Provider Quick Reference Card

Apple Health

https://providers.amerigroup.com/WA

WAPEC-1819-19
Easy access to prior authorization/notification requirements and other important information

For more information about requirements, benefits and services, visit our provider website to get the most recent version of our provider manual. If you have questions about this document or recommendations to improve it, call your local Network Relations consultant. We want to hear from you and improve our service so you can focus on serving your patients!

Prior authorization/notification instructions and definitions

Request inpatient and outpatient prior authorization and inpatient admission notifications:

Phone: 1-800-454-3730; Fax: 1-800-964-3627

Outpatient rehabilitation services (physical/occupational/speech therapy), bariatrics, podiatry and orthotics/prosthetics: Phone: 1-855-323-4688; Fax: 1-855-213-3627

Home health, home infusion and durable medical equipment: Phone: 1-855-323-4688; Fax: 1-884-528-3681

For members assigned to Highline Medical Services Organization (HMSO): Phone: 206-878-1385, option 3; Fax: 206-878-1857


Outpatient fax requests: 1-844-877-6357

Inpatient fax requests: 1-877-443-7578

Mental health

Prior authorization is not required for network providers requesting most outpatient behavioral health (BH) services. Call Provider Services at 1-800-454-3730 and say mental health at the first voice prompt for clinical assistance if mental health and/or developmental needs are suspected or identified. You may contact the local mental health provider directly. A referral from the PCP is not necessary.

Prior authorization is required for most inpatient admissions, partial hospitalization programs, applied behavioral analysis, electroconvulsive therapy, transcranial magnetic stimulation, and psychological and neuropsychological testing.

Out-of-network services are required to request prior authorization for all services.

To assist prescribers in meeting the needs of children with a mental health diagnosis, HCA provides access to consultation with a child psychiatrist through the Partnership Access Line (PAL) at 1-866-599-7257.

Substance use disorders

Prior authorization is not required for network providers requesting nonacute outpatient and intensive outpatient substance use disorder (SUD) services. You can call Provider Services at 1-866-599-7257 for clinical assistance if substance use disorders are suspected or identified. You may also contact any SUD provider directly. A referral from a PCP is not necessary.

Prior authorization is required for planned inpatient detox and residential treatment admissions as well as for partial hospitalization programs. Out-of-network providers are required to request prior authorization for all services.

Screening, brief intervention and referral for treatment (SBIRT) services, substance abuse services are covered when the provider is a certified SBIRT provider as reported by the Health Care Authority.

Medication-assisted therapy (MAT)

Amerigroup Washington, Inc. follows the Health Care Authority’s clinical prior authorization criteria for medication treatment for substance use disorders (SUDs), which is located on the Health Care Authority’s website.

Questions related to the MAT prior authorization process may be directed to Provider Services at 1-800-454-3730. Requests for MAT medications may be submitted online at wwwCOVERMyMed.com or via phone or fax. Urine drug screens related to MAT and quantity limits on MAT therapy are subject to Washington State HCA limitations.

Hospital admissions

The following contact information should be used in the event of a hospital admission:

Identification of contact: by fax: 1-855-323-4689

Individual notification of admission by phone: 1-800-454-3730

Individual notification of admission by fax: 1-800-964-3627

Admission and continued stay clinical fax: 1-855-225-9940

Discharge notification fax: 1-855-225-9940

For members assigned to HMSO:

By phone: 206-878-1385, option 4

By fax: 206-878-1539

Prior authorization:
The act of authorizing specific services or activities before they are rendered or occur.

Notification: Telephonic or electronic communication from a provider to inform Amerigroup of the intent to render covered medical services to a member.

Notify us prior to rendering services requiring prior authorization, as outlined in this document.

For emergency or urgent services, notify us within 24 hours or by the next business day if it results in an admission.

Referring providers, PCPs, specialists or those rendering the service may make the notification.

