Amerigroup

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Provider Manual

Maryland HealthChoice Program

1-800-454-3730

https://provider.amerigroup.com/MD

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This manual is a Maryland Department of Health template and is not wholly inclusive of all Amerigroup policies and procedures. For more information on Amerigroup policies and procedures, visit the provider self-service website at https://provider.amerigroup.com/MD or contact your Provider Relations representative.

HealthChoice Provider Manual
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SECTION I. INTRODUCTION

Medicaid and the HealthChoice Program

Medicaid and HealthChoice

HealthChoice is the name of Maryland Medicaid's managed care program. There are approximately 1.3 million Marylanders enrolled in Medicaid and the Maryland Children's Health Program (MCHP). With few exceptions, Medicaid beneficiaries under age 65 must enroll in HealthChoice. Individuals that do not select a managed care organization (MCO) will be auto-assigned to an MCO with available capacity that accepts new enrollees in the county where the beneficiary lives. Individuals may apply for Medicaid, renew their eligibility and select their MCO online at www.marylandhealthconnection.gov or by calling 1-855-642-8572 (TTY: 1-855-642-8572). Members are encouraged to select an MCO that their PCP participates with. If they do not have a PCP, they can choose one at the time of enrollment. MCO members who are initially auto-assigned can change MCOs within 90 days of enrollment. Members have the right to change MCOs once every 12 months. The HealthChoice program's goal is to provide patient-focused, accessible, cost-effective, high quality health care**.** The state assesses the quality of services provided by MCOs through various processes and data reports. To learn more about the state's quality initiatives and oversight of the HealthChoice Program, go to: https://mmcp.health.maryland.gov/healthchoice/Pages/Home.aspx.

Providers who wish to serve individuals enrolled in Medicaid MCOs are now required to register with Medicaid. Amerigroup Community Care also encourages providers to actively participate in the Medicaid fee-for service (FFS) program. Beneficiaries will have periods of Medicaid eligibility when they are not active in an MCO. These periods occur after initial eligibility determinations and temporarily lapses in Medicaid coverage. While MCO providers are not required to accept FFS Medicaid, it is important for continuity of care. For more information, go to: https://eprep.health.maryland.gov/sso/login.do. All providers must verify Medicaid and MCO eligibility through the Eligibility Verification System (EVS) before rendering services.

We do not prohibit or otherwise restrict a provider, acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient.

HealthChoice Eligibility

All individuals qualifying for Maryland Medicaid or MCHP are enrolled in the HealthChoice program, with the exception of the following:

- Individuals enrolled in a Medicare Advantage program
- Individuals age 65 or older
- Individuals who are eligible for Medicaid under spend-down provisions
- Medicaid participants who have been or are expected to be continuously institutionalized for more than 30 successive days in a long-term care facility or in an institution for mental disease (IMD)
- Individuals institutionalized in an intermediate care facility for persons with intellectual disabilities/mentally retarded persons (ICF-MR)
- Participants enrolled in the Model Waiver Program
- Participants who receive limited coverage, such as individuals who receive family planning services through the Family Planning Waiver or Employed Individuals with Disabilities Program
- Inmates of public institutions, including state-operated institutions or facilities
- A child receiving an adoption subsidy who is covered under the parents' private insurance
- A child under state supervision who receives an adoption subsidy and lives outside of the state
- A child who is in an out-of-state placement

All Medicaid participants who are eligible for the HealthChoice program, without exception, are enrolled in an MCO or in the Rare and Expensive Case Management (REM) program. See the Rare and Expensive Case Management Program section and Attachment 1 for more information.
Medicaid-eligible individuals who are not eligible for HealthChoice will continue to receive services in the Medicaid Fee-For-Service (FFS) system.

Members must complete an updated eligibility application every year to maintain their coverage through the HealthChoice program.

HealthChoice members are permitted to change MCOs if they have been in the same MCO for 12 months or more.

HealthChoice providers are prohibited from steering members to a specific MCO. Providers are only allowed to provide information on which MCOs they participate with if a current or potential member seeks their advice about selecting an MCO.

Introduction to Amerigroup

HealthChoice, which is overseen by the Maryland Department of Health (MDH), serves most Medicaid participants. These individuals are enrolled in one of the participating managed care organizations (MCOs). Amerigroup Maryland, Inc., doing business as Amerigroup Community Care, is a wholly owned subsidiary of Amerigroup Corporation. Amerigroup Corporation is a wholly owned subsidiary of Anthem, Inc. and is an MCO that participates in the HealthChoice program.

The purpose of this provider manual is to highlight and explain the program's elements and to serve as a useful reference for providers who participate in the HealthChoice program.

Member Rights and Responsibilities

Members have rights and responsibilities when participating in an MCO. Member Services representatives serve as advocates for Amerigroup members.

Members have the right to:

- Be treated respectfully and with due consideration for dignity and privacy.
- Privacy during a visit with their doctor.
- Talk about their medical record with their PCP, ask for a summary of that record and request to amend or correct the record as appropriate.
- Be properly educated about and helped to understand their illness and available health care options, including a candid discussion of appropriate clinically or medically necessary treatment options, including medication treatment options regardless of the cost or benefit coverage.
- Participate in decision-making about the health care services they receive.
- Refuse health care (to the extent of the law) and understand the consequences of their refusal.
- Be free from any form of restraint, seclusion as a means of coercion, discipline, inconvenience or retaliation as specified in other federal regulations on the use of restraints and seclusion.
- Decide ahead of time regarding the kinds of care they want if they become sick, injured or seriously ill by making a living will.
- Expect their records (including medical and personal information) and communications will be treated confidentially.

- If under age 18 and married, pregnant or have a child, be able to make decisions about his or her own health care and/or his or her child's health care.
- Choose their PCP from the Amerigroup network of providers.
- Make a complaint to Amerigroup and get a response within 30 days.
- Have information about Amerigroup, its services, practitioners, and provider and member rights and responsibilities.
- Receive information on the Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA).
- Get a current member handbook and a directory of health care providers within the Amerigroup network.
- Choose any Amerigroup network specialist.
- Change their doctor to another Amerigroup network doctor if the doctor is unable to refer them to the Amerigroup network specialist of their choice.
- Be connected to health care providers for ongoing treatment of chronic disabilities.
- Have access to their PCP or a backup 24 hours a day, 365 days a year for urgent or emergency care.
- Receive care right away from any hospital when their medical condition meets the definition of an emergency.
- Receive poststabilization services following an emergency condition in some situations.
  Call the Amerigroup toll-free 24-hour Nurse HelpLine 24 hours a day, 7 days a week. English: 866-864-2544; Spanish: 866-864-2545
- Call the Amerigroup toll-free Member Services telephone line from 8 a.m.-6 p.m. Eastern time, Monday- Friday.
- Know what payment methodology Amerigroup utilizes with health care providers.
- Receive assistance in filing a grievance and/or appeal and appeal through the Amerigroup internal system.
- File a grievance or appeal if he or she is not happy with the results of a grievance and receive acknowledgement within 10 days and a resolution within 30 days.
- Ask Amerigroup to reconsider previously denied coverage; upon receipt of the member's medical information, Amerigroup will review the request.
- Freely exercise the right to file a grievance or appeal such that exercising of these rights will not adversely affect the way the member is treated.
- Receive notification to present supporting documentation for their appeal.
- Examine files before, during and after their appeal.
- Request an administrative hearing when dissatisfied with the Amerigroup decision.
- Continue to receive benefits pending the outcome of an appeal decision or state administrative hearing if the appropriate rules are followed.
- Only be responsible for cost-sharing in accordance with *42 CFR 447.50-42 CFR 447.60* and Maryland Medicaid provisions.
- To make recommendations regarding the Amerigroup *Rights and Responsibilities Policy*.

Members have the responsibility to:

- Treat their providers, their providers' staff and Amerigroup employees with respect and dignity.
- Not behave in a disruptive manner while in the provider's office.
- Respect the rights and property of all providers.
- Cooperate with people providing health care.
- Tell their PCP about their symptoms and problems and ask questions.
- Get information and consider treatments before they are performed.

- Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Discuss anticipated problems with following their provider's directions.
- Consider the outcome of refusing treatment recommended by a provider.
- Follow plans and instructions for care they have agreed on with their providers, to the best of their ability.
- Help their provider obtain medical records from the previous provider and help their provider complete new medical records as necessary.
- Supply information (to the extent possible) the organization and its practitioners and providers need to provide care.
- Respect the privacy of other people waiting in providers' offices.
- Call Amerigroup and change their PCP before seeing a new PCP.
- Make and keep appointments and arrive on time; members should always call if they need to cancel an appointment, change an appointment time or if they will be late.
- Discuss complaints, concerns and opinions in an appropriate and courteous way.
- Tell their provider how they want to receive their health information.
- Obtain medical services from their PCP.
- Learn and follow the Amerigroup policies outlined in the member handbook.
- Read the member handbook to understand how Amerigroup works.
- Notify Amerigroup when a member or family member who is enrolled in Amerigroup has died.
- Become involved in their health care and cooperate with their provider about recommended treatment.
- Learn the correct method by which his or her medications should be taken.
- Carry his or her Amerigroup ID card at all times and quickly report any lost or stolen cards to Amerigroup; members should contact Amerigroup if information on the ID card is wrong or if there are changes to their name, address or marital status.
- Show their ID cards to each provider.
- Tell Amerigroup about any providers they are currently seeing.
- Provide true and complete information about their circumstances.
- Report change(s) in their circumstances.
- Notify his or her PCP as soon as possible after they receive emergency services.
- Go to the emergency room only when they have an emergency.
- Report suspected fraud and abuse.

HIPAA and Member Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) 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.

Amerigroup strives to ensure both Amerigroup and contracted participating providers conduct business in a manner that safeguards member information in accordance with the privacy regulations enacted pursuant to HIPAA. Contracted providers shall have the following procedures implemented to demonstrate compliance with the HIPAA privacy regulations:

- Amerigroup recognizes its responsibility under HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose; conversely, network providers should only request the minimum necessary member information

required to accomplish the intended purpose when contacting Amerigroup. However, privacy regulations allow the transfer or sharing of member information, which may be requested by Amerigroup to conduct business and make decisions about care, such as a member's medical record, authorization determinations or payment appeal resolutions. 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, verify the receiving fax number is correct, notify the appropriate staff at Amerigroup and verify the fax was appropriately received.
- Internet email (unless encrypted) should not be used to transfer files containing member information to Amerigroup (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.
- The Amerigroup voicemail system is secure and password protected. When leaving messages for Amerigroup associates, leave only the minimum amount of member information required to accomplish the intended purpose.
- When contacting Amerigroup, please be prepared to verify the provider's name, address and tax identification number (TIN) or Amerigroup provider number.

Anti-Gag Provisions

Providers participating with Amerigroup will not be restricted from discussing with or communicating to a member, enrollee, subscriber, public official, or other person information that is necessary or appropriate for the delivery of health care services, including:

1. Communications that relate to treatment alternatives, including medication treatment options regardless of benefit coverage limitations.
2. Communications that are necessary or appropriate to maintain the provider-patient relationship while the member is under the participating physician's care.
3. Communications that relate to a member's or subscriber's right to appeal a coverage determination with which the participating physician, member, enrollee or subscriber does not agree.
4. Opinions and the basis of an opinion about public policy issues.

Participating providers agree that a determination by Amerigroup that a particular course of medical treatment is not a covered benefit shall not relieve participating providers from recommending such care as he/she deems to be appropriate nor shall such benefit determination be considered to be a medical determination. Participating providers further agree to inform beneficiaries of their right to appeal a coverage determination pursuant to the applicable grievance procedures and according to law. **Providers contracted with multiple MCOs are prohibited from steering recipients to any one specific MCO.**

Assignment and Reassignment of Members

Members have the right to select their PCP. Upon enrollment, the member may select a PCP by:

- Going to the Amerigroup member website (https://www.myamerigroup.com/md) and using the online provider directory.
- Calling Member Services (1-800-600-4441) from Monday-Friday, 8 a.m.-6 p.m. for help.

The member may consider the provider's specialty, accessibility, gender, ethnic background and languages spoken in the selection process. The member handbook also includes a description of how to choose a PCP. Members who do not select a PCP will be assigned to one using the enrollment information provided (e.g., geographic proximity to the provider, age and language).

Once an individual chooses or is auto-assigned to Amerigroup and selects a PCP, Amerigroup enrolls the member into that practice and mails him or her a member ID card. Amerigroup will choose a PCP close to the member's residence if a PCP is not selected. MCO members may change PCPs at any time using the same options listed above for selecting a PCP.

Amerigroup is required to provide PCPs with their rosters on a monthly basis. Providers can access their member rosters by logging on to Availity at https://www.availity.com, and selecting the **Provider Online Reporting** application located on Payer Spaces

The Provider Inquiry Line is available 24 hours a day, 7 days a week at 1-800-454-3730. This is an automated telephone tool that enables providers to verify member eligibility, prior authorization and claims status. Providers can also log in to the self-service website at https://provider.amerigroup.com/MD > Login to verify member eligibility or call a Provider Services representative at 1-800-454-3730 to answer eligibility questions.

Members can request to change their MCO one time during the first 90 days if they are new to the HealthChoice program as long as they are not hospitalized at the time of the request. They can also make this request within 90 days if they are automatically assigned to an MCO. Members may also change their MCO if they have been in the same MCO for 12 or more months. Members may change their MCO and join another MCO near where they live for any of the following reasons at any time:

- If they move to another county where Amerigroup does not offer care
- If they become homeless and find that there is another MCO closer to where they live or have shelter, which would make getting to appointments easier
- If they or any member of their family have a doctor in a different MCO and the adult member wishes to keep all family members together in the same MCO
- If a child is placed in foster care and the foster care children or the family members receive care by a doctor in a different MCO than the child being placed, the child being placed can switch to the foster family's MCO
- If the member desires to continue to receive care from their PCP and the MCO terminated the PCP's contract for one of the following reasons:
    - For reasons other than quality of care
    - The provider and the MCO cannot agree on a contract for certain financial reasons
    - Their MCO has been purchased by another MCO

Note: Newborns are enrolled in the MCO the mother was enrolled in on the date of delivery and cannot change for 90 days.

Credentialing Requirements

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit Amerigroup's discretion in any way to amend, change or suspend any aspect of Amerigroup's

credentialing program ("Credentialing Program") nor is it intended to create rights on the part of practitioners who seek to provide healthcare services to our members. Amerigroup further retains the right to approve, suspend, or terminate individual physicians and health care professionals, and sites in those instances where it has delegated credentialing decision making.

Credentialing Scope

Amerigroup credentials the following licensed/state certified independent health care practitioners:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry
- Chiropractors
- Optometrists providing Health Services covered under the Health Benefit Plan
- Doctors of dentistry providing Health Services covered under the Health Benefit Plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral health care specialists who provide treatment services under the Health Benefit Plan
- Telemedicine practitioners who provide treatment services under the Health Benefit Plan
- Medical therapists (e.g., physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives
- Registered Dietitians

Amerigroup credentials the following Health Delivery Organizations ("HDOs"):

- Hospitals
- Home Health agencies
- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Birthing Centers
- Home Infusion Therapy when not associated with another currently credentialed HDO

The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
- End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission
- Portable x-ray Suppliers (CMS Certification)

- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)

Credentials Committee

The decision to accept, retain, deny or terminate a practitioner's participation in a Network or Plan program is conducted by a peer review body, known as Amerigroup's Credentials Committee ("CC").

The CC will meet at least once every forty-five (45) calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the Vice President of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage ("MA") is represented, a second vice-chair representing MA may be designated. In states or regions where an Amerigroup affiliated provider organization is represented, a second vice-chair representing that organization may be designated. The chair must be a state or regional lead medical director, or an Amerigroup medical director designee and the vice-chair must be a lead medical officer or an Amerigroup medical director designee, for that line of business not represented by the chair. In states or regions where only one (1) line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five (5), but no more than ten (10) external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one (1) to two (2) other types of credentialed health providers (e.g. nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two (2) of the physician committee members must be credentialed for each line of business (e.g. Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation, or terminate a practitioner from participation in one (1) or more networks or plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the Credentialing Program. In particular, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion.

Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulating agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified that they have the right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, Amerigroup's credentialing staff ("Credentialing Department") will contact the practitioner or HDO within thirty (30) calendar days of the identification of the issue. This communication will notify the practitioner or HDO of the right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue(s) in question, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner's credentials file. The practitioner or HDO will be given no less than fourteen (14) calendar days in which to provide additional information. On request, the practitioner will be provided with the status of their credentialing or re-credentialing application.

Amerigroup may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

Nondiscrimination Policy

Amerigroup will not discriminate against any applicant for participation in its programs or provider Network(s) on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Amerigroup will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence. The CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Amerigroup will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. In the event discriminatory practices are identified through an audit or through other means, Amerigroup will take appropriate action(s) to track and eliminate those practices.

Initial Credentialing

Each practitioner or HDO must complete a standard application form deemed acceptable by Amerigroup when applying for initial participation in one (1) or more of Amerigroup's networks or plan programs. For practitioners, the Council for Affordable Quality Healthcare ("CAQH") ProView system is utilized. To learn more about CAQH, visit their web site at www.CAQH.org.

Amerigroup will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the one hundred eighty (180) calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Amerigroup will review, among other things, verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Members.
Hospital admitting privileges at a TJC, NIAHO or AOA accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state controlled substance registrations • The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

Verification Element
Accreditation, if applicable
License to practice, if applicable
Malpractice insurance
Medicare certification, if applicable
Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions

Re-credentialing

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is

reviewed in order to assess whether practitioners and HDOs continue to meet Amerigroup credentialing standards ("Credentialing Standards").

