hospital, within the number of days specified from the date of discharge.
- In the case of other insurance, submit the claim within the number of days specified for each market after receiving a response from the third-party payer.
- Claims for members whose eligibility has not been added to the state’s eligibility system must be received within 365 days from the date the eligibility is added, and Amerigroup STAR+PLUS MMP is notified of the eligibility/enrollment.
- Claims submitted after the market-specific timely filing deadline will be denied.

After filing a claim with Amerigroup STAR+PLUS MMP, review the twice weekly EOP. If the claim does not appear on an EOP within 30 business days as adjudicated or you have no other written indication the claim has been received, check the status of your claim on the Availity website at https://www.availity.com or by calling Provider Services at 1-855-878-1785. If the claim is not on file with Amerigroup STAR+PLUS MMP, resubmit your claim within the timely claim filing guidelines. If filing electronically, check the confirmation reports you receive from your EDI or practice management vendor for acceptance of the claim.

Clean Claims Payment

A clean claim is a request for payment for a service rendered by a provider that:

- Is submitted in a timely manner.
- Is free of defects.
- Is submitted on a HIPAA-compliant standard claim form CMS-1500 (02-12) or CMS-1450 (UB-04) or successor forms thereto or the electronic equivalent.
- Does not require developing, outreach to an external source, adjustment or alteration by the provider or by a third party to be processed and paid by Amerigroup STAR+PLUS MMP.

Clean claims are typically adjudicated within 30 calendar days of receipt. However, clean claims from providers of Medicaid-covered services (e.g., nursing facilities, long-term services and supports, community behavioral health) will be processed within 10 days of receipt of the clean claim. Pharmacy nonelectronic claims will be processed within 21 days and pharmacy electronic claims within 18 days. Amerigroup STAR+PLUS MMP will pay all applicable interest as required by law on clean claims not adjudicated within the required time frames.
Amerigroup STAR+PLUS MMP produces and mails an Explanation of Payment (EOP) twice per week. The EOP delineates for the provider the status of each claim adjudicated during the previous payment cycle.

Electronic claims determined to be unclean will be returned to the Amerigroup STAR+PLUS MMP contracted clearinghouse that submitted the claim.

In accordance with the contract with the state of Texas, Amerigroup STAR+PLUS MMP will adjudicate at least 98 percent of all clean claims within 30 calendar days of the date of receipt except for shorter time frames required for pharmacy and certain nursing facility services. The date of receipt is the date Amerigroup STAR+PLUS MMP receives the claim as indicated by its date stamp on the claim. The date of payment is the date on the check or other form of payment.

**Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)**

Amerigroup STAR+PLUS MMP offers electronic funds transfer (EFT) and electronic remittance advice (ERA) with online viewing capability. Providers can elect to receive Amerigroup STAR+PLUS MMP payments electronically through direct-deposit to their bank account. In addition, providers can select from a variety of remittance information options, including:

- HIPAA-compliant data file for download directly to your practice management or patient accounting system.
- Paper remittance printed and mailed by Amerigroup STAR+PLUS MMP.

Some of the benefits providers may experience include:

- Faster receipt of payments from Amerigroup STAR+PLUS MMP.
- The ability to generate custom reports on both payment and claim information based on the criteria specified.
- Online capability to search claims and remittance details across multiple remittances.
- Elimination of the need for manual entry of remittance information and user errors.

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

**Specialist Reimbursement**

Specialty care providers must obtain Amerigroup STAR+PLUS MMP approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized or beyond the scope permitted under this program. Specialty care provider services will be covered only when there is documentation of appropriate notification or prior authorization as appropriate, and receipt of the required claims and encounter information to Amerigroup STAR+PLUS MMP.

**Reimbursement Policies**

Reimbursement policies serve as a guide to assist you with accurate claims submissions and outline the basis for reimbursements when services are covered by Amerigroup STAR+PLUS MMP. The determination that a service, procedure, item, etc. is covered under a member’s benefit plan is not a determination that you will be reimbursed. Services must meet
authorization and medical necessity guidelines appropriate to the procedure and diagnosis. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claims submissions. Services should be billed with CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

The Amerigroup STAR+PLUS MMP reimbursement policies are based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider or state contracts, or state, federal or CMS requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup STAR+PLUS MMP strives to minimize these variations.

We reserve the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policies to our provider website under the Quick Tools menu.

**Reimbursement Hierarchy**

Claims submitted for payments must meet all aspects of criteria for reimbursements. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity, authorization requirements or stipulations within a reimbursement policy. Neither payment rates nor methodologies are considered to be conditions of payments.

**Review Schedule and Updates**

Reimbursement policies undergo reviews every two years for updates to state contracts or state, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to an Amerigroup STAR+PLUS MMP business decision. When there is an update, we will publish the most current policies to our provider website.

**Reimbursement by Code Definition**

Amerigroup STAR+PLUS MMP allows reimbursements for covered services based on their procedure code definitions or descriptors as opposed to their appearance under particular CPT categories or sections unless otherwise noted by state or provider contracts, or state, federal or CMS requirements.
There are seven CPT sections:
- Evaluation and management
- Anesthesia
- Surgery
- Radiology (nuclear medicine and diagnostic imaging)
- Pathology and laboratory
- Medicine
- Temporary codes for emerging technology, services or procedures

At times, procedure codes are located in particular CPT categories when those procedures may not, as a general understanding, be classified within that particular category (e.g., venipuncture is located in the CPT surgical section but is not considered to be a surgical procedure).

Documentation Standards for an Episode of Care
When we request clinical documentation from you to support claims payments for services, you must ensure the information provided to us:
- Identifies the member.
- Is legible.
- Reflects all aspects of care.

To be considered complete, documentation for episodes of care will include, at a minimum, the following elements:
- Patient identifying information.
- Consent forms.
- Health history, including applicable drug allergies.
- Types and dates of physical examinations.
- Diagnoses and treatment plans for individual episodes of care.
- Physician orders.
- Face-to-face evaluations.
- Progress notes.
- Referrals.
- Consultation reports.
- Laboratory reports.
- Imaging reports (including X-rays).
- Surgical reports.
- Admission and discharge dates and instructions.
- Preventive services provided or offered appropriate to the member’s age and health status.
- Evidence of coordination of care between primary and specialty physicians.