Primary care providers: Though we encourage members to see their assigned PCP, PCPs do not need to be the member’s assigned PCP to be paid for rendering primary care services.

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

Network providers: Requirements are listed below.

Out-of-network providers: Out of network providers are required to request prior authorization for all services.

Acupuncture

Amerigroup pays for three visits per member, per calendar year. Use the following CPT codes: 97810, 97811, 97813 and 97814. This is a value-added benefit paid only to participating providers. Requests for more than three visits may not be approved and may not be considered under the limitation extension process.

Cardiac rehabilitation

Prior authorization is required for all services. Prior authorization is not a guarantee of payment. Per HCA, services are only payable if billed with one of the following diagnosis codes: acute myocardial infarction, angioplasty, aortocoronary bypass status or percutaneous transluminal coronary angioplasty status as your primary diagnosis code.

Chemotherapy

Prior authorization is not required for procedures related to chemotherapy performed in the following outpatient settings:

- Offices
- Outpatient hospital
- Ambulatory surgery centers

Many chemotherapy agents do require prior authorization. Prior authorization for oncology medications is managed by AIM Specialty Health® (AIM). Providers can request authorization for oncology regimens any time of day via the link to AIM in dawdly, www.providerportal.com. Alternatively, providers may contact AIM directly at 1-800-714-0040 during normal business hours to begin the prior authorization process. Prior authorization is required for inpatient chemotherapy as part of inpatient admission.

Limitations and exclusions apply for experimental and investigational treatments.

Circumcision

Prior authorization is not required for CPT codes 54150, 54160 and 54161. Amerigroup pays providers up to $150 for this service.

Dermatology

Prior authorization is not required for evaluation and management (E&M), testing, and certain procedures. Prior authorization is not required.

Dialysis

Prior authorization is required for all dialysis services.

Durable medical equipment (DME)

Providers may use the Amerigroup Prior Authorization Request form. Attach a complete prescription for the services and any clinical support documentation. Amerigroup must agree on the HCPCS values and/or other codes for billing.

Ear, nose and throat services (otolaryngology)

Prior authorization is not required for E&M, testing, and certain procedures. Prior authorization is required for:

- Tonsillectomies.
- Nasal/sinus surgeries.
- Cochlear implant surgeries and services.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visits

Prior authorization is not required.

Vaccine serum must be received under the Vaccines for Children program (VFC).

Members may self-refer for services.

Use the EPSDT schedule and document all screenings and visits.

Note: Amerigroup encourages annual EPSDT visits for members ages birth-20 years per the nationally recognized pediatric periodicity schedule. Amerigroup will pay for both a sick visit and an EPSDT visit performed on the same day. To receive payment, be sure to include modifier 25 on claims.

Educational consultation

Prior authorization is not required.

Emergency room (ER)

Prior authorization is not required.

For inpatient services to be covered beyond ER, notification is required within 24 hours or by the next business day when a member is admitted to the hospital through the ER.

Family planning/sexually transmitted disease (STD) care

Prior authorization is not required.

Providers should encourage members to obtain family planning services from network providers to ensure continuity of services.

Members may self-refer to any network or out-of-network provider.

Flu shots

Child and adult members may receive the flu immunization in a provider office. Children and adults with Amerigroup pharmacy benefits may get a free flu immunization at participating pharmacies.

Gastroenterology services

Prior authorization is not required for E&M, testing, and certain procedures.

Use the EPSDT schedule and document all screenings and visits.

Note: Amerigroup encourages annual EPSDT visits for members ages birth-20 years per the nationally recognized pediatric periodicity schedule. Amerigroup will pay for both a sick visit and an EPSDT visit performed on the same day. To receive payment, be sure to include modifier 25 on claims.
Prior authorization is required for:
- Bariatric surgeries.
- Insertion, removal and/or replacement of adjustable gastric restrictive device and subcutaneous port components.
- Upper endoscopy.