All applicable practitioners and HDOs in the Network within the scope of the Credentialing Program are required to be re-credentialed every three (3) years unless otherwise required by applicable state contract or state regulations.

Health Delivery Organizations

New HDO applicants will submit a standardized application to Amerigroup for review. If the candidate meets Amerigroup screening criteria, the credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail below, in the "Amerigroup Credentialing Program Standards" section, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Amerigroup may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past thirty-six (36) months for that HDO.

Re-credentialing of HDOs occurs every three (3) years unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in networks or plan programs must submit all required supporting documentation.

Upon request, HDOs will be provided with the status of their credentialing application. Amerigroup may request, and will accept, additional information from the HDO to correct incomplete, inaccurate, or conflicting credentialing information. The CC will review this information and the rationale behind it, as presented by the HDO, and determine if a material omission has occurred or if other credentialing criteria are met.

Ongoing Sanction Monitoring

To support certain Credentialing Standards between the re-credentialing cycles, Amerigroup has established an ongoing monitoring program. The Credentialing Department performs ongoing monitoring to help ensure continued compliance with Credentialing Standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the Credentialing Department will review periodic listings/reports within thirty (30) calendar days of the time they are made available from the various sources including, but not limited to, the following:

Office of the Inspector General ("OIG")
Federal Medicare/Medicaid Reports
Office of Personnel Management ("OPM")
State licensing Boards/Agencies
Member/Customer services departments
Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
Other internal Amerigroup departments
Any other information received from sources deemed reliable by Amerigroup.

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

Appeals Process

Amerigroup has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one (1) or more of Amerigroup's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Amerigroup may wish to terminate practitioners or HDOs. Amerigroup also seeks to treat Network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Amerigroup's Networks for professional conduct and competence reasons, or which would otherwise result in a report to the National Practitioner Data Bank ("NPDB"). Additionally, Amerigroup will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is Amerigroup's intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one (1) or more of Amerigroup's Networks or Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional conduct and competence considerations. Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, has a criminal conviction, or Amerigroup's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal Review/Reconsideration or Formal Appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for Informal Review/Reconsideration or Formal Appeal.

Reporting Requirements

When Amerigroup takes a professional review action with respect to a practitioner's or HDO's participation in one (1) or more of its Networks or Plan Programs, Amerigroup may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

Amerigroup Credentialing Program Standards

I. Eligibility Criteria

Health care practitioners:

Initial applicants must meet the following criteria in order to be considered for participation:

A. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;

B. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he or she provides services to Members; and
C. Possess a current, valid, and unrestricted Drug Enforcement Agency ("DEA") and/or Controlled Dangerous Substances ("CDS") registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members; the DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who see Members in more than one (1) state must have a DEA/CDS registration for each state.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

A. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties ("ABMS"), American Osteopathic Association ("AOA"), Royal College of Physicians and Surgeons of Canada ("RCPSC"), College of Family Physicians of Canada ("CFPC"), American Board of Foot and Ankle Surgery ("ABFAS"), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery ("ABOMS") in the clinical discipline for which they are applying.
B. If not certified, MDs and DOs will be granted five (5) years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
C. If not certified, DPMs will be granted five (5) years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven (7) years after completion of their residency to meet this requirement for ABFAS.
D. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

1. As alternatives, MDs and DOs meeting any one (1) of the following criteria will be viewed as meeting the education, training and certification requirement:
    a. Previous board certification (as defined by one (1) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of ten (10) consecutive years of clinical practice;
    b. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or

c. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Amerigroup's network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

2. Practitioners meeting one (1) of these three (3) alternative criteria (a, b, c) will be viewed as meeting all Amerigroup education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Amerigroup review and approval. Reports submitted by delegates to Amerigroup must contain sufficient documentation to support the above alternatives, as determined by Amerigroup.

E. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission ("TJC"), National Integrated Accreditation for Healthcare Organizations ("NIAHO"), Center for Improvement in Healthcare Quality ("CIHQ"), a Healthcare Facilities Accreditation

Program (“HFAP”) accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.

F. For Genetic Counselors, the applicant must be licensed by the state to practice independently. If the state where the applicant practices does not license Genetic Counselors, the applicant must be certified by the American Board of Genetic Counseling or the American Board of Genetics and Genomics.

II. Criteria for Selecting Practitioners

A. New Applicants (Credentialing)
    1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions;
    2. Application attestation signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;
    3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;
    4. No evidence of potential material omission(s) on application;
    5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members;
    6. No current license action;
    7. No history of licensing board action in any state;
    8. No current federal sanction and no history of federal sanctions (per System for Award Management (“SAM”), OIG and OPM report nor on NPDB report);
    9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who treat Members in more than one (1) state must have a valid DEA/CDS registration for each applicable state.

Initial applicants who have no DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:

    a. It can be verified that this application is pending.
    b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber;
    c. The applicant agrees to notify Amerigroup upon receipt of the required DEA/CDS registration.

d. Amerigroup will verify the appropriate DEA/CDS registration via standard sources.
    i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a ninety (90) calendar day timeframe will result in termination from the Network.
    ii. Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Amerigroup's members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:
        (a) It can be verified that the applicant's application is pending; and
        (b) The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
        (c) The applicant agrees to notify Amerigroup upon receipt of the required DEA registration; and
        (d) Amerigroup will verify the appropriate DEA/CDS registration via standard sources; and
        (e) The applicant agrees that failure to provide the appropriate DEA registration within a ninety (90) day timeframe will result in termination from the network.
    iii. Practitioners who voluntarily choose to not have a DEA/CDS registration if that practitioner certifies the following:
        (a) controlled substances are not prescribed within his/her scope of practice; or in their professional judgement, the patients receiving their care do not require controlled substances and
        (b) he or she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances should it be clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber; and
        (c) DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.

10. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions;
11. No history of or current use of illegal drugs or history of or current alcoholism;
12. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
13. No gap in work history greater than six (6) months in the past five (5) years with the exception of those gaps related to parental leave or immigration where twelve (12) month gaps will be acceptable and viewed as "Level I". Other gaps in work history of six (6) months to five (5) years will be reviewed by the chair/vice-chair of the geographic CC

and may be presented to the geographic CC if the gap raises concerns of future substandard Professional Conduct and Competence. In the absence of this concern the chair/vice-chair of the CC may approve work history gaps up to five (5) years;

14. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence. A minimum of the past ten (10) years of malpractice case history is reviewed.
15. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Amerigroup's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
16. No involuntary terminations from an HMO or PPO;
17. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
    a. Investment or business interest in ancillary services, equipment or supplies;
    b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    c. Voluntary surrender of state license related to relocation or nonuse of said license;
    d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window;
    g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

Note: the CC will individually review any practitioner that does not meet one (1) or more of the criteria required for initial applicants.

B. Additional Participation Criteria and Exceptions for Behavioral Health practitioners (Non Physician) Credentialing.

1. Licensed Clinical Social Workers ("LCSW") or other master level social work license type:
    a. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education ("CSWE") or the Canadian Association on Social Work Education ("CASWE");
    b. Program must have been accredited within three (3) years of the time the practitioner graduated;
    c. Full accreditation is required, candidacy programs will not be considered; and
    d. If master's level degree does not meet criteria and practitioner obtained PhD

degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet the criteria, the doctoral program must be accredited by the American Psychological Association ("APA") or be regionally accredited by the Council for Higher Education Accreditation ("CHEA"). In addition, a doctor of social work from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.

2. Licensed professional counselor ("LPC") and marriage and family therapist ("MFT") or other master level license type:

a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one (1) of the fields of study above;
b. Master or doctoral degrees in divinity do not meet criteria as a related field of study;
c. Graduate school must be accredited by one (1) of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, Council for Accreditation of Counseling and Related Educational Programs ("CACREP"), or Commission on Accreditation for Marriage and Family Therapy Education ("COAMFTE") listings. The institution must have been accredited within three (3) years of the time the practitioner graduated;
d. Practitioners with PhD training as a clinical psychologist can be reviewed. To meet criteria this doctoral program must either be accredited by the APA or be regionally accredited by the CHEA. A Practitioner with a doctoral degree in one (1) of the fields of study noted will be viewed as acceptable if the institution granting the degree has regional accreditation from the CHEA and;
e. Licensure to practice independently.

3. Clinical nurse specialist/psychiatric and mental health nurse practitioner:

a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing. Graduate school must be accredited from an institution accredited by one (1) of the Regional Institutional Accrediting Bodies within three (3) years of the time of the practitioner's graduation;
b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable;
c. Certification by the American Nurses Association ("ANA") in psychiatric nursing. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner; and
d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.

4. Clinical Psychologists:

a. Valid state clinical psychologist license;
b. Doctoral degree in clinical or counseling, psychology or other applicable field of study from an institution accredited by the APA within three (3) years of the time of the practitioner's graduation;
c. Education/Training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA accredited institution, but who is listed in the National Register of Health Service Providers in Psychology or is a diplomat of the American Board of Professional Psychology; and
d. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

5. Clinical Neuropsychologist:
    a. Must meet all the criteria for a clinical psychologist listed in B.4 above and be Board certified by either the American Board of Professional Neuropsychology ("ABPN") or American Board of Clinical Neuropsychology ("ABCN");
    b. A practitioner credentialed by the National Register of Health Service Providers ("National Register") in psychology with an area of expertise in neuropsychology may be considered; and
    c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one (1) or more of the following:
        i Transcript of applicable pre-doctoral training;
        ii Documentation of applicable formal one (1) year post-doctoral training (participation in CEU training alone would not be considered adequate);
        iii Letters from supervisors in clinical neuropsychology (including number of hours per week); or
        iv Minimum of five (5) years' experience practicing neuropsychology at least ten (10) hours per week.

6. Licensed Psychoanalysts:
    a. Applies only to practitioners in states that license psychoanalysts.
    b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Credentialing Policy (e.g. psychiatrist, clinical psychologist, licensed clinical social worker).
    c. Practitioner must possess a valid psychoanalysis state license.
        i. Practitioner shall possess a master's or higher degree from a program accredited by one (1) of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, CACREP, or the COAMFTE listings. The institution must have been accredited within three (3) years of the time the practitioner graduates.
        ii. Completion of a program in psychoanalysis that is registered by the licensing state as licensure qualifying; or accredited by the American Board for Accreditation in Psychoanalysis (ABAP) or another acceptable accrediting agency; or determined by the licensing state to be the

substantial equivalent of such a registered or accredited program.

(a) A program located outside the United States and its territories may be used to satisfy the psychoanalytic study requirement if the licensing state determines the following: it prepares individuals for the professional practice of psychoanalysis; and is recognized by the appropriate civil authorities of that jurisdiction; and can be appropriately verified; and is determined by the licensing state to be the substantial equivalent of an acceptable registered licensure qualifying or accredited program.

(b) Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.

(c) Meet examination requirements for licensure as determined by the licensing state.

C. Additional Participation Criteria and Exceptions for Nurse Practitioners, Certified Nurse Midwives, Physicians Assistants (Non Physician) Credentialing.

1. Process, requirements and Verification – Nurse Practitioners:
    a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
    b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
    d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Amerigroup procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
    e. All NP applicants will be certified in the area which reflects their scope of practice by any one (1) of the following:

i. Certification program of the American Nurse Credentialing Center (www.nursecredentialing.org), a subsidiary of the American Nursing Association (http://www.nursingcertification.org/exam_programs.htm);
ii. American Academy of Nurse Practitioners – Certification Program (www.aanpcertification.org);
iii. National Certification Corporation (http://www.nccwebsite.org);
iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner) (http://www.pncb.org/ptistore/control/exams/ac/progs);
v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY (http://oncc.org); or
vi. American Association of Critical Care Nurses (https://www.aacn.org/certification/verify-certification) ACNPC – Adult Care Nurse Practitioner; ACNPC-AG – Adult Gerontology Acute Care. This certification must be active and primary source verified.

If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Amerigroup is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.

f. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.
g. The NP applicant will undergo the standard credentialing processes outlined in Amerigroup's Credentialing Policies ("Credentialing Policies" or Credentialing Policy). NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three (3) years, and continuous sanction and performance monitoring upon participation in the network.
h. Upon completion of the credentialing process, the NP may be listed in Amerigroup's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. NPs will be clearly identified:
    i. On the credentialing file;
    ii. At presentation to the CC; and
    iii. Upon notification to network services and to the provider database.

2. Process, Requirements and Verifications – Certified Nurse Midwives:
    a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.
    b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of

this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.

c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Amerigroup procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
e. All CNM applicants will be certified by either:
    i. The National Certification Corporation for Ob/Gyn and neonatal nursing; or
    ii. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.

This certification must be active and primary source verified. If the state licensing board primary source verifies one (1) of these certifications as a requirement for licensure, additional verification by Amerigroup is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.

f. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.
g. The CNM applicant will undergo the standard credentialing process outlined in Amerigroup's Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three (3) years, and continuous sanction and performance monitoring upon participation in the network.
h. Upon completion of the credentialing process, the CNM may be listed in Amerigroup's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. CNMs will be clearly identified:

i. On the credentialing file;
ii. At presentation to the CC; and
iii. Upon notification to network services and to the provider database.

3. Process, Requirements and Verifications – Physician's Assistants (PA):
    a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
    b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
    d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Amerigroup procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
    e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Amerigroup is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or amended by each Amerigroup Health Plan and submitted for individual review by the CC.
    f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
    g. The PA applicant will undergo the standard credentialing process outlined in Amerigroup's Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three (3) years, and continuous sanction and performance monitoring upon participation in the network.
    h. Upon completion of the credentialing process, the PA may be listed in Amerigroup provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
    i. PA's will be clearly identified:

i. On the credentialing file;
ii. At presentation to the CC; and
iii. Upon notification to network services and to the provider database.

D. Currently Participating Applicants (Re-credentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in Amerigroup's programs or provider Network(s), federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider Network(s) as well as Amerigroup's other credentialed provider Network(s).
4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
5. No new history of licensing board reprimand since prior credentialing review;
6. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Members needing hospitalization;
9. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism;
10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five (5) years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    b. Voluntary surrender of state license related to relocation or nonuse of said license;

c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window;
f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

15. No quality improvement data or other performance data including complaints above the set threshold.
16. Re-credentialed at least every three (3) years to assess the practitioner's continued compliance with Amerigroup standards.

*It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Network practitioners and HDOs that do not meet one (1) or more of the criteria for re-credentialing.

III. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Amerigroup may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past thirty-six (36) months. If a HDO has satellite facilities that follow the same policy and procedures, Amerigroup may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for Member access need only when the CC review indicates compliance with Amerigroup standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are re-credentialed at least every three (3) years to assess the HDO's continued compliance with Amerigroup standards.

A. General Criteria for HDOs:
    1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Members. The license must be in good standing with no sanctions.
    2. Valid and current Medicare certification.
    3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in Amerigroup's programs or provider Network(s), exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Network(s) as well as Amerigroup's other credentialed provider Network(s).
    4. Liability insurance acceptable to Amerigroup.
    5. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a

designated independent external entity survey for review by the CC to determine if Amerigroup's quality and certification criteria standards have been met.

B. Additional Participation Criteria for HDO by Provider Type:

HDO Type and Amerigroup Approved Accrediting Agent(s)

Medical Facilities

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, CTEAM, DNV/NIAHO, HFAP, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, CTEAM , DNV/NIAHO, TJC
Home Infusion Therapy (HIT)	ACHC, CHAP, CTEAM, HQAA, TJC
Skilled Nursing Facilities/Nursing Homes	CARF, TJC

Peer Review Behavioral Health

Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, HFAP, TJC

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	CTEAM, DNV/NIAHO, HFAP, TJC
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Abuse	ACHC, CARF, COA, DNV/NIAHO, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Abuse	CARF, DNV/NIAHO, HFAP, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Abuse	CARF, COA, DNV/NIAHO, HFAP, TJC

Rehabilitation

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	CTEAM, DNV/NIAHO, HFAP, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Abuse Clinics	CARF, TJC, COA,

Provider Reimbursement

Payment to providers is in accordance with your provider contract with Amerigroup or with the management groups that contract on your behalf with Amerigroup. In accordance with the *Maryland Annotated Code, Health General Article 15-1005*, we must mail or transmit payment to our providers eligible for reimbursement for covered services within 30 days after receipt of a clean claim. If additional information is necessary, we shall reimburse providers for covered services within 30 days after receipt of all reasonable and necessary documentation. We shall pay interest on the amount of the clean claim that remains unpaid 30 days after the claim is filed.

Reimbursement for Maryland hospitals and other applicable provider sites will be in accordance with Health Services Cost Review Commission (HSCRC) rates. Amerigroup is not responsible for payment of any remaining days of a hospital admission that began prior to a Medicaid participant's enrollment in our MCO. However, we are responsible for reimbursement to providers for professional services rendered during the remaining days of the admission if the member remains Medicaid eligible.

Amerigroup Reimbursement Policies
Reimbursement policies serve as a guide to assist you with accurate claims submissions and to outline the basis for reimbursements when services are covered by the member's Amerigroup plan. Services must meet authorization and medical necessity guidelines appropriate to the procedures, diagnoses and members' state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines, including using industry-standard, compliant codes on all claims submissions. Services should be billed with CPT codes, HCPCS codes and/or revenue codes that indicate 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, Amerigroup policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup may:

- Reject or deny the claim
- Recover and/or recoup claim payment

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by provider or state contract language or state, federal requirements or mandates. System logic or setup may prevent loading some policies in the same manner described; however, Amerigroup strives to minimize these variations.