Refer to the standard data elements to be included for specific episodes of care as established by The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A single episode of care refers to continuous care or a series of intervals of brief separations from care to a member by a provider or facility for the same specific medical problem or condition.
Documentation for all episodes of care must meet the following criteria:

- Is legible to someone other than the writer
- Contains information that identifies the member on each page in the medical record
- Contains entries in the medical record that are dated and include author identification (e.g., handwritten signatures, unique electronic identifiers or initials)

**Other Documentation Not Related to the Member**

Other documentation not directly related to the member but relevant to support clinical practice may be used to support documentation regarding episodes of care, including:

- Policies, procedures and protocols.
- Critical incident/occupational health and safety reports.
- Statistical and research data.
- Clinical assessments.
- Published reports/data.

Amerigroup STAR+PLUS MMP may request that you submit additional documentation, including medical records or other documentation not directly related to the member, to support claims you submit. If documentation is not provided following the request or notification or if documentation does not support the services billed for the episode of care, we may deny the claim or recover and/or recoup monies previously paid on the claim.

Amerigroup STAR+PLUS MMP is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

**Overpayment Process**

Refund notifications may be identified either by the Amerigroup STAR+PLUS MMP Cost Containment Unit (CCU) or the provider. The CCU researches and notifies the provider of an overpayment by 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 STAR+PLUS MMP, the CCU will notify the provider of the overpayment. The provider will submit a Refund Notification Form along with the refund check. If a provider identified the overpayment and returns the Amerigroup STAR+PLUS MMP check, please include a completed Refund Notification Form specifying the reason for the return. This form can be found on the provider website at [https://providers.amerigroup.com/TX](https://providers.amerigroup.com/TX). Submission of the Refund Notification Form will allow the CCU to process and reconcile the overpayment in a timely manner. Once the CCU has reviewed the overpayment, you will receive a confirmation letter explaining the details of the reconciliation. For questions regarding the refund notification procedure, call Provider Services at 1-855-878-1785.

Amerigroup STAR+PLUS MMP uses an automated claims auditing system to ensure claims are adjudicated in accordance with industry billing and reimbursement standards. Claims auditing software ensures compliance with an ever-widening array of edits and rules, as well as
consistency of payment for providers, by ensuring correct coding and billing practices are being followed. Using a sophisticated auditing logic, our code editing system determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes and processes those services according to the National Correct Coding Initiative (NCCI). NCCI was implemented to promote national correct coding methodologies and control improper coding leading to inappropriate payment. NCCI code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services.

In addition to code pair edits, the NCCI includes a set of edits known as medically unlikely edits (MUEs). An MUE is a maximum number of units of service (UOS) allowable under most circumstances for a single HCPCS/CPT code billed by a provider on a date of service for a single beneficiary.

**Administrative and Member Liability Appeals**

Appeals are any of the procedures that deal with the review of adverse organization or coverage determinations on the health care services or prescription drug benefits a member is entitled to receive or any amounts the member must pay for a covered service. If a provider appeals a decision rendered with member liability, then the appeal follows the member liability appeals process and is handled by the Complaints, Appeals and Grievance department. See the section on the member liability appeals process for more information.

**Provider Payment Disputes**

If you believe Amerigroup STAR+PLUS MMP has not paid for your services according to the terms of your Provider Agreement, submit a request using the Provider Payment Dispute Form located online under Forms at [https://providers.amerigroup.com/TX](https://providers.amerigroup.com/TX).

Providers will not be penalized for filing a dispute.

Submit provider payment disputes to:

Provider Payment Disputes  
Amerigroup STAR+PLUS MMP  
P.O. Box 61599  
Virginia Beach, VA 23466-1599

The Provider Dispute Unit will receive, distribute and coordinate all payment disputes.

1. Submit a written request with supporting documentation, such as an EOP or a copy of the claims or denial letter received along with other written documentation; a full explanation of the dispute is required and must be submitted within 120 days of when the Amerigroup STAR+PLUS MMP notice of initial determination was generated, or we will not accept the request; the provider is responsible to submit all necessary documentation at the time of the request.
2. The Amerigroup STAR+PLUS MMP Claims department conducts the review, and/or the health plan medical director reviews the dispute if medical information is involved; if additional information is submitted that would support payment, the denial is overturned.

3. An internal review is conducted and results communicated in a written decision to the provider within 45 calendar days; the written decision includes:
   - A statement of the provider's dispute.
   - The reviewer's decision along with a detailed explanation of the contractual and/or medical basis for such decision.
   - A description of the evidence or document that supports the decision.
CHAPTER 15: PROVIDER COMPLAINT AND GRIEVANCE PROCEDURES

Overview

Amerigroup STAR+PLUS MMP has a formal process for the handling of complaints pertaining to administrative issues and nonpayment-related matters. For payment disputes, see Provider Payment Disputes. For MMP member liability appeals, see Member Appeals. Providers may access this process by filing a written grievance. Provider grievances will be resolved fairly and consistently with Amerigroup STAR+PLUS MMP policies and covered benefits.

Providers are not penalized for filing complaints. Any supporting documentation should accompany the complaint and be forwarded to:

Provider Complaints and Grievances
Amerigroup STAR+PLUS MMP
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, OH 45040
Fax: 1-888-458-1406

Provider Obligations and Notifications

Denial Notification and Member Complaints, Appeals and Grievances
Providers are required to adhere to CMS and Amerigroup STAR+PLUS MMP requirements concerning issuing letters and notices.

Skilled Nursing Facilities and Home Health Agencies
The Notice of Medicare Noncoverage (NOMNC) is a statutorily required notice issued to members to alert them of a discontinuation of skilled nursing facility, comprehensive outpatient rehabilitation facility or home health services. This notice explains it has been determined that continued coverage after a specific effective date will no longer be covered by the plan. At least two days prior to discharge, or no later than the next to last time services are furnished, a NOMNC should be issued to a member. This notice informs the member his or her stay or visits no longer meet coverage criteria and will end in two days or after two visits.