Gynecology
Prior authorization is not required for E&M, testing, and certain procedures.

Habitual services
Services are limited to members in the Medicaid Expansion population who are eligible for the Alternative Benefit Plan (ABP) and are subject to limitation extensions in accordance with medical necessity.

Prior authorization is required for adults only. Covered services include the following:

Children (age 20 and under):
- Hearing aids
- Monaural and binaural hearing aids, including fitting, follow-up care, batteries and repair
- Bone-anchored hearing aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts and batteries
- No limit on the number of batteries or repairs

Adults:
- Hearing aids, implants and related services are not covered by Amerigroup.

Hearing aids and cochlear implants
Prior authorization is required. The covered benefit is as follows:

Children (age 20 and under):
- Hearing aids
- Monaural and binaural hearing aids, including fitting, follow-up care, batteries and repair
- Bone-anchored hearing aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts and batteries
- No limit on the number of batteries or repairs

Adults:
- Hearing aids, implants and related services are not covered by Amerigroup.

Hearing screening
Prior authorization is required for digital hearing aids.

Prior authorization is not required for:
- Diagnostic and screening tests.
- Hearing aid evaluations.
- Counseling services.

Home health care
Prior authorization is required.

Drugs and DME require separate prior authorization.

Covered services include:
- Skilled nursing.
- Home health aides.
- Physical, occupational and speech therapy services.
- Physician-supplied services.

Hospital admissions
Prior authorization is required for:
- Elective admissions.
- Some same-day/ambulatory surgeries.

Hospitals must notify Amerigroup within 24 hours or by the next business day of all member admissions, including those through the ER. Notification by faxing daily census is acceptable. See https://providers.amerigroup.com/WA for required data elements. Actual emergency services will not be denied solely for the lack of notification.

Pre-admission testing must be performed by Amerigroup-preferred lab vendors or network facility outpatient departments. See our online provider directory for a complete list of locations.

Amerigroup does not cover:
- Personal comfort and convenience items.
- Services and supplies not directly related to patient care (e.g., telephone charges, take-home supplies, etc.)

Laboratory services (outpatient)
All laboratory tests must be submitted to LabCorp, PCLLAB, PAML, Quest Diagnostics or TriCities Laboratory, the preferred lab vendors for our members, or to other network laboratories.

Prior authorization is required for diagnostic testing and all laboratory services furnished by non-network providers, except hospital laboratory services occurring in events of emergency medical conditions.

For more information or to receive a specimen drop box, testing solutions and services, or set up an account, contact one of the following:
- LabCorp: 1-800-345-4363
- PCLLAB/PAML/TriCities Lab: 1-800-541-7891
- Quest Diagnostics: 1-866-MY-QUEST (1-866-697-8378)

Medical supplies
Prior authorization is required for disposable medical supplies.

Medical injectables
The following are examples of drugs that require prior authorization. This is not a complete list, but it represents the most commonly prescribed injectables: Synagis®, erythropoiesis-stimulating agents (ESA) such as Epogen®, Procrit® and Aranesp®; Makena®; colony-stimulating factors (CSF) such as Neupogen® and Neulasta®; intravenous formulations (IVIG); growth hormones; interferons; biologic response modifiers such as Remicade®; hyaluronic acid derivatives such as Synvisc® and Orthovisc®. For a complete list, visit our provider website.

Neurology
Prior authorization is not required for E&M, testing, and certain procedures including electromyography testing.

Prior authorization is required for:
- Neurosurgery.
- Spinal fusion.
- Artificial intervertebral disc surgery.

Observation
Prior authorization is not required for in-network observation.

If an observation results in admission, hospitals must notify Amerigroup within 24 hours or one business day of conversion to inpatient.

Obstetrical (OB) care
Prior authorization is not required for:
- OB services.
- Certain diagnostic tests and lab services by participating providers.
- Labor and deliveries for newborns.