Claims submitted for payments must meet all aspects of criteria for reimbursement. 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/clinical criteria, authorization requirements and/or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

Reimbursement policies undergo review for updates to state contracts or state, federal or CMS requirements. Additionally, updates may be made any time if Amerigroup is notified of a mandated change or due to an Amerigroup business decision. We reserve the right to review and revise Amerigroup policies when necessary. When there is an update, Amerigroup will publish the most

current policies on the provider website at https://provider.amerigroup.com/md > Claims > Reimbursement Policies.

Medical Coding

The Medical Coding department ensures that correct coding guidelines have been applied consistently through Amerigroup. Those guidelines include, but are not limited to:

- Correct modifier use
- Effective date of transaction code sets (CPT, HCPCS, ICD diagnosis/procedures, revenue codes, etc.)
- Code editing rules are appropriately applied and within regulatory requirements
- Analysis of codes, code definition and appropriate use

Reimbursement by Code Definition

Amerigroup allows reimbursement for covered services based on their procedure code definitions or descriptor, as opposed to their appearance under particular CPT categories or sections, or descriptors unless otherwise noted by state or provider contracts or state, federal or CMS contracts and/or requirements. There are eight CPT sections:

1. Evaluation and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Category II codes: supplemental tracking codes that can be used for performance measurement
8. Category III codes: temporary codes for emerging technology, services or procedures

Acute Care Hospital Reimbursement

"Acute care hospital" means an institution providing medical, nursing and surgical treatment for sick or injured members, usually for a short-term illness or condition. Acute care hospital reimbursement is for facility services only.

Inpatient Services

Reimbursement policies serve as a guide to assist you with accurate claims submissions and to outline the basis for reimbursements when services are covered by the member's Amerigroup plan. Services must meet authorization and medical necessity guidelines

Outpatient Services

- The initial State Medicaid cost-to-charge ratio (CCR) will be the current CCR in effect as of the effective date of the Agreement.
- Changes to the CCR will occur either:
  - Upon official notification to Amerigroup by the state or the provider of CCR updates.
  - Upon the mutual written agreement of Amerigroup and the provider.
- Amerigroup will update the CCR no more than 60 days from the date of receipt of notice of final changes or on the effective date of such changes, whichever is later.
- CCR changes will be applied on a prospective basis. The effective date of a change in the CCR is the effective date of the change as published by the state or an effective date mutually agreed upon by the provider and Amerigroup.

- Amerigroup will not be responsible for interest payments that are the result of late notification to Amerigroup of CCR changes.
- For adjustments based on changes in the provider's charge master: Within 30 days of any adjustment to the charge amounts set forth in the provider's charge master for a covered service set forth above for which the provider's reimbursement hereunder is based on a percentage of eligible charges, the provider must give notice to Amerigroup in writing regarding the increase. Amerigroup is entitled to reduce, as of the date of such charge master increase, the percentage set forth above applicable to such covered service by an offsetting amount so the amount payable by Amerigroup to the provider for the covered service on and after such date will equal the amount payable to Amerigroup to the provider for the covered service prior to the date of the charge master increase.

Allied Health Professional Reimbursement
"Allied health professionals" means health care practitioners with formal education and clinical training who are credentialed through certification, registration and/or licensure. They collaborate with physicians and other members of the health care team to deliver high-quality patient care services for the identification, prevention and treatment of diseases, disabilities and disorders. Such health care practitioners include but are not limited to nurse practitioners, nurse midwives, chiropractors, audiologists, optometrists, opticians, registered nurse anesthetists, clinical nurse specialists, physician assistants and registered nurse first assistants.

Allied health professionals will be reimbursed in accordance with regulatory requirements for the applicable methodology based on the referenced fee schedule. If the reimbursement is based on an Amerigroup rate, the applicable state methodology on which the fee schedule is based will be used to determine the appropriate level of reimbursement.

Ambulatory Surgical Center (ASC) (Freestanding) Reimbursement
"Ambulatory surgical center" means a freestanding facility with an organized staff of providers, which has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis and provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility. ASC reimbursement is for facility services only.

Reimbursement for multiple outpatient surgical procedures performed during the same admission will be paid in accordance with regulatory requirements. Codes for procedures that are incidental to other procedures performed on the same day will not be eligible for separate reimbursement.

Anesthesiology Services Reimbursement
"Anesthesiology services" refers to the branch of medicine that studies how to suppress the perception of pain and sensation in the brain. An anesthesiologist administers anesthesia for members who undergo surgery and other medical procedures that cause pain.

Reimbursement for anesthesiology services will be in accordance with the CMS Anesthesia Conversion Factor Fee Schedule in effect as of the date of service.

When multiple surgical procedures are carried out during the same anesthetic/anesthesia session, Amerigroup will reimburse according to the maximum number of base units carried by the primary procedure. Services should be billed in minute increments. One time unit will be allowed for each 15-minute interval, or fraction thereof, starting from the time the provider begins to prepare the member for induction and ending when the member may safely be placed under postoperative

supervision, and the provider is no longer in personal attendance. Anesthesia consultation on the same date as surgery or the day prior to surgery is not payable if part of the preoperative assessment.

Durable Medical Equipment (DME) Reimbursement
Miscellaneous codes A4421, E1399, K0108, L9990 and T5999 may only be used by the provider if no other codes have been assigned by CMS to the product or service to be supplied. For miscellaneous HCPCS codes that don't have an established fee schedule reimbursement rate, the provider must furnish documentation describing the following:

- Service or item
- Manufacturer's name
- Product name and number
- Invoice cost

Note: If it is a customized option or accessory, the statement must clearly describe what options or accessories were customized. The provider must submit this information when billing services.

Amerigroup has a rent-to-purchase policy for DME (e.g., standard or customized wheelchairs or accessories). Original standard accessories are included in the rental or purchase price of the DME item and won't be billed separately by the provider nor reimbursed separately by Amerigroup. For patient-owned equipment, replacement standard and/or customized accessories for DME will be billed separately by the provider, following industry-standard guidelines.

For DME items that are not authorized for rental-to-purchase, rental payments for DME will be applied to the purchase of such item in the event Amerigroup authorizes conversion of the rental to purchase. Under no circumstances will the Amerigroup total rental payments exceed the purchase price of the item. Original standard accessories are included in the rental or purchase price of certain DME items and will not be billed or separately reimbursable expenses. These include but are not limited to: hospital beds, oxygen, wheelchairs, power-operated vehicles (POVs), power-mobility devices (PMDs).

Amerigroup does not allow reimbursement for repair or replacement of purchased items while under the warranty period designated by the applicable manufacturer. This charge will not be allowed on regular or rental DME prosthetics, orthotics and supplies (POS) items (the repair of a rental item is included in the rental price and is not separately reimbursable).

The only exception to the Amerigroup rent-to-purchase policy is a custom wheelchair. The Amerigroup definition of a custom wheelchair is a wheelchair that is not readily available from manufacturers, but one that has been uniquely constructed or substantially modified for a specific member based on medical necessity, according to the description and orders of the member's physician. There must be customization of the base frame of the wheelchair for the wheelchair to meet the definition of a custom-made wheelchair. The addition of customized options or accessories to a standard wheelchair does not result in that wheelchair being considered custom-made. Only custom-made wheelchairs will be considered for outright purchase by Amerigroup.

For custom wheelchairs ordered by the physician, Amerigroup will conduct a medical necessity review. Should the custom wheelchair meet the Amerigroup medical necessity criteria, we will determine if the customizing parts are necessary for the member's particular condition and notify the provider of the subsequent approval or denial of the custom wheelchair and/or customizing parts for the wheelchair.

Mounting hardware is included with the accessory item and should not be billed separately or under a miscellaneous code. If the description, manufacturer name, product name, product number and invoice cost are not provided with the claim, the claims will be denied for lack of adequate documentation. There is no separate or additional reimbursement for administration charges, measurements, fitting, delivery fees, taxes, etc.

Home Infusion Therapy (HIT) Reimbursement

"Home infusion therapy provider" means a health care provider that is a licensed pharmacy which offers intravenous administration of drugs or other substances that require infusion to be administered, subcutaneous treatments or administered injections in a home setting when ordered by a physician or other authorized health care professional.

HIT providers provide a wide range of services required to safely and effectively administer home infusion, nutritional therapies, specialty drugs, and disease state and care management services in a home setting. Typical therapies include but are not limited to antibiotic therapy, total parenteral nutrition, chemotherapy and pain management. HIT providers offer supplies and clinical services to a member who is under the care of a physician or other health care provider. Such supplies and clinical services are provided in an integrated manner under a plan established and periodically reviewed by the ordering physician or other health care provider. Routine supplies, as defined by CMS, are included in these services.

- Multiple discipline visits (e.g., occupational vs. physical vs. speech therapy) may be reimbursed separately on the same day.
- For DME items that are not authorized for rental-to-purchase, rental payments for DME will be applied to the purchase of the item in the event Amerigroup authorizes conversion of the rental to purchase. Under no circumstances will the Amerigroup total rental payments for a DME item exceed the purchase price of the item.
- Original standard accessories are included in the rental or purchase price of certain DME items and will not be billed or separately reimbursable expenses. These items include but are not limited to: hospital beds, oxygen, wheelchairs, POVs and PMDs.
- The only exception to the Amerigroup rent-to-purchase policy is a custom wheelchair. The Amerigroup definition of a custom wheelchair is a wheelchair that is not readily available from manufacturers, but one that has been uniquely constructed or substantially modified for a specific member based on medical necessity, according to the description and orders of the member's physician. There must be customization of the base frame of the wheelchair for the wheelchair to meet the definition of a custom-made wheelchair. The addition of customized options or accessories to a standard wheelchair does not result in that wheelchair being considered custom-made. Only custom-made wheelchairs will be considered for outright purchase by Amerigroup.
- For a custom wheelchair ordered by the physician, Amerigroup will conduct a medical necessity review. Should the custom wheelchair meet the Amerigroup medical necessity criteria, we will determine if the customizing parts are necessary for the member's particular condition and notify the provider of the subsequent approval or denial of the custom wheelchair and/or customizing parts for the wheelchair.
- If it is a customized option/accessory, the statement must clearly describe what options or accessory was customized. The provider must submit this information when billing services.
- Mounting hardware is included with the accessory item and should not be billed separately or under a miscellaneous code. If the description, manufacturer name, product name, product number and invoice cost are not provided with the claim, the claims will be denied for lack of adequate documentation.

- There is no separate or additional reimbursement for administration charges, measurements, fitting, delivery fees, taxes, etc.

Hospice Reimbursement

"Hospice" means covered services designed to give supportive care to members in the final phase of a terminal illness. Services include but are not limited to routine home care day, continuous home care day, inpatient respite care day and general inpatient care day. Reimbursement is inclusive of skilled nursing, home health aide, medical social worker services, dietary, pastoral, bereavement counseling, DME, medical supplies and administration of medication.

- "Routine home care day" means covered services for a day on which a member who has elected to receive hospice care at his or her current residence and is not receiving continuous care. Routine home care day is payable at the Amerigroup rate using the appropriate coded service identifier(s). Covered services include but are not limited to any combination of the following services, without regard to volume or intensity occurring in one day: skilled nursing care, certified nurse assistance, homemaker, social worker, family counseling, respite care, therapies and bereavement services.
- "Continuous home care day" means covered services for a day on which a member who has elected hospice care is at home and receives hospice care consisting predominantly of nursing care on a continuous basis at home. A continuous home care day is only furnished during brief periods of crisis and only as necessary to maintain the terminally ill patient at home, with a minimum of eight hours of care being furnished on a particular day to qualify as a continuous home care day. Continuous home care day is payable at the Amerigroup rate; however, billing is required at an hourly rate using the appropriate revenue code. Billing for continuous home care day is required at an hourly rate using the appropriate coded service identifier(s), and reimbursement will not exceed the general inpatient care day reimbursement. Claims with less than eight hours of direct patient care in one day will be at the routine home care day reimbursement.
- "Inpatient respite care day" means covered services for a day on which a member who has elected hospice care receives services in an inpatient facility (skilled nursing facility, hospital or inpatient hospice house) on a short-term basis when necessary to relieve family members or others caring for the member, for respite. The inpatient respite care day is payable as a per diem rate using the appropriate revenue code.
- "General inpatient care day" means covered services for a day on which the member who has elected hospice care receives inpatient services for pain control or acute or chronic symptom management that cannot be managed in other settings. The general inpatient care day is payable as a per diem rate using the appropriate revenue code.

The per diem rate includes but is not limited to: 1) provider services performed by the hospice medical director or any other hospice staff provider, including establishing, reviewing and updating plans of care as well as supervision of care and services and establishment of governing policies; 2) nursing care; 3) medical equipment and/or DME related to terminal illness, such as oxygen and hospital appropriate beds; 4) medical supplies related to terminal illness, such as IV fluids/IV antibiotics (including administration); 5) drugs related to the terminal illness for symptom management and pain relief and other special modalities if used for palliative purposes (including pain pumps, infusion therapy and supplies, etc.).

This determination is based on the member's condition and the caregiving philosophy of the hospice. Amerigroup will make no additional payment regardless of the cost of the services, home health aide and homemaker services, physical and occupational therapy, speech/language pathology services, medical social services/chaplain, counseling services including dietary counseling, all labs/X-ray services

related to the terminal illness, ambulance used as transport, nonemergent, bereavement counseling for family members and/or significant others one year after the member's death. Hospice may not bill for health services while a member is considered an inpatient at a facility other than the same facility. The Amerigroup rate does not include the following: nonstaff physician consultants and visits, chemotherapy, radiation therapy, or third-party network (TPN) solution. These services must be provided and billed by a network/participating provider under a separate agreement with Amerigroup. The facility must agree that it will neither bill nor seek payment from Amerigroup for any of these items.

Independent Diagnostic Treatment Facility (IDTF) Reimbursement
"Independent diagnostic treatment facility" means a facility that is independent of a physician office or hospital (e.g., not owned by a hospital, individual or physician group practice) where therapeutic and diagnostic services are performed.

If an IDTF and/or a freestanding radiology facility employs the physicians interpreting the radiology procedures, the global payment, including the technical and professional component, will be made to the provider. If the physicians are not employed, the provider will bill for the technical component only.

Independent Laboratory (LAB) Reimbursement
"Independent laboratory" means an entity that provides health services involving the procurement, transportation, testing (which includes clinical and anatomic/surgical pathology), reporting of specimens and consulting services provided by the LAB. LAB does not include providers of laboratory services rendered in connection with an inpatient service, outpatient surgery, observation room stay and presurgery testing.

Collection of specimens (including venipuncture), lab handling, and/or stat services are considered as part of the primary laboratory test components and are not separately reimbursable expenses.

Rehabilitation Facility Reimbursement
"Rehabilitation facility" means a facility that is licensed to provide comprehensive rehabilitation services, including but not limited to therapy and training for rehabilitation, occupational therapy, physical therapy, and speech therapy to members for the alleviation of disabling effects of illness or intended to achieve the goal of maximizing the self-sufficiency of the member. Rehabilitation facility reimbursement is for facility services only.

Multiple discipline visits (e.g., OT vs. PT vs. ST) may be reimbursed separately on the same day.

Skilled Nursing Facility (SNF) Reimbursement
"Skilled nursing facility" means a facility that mainly provides inpatient skilled nursing and related services to members requiring convalescent and rehabilitation care given by or under the supervision of a qualified/certified practitioner as licensed in the state, following a hospitalization, for a limited period. SNF reimbursement is for facility services only.

The facility must agree the per diem rate includes but is not limited to room and board, nursing care, therapies, oxygen, case management, social services, discharge planning services, family education, special diets, legend pharmaceuticals, medical supplies, wound care, ventilators, laboratory services, DME, specialized beds, prosthetics and orthotics, X-rays, total parenteral nutrition, third-generation antibiotics, prescriptions, and DME purchased during the admission — for use during the admission

and/or after the member is discharged. If the member requires excess and/or extraordinary labs, the provider must use the Amerigroup contracted lab vendor for the lab draws and processing.

Urgent Care Center (UCC) Reimbursement
"Urgent care center" means an entity that provides treatment and diagnosis of conditions that require prompt attention to prevent serious deterioration to the member's health but would not generally be considered to require treatment in an emergency room.

The-per visit rate is all inclusive of professional, technical and facility charges, including laboratory and radiology on site.

The provider cannot bill as a PCP in the urgent care center when he or she renders services to members assigned to him or her as a PCP.

Self-Referral and Emergency Services

Members have the right to access certain services without prior referral or authorization by a PCP. Amerigroup is responsible for reimbursing out-of-plan providers who have furnished these services to our members.

The state allows members to self-refer to out-of-network providers for the services listed below. Amerigroup will pay out-of-network providers the state's Medicaid rate for the following services:

- Emergency services provided in a hospital emergency facility and medically necessary post-stabilization services
- Family planning services excluding sterilizations
- Maryland school-based health center services
    - School-based health centers are required to send a medical encounter form to the child's MCO. We will forward this form to the child's PCP, who will be responsible for filing the form in the child's medical record. See Attachment 2 for a sample *School-Based Health Center Report Form*.
- Pregnancy-related services when a member has begun receiving services from an out-of-plan provider prior to enrolling in an MCO
- Initial medical examination for children in state custody (Identified by Modifier 32 on the claim)
- Annual diagnostic and evaluation services for members with HIV/AIDS
- Renal dialysis provided at a Medicare-certified facility
- The initial examination of a newborn by an on-call hospital physician when we do not provide for the service prior to the baby's discharge
- Services performed at a birthing center

Children with special health care needs may self-refer to providers outside of the Amerigroup network under certain conditions (see Section II, Children with Special Health Care Needs and the section below for additional information).