In most cases, the notice is required to be issued by the provider, and Amerigroup STAR+PLUS MMP is required to ensure proper delivery and that the member’s signature is obtained. The member’s signature is not an agreement with the denial; however, it is documentation he or she has received the notification. If a member refuses to sign the notice, the provider may contact the member’s representative to have that person sign. If no representative is available, the provider may annotate the notice to indicate the refusal and document that notification was provided to the member, but the member refused to sign. If a representative can be contacted, the representative should sign the notice. If in-person notification cannot be provided to a representative, he or she can be contacted by telephone to advise him or her of the notice and appeal rights. If agreed by both parties, the notice can be emailed or faxed (in accordance with HIPAA privacy and security requirements). The notice should be annotated by
the person providing the notification to the representative indicating the date, time, person’s name, relation to the member, telephone number called and that the notice was read to the representative, including all appeal rights. If a member (or representative) elects to exercise his or her right to an immediate review, the member (or representative) must submit a request to the appropriate Quality Improvement Organization (QIO) for the state by the deadline indicated in the notice. The provider is responsible for submitting any documents or medical records as requested by the QIO or the Amerigroup STAR+PLUS MMP Complaints, Appeals and Grievance department within the time frame indicated on the request.

**Hospitals**

The Important Message from Medicare (IMM) is a statutorily required notice issued to Medicare Advantage members to alert them of a discontinuation of acute inpatient hospital services. Within two days after an admission or at the preadmission visit (but not more than seven calendar days in advance of the admission), the hospital providing the inpatient services is required to issue the IMM. This statutorily required notice explains the Medicare beneficiary’s rights as a hospital inpatient, including discharge appeal rights. The hospital is required to deliver the notice in person and obtain the signature of the member or representative and provide a copy at that time. The hospital is also responsible for ensuring the member can comprehend the contents of the notice before obtaining the signature, should explain the notice if necessary and be able to answer any questions about the notice.

Notices should not be delivered while the member is receiving emergency treatment but should be delivered once the patient is stable. If a member refuses to sign the notice, the hospital may annotate the notice to indicate the refusal and document notification was attempted. If in-person notification cannot be provided to a representative, the hospital is responsible for telephonically contacting the representative to advise him or her of the appeal rights, or if agreed by both parties, the notice can be emailed or faxed (in accordance with HIPAA privacy and security requirements). Prior to discharge (but not more than two days in advance of discharge), the hospital must deliver another copy of the signed notice to the member or representative in person. If the notice is being given on the day of discharge, the member must be provided at least four hours to consider his or her rights and to request the QIO review. Hospitals should not routinely provide the notice on the day of discharge. If the member requests additional information on the discharge, the detailed notice can be issued prior to an immediate review request being initiated. If discharge occurs within two calendar days of the original notice, no additional copy needs to be delivered. If a member elects to exercise his or her right to an immediate review, he or she must submit a request to the appropriate QIO, as outlined in the notice, by midnight of the day of discharge either verbally or in writing, before that person leaves the hospital.

**In-Office Denials**

There may be situations where a member disagrees with the provider’s decision about a request for service or a course of treatment. At each patient encounter with an Amerigroup STAR+PLUS MMP member, the provider must notify the member of his or her right to receive, upon request, a detailed written notice from Amerigroup STAR+PLUS MMP regarding the member’s services. The provider’s notification must provide the member with the information
necessary to contact Medicare or HHSC. If a member (or provider) requests us to provide a detailed notice of a provider’s decision to deny a service in whole or part, we must give the member a written notice of the determination.

**Precertification**
Providers are responsible for obtaining precertification from Amerigroup STAR+PLUS MMP before performing certain procedures or when referring members to noncontracted providers. Please refer to the Summary of Benefits document for those procedures that require precertification or call Provider Services at 1-855-878-1785.

Amerigroup STAR+PLUS MMP will render a determination on the request within the appropriate time frame and provide notification of the decision. Requests that are denied will generate a notice that includes the denial rationale and applicable appeal rights. Members will receive a denial letter as well that includes appeal rights. Denials that are the result of contractual issues between Amerigroup STAR+PLUS MMP and the provider will not generate a member denial letter.

- An initial *organization* determination is any determination (e.g., an approval or denial) made by Amerigroup STAR+PLUS MMP for coverage of medical services
- An initial *coverage* determination is any determination (e.g., an approval or denial) made by Amerigroup STAR+PLUS MMP for coverage of prescription drugs.

**Appeals (Both Member and Provider Appeals)**
Providers must cooperate with Amerigroup STAR+PLUS MMP and members in providing necessary information to resolve appeals within the required time frames. Providers must provide the pertinent medical records and any other relevant information upon request and when initiating an appeal. In some instances, providers must provide the records and information very quickly to allow Amerigroup STAR+PLUS MMP to make an expedited decision. Your participation in and the member’s election of Amerigroup STAR+PLUS MMP are an indication of consent to release those records as part of health care operations.

**Provider Payment Disputes**
Disputes that are the result of contractual issues between the provider and Amerigroup STAR+PLUS MMP carry no member liability, and the member is held harmless for any payment. It is important to follow the directions in the denial letter issued to ensure the proper dispute process is followed. The provider liability dispute process is located in the Provider Payment Disputes section.

**Administrative and Member Liability Appeals**
A member appeal is the type of request a member (or authorized representative) makes when the member wants Amerigroup STAR+PLUS MMP to reconsider and change an initial coverage/organization determination (by Amerigroup STAR+PLUS MMP or a provider) about what services, benefits or prescription drugs are necessary or covered, or whether Amerigroup STAR+PLUS MMP will reimburse for a service, benefit or prescription drug.
A member, or provider on the member’s behalf, may appeal:

- An adverse initial organization determination by Amerigroup STAR+PLUS MMP or a provider concerning authorization for or termination of coverage of a health care service.
- An adverse initial organization determination by Amerigroup STAR+PLUS MMP concerning reimbursement for a health care service.
- An adverse initial organization determination by Amerigroup STAR+PLUS MMP concerning a refusal to reimburse for a health service already received if the refusal would result in the member being financially liable for the service.
- An adverse coverage determination by Amerigroup STAR+PLUS MMP or a provider concerning authorization for prescription drugs.