Ultrasounds — Two routine (CPT codes 76801, 76805) ultrasounds are allowed per pregnancy without authorization. Diagnosis codes on claims must reflect medical necessity for all additional nonroutine ultrasound services. See https://providers.amerigroup.com/WA for codes deemed medically necessary.

OB practitioners must notify Amerigroup after the first prenatal visit.

Hospitals and midwives must notify Amerigroup within 24 hours of delivery with newborn information (include baby’s weight, gestational age at admission at birth). We request notification but will not deny claims payment based solely on lack of notification for OB care (at first visit) and OB admissions exceeding 48 hours after vaginal delivery and 96 hours after cesarean section delivery. Review of newborn stay beyond the mother’s inpatient stay does require notification and admission/concurrent reviews to ensure payment.

Services for early, elective inductions (before 39 weeks) that do not meet medically necessary indicators will not be paid.

OB case management programs are available. Refer members by calling Care Management Services.

Ophthalmology
Prior authorization is not required for E&M, testing, and certain procedures.

Prior authorization is required for repair of eyelid defects.

Amerigroup does not cover services considered to be cosmetic in nature.

For all eye care services, call eyeQuest at 1-855-230-4656 or go to www.eyequest.com. Providers must be contracted directly with eyeQuest to render services.

Oral maxillofacial
See plastic/cosmetic/reconstructive surgery.

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Oral maxillofacial
See plastic/cosmetic/reconstructive surgery.
Amerigroup encourages annual EPSDT visits for members and older.

We approve up to one evaluation and six occupational/physical/respiratory therapy visits when authorization is requested without clinical evaluation. Evaluation, an additional six visits may be approved for adults. Up to six visits of speech therapy may be approved with or without evaluation.

Amerigroup provides additional resource information and local tobacco cessation program promotion via collaborative partnerships. For more information regarding tobacco cessation partnership opportunities and resources, please call Amerigroup Provider Services at 1-800-454-3730, Monday–Friday from 8 a.m.–5 p.m. Pacific time.

To receive payment, use CPT code 99212 with DX 202.5 and include the modifier 25.

**Sterilization**

Prior authorization is not required for:
- Sterilizations.
- Tubal ligations.
- Vasectomies.

However, Amerigroup requires complete state-approved sterilization consent forms signed by members 30 days in advance of the procedure with claim submissions. Amerigroup does not cover reversals of sterilizations.

**Urgent care centers**

Prior authorization is not required for participating facilities.

**Well-woman exams**

Prior authorization is not required. Amerigroup covers one well-woman exam per member per year when performed by a PCP or network women’s health care provider. Exams include:
- Examinations.
- Routine lab work.
- Sexually transmitted infections (STI) screenings, including human papillomavirus (HPV).
- Mammograms for members 50 years of age or older.
- Pap smears for members 21–65 years of age, excluding women with a history of prior abnormal results, precancerous cervical lesions, cervical cancer or those who are immunocompromised:
  - Pap smears for members under 21 years of age with average risk are not covered.
  - Pap smears for members over 65 years of age with prior history of negative screenings are not covered.
- Routine screening for ages 21–65 are covered no more frequently than every three years.

Members may receive family planning services without prior authorization from any qualified provider. Amerigroup encourages members to receive family planning services in-network to ensure continuity of service.

**Revenue (RV) codes**

Prior authorization is required for services billed with RV codes for:
- Inpatient care.
- Home health care.
- Hospice care.
- CT, MRI and PET scans and nuclear cardiology.
- Chemotherapeutic agents.
- Pain management.
- Rehabilitation (physical/occupational/respiratory therapy).
- Short-term rehabilitation (speech therapy).
- Specialty pharmacy agents.

For a complete list of specific RV codes, visit our website.
Important contact information (continued)

- **Provider Services program**
  The Amerigroup Provider Services call center offers prior authorization, automated member eligibility, case and disease management, claims assistance such as simple adjustments, health education materials, outreach services, and more. Call 1-800-454-3730, Monday-Friday from 8 a.m.-5 p.m. Pacific time.