If a provider contracts with Amerigroup for any of the services listed above, the provider must follow our billing and preauthorization procedures. Reimbursements will be paid the contracted rate.

Self-Referred Services for Children with Special Health Care Needs
Children with special health care needs may self-refer to providers outside the Amerigroup network under certain conditions. Self-referral for children with special needs is intended to ensure continuity of

care and appropriate plans of care. Self-referral for children with special health care needs will depend on whether the condition that is the basis for the child's special health care needs is diagnosed before or after the child's initial enrollment in Amerigroup. Medical services directly related to a special-needs child's medical condition may be accessed out-of-network only if the following specific conditions are satisfied:

- **For a new member:** A child who at the time of initial enrollment was already receiving these services as part of a current plan of care may continue to receive these specialty services, provided the preexisting out-of-network provider submits the plan of care to Amerigroup for review and approval within 30 days of the child's effective date of enrollment into Amerigroup, and Amerigroup approves the services as medically necessary.
- **For an established member:** A child who is already enrolled in Amerigroup when diagnosed as having a special health care need that requires a plan of care, including specific types of services, may request a specific out-of-network provider. Amerigroup is obligated to grant the member's request unless a local, in-network specialty provider with the same professional training and expertise is reasonably available to provide the same services and service modalities.

If Amerigroup denies, reduces or terminates services, members have an appeal right regardless of whether they are a new or established member. Pending the outcome of an appeal, Amerigroup may reimburse for services provided.

Specialty Network

Amerigroup will maintain a complete network of adult and pediatric providers adequate to deliver the full scope of benefits as required by COMAR. If a specialty provider cannot be identified, call us for assistance at 1-800-454-3730.

Emergency Room Medical Record Review

Amerigroup promotes the provision of services in the most appropriate setting and reinforces to members the need to coordinate care with their primary care provider, unless the injury or sudden onset of illness requires immediate medical attention. The existing medical record review process for emergency room services is to determine the appropriate level of reimbursement for the emergency room visit. For more information on the ER auto-pay list, visit the provider self-service website.

Emergency room facility claims received with revenue code 452 and a principal diagnosis **not** on the auto-pay list require medical record review to confirm the emergency medical condition prior to payment. If revenue code 452 and the principal diagnosis are **not** on the auto-pay list, the claim will be pended. The hospital will receive an *Explanation of Payment* (*EOP*) with the appropriate code requesting medical records. Medical records must be submitted to Amerigroup within 90 business days of receiving the request on the *EOP*. Amerigroup will complete the medical records review based on the member's presenting symptoms within 30 days. The outcome of the medical record review will be sent to the hospital via the *EOP*.

ER physician claims received with CPT code 99284 or 99285 and a principal diagnosis **not** included on the ER auto-pay list require medical record review to confirm the level of care provided to members. The principal diagnosis is the condition established after study to be chiefly responsible for the ER visit. Amerigroup uses the *1995 Centers for Medicare & Medicaid Services (CMS) Evaluation & Management Services* guidelines to perform the medical record review. Guidelines are available on the CMS website at www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf. Following the review of the medical record

and the receipt of the final *EOP* notification, providers should follow the Amerigroup appeal policy to request additional reimbursement.

Amerigroup will reimburse all Maryland hospitals in accordance with COMAR and pursuant to the *Maryland Medical Assistance Program Managed Care Organization (MCO) Transmittal No.90* (https://mmcp.health.maryland.gov/MCOupdates/pdf/PT24-12-MCO-90.pdf).

Maryland Continuity of Care Provisions

Under Maryland Insurance law, HealthChoice members have certain continuity of care rights. These apply when the member:

- Is new to the HealthChoice Program.
- Switched from another company's health benefit plan.
- Switched to Amerigroup from another MCO.

As part of the HealthChoice program design, Amerigroup is responsible for providing ongoing treatment and patient care to new members until an initial evaluation is performed and a new plan of care is developed.

The following steps are taken to ensure members continue to receive necessary health services at the time of enrollment into Amerigroup:

- Appropriate service referrals to specialty care providers will be provided in a timely manner.
- Authorization for ongoing specialty services will not be delayed while members await their initial PCP visit and comprehensive assessment. Services comparable to those the member was receiving upon enrollment into Amerigroup are to be continued during this transition period.
- If, after the member receives a comprehensive assessment, Amerigroup determines a reduction in or termination of services is warranted, Amerigroup will notify the member of this change at least 10 days before it is implemented. This notification will tell the member that he or she has the right to formally appeal to MDH by calling the HealthChoice Enrollee Help Line at 1-800-284-4510 or to Amerigroup. In addition, the notice will explain that if the member files an appeal within 10 days of notification and requests to continue receiving services, Amerigroup will continue to provide these services until the appeal is resolved. You will also receive a copy of this notification.

MCOs must adhere to the continuity of care requirements in *§15-140, Insurance Article, Annotated Code of Maryland*, as outlined in the Maryland Insurance Administration's *Bulletin 14-22* at http://insurance.maryland.gov/Insurer/Documents/bulletins/14-22-continuity-of-care-notice-amended.pdf.

The following services are excluded from continuity of care provisions for HealthChoice members:

- Dental services
- Mental health services
- Substance use disorder services
- Benefits or services provided through the Maryland Medicaid fee-for-service program

Preauthorization for Health Care Services

If the previous MCO or company preauthorized services, we will honor the approval if the member calls Amerigroup. Under Maryland law, insurers must provide a copy of the preauthorization within 10 days of the member's request.

There is a time limit for how long we must honor this preauthorization. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date the member's coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health practitioner after the baby is born.

Right to Use Nonparticipating Providers
Members can contact us to request the right to continue to see a nonparticipating provider. This right applies only for one or more of the following types of conditions:

- Acute conditions
- Serious chronic conditions
- Pregnancy
- Any other condition upon which we and the out-of-network provider agree

There is a time limit for how long we must allow the member to receive services from an out-of-network provider. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date the member's coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health care provider after the baby is born.

If the member has any questions they should call Amerigroup Member Services at 1-800-600-4441 or the state's HealthChoice Help Line at 1-800-284-4510.

SECTION II. OUTREACH AND SUPPORT SERVICES, APPOINTMENT SCHEDULING, EPSDT, AND SPECIAL POPULATIONS

MCO Member Outreach and Support Services

Amerigroup member outreach campaigns are coordinated between several departments, including Health Promotion, Marketing, Quality Management, Disease Management and Health Care Management Services (HCMS). HCMS provides additional outreach to the special needs population (see the Special Needs Populations section for details).

Member Services makes new member outreach welcome calls with additional assessments for Supplemental Security Insurance members. Outreach services are also provided by the Case Management department (see the MCO Benefits and Services Overview section for details). Case Management also provides outreach services for high-risk obstetric members (see the Services for Pregnant and Postpartum Women section for details).

State Nonemergency Medical Transportation Assistance

If a member needs transportation assistance, contact the local health department (LHD) to assist him or her in accessing nonemergency medical transportation services (NEMT). Amerigroup will cooperate with and make reasonable efforts to accommodate logistical and scheduling concerns of the LHD. **See Attachment 3 for NEMT contact information.**

MCO Transportation Assistance

Under certain circumstances, Amerigroup may provide limited transportation assistance when members do not qualify for NEMT through the LHD.

Call the Amerigroup Case Management Department at 1-800-454-3730 for assistance.

State Support Services

The state provides grants to local health departments to operate administrative care coordination/ombudsman services (ACCUs) to assist with outreach to certain noncompliant members and special populations as outlined below. MCOs and providers are encouraged to develop collaborative relationships with the local ACCU. **See Attachment 3 for the local ACCU contact information**.

If you have questions, call the Division of Community Liaison and Care Coordination, which oversees the ACCUs, at 410-767-6750 or the HealthChoice Provider Help Line at 1-800-766-8692.

Scheduling Initial Appointments

HealthChoice members must be scheduled for an initial appointment within 90 days of enrollment unless one of the following exceptions apply:

- You determine no immediate initial appointment is necessary because the member already has an established relationship with you.
- For children under 21, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) periodicity schedule requires a visit in a shorter time frame. For example, new members up to 2 years of age must have a well-child visit within 30 days of enrollment unless the child already has an established relationship with a provider and is not due for a well-child visit.

- For pregnant and postpartum women who have not started to receive care, the initial health visit must be scheduled and the women seen within 10 days of a request.
- As part of the MCO enrollment process, the state asks the member to complete a *Health Services Needs Information* (*HSNI*) form. This information is then transmitted to the MCO. A member who has an identified need must be seen for their initial health visit within 15 days of Amerigroup receiving the *HSNI*.

During the initial health visit, the PCP is responsible for documenting a complete medical history and performing and documenting results of an age-appropriate physical exam. In addition, at the initial health visit, initial prenatal visit, or when a member's physical status, behavior or laboratory findings indicate possible substance use disorder, you must refer the member to the Behavioral Health System at 1-800-888-1965.

Before referring an adult member to the local health department, Amerigroup will make documented attempts to ensure follow-up appointments are scheduled in accordance with the member's treatment plan by attempting a variety of contact methods, which may include written correspondence, telephone contact and face-to-face contact.

Routine and Urgent Appointments for HealthChoice Members
To ensure members receive care in a timely manner, PCPs and specialists must maintain the following COMAR appointment availability standards:

Type of visit	Availability standard
Urgent care visits	Within 48 hours of request
Routine and preventive care visits	Within 30 days of request
Routine specialist follow-up appointments	Within 30 days or sooner as deemed necessary by the PCP Note: The PCP's office staff will make the appointment directly with the specialist's office staff.
Initial newborn visits	Within 14 days of discharge from the hospital (if no home visit)

Early and Periodic Screening, Diagnosis and Treatment Requirements

Amerigroup will assign children and adolescents under age 21 to a PCP who is certified by the Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Healthy Kids program. If the member's parent, guardian or caretaker, as appropriate, specifically requests assignment to a PCP who is not EPSDT-certified, the non-EPSDT provider is responsible for ensuring the child receives well-child care according to the EPSDT schedule. If you provide primary care services to individuals under age 21 and are not EPSDT-certified, call 410-767-1836. For more information about the HealthyKids/EPSDT Program and expanded EPSDT services for children under age 21, go to https://mmcp.health.maryland.gov/epsdt/Pages/Home.aspx.

Providers must follow the Maryland Healthy Kids/EPSDT program periodicity schedule and all associated rules to fulfill the requirements under "Title XIX" of the *Social Security Act* for providing children under 21 with EPSDT services. The program requires you to:

- Notify members of their due dates for wellness services and immunizations**.**

- Schedule and provide preventive health services according to the state's EPSDT periodicity schedule and screening manual.
- Refer infants and children under age 5 and pregnant teens to the Supplemental Nutritional Program for Women Infants and Children (WIC).
- Provide the WIC program with member information about hematocrits and nutrition status to assist in determining a member's eligibility for WIC.
- Participate in the Vaccines for Children (VFC) program. Many of the routine childhood immunizations are furnished under the VFC program. The VFC program provides free vaccines for health care providers who participate in the VFC program. Amerigroup will pay for new vaccines that are not yet available through the VFC program.
- Schedule appointments at an appropriate time interval for any member who has an identified need for follow-up treatment as the result of a diagnosed condition.

Members under age 21 are eligible for a wider range of services under EPSDT than adults; PCPs are responsible for understanding these expanded services (see the EPSDT Services section). PCPs must make appropriate referrals for services that prevent, treat or ameliorate physical, mental or developmental problems or conditions.

Providers shall refer children for specialty care as appropriate. Referrals must be made when a child:
- Is identified as being at risk of a developmental delay by the developmental screen required by EPSDT.
- Has a 25 percent or more delay in any developmental area as measured by appropriate diagnostic instruments and procedures.
- Manifests atypical development or behavior.
- Has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

A child thought to have been physically, mentally or sexually abused must be referred to a specialist who is able to make that determination.

EPSDT Outreach and Referral to the LHD

For each scheduled Healthy Kids appointment, written notice of the appointment date and time must be sent by mail to the child's parent, guardian or caretaker, and attempts must be made to notify the child's parent, guardian or caretaker of the appointment date and time by telephone.

For children from birth through 2 years of age who miss EPSDT appointments and for children under age 21 who are determined to have parents, caregivers or guardians who are difficult to reach or repeatedly fail to comply with a regimen of treatment for the child, you should follow the procedures below to bring the child into care:

1. Document outreach efforts in the medical record. These efforts should include attempts to notify the member by mail, phone and face-to-face contact.
2. Schedule a second appointment within 30 days of the first missed appointment.
3. Within 10 days of the child missing the second consecutive appointment, request assistance in locating and contacting the child's parent, guardian or caretaker by calling Amerigroup at 1-800-454-3730. You may concurrently make a written referral to the LHD ACCU by completing the *Local Health Services Request* form (see Attachment 4 or https://mmcp.health.maryland.gov/pages/Local-Health-Services-Request-Form.aspx).

4. Continue to work collaboratively with Amerigroup and the ACCU until the child is in care and up to date with the EPSDT periodicity schedule or receives appropriate follow-up care.

Support and outreach services are also available to members that have **impaired cognitive ability or psychosocial problems such as homelessness** or other conditions likely to cause them to have difficulty understanding the importance of care instructions or difficulty navigating the health care system. You must notify Amerigroup if these members miss three consecutive appointments or repeatedly do not follow their treatment plan. We will attempt to outreach the member and may make a referral to the ACCU to help locate the member and get him or her into care.

Special Needs Populations

The state of Maryland has identified certain groups as requiring special clinical and support services from their MCO. These special needs populations are:

- Pregnant and postpartum women
- Children with special health care needs
- Children in state-supervised care
- Individuals with HIV/AIDS
- Individuals with a physical disability
- Individuals with a developmental disability
- Individuals who are homeless

To provide care to a special needs population, it is important for the PCP and specialist to:

- Demonstrate their credentials and experience to us in treating special populations.
- Collaborate with our Case Management staff on issues pertaining to the care of a special needs member.
- Document the plan of care and care modalities and update the plan annually.

Individuals in one or more of these special needs populations must receive services in the following manner from us and/or our providers:

- Upon the request of the member or the PCP, a case manager trained as a nurse or a social worker will be assigned to the member. The case manager will work with the member and the PCP to plan the treatment and services needed. The case manager will not only help plan the care, but will help keep track of the health care services the member receives during the year and will serve as the coordinator of care with the PCP across a continuum of inpatient and outpatient care.
- The PCP and our case managers, when required, coordinate needed specialty care. This includes specialists for disposable medical supplies (DMS), durable medical equipment (DME) and assistive technology devices based on medical necessity. **PCPs should follow protocols established by us for sending HealthChoice members to specialty care networks.**
- We have a special needs coordinator on staff to focus on the concerns and issues of special needs populations. The special needs coordinator helps members find information about their condition or suggests places in their area where they may receive community services and/or referrals. To contact the special needs coordinator, call 410-981-4060.
- Providers are required to treat individuals with disabilities consistent with the requirements of the *Americans with Disabilities Act of 1990* (*P.L. 101-336 42 U.S.C. 12101 et. seq.* and regulations promulgated under it).

Special Needs Population — Outreach and Referral to the LHD
A member of a special needs population who fails to appear for appointments or who has been noncompliant with a regimen of care must be referred to Amerigroup. If a member continues to miss appointments, call Amerigroup at 1-800-454-3730. We will attempt to contact the member by mail, phone and/or face-to-face visit. If we are unsuccessful in these outreach attempts, we will notify the LHD ACCU. You may also make a written referral to the ACCU by completing the *Local Health Services Request Form* (see Attachment 4 or https://mmcp.health.maryland.gov/pages/Local-Health-Services-Request-Form.aspx). The local ACCU staff will work collaboratively with Amerigroup to contact members and encourage them to keep appointments and provide guidance on how to effectively use their Medicaid/HealthChoice benefits.

Services for Pregnant and Postpartum Women
Prenatal care providers are key to assuring pregnant women have access to all available services. Many pregnant women will be new to HealthChoice and will only be enrolled in Medicaid during pregnancy and the postpartum period. Medicaid provides full benefits to these women during pregnancy and for two months after delivery, after which they will automatically be enrolled in the Family Planning Waiver Program (for more information, visit https://mmcp.health.maryland.gov/Documents/Factsheet3_Maryland%20Family%20Planning%20Waiver%20Program.pdf).

Amerigroup and our providers are responsible for providing pregnancy-related services, which include:
- Comprehensive prenatal, perinatal and postpartum care (including high-risk specialty care).
- Prenatal risk assessment and completion of the *Maryland Prenatal Risk Assessment* form (MDH 4950; see Attachment 5).
- An individualized plan of care based upon the risk assessment and is modified during the course of care as needed.
- Appropriate levels of inpatient care, including emergency transfer of pregnant women and newborns to tertiary care centers.
- Case management services.
- Prenatal and postpartum counseling and education, including basic nutrition education.
- Nutrition counseling by a licensed nutritionist or dietician for nutritionally high-risk pregnant women.
- Postpartum home visits.
- Referrals to ACCU.