The following are scenarios that do not meet criteria for member liability appeals:

- Nonreimbursable services
- Bundled services
- Timely filing denials
- Invalid diagnosis, procedure and modifier denials

Appeals must be filed within 60 days of the Amerigroup STAR+PLUS MMP notification of the denial. The request may be made telephonically or in writing.

If the member or physician believes waiting the normal time period for an appeal could seriously jeopardize the member’s life, health or ability to regain maximum function (the same expedited criteria used in initial decisions), the member or the member’s physician can request an expedited appeal. Such appeals generally are resolved within 72 hours unless it is in the member’s interest to extend this time period. If a physician requests the expedited appeal and indicates the case meets the expedited criteria, Amerigroup STAR+PLUS MMP will automatically expedite the appeal.

Appeals should be sent to:

Complaints, Appeals and Grievances Department
Amerigroup STAR+PLUS MMP
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, OH 45040
Phone: 1-855-817-5787
Fax: 1-888-458-1406

Providers may have to complete an Appointment of Representative Form to submit an appeal on behalf of an Amerigroup STAR+PLUS MMP member if the appeal is regarding a claim denial for services that have already been provided. The Appointment of Representative Form can be found online and downloaded at www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf. Providers can also obtain a signed written statement from the member.
Noncontracted Providers
If a claim is partially or fully denied for payment, the noncontracted provider must request a reconsideration of the denial within 60 calendar days from the remittance notification. When submitting the reconsideration of the denial of payment on a claim, a signed Waiver of Liability form must be included. To obtain this form, go to https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf and select Appendix 7. The purpose of the Waiver of Liability form is to hold the enrollee harmless regardless of the outcome of the appeal.

With the appeal, the noncontracted provider should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement.

The appeal must be in writing and mailed to:

Grievances and Appeals
Amerigroup STAR+PLUS MMP
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

Member Liability – Appeal Time Frame Table
Member appeals have standard and expedited processes as shown below.

<table>
<thead>
<tr>
<th>Type of Appeal</th>
<th>Provider Timeline for Submission</th>
<th>Applies to</th>
<th>Appeal Review</th>
<th>Standard Turnaround Time</th>
<th>Expedited Turnaround Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment</td>
<td>60 calendar days from EOP</td>
<td>Denied payment for a service already received</td>
<td>Amerigroup STAR+PLUS MMP G&amp;A department</td>
<td>Within 30 calendar days</td>
<td>* A 14-day extension may be taken.</td>
</tr>
<tr>
<td>Service</td>
<td>60 calendar days from denial letter</td>
<td>Denied request for a health service not already received</td>
<td>Amerigroup STAR+PLUS MMP G&amp;A department</td>
<td>Within 30 calendar days</td>
<td>* A 14-day extension may be taken.</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>60 calendar days from denial letter</td>
<td>Denied request for a prescription drug not already received</td>
<td>Amerigroup STAR+PLUS MMP G&amp;A department</td>
<td>Within 7 calendar days</td>
<td>Within 72 hours</td>
</tr>
</tbody>
</table>

* A 14-day extension may be taken.
<table>
<thead>
<tr>
<th>Type of Appeal</th>
<th>Provider Timeline for Submission</th>
<th>Applies to</th>
<th>Appeal Review</th>
<th>Standard Turnaround Time</th>
<th>Expedited Turnaround Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discontinuation of SNF, HHA or CORF services</td>
<td>Discontinuation of SNF, HHA, CORF services previously approved and no longer determined to be medically necessary (does not apply to preservice or benefit denials).</td>
<td>Appeals should be lodged as per the denial letter issued to the appropriate QIO within the applicable time frame. The QIO will provide an immediate review. If the time frame has been missed, the appeal can be lodged with the Amerigroup STAR+PLUS MMP G&amp;A department. G&amp;A will review the request as expedited (within 72 hours).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discontinuation of inpatient hospital care</td>
<td>When a member receives the “Important Message from Medicare” when being discharged from the hospital.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Further Appeal Rights**

If Amerigroup STAR+PLUS MMP is unable to reverse the original denial decision in whole or part, the following additional steps will be taken:

- **Medicare-Covered Services**
  - Amerigroup STAR+PLUS MMP will forward the appeal to an independent review entity (IRE) contracted with the federal government. The IRE will review the appeal and make a decision:
    - Within 72 hours if expedited (A 14-day extension may be taken if additional information is needed).
    - Within 30 days if the appeal is related to authorization for health care (A 14-day extension may be taken if additional information is needed).
    - Within 30 days if the appeal involves reimbursement for care (A 14-day extension may be taken if additional information is needed).
    - Note: Prescription drug appeals are not forwarded to the IRO by Amerigroup STAR+PLUS MMP but may be requested by the member or representative; information will be provided on this process during the Amerigroup STAR+PLUS MMP member appeals process.
  - If the IRE issues an adverse decision (not in the member’s favor) and the amount at issue meets a specified dollar threshold, the member may appeal to an administrative law judge (ALJ).
  - If the member is not satisfied with the ALJ’s decision, the member may request review by the Medicare Appeals Council. If the Medicare Appeals Council refuses to hear the case or issues an adverse decision, the member may be able to appeal to a federal court.
• Medicaid-Covered Services
  o Only covered under Medicaid (HHSC), including LTSS services, covered non-Part D Drugs and behavioral health:
    ▪ The appeal may be filed externally by the member to the HHSC Appeals Division.
    ▪ A response will be issued within 72 hours for an expedited appeal.
    ▪ During the first year of the demonstration, a response will be issued within 90 calendar days (75 calendar days in year two and 30 calendar days in subsequent years).

• Medicare- and Medicaid-Covered Services
  o Any appeals that overlap Medicare and Medicaid (including but not limited to: home health, durable medical equipment and skilled therapies but excluding Part D) will be automatically forwarded to the IRE. The member may also submit a request to the HHSC Appeals Division. Amerigroup STAR+PLUS MMP is bound to the outcome more favorable to the member.

Member Grievance

A member grievance is the type of complaint a member makes regarding any other type of problem with Amerigroup STAR+PLUS MMP or a provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room, and the cleanliness of the provider’s facilities are grievances.