  **The provider website and interactive voice response (IVR) are available 24 hours a day, 7 days a week, 365 days a year:** To verify eligibility and check claims and referral authorization status, visit https://www.availity.com and choose Amerigroup. To look up prior authorization/notification requirements and find many other provider reference tools, go to https://providers.amerigroup.com/WA.

  Can’t access the internet? Call Provider Services at 1-800-454-3730 and follow the voice prompts. The recording guides callers through our menu of options. Select the information or materials you need when you hear it. A live representative is always available during regular hours, which are 8 a.m.-5 p.m. Pacific time.

- **Claims services**
  Claims for covered services must be received within the timelines stated in your provider contract.

  The HCA Medicaid Provider guides, found at https://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides, provide guidelines for claim submission and payment. Amerigroup generally follows these guidelines.

  **Electronic data interchange (EDI)**
  Call our EDI hotline at 1-800-590-5745 to get started. We accept claims through Availity (payer 26375) as our preferred clearinghouse for EDI transactions. Contact Availity at 1-877-334-8446.

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

  Claims, Amerigroup Washington, Inc.
  P.O. Box 61010, Virginia Beach, VA 23466-1010

  **For members assigned to Highline Medical Services (HMSO):**
  Highline Medical Services Organization
  P.O. Box 48319, Burien, WA 98148
  HMSO Payer ID: 91164

- **Payment disputes**
  Claims payment disputes, where the provider believes the claim was incorrectly adjudicated, must be filed within 24 months of the adjudication date on your *Explanation of Payment*. Forms for provider appeals are available on our website. Providers can submit claim payment disputes through the Availity Portal or by mail to:

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

- **Medical necessity appeals**
  Medical necessity appeals or medical administrative reviews can be initiated by a member or a provider on behalf of a member with the member’s written consent. These must be submitted within 60 calendar days from the date on the *Notice of Action*, which is defined by a denial of service.

  A provider may submit an appeal on behalf of a member. Please include the member’s written consent so we may proceed with the request. We cannot process a request without the member’s written consent. Submit appeals to:

  **Appeals Department**
  Amerigroup Washington, Inc.
  705 5th Ave., Suite 300
  Seattle, WA 98104
  Fax: 1-844-759-5953

- **Health services**
  **Care Management services • 1-800-454-3730**
  We offer care management services to members who are likely to have extensive health care needs. Our nurse care managers work with providers to develop individualized care plans, including identifying community resources, providing health education, monitoring compliance, assisting with transportation, etc.

  **Disease Management Centralized Care Unit (DMCCU) services • 1-888-830-4300**
  DMCCU services include educational information like local community support agencies and events in the Amerigroup service area. Services are available for members with the following medical conditions: asthma, bipolar disorder, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, diabetes, HIV/AIDS, hypertension, obesity, major depressive disorder, schizophrenia and transplants.

  **24-hour Nurse HelpLine • 1-866-864-2544**
  Members can call our 24-hour Nurse HelpLine for health advice 7 days a week, 365 days a year. When a member uses this service, a report is faxed to his or her assigned PCP’s office within 24 hours of receipt of the call.

  **Member Services • 1-800-600-4441**
  **Primary care provider changes:**
  The fastest way to make PCP assignment changes for members is by calling our National Call Center (NCC) at 1-800-600-4441.

  *Call done by member* — The member needs to know the full name or NPI of the PCP to whom they want to transfer.

  *Call done by provider* — The provider may call the NCC to help make the change, but the member needs to be present during the call. The NCC will ask to speak to the member to verify the change.

  Calling the NCC ensures the member is moved to the correct provider/location within 24-72 hours of the call. All family members will be moved as requested, and the member will receive confirmation the change has been completed.