The state provides these additional services for pregnant women:
- Special access to substance use disorder treatment within 24 hours of request and intensive outpatient programs that allow for children to accompany their mother
- Dental services

Encourage all pregnant women to call the state's Help Line for Pregnant Woman at 1-800-456-8900. This is especially important for women who are newly eligible or not yet enrolled in Medicaid. If the woman is already enrolled in HealthChoice, call us and also instruct her to call our Member Services department at 1-800-600-4441.

Pregnant women who are already under the care of an out-of-network practitioner qualified in obstetrics may continue with that practitioner if they agree to accept payment from Amerigroup. If the practitioner is not contracted with us, a care manager and/or Member Services representative will

coordinate services necessary for the practitioner to continue the member's care until postpartum care is completed.

The prenatal care providers must follow, at a minimum, the applicable American College of Obstetricians and Gynecologists (ACOG) clinical practice guidelines. For each scheduled appointment, you must provide written and telephonic, if possible, notice to member of the prenatal appointment dates and times. The prenatal care provider, PCP and Amerigroup are responsible for making appropriate referrals of pregnant members to publicly provided services that may improve pregnancy outcome. Examples of appropriate referrals include the Women Infants and Children special supplemental nutritional program (WIC) and local, evidenced-based home visiting programs such as Healthy Families America or Nurse Family Partnership. Prenatal care providers are also required to:

- Provide the initial health visit within 10 days of the request.
- Complete the *Maryland Prenatal Risk Assessment* (MDH 4850; see Attachment 5) during the initial visit and submit it to the local health department within 10 days of the initial visit.
    - Amerigroup will pay for the initial prenatal risk assessment (use CPT code H1000).
- Offer HIV counseling and testing and provide information on HIV infection and its effects on the unborn child.
- At each visit, provide health education relevant to the member's stage of pregnancy.
    - Amerigroup will pay for this — use CPT code H1003 for an "Enriched Maternity Services." You may only bill for one unit of "Enriched Maternity Services" per visit. Refer pregnant and postpartum women to the WIC program.
- If under age 21, refer the member to his or her PCP to have EPSDT screening services provided.
- Reschedule appointments within 10 days if a member misses a prenatal appointment. Call Amerigroup if a prenatal appointment is not kept within 30 days of the first missed appointment.
- Refer pregnant women to the Maryland Healthy Smiles Dental Program. If they have questions about dental benefits, members can contact Healthy Smiles at:
    - Phone: 1-855-934-9812 (TDD: 1-855-934-9816).
    - Web Portal: http://member.mdhealthysmiles.com.
- Refer pregnant and postpartum women who may be in need of diagnosis and treatment for a mental health or substance use disorder to the Behavioral Health System; if indicated, they are required to arrange for substance abuse treatment within 24 hours.
- Record the member's choice of pediatric provider in the medical record prior to her eighth month of pregnancy. Amerigroup can assist in choosing a PCP for the newborn.
- Advise the member that she should be prepared to name the newborn at birth.
    - This is required for the hospital to complete the Hospital Report of Newborns (MDH 1184). The hospital must complete this form so Medicaid can issue the newborn's ID number. The newborn will be enrolled in the mother's MCO.

Childbirth-Related Provisions

Special rules for length of hospital stay following childbirth:

- A member's length of hospital stay after childbirth is determined in accordance with the ACOG and AAP Guidelines for perinatal care unless the 48-hour (uncomplicated vaginal delivery)/96-hour (uncomplicated Cesarean section) length of stay guaranteed by state law is longer than that required under the guidelines.
- If a member must remain in the hospital after childbirth for medical reasons and she requests that her newborn remain in the hospital while she is hospitalized, additional hospitalization of up to four days is covered for the newborn and must be provided.

- If a member elects to be discharged earlier than the conclusion of the length of stay guaranteed by state law, a home visit must be provided. When a member opts for early discharge from the hospital following childbirth (before 48 hours for vaginal delivery or before 96 hours for C-section), one home nursing visit within 24 hours after discharge and an additional home visit, if prescribed by the attending provider, are covered.

The hospital is responsible for notifying Amerigroup within 24 hours or by the next day of the following instances:

- The birth of the child
- If a newborn is transferred from the nursery to the NICU
- If a newborn is transferred to another level of care
- If a newborn is detained beyond the OB global period

These changes would be documented as a separate, new admission and not part of the mother's admission.

Postnatal home visits must be performed by a registered nurse, in accordance with generally accepted standards of nursing practice for home care of a mother and newborn, and must include:

- An evaluation to detect immediate problems of dehydration, sepsis, infection, jaundice, respiratory distress, cardiac distress or other adverse symptoms of the newborn.
- An evaluation to detect immediate problems of dehydration, sepsis, infection, bleeding, pain or other adverse symptoms of the mother.
- Blood collection from the newborn for screening, unless previously completed.
- Appropriate referrals and any other nursing services ordered by the referring provider.

If the member remains in the hospital for the standard length of stay following childbirth, a home visit, if prescribed by the provider, is covered.

Unless we provide for the service prior to discharge, a newborn's initial evaluation by an out-of-network on-call hospital physician before the newborn's hospital discharge is covered as a self-referred service.

Amerigroup is required to schedule the newborn for a follow-up visit within two weeks after discharge if no home visit has occurred or within 30 days after discharge if there has been a home visit.

Breast pumps are covered under certain situations for breastfeeding mothers. Call us at 1-800-600-4441.

Children with Special Health Care Needs

Self-referral for children with special needs is intended to ensure continuity of care and appropriate plans of care. Self-referral for children with special health care needs will depend on whether or not the condition that is the basis for the child's special health care needs is diagnosed before or after the child's initial enrollment in Amerigroup. Medical services directly related to a special-needs child's medical condition may be accessed out-of-network only if the following specific conditions are satisfied:

- **New member:** A child who, at the time of initial enrollment, was receiving these services as part of a current plan of care may continue to receive these specialty services provided the pre-existing out-of-network provider submits the plan of care to us for review and approval within 30 days of the child's effective date of enrollment into Amerigroup, and we approve the services as medically necessary.

- **Established member:** A child who is already enrolled in Amerigroup when diagnosed as having a special health care need requiring a plan of care that includes specific types of services may request a specific out-of-network provider. We are obliged to grant the member's request unless we have a local in-network specialty provider with the same professional training and expertise who is reasonably available and provides the same services and service modalities.

If we deny, reduce or terminate the services, members have an appeal right regardless of whether they are a new or established member. Pending the outcome of an appeal, we may reimburse for services provided.

For children with special health care needs, Amerigroup will:

- Provide the full range of medical services for children, including services intended to improve or preserve the continuing health and quality of life, regardless of the ability of services to affect a permanent cure.
- Provide case management services to children with special health care needs as appropriate. For complex cases involving multiple medical interventions, social services or both, a multidisciplinary team must be used to review and develop the plan of care for children with special health care needs.
- Refer special needs children to specialists as needed. This includes specialty referrals for children who have been found to be functioning one-third or more below chronological age in any developmental area as identified by the developmental screen required by the EPSDT periodicity schedule.
- Allow children with special health care needs to access out-of-network specialty providers as specified in the special provisions and guidelines detailed in Section 1, Self-Referred Services for Children with Special Health Care Needs.
- Log any complaints made to the state or to Amerigroup about a child who is denied a service by Amerigroup.
    - We will inform the state about all denials of service to children. All denial letters sent to children or their representatives will state that members can appeal by calling the State's HealthChoice Help Line at 1-800-284-4510.
- Work closely with the schools that provide education and family services programs to children with special needs.

Children in State-Supervised Care

We will ensure coordination of care for children in state-supervised care. If a child in state-supervised care moves out of the area and must transfer to another MCO, the state and Amerigroup will work together to find another MCO as quickly as possible.

Individuals with HIV/AIDS

Children with HIV/AIDS are eligible for enrollment in the Rare and Expensive Case Management (REM) program (see the Rare and Expensive Case Management Program section). All other individuals with HIV/AIDS are enrolled in one of the HealthChoice MCOs.

Amerigroup is required to provide the following services for persons with HIV/AIDS:

- An HIV/AIDS specialist for treatment and coordination of primary and specialty care must be involved in the patient's care. To qualify as an HIV/AIDS specialist, a health care provider must meet the criteria specified under COMAR.

- A diagnostic evaluation service (DES) assessment can be performed once every year at the member's request. The DES includes a physical, mental and social evaluation. The member may choose the DES provider from a list of approved locations or can self-refer to a certified DES for the evaluation.
- Substance use treatment within 24 hours of request.
- The right to ask us to send them to a site doing HIV/AIDS-related clinical trials. We may refer members who are individuals with HIV/AIDS to facilities or organizations that can provide the members access to clinical trials.
- The LHD will designate a single staff member to serve as a contact.
- Providers will maintain the confidentiality of client records and eligibility information, in accordance with all federal, state and local laws and regulations, and use this information only to assist the participant in receiving needed health care services.

Amerigroup will provide case management services for any member who is diagnosed with HIV. These services will be provided with the member's consent and will facilitate timely and coordinated access to appropriate levels of care and support continuity of care across the continuum of qualified service providers. If a member initially refuses HIV case management services, he or she may request services at a later time. Case management will link HIV-infected members with the full range of benefits (e.g., primary behavioral health care and somatic health care services) and referral for any additional needed services including specialty behavioral health services, social services, financial services, educational services, housing services, counseling and other required support services. HIV case management services include:

- Initial and ongoing assessment of the member's needs and personal support systems, including using a multidisciplinary approach to develop a comprehensive, individualized service plan. This includes periodic re-evaluation and adaptation of the plan.
- Coordination of services needed to implement the plan.
- Outreach for the member and the member's family by which the case manager and the PCP track services received, clinical outcomes and the need for additional follow-up care.

The member's case manager will serve as the member's advocate to resolve differences between the member and providers pertaining to the course or content of therapeutic interventions.

Individuals with Physical or Developmental Disabilities

Before placement of an individual with a physical disability into an intermediate or long-term care facility, Amerigroup will assess the needs of the individual and the community as supplemented by other Medicaid services. The Amerigroup medical director will conduct a second-opinion review of the case before placement. If the medical director determines the transfer to an intermediate or long-term care facility is medically necessary and the expected stay will be greater than 30 days, Amerigroup will obtain approval from MDH before making the transfer.

Providers who treat individuals with physical or developmental disabilities must be trained on the special communications requirements of individuals with physical disabilities. We are responsible for accommodating hearing-impaired members who require and request a qualified interpreter. We can delegate the financial risk and responsibility to our providers, but we are ultimately responsible for ensuring that our members have access to these services.

Amerigroup providers must be clinically qualified to provide DME and assistive technology services for both adults and children.

Amerigroup informational materials are approved by persons with experience in the needs of members with disabilities, thereby ensuring the information is presented in a manner in which members understand the material, whether on paper or by voice translation. Amerigroup provides training to its triage, Member Services and Case Management staff on the special communications requirements of members with physical disabilities and will clearly indicate to its providers how this is implemented (see Additional Services Provided by Amerigroup for how to access these services).

Before placement of an individual with a physical disability into an intermediate or long-term care facility, we will cooperate with the facility in meeting their obligation to complete a Pre-Admission Screening and Resident Review (PASRR) ID Screen.

Homeless Individuals
Homeless individuals may use the local health department's address to receive mail. If we know an individual is homeless, we will offer to provide a case manager to coordinate health care services.

Adult Members with Impaired Cognitive Ability/Psychosocial Problems
Support and outreach services are available for adult members needing follow-up care who have impaired cognitive ability or psychosocial problems and who can be expected to have difficulty understanding the importance of care instructions or difficulty navigating the health care system.

Rare and Expensive Case Management Program

The Rare and Expensive Case Management (REM) program is an alternative to managed care for children and adults with certain diagnosis who would otherwise be required to enroll in HealthChoice. If members are determined eligible for REM, they can choose to stay in Amerigroup or they may receive services through the traditional Medicaid fee-for-service program. They cannot be in both an MCO and REM. See Attachment 1 for the list of qualifying diagnosis and a full explanation of the referral process.

SECTION III. HEALTHCHOICE BENEFITS AND SERVICES

MCO Benefits and Services Overview

Amerigroup must provide comprehensive benefits equivalent to the benefits that are available to Maryland Medicaid participants through the Medicaid fee-for-service system. Only benefits and services that are medically necessary are covered. Carved-out services, which are not subject to capitation and are not an Amerigroup responsibility, are still available for HealthChoice members. Medicaid will reimburse these services directly on a fee-for-service basis.

Audiology Services
Audiology services that are medically necessary will be covered by Amerigroup for both adults and children. For individuals under age 21, bilateral hearing amplification devices are covered by the MCO. For adults 21 and older, unilateral hearing amplification devices are covered by the MCO. Bilateral hearing amplification devices are only covered for adults 21 and older in certain circumstances when the individual has a documented history of using bilateral hearing aids before age 21. These circumstances are listed in the Maryland Department of Health Audiology criteria. The state's Audiology medical necessity criteria can be found on the Maryland Department of Health website at https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx.

Blood and Blood Products
We cover blood, blood products, derivatives, components, biologics and serums, to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin and albumin.

Case Management Services
We cover case management services for members who need such services, including but not limited to members of state-designated special needs populations as described in Section II. If warranted, a case manager will be assigned to a member when the results of the initial health screen are received by the MCO or when requested by the state.

A case manager may conduct home visits as necessary as part of the Amerigroup case management program and will have the ability to respond to a member's urgent care needs during a home visit. Call Provider Services at 1-800-454-3730 to refer a member to case management.

Clinical Trial Items and Services
Clinical trials coverage and routine costs are subject to certain conditions specified by the state and outlined in the Code of Maryland Regulations (COMAR). For more information, visit www.dsd.state.md.us/COMAR/ComarHome.html. We cover certain routine costs that would otherwise be a cost to the member.

Dental Services for Children and Pregnant Women
See the State-Covered Dental Services for Children and Pregnant Women section for more information.

Diabetes Care Services
Amerigroup covers all medically necessary diabetes care services. For members who have been diagnosed with diabetes, we cover:

- Diabetes nutrition counseling.
- Diabetes outpatient education.
- Diabetes-related durable medical equipment and disposable medical supplies, including:
  - Blood glucose meters for home use.
  - Finger sticking devices for blood sampling.

- Blood glucose monitoring supplies.
- Diagnostic reagent strips and tablets used for testing for ketone and glucose in urine and glucose in blood.
- Therapeutic footwear and related services to prevent or delay amputation that would be highly probable in the absence of specialized footwear.

- Routine foot care
- Vision Care
  - One ophthalmologic examination per year
  - One pair of eyeglasses per year

Diabetes Prevention Program

Members are eligible to participate in an evidence-based diabetes prevention program established by the Centers for Disease Control and Prevention if they:

- Are 18 to 64 years old
- Overweight or obese
- Have an elevated blood glucose level or a history of gestational diabetes mellitus
- Have never been diagnosed with diabetes; and
- Are not currently pregnant.

Diagnostic and Laboratory Services

Diagnostic services and laboratory services performed by providers who are CLIA-certified or have a waiver of a certificate registration and a CLIA ID number are covered. However, viral load testing, genotypic, phenotypic, or drug-resistance testing used in treatment of HIV/AIDS are reimbursed by the state and must be rendered by a MDH-approved provider and be medically necessary. Prior authorization is required for genetic testing. All laboratory services furnished by nonparticipating providers require prior authorization by Amerigroup, except for hospital laboratory services for an emergency medical condition. If a convenient alternative is not available, prior authorization is required for members to access network hospital outpatient departments for blood drawings and/or specimen collection.

To ensure outpatient diagnostic laboratory services are directed to the most appropriate setting, laboratory services should be sent to an Amerigroup-preferred laboratory vendor (e.g., LabCorp or Quest Diagnostics). Laboratory services provided in a Maryland hospital will be reimbursed under certain circumstances including:

- Services identified by Amerigroup as stat laboratory procedures (for a list of identified stat laboratory procedure codes, refer to the provider website).
- Services rendered in an emergency room setting with an emergent diagnosis.
- Services rendered in conjunction with ambulatory surgery services (RV0360-RV0369, RV0481, RV0490-RV0499, RV0720-RV0729, RV0750-RV0759, and RV0790-RV0799).
- Services rendered in conjunction with observation services (RV0760-RV0769).
- Services billed with certain chemotherapy, obstetric and sickle cell diagnosis codes (C00-C14.8, C15.3-C26.9, C30.0-C39.9, C40.0-C41.9, C43.0-C44.9, C45.0-C49.9, C50.01-C50.92, C51.0-C58, C60.0-C63.9, C6.1-C68.9, C69.0-C72.9, C73-C75.9, C76.0-C80.2, C81.00-C96.9, D00.00-D09.9, D37.01-D48.9, D49.0-D49.9, D57.00-D57.819, O01.0-O01.9, O02.0-O02.81, O02.1, O00.0-O00.9, O03.0-O03.9, O08.0-O08.9, O09.00-O09.93, O10.011-O10.02, O10.111-O10.12, O10.211-O10.22, O10.311-O10.32, O10.411-O10.42, O10.911-O10.92, O11.1-O15.1, O15.9-O16.9, O20.0-O24.02, O24.111-O24.12, O24.311-O24.32, O24.410-O24.429, O24.811-O24.82,

O24.911-024.92, O25.10-O25.2, O26.00-O26.62, O26.711-O26.72, O26.811-O29.93, O30.00-O48, O60.00-O77.9, O80-O82, Z331, Z3400-Z3493, Z390-Z392, Z51.11-Z51.12).