Amerigroup STAR+PLUS MMP must accept grievances from members orally or in writing within 60 days of the event. Amerigroup STAR+PLUS MMP must make a decision and respond to the grievance within 30 days.

The member or Amerigroup STAR+PLUS MMP can request up to 14 additional days to respond to a grievance with good reason. The 14-day extension does not apply to grievances related to Medicaid-only services (LTSS services, covered non-Part D drugs and behavioral health). A member can request an expedited grievance, in which case Amerigroup STAR+PLUS MMP has 24 hours to respond. An expedited grievance can be initiated if Amerigroup STAR+PLUS MMP refuses to grant the member an expedited organization/coverage determination or an expedited reconsideration/redetermination. An expedited grievance can also be requested if the member disagrees with our decision to extend the appeal processing time frame.

Amerigroup STAR+PLUS MMP will display on its main website page a link to the electronic grievance form located on Medicare.gov. Associates will also provide assistance in completing any forms, or other procedural steps, to support the member filing the grievance.

Members may also file a grievance with CMS by dialing 1-800 MEDICARE, completing the electronic Grievance form on Medicare.gov, emailing CMSgrievancecontact@CMS.Gov or by mailing the grievance to:

Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850
Resolving Member Grievances
If a member has a grievance about Amerigroup STAR+PLUS MMP, a provider or any other issue, providers should instruct the member to call Member Services at 1-855-817-5787 (TTY 711) during regular business hours or send a written grievance to:

Complaints, Appeals and Grievances Department
Amerigroup STAR+PLUS MMP
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, OH 45040
Fax: 1-888-458-1406

Billing Members/Cost Sharing
Providers may NOT collect any additional payment for cost-sharing obligations from Amerigroup STAR+PLUS MMP members other than those specified in a member’s plan Summary of Benefits. In the MMP program, member cost-sharing obligations are limited to patient-pay amounts authorized by HHSC for some members for certain nursing home services and copays for some prescription drugs covered under Medicare Part D.

Amerigroup STAR+PLUS MMP will process provider claims in accordance with the Amerigroup STAR+PLUS MMP benefit package. Unless specifically noted as one of the exceptions above, our payment is payment in full, and providers may not bill members for cost sharing.

Noncovered Services
Before rendering services, providers should always inform members of the cost of services not covered under Amerigroup STAR+PLUS MMP that will be charged to the member. A provider who chooses to provide services not covered under Amerigroup STAR+PLUS MMP:

- Understands Amerigroup STAR+PLUS MMP only reimburses for services that are medically necessary, including hospital admissions and other services.
- Understands he or she may not bill for or take recourse against a member for denied or reduced claims for services within the amount, duration and scope of Amerigroup STAR+PLUS MMP benefits.
- Obtains the member’s signature on the Client Acknowledgment Statement, which specifies the member will be held responsible for payment of services prior to rendering services; alternatively, the provider can follow the in-office denial process.

Client Acknowledgement Statement
A provider may bill an Amerigroup STAR+PLUS MMP 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:
IMPORTANT: Amerigroup STAR+PLUS MMP members must NOT be balance billed for the difference between the amount paid by Amerigroup STAR+PLUS MMP and the billed amount for covered services.

In addition, providers may not bill a member if any of the following occurs:
- Failure to submit a claim in a timely manner, including claims not received by Amerigroup STAR+PLUS MMP
- Failure to submit a claim to Amerigroup STAR+PLUS MMP for initial processing within the required filing deadline
- Failure to submit a corrected claim within the required filing resubmission period
- Failure to appeal a claim within the 60-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 appeal process

Self-Service Website and Provider Inquiry Line
The Amerigroup STAR+PLUS MMP self-service website at https://providers.amerigroup.com/TX provides a host of online resources, such as our Online Provider Inquiry Tool for real-time claim status, eligibility verification and precertification status. You can also submit a claim or precertification request, print referral forms or directories, or obtain a member roster. Detailed instructions for use of the Online Provider Inquiry Tool can be found on our website.

Toll-Free Automated Member Services and Provider Services
To support our providers and members, we have established MMP Customer Care to assist with questions and concerns about Amerigroup STAR+PLUS MMP. MMP Customer Care is comprised of coordinated care subject matter experts and specializes in first-call resolution for provider and member inquires.
Our MMP Customer Care representatives can help:
- Resolve payment questions, appeals and other claims issues.
- Verify claims status, member eligibility, preauthorization requirements and the status of health care services.
- Identify participating Amerigroup STAR+PLUS MMP providers for referring members to specialty services.
- Support noncompliant members (e.g., members who repeatedly miss appointments, members who are noncompliant with their treatment plans, etc.).

**MMP Customer Care**
Member Services: 1-855-817-5789 (TTY 711), 8 a.m.-8 p.m. local time
Provider Services: 1-855-878-1785, Monday-Friday, 8 a.m.-8 p.m. local time

Information is also available through the automated system, or you can be transferred to the appropriate department for other needs, such as seeking advice in service coordination or case management.
CHAPTER 16: MEMBER RIGHTS AND RESPONSIBILITIES

Overview
Providers are required to adhere to CMS, HHSC and Amerigroup STAR+PLUS MMP requirements concerning issuing letters and notices.

Amerigroup STAR+PLUS MMP members have the right to timely quality care and treatment with dignity and respect. Providers must respect the rights of all Amerigroup STAR+PLUS MMP members.

Members have the right to:
• Be treated with dignity and respect.
• Be afforded privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.
• Be provided a copy of his or her medical records, upon request, and to request corrections or amendments to these records.
• Not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or claim history, mental or physical disability, genetic information, or source of payment.
• Have all plan options, rules and benefits fully explained, including through use of a qualified interpreter if needed.
• Access to an adequate network of primary and specialty providers who are capable of meeting the his or her needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting.
• Choose a plan and provider at any time, including a plan outside of the demonstration, and have that choice be effective the first calendar day of the following month.
• Have a voice in the governance and operation of the integrated system, provider or health plan.
• Participate in all aspects of care and exercise all rights of appeal.
• Receive a Health Risk Assessment upon enrollment in a plan and to participate in the development and implementation of a Plan of Care. The assessment must include considerations of social, functional medical, behavioral, wellness and prevention domains, and evaluation of the member’s strengths and weaknesses, and a plan for managing and coordinating member’s care. Members, or their designated representatives, also have the right to request a reassessment by the service coordination team, and be fully involved in any such reassessment.
• Receive complete and accurate information on his or her health and functional status by the service coordination team.
• Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking into consideration the member’s condition and ability to understand. A participant who is unable to participate fully in treatment decisions has the right to designate a
representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:
- Before enrollment.
- At enrollment.
- At the time a participant’s needs necessitate the disclosure and delivery of such information in order to allow the participant to make an informed choice.

- Be encouraged to involve caregivers or family members in treatment discussions and decisions.
- Have advanced directives explained and to establish them, if the participant so desires.
- Receive reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer.
- Be afforded the opportunity to file an appeal if services are denied that he or she thinks are medically indicated, and to be able to ultimately take that appeal to an independent external system of review.
- Receive medical and non-medical care from a team that meets the member’s needs, in a manner that is sensitive to the member’s language and culture, and in appropriate care setting, including the home and community.
- Be free from any form or restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Be free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the health plan, providers or the State agency treat the member.
- Receive timely information about plan changes. This includes the right to request and obtain the information listed in the Orientation materials at least once per year, and the right to receive notices of any significant change in the information provided in the Orientation materials at least 30 days prior to the intended effective date of the change.
- Be protected from liability for payment of any fees that are the obligation of the health plan.
- Not to be charged any cost sharing for Medicare Part A and B services.

**Members have the responsibility to:**
- Be fully involved in maintaining his or her health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end.
- Provide to his or her health care provider accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters related to his or her health to the best of his or her knowledge.
- Report unexpected changes in his or her condition to the health care provider.
- Report to the health care provider whether he or she understands a suggested course of action and what is expected of him or her.
- Follow the treatment plan recommended by his or her health care provider.
- Keep appointments and, when unable to do so for any reason, notify the health care provider or health care facility.
- Be responsible for his or her actions if refusing treatment or not following the health care provider’s instructions.
- Ensure the financial obligations of his or her health care are fulfilled as promptly as possible.
• Follow health care facility rules and regulations affecting patient care and conduct.
• Notify Amerigroup STAR+PLUS MMP if they have questions, concerns, problems or suggestions.
CHAPTER 17: FRAUD AND ABUSE

General Obligations to Prevent, Detect and Deter Fraud, Waste and Abuse

As a recipient of funds from state and federally sponsored health care programs, Amerigroup STAR+PLUS MMP has a duty to help prevent, detect and deter fraud, waste and abuse. Amerigroup STAR+PLUS MMP is committed to detecting, mitigating and preventing fraud, waste and abuse as outlined in its Corporate Compliance Program. Electronic copies of this policy and the Code of Business Conduct and Ethics can be found on the website at https://providers.amerigroup.com/TX.

As part of the requirements of the federal Deficit Reduction Act, each provider is required to adopt Amerigroup STAR+PLUS MMP policies on detecting, preventing and mitigating fraud, waste and abuse in all the federally and state funded health care programs in which Amerigroup STAR+PLUS MMP participates. Provider must also distribute them to any staff members or contractors who work with Amerigroup STAR+PLUS MMP.

Amerigroup STAR+PLUS MMP maintains several ways to report suspected fraud, waste and abuse. As a participant in government-sponsored health care, you and your staff are obligated to report suspected fraud, waste and abuse. These reports can be made anonymously at https://providers.amerigroup.com/TX. In addition to anonymous reporting, suspected fraud, waste and abuse may also be reported by calling Provider Services at 1-855-878-1785.

If you have questions or would like more details concerning the Amerigroup STAR+PLUS MMP fraud, waste and abuse detection, prevention and mitigation program, please contact the Amerigroup STAR+PLUS MMP chief compliance officer.

Importance of Detecting, Deterring and Preventing Fraud, Waste and Abuse

Health care fraud costs taxpayers increasingly more money every year. State and federal laws are designed to crack down on these crimes and impose strict penalties. Fraud, waste 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. The following is education on how to help prevent member and provider fraud by identifying the different types as the first line of defense. Many types of fraud, waste and abuse have been identified:

Provider Fraud, Waste and Abuse
- Billing for services not rendered
- Billing for services that were not medically necessary
- Double billing
- Unbundling
- Upcoding
**Member Fraud, Waste and Abuse**
- Benefit sharing
- Collusion
- Drug trafficking
- Forgery
- Illicit drug seeking
- Impersonation fraud
- Misinformation/misrepresentation
- Subrogation/third-party liability fraud
- Transportation fraud

Providers can prevent fraud, waste and abuse by ensuring the services rendered are medically necessary, accurately documented in the medical records and billed according to American Medical Association guidelines.

To help prevent fraud, waste and abuse, providers can educate members about these types of fraud and the penalties levied. Also, spending time with patients 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 STAR+PLUS MMP member ID card. Amerigroup STAR+PLUS MMP may not accept responsibility for the costs incurred by providers rendering services to a patient who is **not** an Amerigroup STAR+PLUS MMP member even if that patient presents a member ID card. Providers should take measures to ensure the cardholder is the person named on the card.

Additionally, encourage members to protect their cards as they would a credit card or cash, carry their Amerigroup STAR+PLUS MMP member ID card at all times, and report any lost or stolen cards to Amerigroup STAR+PLUS MMP as soon as possible.

Amerigroup STAR+PLUS MMP believes awareness and action are vital to keeping the state and federal programs safe and effective. Understanding the various opportunities for fraud, waste and abuse and working with members to protect their Amerigroup STAR+PLUS MMP ID card can help prevent fraud, waste and abuse. Amerigroup STAR+PLUS MMP encourages its members and providers to report any suspected instance of fraud, waste and abuse using the contact methods referenced earlier. No individual who reports violations or suspected fraud, waste or abuse will be retaliated against, and Amerigroup STAR+PLUS MMP will make every effort to maintain anonymity and confidentiality.