Physicians may continue to perform laboratory testing in their office but must otherwise direct outpatient diagnostic laboratory tests to an Amerigroup-preferred laboratory vendor (e.g., LabCorp or Quest Diagnostics).

Laboratory codes for drug testing or urine drug screening related to a substance use disorder are not the payment responsibility of the MCOs.

Dialysis Services

We cover dialysis services either through participating providers or members can self-refer to nonparticipating Medicare-certified providers. HealthChoice members with end-stage renal disease (ESRD) are eligible for the REM program. To be REM-eligible on the basis of ESRD, members must meet one of the following sets of criteria:

- Children (under 21 years of age) with chronic renal failure (ICD-10 codes N18.1-N18.6) diagnosed by a pediatric nephrologist
- Adults (21-64 years of age) with chronic renal failure and dialysis (ICD-10 code Z992)

For those Amerigroup members needing dialysis treatment, dialysis services are covered either directly through participating providers or members can self-refer to nonparticipating Medicare-certified providers.

Disease Management/Population Health

Disease Management/Population Health (DM/PH) Program is based on a system of coordinated care management interventions and communications designed to help physicians and other health care professionals manage members with chronic conditions.

DM/PHP services focus on the needs of the member through telephonic and community-based resources. Motivational interviewing techniques are used in conjunction with member self-empowerment to coach members on how to manage one or more conditions –in our changing social and healthcare environment.

Who Is Eligible?

We offer Disease Management/Population Health for members diagnosed with one or more of the following chronic conditions:

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disease
- Coronary artery disease
- Congestive heart failure
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder — adult
- Major depressive disorder — child/adolescent
- Schizophrenia
- Substance use disorder

Our member-centric, holistic approach also allows us to assist members with smoking cessation and weight management education.

Program Features

- Proactive population identification processes

- Evidence-based clinical practice guidelines from recognized sources
- Collaborative practice models to include physician and support in treatment planning
- Continuous self-management education
- Ongoing communication with primary and ancillary providers regarding patient status
- Nine of our DM/PHP programs are National Committee for Quality Assurance accredited and incorporate outreach, education, care coordination and follow-up to improve treatment compliance and enhance self-care.

Our programs are based on the nationally approved clinical practice guidelines located at https://provider.amerigroup.com/MD. A copy of these guidelines can be printed from the website.

As a valued provider, you can also refer patients who can benefit from additional education and care management support. Our case managers will work collaboratively with you to obtain your input in the development of care plans.

Members identified for participation in any of the programs are assessed and risk-stratified based on the severity of their disease. Once enrolled in a program, they are provided with continuous education on self-management concepts, including primary prevention, coaching related by healthy behaviors and compliance/monitoring and case/care management for high-risk members. Program evaluation, outcome measurement and process improvement are built into all the programs. Providers are given telephonic and/or written updates regarding patient status and progress.

Disease Management/Population Health Provider Rights and Responsibilities
You have the right to:
- Obtain information about the organization's services, staff qualifications and any contractual relations. :
- Decline to participate in or work with organization's programs and services on behalf of their patients.
- Be informed how the organization coordinates interventions with care plans for individual members.
- Know how to contact the case manager responsible for managing and communicating with their patients.
- Be supported by our organization when interacting with members to make decisions about their health care.
- Receive courteous and respectful treatment from the organization's staff.
- Communicate complaints to the organization.

Hours of Operation
Please contact us via email at DM-PHP-Provider-Referrals@amerigroup.com or call our department directly at 1-888-830-4300. Our DM/PHP case managers are available Monday-Friday from 8:30 a.m.-5:30 p.m. local time. Confidential voicemail is available 24 hours a day. Additional provider information is also online at https://provider.amerigroup.com/MD > Patient Care > Disease Management/Population Health.

Durable Medical Services and Durable Medical Equipment
We cover medically necessary durable medical services and durable medical equipment (DMS/DME). We must provide authorization for DME and/or DMS within a timely manner so as not to adversely affect the member's health and within two business days of receipt of necessary clinical information but

not later than 14 calendar days from the date of the initial request. We must pay for any DME authorized for members even if delivery of the item occurs within 90 days after the member's disenrollment from Amerigroup, as long as the member remains Medicaid eligible during the 90-day time period.

We cover disposable medical supplies, including incontinency pants and disposable underpants for medical conditions associated with prolonged urinary or bowel incontinence, if necessary to prevent institutionalization or infection. We cover all DMS/DME used in the administration or monitoring of prescriptions. We pay for breast pumps under certain circumstances, in accordance with Medicaid policy.

For code-specific prior authorization requirements for DME, prosthetics and orthotics ordered by network providers or facilities, go to https://provider.amerigroup.com/md > Resources > Prior Authorization Lookup Tool.

Prior authorization may be requested by completing a *Certificate of Medical Necessity* (*CMN*) — available on the Amerigroup website — or by submitting a physician order and an *Amerigroup Referral and Authorization Request* form. A properly completed and physician-signed *CMN* must accompany each claim for the following services: hospital beds, support surfaces, motorized wheelchairs, manual wheelchairs, continuous positive airway pressure devices, lymphedema pumps, osteogenesis stimulators, transcutaneous electrical nerve stimulator units, seat-lift mechanisms, power-operated vehicles, external infusion pumps, parenteral nutrition equipment, enteral nutrition equipment and oxygen. Amerigroup and the provider must agree on HCPCS and/or other codes for billing covered services. All custom wheelchair prior authorizations require the medical director's review. All DME billed with an RR modifier (i.e., rental) requires prior authorization.

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

We must cover the following EPSDT services for members under 21 years of age:

- Well-child services provided in accordance with the EPSDT/Healthy Kids periodicity schedule by an EPSDT-certified provider, including:
  - Periodic comprehensive physical examinations
  - Comprehensive health and developmental history, including an evaluation of both physical and mental health development
  - The implementation of an approved developmental screening tool (e.g., Ages and Stations Questionnaire ASQ or Parent's Evaluation of Developmental Status PEDS) should begin at the 9-month, 18-month and 24-30 month visits. The results of the developmental surveillance and screening and the screening tool used should be documented in the patient's chart. Children identified as being at risk for developmental delays should have documented counseling and referral for additional evaluation services (refer to https://mmcp.dhmh.maryland.gov/pages/Provider-Information.aspx > EPSDT/Healthy Kids Resources for more information).
  - Immunizations
  - Laboratory tests including blood level assessments
  - Vision, hearing and oral health screening
  - Health education

The state must also provide or assure the MCO provides expanded EPSDT services and partial or inter-periodic well-child services necessary to prevent, treat or ameliorate physical, mental or developmental problems or conditions. Services must be sufficient in amount, duration and scope to treat the identified condition and all must be covered subject to limitations only on the basis of medical

necessity. These include such services as:

- Chiropractic services.
- Nutrition counseling.
- Audiology.
- Private duty nursing services.
- Durable medical equipment, including assistive devices.
- Behavioral health services.
- Any other benefit listed in this section.

Limitations on covered services do not apply to children under age 21 receiving medically necessary treatment under the EPSDT program. Providers are responsible for making appropriate referrals for publicly funded programs not covered by Medicaid, including Head Start, the WIC program, Early Intervention services, School Health-Related Special Education Services, vocational rehabilitation and evidenced based home visiting services provided by community-based organizations.

Family Planning Services

We will cover comprehensive family planning services such as:

- Office visits for family planning services.
- Laboratory tests, including Pap smears.
- All FDA-approved contraceptive devices, methods and supplies.
- Immediate postpartum insertion of IUDs.
- Oral contraceptives (must allow a 12-month supply to be dispensed for refills).
- Emergency contraceptives and condoms without a prescription.
- Voluntary sterilization procedures (Sterilization procedures are not self-referred; member must be 21 years of age and use an in-network provider or have authorization for out-of-network care.)

Gender Transition Services

We cover medically necessary gender reassignment surgery and other somatic care for members with gender identity disorder.

Habilitation Services

We cover habilitation services when medically necessary for certain adults who are eligible for Medicaid under the *ACA*. These services include physical, occupational and speech therapy. If you have questions about which adults are eligible, call 1-800-454-3730.

Home Health Services

We cover home health services when the member's PCP or ordering provider certifies the services are necessary on a part-time, intermittent basis by a member who requires home visits. Amerigroup may choose to provide coverage of home health services to a non-homebound member, but this is not a mandatory benefit. Covered home health services are delivered in the member's home and include:

- Skilled nursing services, including supervisory visits.
- Home health aide services (including biweekly supervisory visits by a registered nurse in the member's home, with observation of aide's delivery of services to member at least every other visit). These Home health aide services are covered by the State of Maryland.
- Physical therapy services.
- Occupational therapy services.
- Speech pathology services.
- Medical supplies used in a home health visit.

Hospice Care Services
Hospice care services are covered for members who are terminally ill with a life expectancy of six months or less. Hospice services can be provided in a hospice facility, long-term care facility or at home. Notification is required for coverage of outpatient hospice services. Prior authorization is required for home health care and most DME.

We do not require a hospice care member to change his/her out-of-network hospice provider to an in-network hospice provider. Hospice providers should make members aware of the option to change MCOs. MDH will allow new members who are in hospice care to voluntarily change their MCO if they have been auto-assigned to a MCO with whom the hospice provider does not contract. If the new member does not change their MCO, then the MCO in which the new member is currently enrolled must pay the out-of-network hospice provider.

Inpatient Hospital Services
We cover inpatient hospital services. Amerigroup is not responsible for payment of any remaining days of a hospital admission that began prior to the individual's enrollment in our MCO. We are, however, responsible for reimbursement of professional services rendered during the remaining days of the admission if the member remains Medicaid eligible.

Elective admissions require prior authorization for coverage. Emergency admissions require notification within 24 hours or by the next business day. To be covered, preadmission testing must be performed by an Amerigroup-preferred laboratory vendor or network facility outpatient department, and medical necessity review is required. See the *Provider Referral Directory* at https://provider.amerigroup.com/MD for a complete listing of participating vendors. Same-day admission is required for surgery.

For special rules for length of stay for childbirth, see the Childbirth-Related Provisions section.

Long-Term Care Facility Services/Nursing Facility Services

Long-term care facilities include, rehabilitation hospitals and skilled nursing facilities. The first 90 days of medically necessary services in a skilled nursing facility are the responsibility of Amerigroup, subject to specific rules. Prior authorization is required for coverage from Amerigroup.

When a member is transferred to a skilled nursing or long-term care facility and the length of the member's stay is expected to exceed 90 days, medical eligibility approval from the Maryland Department of Health (MDH) for long-term institutionalization must be secured as soon as possible.

For members who were enrolled in Amerigroup prior to admission to a nursing facility, chronic hospital or chronic rehabilitation hospital and meet the state's level of care (LOC) criteria, Amerigroup is responsible for up to 90 days of the stay, if medical necessity is met, subject to specific rules.

Once a member has been disenrolled from Amerigroup, the services they receive in a qualifying long-term care facility will be directly reimbursed by the Maryland Medical Assistance Program as long as the member maintains continued eligibility.

Inpatient acute care services provided within the first 30 days following admission to a long-term care facility are **not** considered an interruption of the Amerigroup-covered 90 continuous days in a long-term care facility, as long as the member is discharged from the hospital back to the long-term care facility.

A member with serious behavioral illness, intellectual disability or a related condition may **not** be admitted to a nursing facility (NF) unless the state determines NF services are appropriate for coverage. For each member seeking NF admission, a preadmission screening and resident review (PASRR) ID screen must be completed.

The first section of the PASRR ID screen exempts a member if both:
1. NF admission is directly from a hospital for the condition treated in the hospital.
2. The attending provider certifies, prior to admission to the NF, that the member is likely to require less than 30 days of NF services.

Newborn Coordinator and Provider Responsibilities
Amerigroup will designate a newborn coordinator (NC) to serve as a point of contact for providers who have questions or concerns related to the eligibility of services for newborns during the first 60 days after birth. For your NC's contact information, visit https://mmcp.dhmh.maryland.gov/healthchoice/pages/MCO-Newborn-Coordinator.aspx.

Outpatient Hospital Services
We cover medically necessary outpatient hospital services. As required by the state, we limit observation stays to 24 hours.

Outpatient Rehabilitative Services
We cover outpatient rehabilitative services including but not limited to medically necessary physical therapy for adult members. For members under 21 rehabilitative services are covered when the service is part of a home health visit or inpatient hospital stay.

Prior authorization must be obtained from the Health Plan for physical or occupational therapy services for adult members 21 years of age and older beyond the initial evaluation. The Health Plan conducts medical necessity reviews for physical and occupational therapy services, and medical necessity criteria must be met. Providers can request authorization from OrthoNet by calling 800-964-3730 or faxing request with clinical information to 866-920-6180.

For members under age 21, rehabilitative services are covered by Amerigroup only as part of a home health visit or inpatient hospital stay. All other rehabilitative services for members under age 21 should be billed to Medicaid fee-for-service.

Oxygen and Related Respiratory Equipment
We cover oxygen and related respiratory equipment.

Pharmacy Services and Copays
We are responsible for most pharmacy services and will expand our drug formulary to include new products approved by the Food and Drug Administration (FDA) (per COMAR) in addition to maintaining drug formularies that are at least equivalent to the standard benefits of the Maryland Medical Assistance Program. We cover medical supplies or equipment used in the administration or monitoring of medication prescribed or ordered for a member by a qualifying provider. Most behavioral health drugs are on the state's formulary and are the responsibility of the state.

There are no pharmacy copays for children, pregnant women or birth control. For drugs covered by the state, such as behavioral health drugs, pharmacy copays are $1 for generic and $3 for brand-name drugs.

Plastic and Restorative Surgery
We cover these services when the service will correct a deformity from disease, trauma, congenital or developmental anomalies or to restore body functions. **Cosmetic surgery to solely improve appearance or mental health is not covered by the state or by the MCO.**

Podiatry Services
We cover medically necessary podiatry services. We also cover routine foot care for children under age 21 and for members with diabetes or vascular disease affecting the lower extremities. Individuals with diabetes receive diabetes care services.

Pregnancy-Related Care
Refer to the Services for Pregnant and Postpartum Women section.

Primary Behavioral Health Services
We cover primary behavioral health services, including assessment, clinical evaluation and referral for additional services. The PCP of a member requiring behavioral health services may elect to treat the member if the treatment, including visits for buprenorphine treatment, falls within the scope of the PCP's practice, training and expertise. Neither the PCP nor Amerigroup may bill the Behavioral Health System for the provision of such services because these services are included in the HealthChoice capitation rates.

When, in the PCP's judgment, a member's need for behavioral health treatment cannot be adequately addressed by primary behavioral health services provided by the PCP, the PCP should, after determining the member's eligibility based on probable diagnosis, refer the member to the Behavioral Health System.

Behavioral health and substance use services are covered by Optum, the state-designated vendor. Members should contact Optum at 1-800-888-1965 to receive care.

Referrals for behavioral health services can be made by calling the state's administrative service organization (ASO) at 1-800-888-1965, Monday-Friday from 8 a.m.-6 p.m.

Specialty Care Services
Specialty care services provided by a physician or an advanced practice nurse (APN) are covered when services are medically necessary and are outside of the PCP's customary scope of practice.

Specialty care services covered under this section also include:
- Services performed by nonphysician, non-APN practitioners, within their scope of practice, employed by a physician to assist in the provision of specialty care services, and working under the physician's direct supervision.
- Services provided in a clinic by or under the direction of a physician or dentist.
- Services performed by a dentist or dental surgeon when the services are customarily performed by physicians.

A member's PCP is responsible for making the determination, based on our requirements, of whether or not a specialty care service is medically necessary. PCPs must follow our special referral protocol for children with special health care needs who suffer from a moderate to severe chronic health condition which:
- Has significant potential or actual impact on health and ability to function.

- Requires special health care services.
- Is expected to last longer than six months.

A child functioning at 25 percent or more below chronological age in any developmental area must be referred for specialty care services intended to improve or preserve the child's continuing health and quality of life, regardless of the service's ability to effect a permanent cure.

Telemedicine and Remote Patient Monitoring
We must offer telemedicine and remote patient monitoring to the extent they are covered by the Medicaid fee-for-service program. Please call us at 1-800-454-3730 for more information.

Transplants
We cover medically necessary transplants to the extent that the service would be covered by the state's fee-for-service program.

Vision Care Services
We cover medically necessary vision care services. We are required to cover one eye examination every two years for members age 21 or older; and for members under age 21, at least one eye examination every year in addition to EPSDT screening. For members under age 21, we are required to cover one pair of eyeglasses per year unless lost, stolen, broken or no longer vision-appropriate; contact lenses must be covered if eyeglasses are not medically appropriate for the condition.

As an added benefit, Amerigroup covers other vision services for adults age 21 and older. See the Additional Services Covered by Amerigroup section.

Additional Services Covered By Amerigroup

In addition to those services previously noted, Amerigroup currently provides the following optional services to our members. These services are not taken into account when setting our capitation rate. MCO optional services may change each calendar year. We may not discontinue or reduce these services without providing advance notification to the state.

Dental Care for Adults Age 21 and Older Who Are Not Pregnant
Amerigroup offers coverage for an oral exam and cleaning every six months, extractions, fillings and x-rays, benefit limits up to $750 per year towards the services and a 20-percent discount on all other dental services. A member may self-refer for these adult dental benefits by contacting DentaQuest directly at 1-800-341-8478.

Vision Care for Adults Age 21 and Older
In addition to one eye exam every 2 years, Amerigroup covers 1 pair of glasses with standard spectacle lenses and $50 retail allowance towards frames **or** a maximum retail allowance of $100 towards contacts every 24 months. A member may self-refer for these adult vision benefits by contacting Superior Vision directly at 1-800-507-3800.

Over-the-Counter Drugs
Amerigroup offers an extra benefit for certain over-the-counter (OTC) drugs. Each member can receive up to $30 worth of these drugs each quarter. Quarters begin on the first day of January, April, July and October. The provider must write a prescription for these drugs. If the member reaches his or her maximum within the quarter, the pharmacy will notify the member. The following drugs are covered as part of this benefit (the brand names listed serve as a reference only):

OTC drug type	Brand name
Antacid	Tums, Alternagel, Maalox, Mylanta, Maalox Plus and Prilosec OTC
Antidiarrheals	Kaopectate, Pepto-Bismol, Pedialyte and Imodium A-D
Antiemetics	Dramamine and Emetrol
Antihistamines	Chlor-Trimeton, Tavist-1, Benadryl, Alavert
Bacitracin	Polysporin, Neosporin
Cough and cold preparations	Dimetapp, Delsym, Vicks 44D, Robitussin, Robitussin DM, Robitussin-CF, Robitussin-PE, and Actifed Cold and Allergy
Decongestants	Sudafed
Ibuprofen	Advil
Laxatives	Dulcolax, Colace, Peri-Colace, Citroma, Phillips' Milk of Magnesia, Fleet Phospho-Soda, Metamucil, Senokot and Senokot-S
Miscellaneous, oral	Cepastat, Gas-X and Mylicon
Miscellaneous, topical	Amlactin, Debrox, Cortizone and Naphcon-A
Nutritionals/Supplements	Os-Cal, Niferex, Niferex-150, Fergon, Feosol, Fer-In-Sol, Strovite, Poly-Vi-Sol, Vi-Daylin, One-A-Day, Centrum, Slo-Niacin, Stuart Prenatal and Nephrovite
Pediculicide	RID, NIX
Respiratory	Broncho Saline

Interpreter Services

Oral interpretive services are available either in-office or telephonically at no cost to you or the member. If you serve an Amerigroup member with whom you cannot communicate, call Member Services at 1-800-600-4441 to access an interpreter. For immediate needs, Amerigroup has Spanish-language interpreters available without delay and can provide access to interpreters of other languages within minutes.

Amerigroup recommends requests for in-office interpreter services be arranged at least one business day in advance of the appointment. If a member with special needs requires an interpreter to accompany him or her to a clinic appointment, a case manager/care coordinator can make arrangements for the interpreter to be present.

Providers are required to offer interpretive services to members who may require assistance. Providers should document the offer and the members' response and reiterate interpretive services are available at no cost. Family and friends should not be used to provide interpretation services, except at a member's request.

Guidelines for Working with an Interpreter

Use the following guidelines for better communication when speaking through an interpreter:

- Keep your sentences short and concise — the longer and more complex your sentences, the less accurate the interpretation.
- When possible, avoid using medical terminology, which is unlikely to translate well.
- Ask key questions in several different ways to ensure the questions are fully understood, and you get the information you need.

- Be sensitive to potential member embarrassment, reticence or confusion. It is possible your questions or statements were not understood.
- Ask the member to repeat the instructions you have given as an effective review of how well the member has understood.

Services for the Deaf and Hard of Hearing
Members have the right to receive assistance through a text telephone/telecommunications device for the deaf (TTY/TDD) line. Amerigroup can help you telephonically communicate with members with impaired hearing via a translation device. Call Member Services using the TTY relay service at 711. In-office sign language assistance is also available. Call Member Services at 1-800-600-4441 to arrange for the service.

Additional Communication Options for Members and Providers
Amerigroup policies are designed to ensure meaningful opportunities for members with limited-English proficiency (LEP) to obtain access to health care services and to help members with LEP overcome language barriers and fully use services or benefits.

The Amerigroup provider directory includes a list of languages spoken by participating primary and specialty care providers. Translation assistance options are available at no cost to the member or provider. Upon request, written materials are available in large print, on tape and in languages other than English (dependent upon the plan's population). Member materials are written at a fifth-grade reading level per state requirement.

Amerigroup will not prohibit a provider, acting within the scope of his practice, from advising a member about his or her medical care or treatment for the condition or disease regardless of whether benefits are provided by Amerigroup. Amerigroup will not retaliate against a provider for advising the member.

Medicaid Benefits covered by the State – Not Covered by Amerigroup

State-Covered Dental Services for Children and Pregnant Women
The State covers dental services for children under age 21, former foster care youth up to age 26, and pregnant women. The Maryland Healthy Smiles Dental Program is responsible for routine preventative services, restorative service and orthodontia. Orthodontia must meet certain criteria and requires preauthorization by Skygen USA the States ASO. Skygen assigns members to a dentist and issues a dental Healthy Smiles ID card. However the member may go to any Healthy Smiles participating dentist. If you have questions about dental benefits for children and pregnant women call 1-855-934-9812.

Dental services for children under age 21 and pregnant women are provided by the Maryland Healthy Smiles Dental Program, administered by Skygen. Call Maryland Healthy Smiles at 1-844-275-8753 with questions about dental providers and benefits. Members should call Maryland Healthy Smiles Customer Service at 1-855-934-9812 (TDD 1-855-934-9816).

As of state fiscal year 2013, coverage of hospital anesthesia services for dental services performed in a hospital setting are covered by the medical assistance fee-for-service program (*Dental Transmittal No.45*).

Additional Services Covered by the State

The following services are paid by the state on a fee-for-service basis:
- Outpatient rehabilitative services for children under age 21

- Specialty mental health and substance use disorders covered by the Specialty Behavioral Health System
- The remaining days of a hospital admission following the member's Amerigroup enrollment (if the member was admitted to the hospital before the date of enrollment)
- Long-term care services except for those outlined in *COMAR 10.09.67.07B* and *COMAR 10.09.67.12A*
- Intermediate care facilities for individuals with intellectual disabilities or persons with developmental disabilities
- Related conditions (ICF/IID) services
- Personal care services
- Medical day care services for adults and children
- The following HIV/AIDS services:
  - Genotypic, phenotypic or other HIV/AIDS drug-resistance testing used in the treatment of HIV/AIDS, if the service is rendered by a department-approved provider and medically necessary
  - Viral load testing used in treatment of HIV/AIDS
  - Antiretroviral drugs in American Hospital Formulary Service therapeutic class 8:18:08 used in the treatment of HIV/AIDS
- Physical therapy, speech therapy, occupational therapy and audiology services when:
  - The member is younger than 21 years old
  - The services are not part of home health services or an inpatient hospital stay
- The following dental services:
  - Services for members younger than 21 years old and pregnant women (Note: Adult dental services are a value-added benefit and are managed by DentaQuest. See the Dental Care for Adults Age 21 and Older Who Are Not Pregnant section for more information.)
  - Surgery fees for the facility and general anesthesia for pregnant women and members younger than 21 years old
- Abortions (covered under limited circumstances — no federal funds are used — claims are paid through the Maryland Medical Care Program; if a woman was determined eligible for Medicaid based on her pregnancy, she is not eligible for abortion services)
- Emergency transportation (billed by local EMS)
- Non-emergency transportation services provided through grants to local governments
- Services provided to members participating in the state's Health Homes program
-

Noncovered Services and Benefit Limitations

Amerigroup does not cover these services except where noted, and the state does not cover these services:

- Services performed before the effective date of the member's enrollment in the MCO are not covered by the MCO, but they may be covered by Medicaid fee-for-service if the member was enrolled in Medicaid.
- Services that are not medically necessary.
- Services not performed or prescribed by or under the direction of a health care practitioner (i.e., by a person who is licensed, certified, or otherwise legally authorized to provide health care services in Maryland or a contiguous state).
- Services that are beyond the scope of practice of the health care practitioner performing the service.
- Experimental or investigational services, including organ transplants determined by Medicare to be experimental, except when a member is participating in an authorized clinical trial.

- Cosmetic surgery to improve appearance or related services, but not including surgery and related services to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental abnormalities.
- While enrolled in an MCO, services, except for emergency services, are not covered when the member is outside the state of Maryland unless the provider is part of the Amerigroup network. Services may be covered when provided by an MCO network provider who has obtained the proper preauthorization if required. If a Medicaid beneficiary is not in an MCO on the date of service, Medicaid fee-for service may cover the service if it is a covered benefit and if the out-of-state provider is enrolled in Maryland Medicaid.
- Services provided outside the United States.
- Immunizations for travel outside the United States.
- Piped-in oxygen or oxygen prescribed for standby purposes or on an as-needed basis.
- Private hospital room is not covered unless medically necessary or no other room is available.
- Autopsies.
- Private duty nursing services for adults 21 years old and older.
- Dental services for adult members (age 21 and older, except pregnant women and former foster care youth up to age 26)
    - Note: Adult dental services are a value-added benefit and are managed by DentaQuest. See the Dental Care for Adults Age 21 and Older Who are Not Pregnant section for more information.
- Orthodontia is not covered by the MCO but may be covered by Healthy Smiles when the member is under 21, scores at least 15 points on the *Handicapping Labio-lingual Deviations Index No. 4* and the condition causes dysfunction.
- Ovulation stimulants, in-vitro fertilization, ovum transplants and gamete intra-fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques used in these or similar.
- Reversal of voluntary sterilization procedures.
- Reversal of gender reassignment surgeries.
- Medications for the treatment of sexual dysfunction.
- MCOs are not permitted to cover abortions. We are required to assist women in locating these services, and we are responsible for related services (sonograms and lab work, but the abortion procedure, when conditions are met, must be billed to Medicaid fee-for service).
- Nonlegend chewable tablets of any ferrous salt when combined with vitamin C, multivitamins, multivitamins and minerals, or other minerals in the formulation when the member is under 12 years old and nonlegend drugs other than insulin and enteric-coated aspirin for arthritis.
- Nonmedical ancillary services such as vocational rehabilitation, employment counseling or educational therapy.
- Diet and exercise programs for weight loss except when medically necessary.
- Lifestyle improvements (physical fitness programs and nutrition counseling, unless specified).
- MCOs do not cover emergency transportation services and are not required to cover nonemergency transportation services (NEMT). Amerigroup will assist members to access NEMT through the local health department. We will provide some transportation if necessary to fill any gaps that may temporarily occur in our network. Additionally, NEMT is provided to access a covered service if Amerigroup chooses to provide the service at a location outside of the closest county in which the service is available.

The following is a list of transportation contact numbers for each county:

County	**Telephone number to call:**
Alleghany	301-759-5123
Anne Arundel	410-222-7152

County	Telephone number to call:
Baltimore City County	Problem Resolution: 410-396-7007 Enrollment & Scheduling: 410-396-6422 Facilities& Professional Offices: 410-396-6665
Baltimore County	TransDev: 410-783-2465 or 410-887-2828
Calvert	410-414-2489
Caroline	410-479-8014
Carroll	210-876-4813
Cecil	410-996-5171
Charles	301-609-7917
Dorchester	410-901-2426
Frederick	301-600-1725
Garrett	Garrett Community Action: 301-334-9431
Harford	410-638-1671
Howard	1-877-312-6571
Kent	410-778-7025
Montgomery	Montgomery County Department of Public Works and Transit: 240-777-5899
Prince George's	301-856-9555
Queen Anne's	443-262-4462 or 410-758-0720, ext. 4462
St. Mary's	301-475-4296
Somerset	443-523-1722
Talbot	410-819-5609
Washington	240-313-3264
Wicomico	410-548-5142, option 1
Worcester	410-632-0092 or 410-632-0093

SECTION IV. PRIOR AUTHORIZATION AND MEMBER COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

Amerigroup, as a corporation and as individuals involved in Utilization Management (UM) decisions, is governed by the following statements:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Amerigroup does not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denials of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization, or create barriers to care and service.

Access to UM staff is available as follows:

- Amerigroup associates are available at least eight hours a day during normal business hours, Monday-Friday, for inbound communications regarding UM inquiries.
- Health plan UM associates are available eight hours a day, Monday-Friday, during normal business hours in their specific market, excluding some state and federal holidays.
- NCC clinical services unit associates are available 24 hours a day, 7 days a week.
- Amerigroup offers TDD/TTY services for deaf, hard of hearing or speech-impaired members. For all members who request language services, Amerigroup provides services free of charge through bilingual staff or interpreters to help members with UM issues.

Services Requiring Prior Authorization

Services requiring prior authorization include but are not limited to:

- Elective inpatient admissions.
- Select outpatient and specialty care provided outside of the PCP's scope of practice.
- High-tech radiology.
- Durable medical equipment.
- Home health services.
- Out-of-network services.
- Selected elective procedures if performed in a hospital
- Selected chemotherapy drugs if infused in a hospital

To verify whether or not a particular service requires prior authorization, use the Prior Authorization Look-Up Tool under the *Resources* menu at https://provider.amerigroup.com/MD.

Services Not Requiring Preauthorization

Prior authorization is not required for the following medically necessary covered services:

- Routine laboratory tests (excluding genetic testing) performed in the PCP's office or free standing contracted laboratory
- Routine X-rays, EKGs, EEGs or mammograms at a network specialist office, at a freestanding radiology facility, or at some network hospitals

The medical director will periodically review and revise this list with the expectation that additional services will be added as practice patterns of the network warrants.

Prior Authorization Procedures

Some covered services require prior authorization prior to services being rendered, while other covered services require notification prior to being rendered.

Notification is a communication received from a provider informing Amerigroup of the intent to render covered medical services to a member. For services that are emergent or urgent, notification should be provided within 24 hours or by the next business day.

- Notification is received by phone, fax or electronically.
- Member eligibility and provider status (in-network and out-of-network) is verified.

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

Prior authorization requests must be submitted a minimum of 72 hours prior to a scheduled admission or scheduled procedure. Routine requests received after business hours, holidays and weekends will be processed with the receipt date specified as the next business day.

Inpatient Admissions and Concurrent Review

Notification/prior authorization requirements are as follows:

- Except for an emergency admission, the admitting physician is responsible for contacting Amerigroup to obtain prior authorization for a hospital admission a minimum of 72 hours prior to the admission or scheduled procedure.
- The hospital is responsible for notifying Amerigroup of the birth of a child in accordance with the emergency admission time frames. The hospital is also responsible for notifying the Maryland Department of Health (MDH) and following the *Hospital Report of Newborn* process (1184) as outlined by the MDH. For additional information about the MDH 1184 process, go to https://health.maryland.gov.
- For transfer of a newborn from the nursery to the NICU or to another level of care, or to detain a newborn beyond the OB global period, the hospital must notify Amerigroup within 24 hours or by the next business day. These circumstances are considered separate, new admissions and are not part of the mother's admission.
- All elective admissions must receive prior approval through Provider Services at least 72 hours prior to the admission or scheduled procedure.
- Urgent and emergent admissions require notification to Amerigroup within 24 hours or by the next business day following the presentation of emergency services.

The following information should be provided to the Medical Management department for prior authorization at 1-800-454-3730:

- Member's name
- Member's address
- Member's Amerigroup ID number
- Member's date of birth
- Member's PCP
- Scheduled date of admission and/or surgery
- Name of hospital

- Member's diagnosis
- Attending provider
- Clinical information (if applicable)

All Amerigroup members scheduled for inpatient surgery must be admitted to the hospital on the day of the surgery except in preapproved medically necessary cases. Amerigroup will not cover any costs associated with admissions on the day before surgery unless specific medical justification is provided and approved. Each member's case will be examined individually in this respect.

The following are not acceptable reasons for an admission before surgery:
- Member, provider or hospital convenience
- Routine laboratory or X-ray
- NPO (i.e., nothing by mouth)
- Distance or transportation to the hospital
- Most preps

Upon notification, Amerigroup reviews the clinical basis for admission and authorizes benefits for the admission. The medical director reviews any potential denial of coverage after evaluating the member's medical condition, medical criteria and practice standards.

Inpatient Specialist Referrals
Referrals to in-network specialists are not required for payment; however, Amerigroup highly recommends PCPs supply the member with instructions for follow-up care. Go to https://provider.amerigroup.com/MD to download the *Personalized Treatment Plan* form under Resources > Forms.

Inpatient Admission Review
- All medical inpatient hospital admissions, including those that are urgent and emergent, will be reviewed for medical necessity within one business day of the facility notification to Amerigroup.
- Clinical information for the initial (admission) review will be requested by Amerigroup at the time of the admission notification.
- For medical admissions, the facilities are required to provide the requested clinical information within one business day of that request.
- If the information is not received within one business day of the request, an administrative adverse determination (i.e., a denial) will be issued.

Inpatient Concurrent Review
Each network hospital will have an assigned concurrent review clinician. The concurrent review clinician will conduct a review of the medical records electronically to determine the authorization of coverage for a continued stay.
- The concurrent review clinician will conduct continued stay reviews daily and will review discharge plans unless the member's condition is such that it is unlikely to change within the upcoming 24 hours and discharge-planning needs cannot be determined.
- When the clinical information received meets the applicable nationally recognized clinical criteria or guidelines, approved days and bed-level coverage will be communicated to the facility for the continued stay.
- The Amerigroup concurrent review clinician will help coordinate discharge planning needs with the designated facility staff and the attending provider. The attending provider is expected to coordinate with the member's PCP or outpatient specialty provider regarding follow-up care and

services after discharge. The PCP or outpatient specialty provider is responsible for contacting the member to schedule all necessary follow-up care.