**Health Insurance Portability and Accountability Act**
The Health Insurance Portability and Accountability Act (HIPAA, also known as the Kennedy-Kassebaum Bill) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud, and simplifies the administration of health insurance.

We strive to ensure both Amerigroup STAR+PLUS MMP and contracted participating providers conduct business in a manner that safeguards patient/member information in accordance with
the privacy regulations enacted pursuant to HIPAA. Providers must have the following procedures in effect to demonstrate compliance with the HIPAA privacy regulations.

Amerigroup STAR+PLUS MMP recognizes its responsibility under HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting Amerigroup STAR+PLUS MMP. However, please note the privacy regulations allow the transfer or sharing of member information, which may be requested by Amerigroup STAR+PLUS MMP to conduct business and make decisions about care such as a member’s medical record, to make an authorization determination, or resolve a payment appeal. Such requests are considered part of the HIPAA definition of treatment, payment or health care operations.

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

Internet email (unless encrypted) should not be used to transfer files containing member information to Amerigroup STAR+PLUS MMP (e.g., Excel spreadsheets with claim information). Such information should be mailed or faxed.

Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific individual, P.O. Box or department at Amerigroup STAR+PLUS MMP.

The Amerigroup STAR+PLUS MMP voicemail system is secure and password-protected. When leaving messages for Amerigroup STAR+PLUS MMP associates, providers should only leave the minimum amount of member information required to accomplish the intended purpose. When contacting Amerigroup STAR+PLUS MMP, providers should be prepared to verify their name, address and Tax Identification Number or National Provider Identifier.
CHAPTER 18: Glossary of Terms

AAPSF: Accreditation Association for Podiatric Surgical Facilities

AAAHC: Accreditation Association for Ambulatory Health Care

AAAASF: American Association for Accreditation of Ambulatory Surgery Facilities

ABMS: American Board of Medical Specialties

ABCN: American Board of Clinical Neuropsychology

ABPN: American Board of Professional Neuropsychology

ACHC: Accreditation Commission for Health Care

AOA: American Osteopathic Association

APA: American Psychological Association

Appeal: Appeals are any of the procedures that deal with the review of adverse organization or coverage determinations on the health care services or prescription drug benefits a member is entitled to receive or any amounts the member must pay for a covered service. These procedures include reconsiderations by Amerigroup STAR+PLUS MMP, the Part D Quality Improvement Council, hearings before an administrative law judge, reviews by the Medical Appeals Council and federal judicial reviews. This process is separate from the provider administrative appeals/payment appeal process.

Attestation: A signed statement indicating that a practitioner or HDO designee personally confirmed the validity, correctness and completeness of his, her or its credentialing application at the time that he, she or it applied for participation.

CACREP: Council for Accreditation of Counseling and Related Educational Programs

CARF: Commission on Accreditation of Rehabilitation Facilities

CASWE: Canadian Association for Social Work Education

Certification: Board Certification as recognized by the American Board of Medical Specialties, the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, the American Board of Orthopedic and Primary Podiatric Medicine, the American Board of Podiatric Surgery or the American Board of Oral and Maxillofacial Surgery
**CHAMPUS**: The Civilian Health and Medical Program of the Uniformed Services (in the United States). CHAMPUS is a federally funded health program that provides beneficiaries with medical care supplemental to that available in military and Public Health Service (PHS) facilities.

**CHAP**: Community Health Accreditation Program

**CHEA**: Council for Higher Education Accreditation, an agency recognized by the Company which publishes a reference used to verify the status of educational programs

**CMS**: Centers for Medicare & Medicaid Services; the federal agency under the Department of Health and Human Services responsible for administering the Medicare and Medicaid programs

**COAMFTE**: Committee on Accreditation for Marriage and Family Therapy Education

**Company Credentials Committee (CC)**: A local credentialing and peer review body authorized to make decisions regarding the credentials of all practitioners and HDOs initially applying for and those requesting continued participation in the Amerigroup STAR+PLUS MMP network

**Company Medical Directors**: Those medical directors with responsibility for medical operations and quality management activities

**Covered services**: Those benefits, services or supplies that are:
- Provided or furnished by providers or authorized by Amerigroup STAR+PLUS MMP or its providers.
- Emergency services and urgently needed services that may be provided by nonproviders.
- Renal dialysis services provided while members are temporarily outside the service area.
- Basic and supplemental benefits.

**Credentialing staff**: Any associate in the Credentialing department

**CSWE**: Council on Social Work Education

**Elderly or Disabled with Consumer Direction (EDCD) Waiver**: The CMS-approved 1.27.§1915(c) waiver that covers a range of community support services offered to members who are elderly or who have a disability who would otherwise require a nursing facility (NF) level of care.

**Emergency medical condition**: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) 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; and/or 3) serious dysfunction of any bodily organ or part; or 4) with respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe
transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.

**Emergency services:** Covered Inpatient and outpatient services that are furnished by a provider qualified to furnish such services and that are needed to evaluate or stabilize a member’s emergency medical condition.

**Experimental procedures and items:** Procedures and items determined by Amerigroup STAR+PLUS MMP and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, Amerigroup STAR+PLUS MMP will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable or CMS guidance already made by Medicare and Medicaid.

**Exceptions:** An exception request is a type of coverage determination request. Through the exception process, the member can request an off-formulary drug, an exception to the Amerigroup STAR+PLUS MMP tiered cost-sharing structure or an exception to the application of a cost utilization management tool (e.g., step therapy requirement, dose restriction or precertification requirement).

**Fee-for-service Medicare:** A payment system by which doctors, hospitals and other providers are reimbursed on a fee-for-service basis

**Formal appeal:** The process by which an Amerigroup STAR+PLUS MMP adverse credentialing decision is challenged.

**Grievance:** A complaint or dispute other than one involving an organization determination. Examples of issues involving a complaint that is resolved through the grievance rather than the appeal process are waiting times in physician offices and rudeness or unresponsiveness of customer service staff.

**Healthcare Integrity and Protection Data Bank (HIPDB):** The national databank maintained by the U.S. Department of Health and Human Services or its designated contractor, created pursuant to the Health Insurance Portability and Accountability Act (HIPAA) to combat fraud and abuse in the health insurance and health care delivery system

**Health Delivery Organization (HDO):** A facility, institution or entity that is licensed in accordance with all applicable state and/or federal laws and provides or delivers health care services

**HFAP:** Healthcare Facilities Accreditation Program (a program of the American Osteopathic Association formerly referred to as AOACHA - American Osteopathic Association Committee on Hospital Accreditation)

**Home health agency:** A Medicare-certified home health agency is one that provides intermittent skilled nursing care and other therapeutic services in a member’s home when
medically necessary, when members are confined to their home and when authorized by their primary care physician.

**Hospice:** A Medicare-certified organization or agency primarily engaged in providing pain relief, symptom management and support services to terminally ill people and their families.

**Hospital:** A Medicare-certified institution licensed by the state that provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term hospital does not include a convalescent nursing home, rest facility or facility for the aged that furnishes primarily custodial care, including training in routines of daily living.

**Immediate termination:** A termination of network participation, which is effective immediately. It occurs prior to review by the committee and prior to the provider/HDO being allowed an appeal. It is used when determined necessary by Amerigroup STAR+PLUS MMP to protect against imminent danger to the health or welfare of its members.

**IMQ:** Institute for Medical Quality

**Independent practice association:** A group of physicians that function as a contracting medical provider/group but in which the individual member physicians operate their respective independent medical offices.

**Informal review/reconsideration:** A process through which a practitioner or HDO is given the opportunity to submit additional information to Amerigroup STAR+PLUS MMP for its consideration. Reviewer(s) may be the same person(s) who were part of the original decision. As part of the informal review/reconsideration, Amerigroup STAR+PLUS MMP at its discretion may afford additional privileges to the practitioner or HDO, such as by way of example only, an opportunity to discuss the decision with an Amerigroup STAR+PLUS MMP representative telephonically. In any event, an informal review/reconsideration shall not include privileges equal to or greater than those offered in a formal appeal.

**Initial applicant:** Any person or organization that provides health care services that has applied for participation with Amerigroup STAR+PLUS MMP to provide health care services to Amerigroup STAR+PLUS MMP members.

**Medicaid:** The federal health insurance program established by Title XIX of the Social Security Act and administered by states for low-income individuals.

**Medically necessary:** Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member or otherwise medically necessary under 42 U.S.C. 1395y.

We make determinations of medical necessity based on peer-reviewed medical literature, publications, reports and evaluations; regulations and other types of policies issued by federal
government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by Amerigroup STAR+PLUS MMP.

**Medicare:** The federal health insurance program established by Title XVIII of the Social Security Act and administered by the federal government for elderly and disabled individuals.

**Member:** A Medicare and Medicaid beneficiary entitled to receive covered services who is enrolled in the Amerigroup STAR+PLUS MMP plan and whose enrollment has been confirmed by CMS.

**National Credentials Committee:** A committee composed of Amerigroup STAR+PLUS MMP medical directors, medical director of medical policy and credentialing and chaired by the VP medical policy, technology assessment and credentialing. It is responsible for the development and maintenance of a consistent national credentialing policy. This committee shall establish policy governing all aspects of credentialing of network practitioners and HDOs, including but not limited to scope, criteria, confidentiality, delegation and appeals.

**National Credentialing Policy:** Policy defined by the National Credentials Committee and set forth in this document

**NIAHO:** National Integrated Accreditation for Healthcare Organizations

**National Practitioner Data Bank (NPDB):** A federal data bank maintained by the U.S. Department of Health & Human Services or its authorized contractor that houses information regarding providers and any state or federal sanctions, closed malpractice cases where findings are for the plaintiff, settlements and hospital privilege actions.

**National Register of Health Service Providers in Psychology (a.k.a. The Register):** An organization providing primary source verification for education and training and board certification of psychologists. This entity has a deemed status from the NCQA.

**Participating provider:** Any person or organization, including practitioners and facilities, that provides health care services and has entered into an agreement with Amerigroup STAR+PLUS MMP to provide health care services to Amerigroup STAR+PLUS MMP members

**Patient pay:** When a member’s income exceeds an allowable amount, he or she must contribute toward the cost of their LTC services. This contribution, known as the patient pay or applied income amount, is required for members residing in an NF and for those receiving services. Patient pay is required to be calculated for every member receiving NF or waiver services, although not every eligible member will end up having to pay each month.

**Peer review:** Evaluation or review of the professional competency and conduct of colleagues by professionals with similar types and degrees of expertise (e.g., the evaluation of one physician’s practice by another physician)
Practitioner: An individual person who is licensed in accordance with all applicable state and federal laws to deliver health care services

Primary care providers and/or primary care physicians (PCPs): Physicians who elect and are selected as PCPs and who practice in the following specialties: pediatrics, internal medicine, family practice, geriatricians, general practice

Professional review action: A decision to terminate or reject a provider from network participation that is based on the competence or professional conduct of a provider, which affects or could adversely affect the health or welfare of a patient.

Provider: Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the state and/or Medicare to deliver or furnish health care services. This individual or organization has a contract directly or indirectly with Amerigroup STAR+PLUS MMP to provide services directly or indirectly to MMP members pursuant to the terms of the participating Provider Agreement.

Provider payment dispute: A request for Amerigroup STAR+PLUS MMP to review the claim adjudication as the provider feels payment was not rendered as per the contractual agreement between Amerigroup STAR+PLUS MMP and the provider.

Service area: A geographic area approved by CMS and HHSC within which an eligible individual may enroll in a Medicare-Medicaid Plan. Amerigroup STAR+PLUS MMP geographic areas are located in the Summary of Benefits document.

Specialty: Those fields of clinical practice recognized by the Amerigroup STAR+PLUS MMP Credentialing program

TJC: The Joint Commission

Urgently needed services: Those covered services provided when the member is temporarily absent from the MMP service area or under unusual and extraordinary circumstances, services provided when the member is in the service area but the member’s PCP is temporarily unavailable or inaccessible, when such services are medically necessary and immediately required as a result of an unforeseen illness, injury or condition; and it is not reasonable given the circumstances to obtain the services through the PCP
Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees.

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