- Amerigroup will authorize covered length of stay one day at a time based on the clinical information provided to support the continued stay. Additional information may be requested to make a determination and must be provided within one business day of the request. If the information is not received within one business day of the request, an administrative adverse determination (i.e., a denial) will be issued.

Exceptions to one-day-at-a-time authorizations may be made for confinements when the severity of the illness and subsequent course of treatment is likely to be several days. Examples of confinements may include NICU, CCU, rehabilitation and Cesarean section or vaginal deliveries. Exceptions are made by the medical director/physician reviewer.

If the medical director/physician reviewer denies authorization for an inpatient day or entire stay based on applicable guidelines or criteria, a notice of intent to deny will be provided to the facility and to the member's attending provider.

Upon notification of the intention to deny, the member's treating physician can request a physician-to-physician review to provide additional information not previously submitted to Amerigroup. The request for this review must be made within one business day of the notification of intent to deny. To initiate this request, the physician may contact Amerigroup at 1-866-696-2709 from 8:30 a.m.-5:30 p.m. Eastern time.

Inpatient Retrospective Review

Inpatient admissions may be retrospectively reviewed after the member is discharged. If Amerigroup is notified of the admission while the member is still in the hospital, the review will be considered concurrent and subject to concurrent time frames and guidelines. For additional questions and a quick reference guide, visit the provider website.

Discharge Planning

Discharge planning is designed to assist the provider with coordination of the member's discharge when acute care (i.e., hospitalization) is no longer necessary.

When a lower level of care is necessary, Amerigroup works with the provider to help plan the member's discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital facility such as:

- Hospice facility.
- Skilled nursing facility.
- Home health care program (e.g., home IV antibiotics).

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

Discharge plan authorizations follow the applicable nationally recognized clinical criteria or guidelines and documentation requirements. Authorizations include but are not limited to home health, durable medical equipment (DME) or outpatient procedures.

Outpatient Prior authorization
Prior authorization is required and must be requested at a minimum of 72 hours before the service/procedure/etc. is provided. Examples of services that require prior authorization include but are not limited to:

- Home health care
- Hospice programs (notification only for outpatient hospice services)
- Skilled nursing or extended care facilities
- Physical and speech therapy beyond the initial evaluation (subsequent visits require clinical documentation and prior authorization from Amerigroup)
- DME
- Cardiac rehabilitation
- Outpatient diagnostic radiology
- Selected surgical procedures if performed in a hospital
- Selected chemotherapy if infused in a hospital

In addition, prior authorization is required for all out-of-network care (certain exclusions apply) and for specialty visits (i.e., services beyond the initial evaluation and management) if performed by a nonparticipating provider.

For code-specific prior authorization requirements for dermatology, genetics, otolaryngology, podiatry, plastic surgery and pain management performed in a participating clinic/outpatient facility/ambulatory surgery center, visit https://provider.amerigroup.com/md and select **Prior Authorization Lookup Tool** from the *Resources* menu.

For prior authorization requirements for behavioral health services, please refer to the MDH website at http://dhmh.maryland.gov/ohcq/Pages/home.aspx.

Ambulatory Surgery Prior authorization
Amerigroup is committed to providing quality, accessible health care in the most efficient manner. In most cases, certain outpatient services can be safely performed in a freestanding facility rather than a hospital outpatient setting. Therefore, certain types of outpatient surgery/services will require site-of-service prior authorization if hospital outpatient service is requested. Services that cannot be safely and effectively provided at a freestanding site will be precertified at hospitals in these areas. These ambulatory surgical procedures must receive coverage approval through the Medical Management department at least 72 hours prior to the scheduled procedure.

For code-specific prior authorization requirements for these services when performed in a participating clinic/outpatient facility/ambulatory surgery center, visit https://provider.amerigroup.com/md and select **Prior Authorization Lookup Tool** from the *Resources* menu.

Prior authorization Requirement Review and Updates
Amerigroup will review and revise policies when necessary. The most current policies are available on the provider self-service website.

Period of preauthorization
Prior authorization numbers are valid for the date of service authorized or for a period not to exceed the date of service authorized. The member must be eligible for Medicaid and enrolled in Amerigroup on each date of service. For information about how to verify member eligibility visit the Maryland

Department of Health website to access the Eligibility Verifications Systems (EVS). This can be found at this site: https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

Prior authorization and coordination of benefits
Amerigroup may not refuse to pre-authorize a service because the member has other insurance. Even if the service is covered by the primary payer, the provider must follow our prior authorization rules. Preauthorization is not a guarantee of payment. Except for prenatal care and Healthy Kids/EPSDT screening services, providers are required to bill other insurers first. For these services, we will pay the provider and then seek payment from the other insurer.

Medical Necessity Criteria

A "medically necessary" service or benefit must be:

- Directly related to diagnostic, preventive, curative, palliative, habilitative or ameliorative treatment of an illness, injury, disability, or health condition.
- Consistent with current accepted standards of good medical practice.
- The most cost-effective service that can be provided without sacrificing effectiveness or access to care.
- Not primarily for the convenience of the member, the member's family or the provider.

Clinical Guidelines

Amerigroup *Medical Policies*, which are publicly accessible from the website, or may be obtained by calling provider services, are the primary benefit plan policies for determining whether services are considered to be a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive.

MCG Care Guidelines is the criteria used for review of prior authorization requests for planned inpatient admissions and acute inpatient care. Acute inpatient neonatal care will be reviewed using Clinical Utilization Management (UM) Guideline Neonatal Levels of Care, CG-MED-26. Clinical UM Guideline Home Health, CG-MED-23 is the criteria to be used for home care services. Clinical UM Guidelines CG-MED-71: Wound Care in the Home Setting ill be used to review wound care provided by a home health agency. All acute rehabilitation inpatient care and skilled nursing inpatient care will continue to be reviewed for medical necessity using InterQual Level of Care Criteria.

Federal and state law as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and are considered first when determining eligibility for coverage. As such, in all cases, the Maryland Department of Health policies and requirements will supersede InterQual criteria, MCG Guidelines, and Amerigroup *Medical Policies* and *Clinical UM Guidelines*. Medical technology is constantly evolving, and Amerigroup reserves the right to review and periodically update medical policy and utilization management criteria. The Amerigroup Utilization Management department reviews the medical necessity of medical services using:

- State of Maryland Department of Health (MDH) Clinical Coverage Criteria is used for medical necessity review of the following services: Clinical trials, gender reassignment surgery, hearing aids, cochlear implants, bone-anchored hearing aids.
- Amerigroup Medical Policy and Clinical UM Guidelines are used for medical necessity review of the following services: Outpatient services, home health services, pharmaceuticals, and NICU inpatient acute care.

- MCG Care Guidelines are used for medical necessity review of the following services: Planned adult and pediatric acute inpatient care.
- InterQual Level of Care Criteria is used for medical necessity review of the following services: Acute inpatient rehabilitation, inpatient skilled nursing
- AIM Diagnostic Clinical Appropriateness Guidelines are used for medical necessity review of the following services: High-tech radiology, sleep disorder management, genetic testing, radiation oncology, pain management and muscular skeletal surgery

Amerigroup follows established procedures for applying medical necessity criteria based on individual member needs and an assessment of the availability of services within the local delivery system. To learn more about these procedures, visit the provider self-service website at https://provider.amerigroup.com/MD or call Provider Services. These procedures apply to:

- Prior authorization.
- Concurrent review.
- Retrospective review.

Only a medical director/physician reviewer may make an adverse determination (denial) based on medical necessity. Requests for services/care should include current applicable and appropriate ICD and CPT codes and relevant clinical information. Appropriate clinical information includes:

- Office and/or hospital records.
- A history of the presenting problem.
- A clinical examination.
- Diagnostic testing results.
- Treatment plans and progress notes.
- Psychosocial history.
- Consultation notes.
- Operative and pathological reports.
- Rehabilitation evaluations.
- Patient characteristics and information.
- Estimated/anticipated length and/or frequency of treatment.

To request a copy of the criteria on which a medical decision was based, call Provider Services at 1-800-454-3730.

Timeliness of Decisions and Notifications to Providers and Members

For certain services to enrollees that require preauthorization, Amerigroup makes decisions and notifies providers and applicable members in a timely manner. So as not to adversely affect the health of the enrollee, unless otherwise required by the Maryland Department of Health, Amerigroup adheres to the following decision/notification time standards:

- For standard authorization decisions — Amerigroup shall make a determination within 2 business days of receipt of necessary clinical information, but not later than 14 calendar days of the date of the initial request.
- For expedited authorization decisions — Amerigroup shall make a determination and provide notice no later than 72 hours after receipt of the request for service if the provider determines that the standard time frame could jeopardize the member's life; health; or ability to attain, maintain or regain maximum function

- For all covered outpatient drug authorization decisions — Amerigroup shall provide notice within 24 hours by telephone or telecommunication device to either authorize the drug or request additional clinical information in accordance with section 1927 (d)(5)(A) of the Social Security Act.

Amerigroup will send notice to deny authorizations to providers and members:
- Standard authorizations — within 72 hours from the date of determination
- Expedited authorizations — within 24 hours from the date of determination

Out-of-Network Providers

When approving or denying a service from an out-of-network provider, Amerigroup will assign a prior authorization number, which refers to and documents the approval. Amerigroup sends written documentation of a denial to the out-of-network provider within the time frames appropriate to the type of request. Refer to Section I for a list of self-referred services, which are services we must allow members to access out-of-network. Occasionally, a member may be referred to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. Amerigroup makes such decisions on a case-by-case basis.

Overview of Member Complaint, Grievance and Appeal Processes

Our MCO member services line, 1-800-600-4441, operates Monday-Friday from 8 a.m.- 6 p.m. Member Services resolves or properly refers members' inquiries or complaints to the state or other agencies. Amerigroup informs members and providers of the grievance system processes for complaints, grievances, appeals and Maryland state fair hearings. This information is contained in the *Member Handbook* and is available on the Amerigroup member website at www.myamerigroup.com/md/benefits/member-materials.html.

Members or their authorized representatives can file an appeal or a grievance with Amerigroup orally or in writing. An authorized representative is someone who assists with the appeal on the member's behalf, including but not limited to a family member, friend, guardian, provider or an attorney. Representatives must be designated in writing.

Providers will not be penalized for advising or advocating on behalf of an enrollee.

Members and their representatives may also request any of the following information from Amerigroup, free of charge, to help with their appeal by calling 1-800-600-4441:
- Medical records
- Any benefit provision, guideline, protocol or criterion Amerigroup used to make its decision.
- Oral interpretation and written translation assistance.
- Assistance with filling out the Amerigroup appeal forms.

Amerigroup will take no punitive action for:
- Members requesting appeals or grievances.
- Providers requesting expedited resolution of appeals or grievances.
- Providers supporting a member's appeal or grievance.
- Members or providers making complaints against Amerigroup or the Department.

Amerigroup will also verify that no provider or facility takes punitive action against a member or provider for using the appeals and grievance system. Providers may not discriminate or initiate disenrollment of a member for filing a complaint, grievance or appeal with Amerigroup.

Our internal complaint materials are developed in a culturally sensitive manner, at a suitable reading comprehension level, and in the member's native language if the member is a member of a substantial minority. Amerigroup delivers a copy of its complaint policy and procedures to each new member at the time of initial enrollment and at any time upon a member's request.

MCO Member Grievance Procedures

A grievance is a complaint about a matter that cannot be appealed. Grievance subjects may include but are not limited to dissatisfaction with access to coverage, any internal process or policy, actions or behaviors of our employees or vendors or provider office teams, care or treatment received from a provider, and drug utilization review programs applying drug utilization review standards.

Examples of reasons to file an administrative grievance include:

- The member's provider's office was dirty, understaffed or difficult to access.
- The provider was rude or unprofessional.
- The member cannot find a conveniently located provider for his/her health care needs.
- The member is dissatisfied with the help he/she received from the provider's staff or Amerigroup.

Examples of reasons to file a medical grievance include:

- The member is having issues with filling his/her prescriptions or contacting the provider.
- The member does not feel he/she is receiving the right care for his/her condition.
- Amerigroup is taking too long to resolve the member's appeal or grievance about a medical issue.
- Amerigroup denies the member's request to expedite his/her appeal about a medical issue.

Grievances may be filed at any time with Amerigroup orally or in writing by the member or their authorized representative, including providers. Amerigroup responds to grievances within the following time frames:

- 30 calendar days of receipt for an administrative (standard) grievance
- 5 calendar days of receipt for a medically related grievance
- 24 hours of receipt for an emergent or an expedited medical grievance

If we are unable to resolve an urgent or administrative grievance within the specified time frame, we may extend the time frame of the grievance by up to 14 calendar days if the member requests the extension or if we demonstrate to the satisfaction of the Maryland Department of Health (MDH), upon its request, that there is need for additional information and how the delay is in the member's interest. In these cases, we will attempt to reach you and the member by phone to provide information describing the reason for the delay and will follow with a letter within two calendar days detailing the reasons for our decision to extend.

For expedited grievances, Amerigroup will make reasonable efforts to provide oral notice of the grievance decision and will follow the oral notice with written notification. Members are advised in writing of the outcome of the investigation of all grievances within the specified processing time frame. The *Notice of Resolution* includes the decision reached, the reasons for the decision, and the telephone number and address where the member can speak with someone regarding the decision. The notice also tells members how to ask the state to review our decision and to obtain information on filing a request for a state fair hearing, if applicable.

MCO Member Appeal Procedures

An appeal is a review by the MCO or the Department when a member is dissatisfied with a decision that impacts their care. Reasons a member may file an appeal include:

- Amerigroup denies covering a service ordered or prescribed by the member's provider. The reasons a service might be denied include:
  - The treatment is not needed for the member's condition, or would not help you in diagnosing the member's condition.
  - Another more effective service could be provided instead.
  - The service could be offered in a more appropriate setting, such as a provider's office, instead of the hospital.
- Amerigroup limits, reduces, suspends or stops a service that a member is already receiving. For example:
  - The member has been getting physical therapy for a hip injury and he/she has reached the frequency of physical therapy visits allowed.
  - The member has been prescribed a medication, it runs out, and he/she does not receive any more refills for the medication.
- Amerigroup denies all or part of payment for a service a member has received.
- Amerigroup fails to provide services in a timely manner, as defined by the Department (e.g., it takes too long to authorize a service a member or his/her provider requested).
- Amerigroup denies a member's request to speed up (or expedite) the resolution about a medical issue.

The member will receive a *Notice of Adverse Benefit Determination* (also known as a denial letter) from Amerigroup. The *Notice of Adverse Benefit Determination* informs the member of the following:

- The Amerigroup decision and the reasons for the decision, including the policies or procedures that provide the basis for the decision
- A clear explanation of further appeal rights and the time frame for filing an appeal
- The availability of assistance in filing an appeal
- The procedures for members to exercise their rights to an appeal and request a state fair hearing if they remain dissatisfied with the Amerigroup decision
- That members may represent themselves or designate a legal counsel, a relative, a friend, a provider or other spokesperson to represent them, in writing
- The right to request an expedited resolution and the process for doing so
- The right to request a continuation of benefits and the process for doing so

If the member wants to file an appeal with Amerigroup, they have to file it within 60 days from the date of the denial letter. Our denial letters must include information about the HealthChoice Help Line. If the member has questions or needs assistance, direct them to call 1-800-284-4510. Providers may call the State's HealthChoice Provider Help Line at 1-800-766-8692.

When the member files an appeal, or at any time during our review, the member and/or provider should provide us with any new information that will help us make our decision. The member or representative may ask for up to 14 additional days to gather information to resolve the appeal. If the member or representative needs more time to gather information to help Amerigroup make a decision, they may call Amerigroup at 1-800-600-4441 and ask for an extension.

Amerigroup may also request up to 14 additional days to resolve the appeal if we need to get additional information from other sources. If the MCO requests an extension, the MCO will send the member a letter and call the member and his/her provider.

When reviewing the member's appeal, we will:

- Use doctors with appropriate clinical expertise in treating the member's condition or disease.
- Not use the same MCO staff to review the appeal who denied the original request for service.
- Make a decision within 30 days, if the member's ability to attain, maintain or regain maximum function is not at risk.

On occasion, certain issues may require a quick decision. These issues, known as expedited appeals, occur in situations where a member's life; health; or ability to attain, maintain or regain maximum function may be at risk, or in the opinion of the treating provider, the member's condition cannot be adequately managed without urgent care or services. Amerigroup resolves expedited appeals effectively and efficiently as the member's health requires. Written confirmation or the member's written consent is not required to have the provider act on the member's behalf for an expedited appeal. If the appeal needs to be reviewed quickly due to the seriousness of the member's condition and Amerigroup agrees, the member will receive a decision about their appeal as expeditiously as the member health condition requires or no later than 72 hours from the request. If an appeal does not meet expedited criteria, it will automatically be transferred to a standard time frame. Amerigroup will make a reasonable effort to provide verbal notification and will send written notification within two calendar days.

Once we complete our review, we will send the member a letter letting them know our decision. Amerigroup will send written notification for a standard appeal time frame, including an explanation for the decision, **within two business days of the decision**.

For an expedited appeal time frame, Amerigroup will communicate the decision verbally at the time of the decision and in writing, including an explanation for the decision, within 24 hours of the decision.

If we decide that they should not receive the denied service, that letter will tell them how to ask for a state fair hearing.

Request to Continue Benefits during the Appeal

If the member's appeal is about ending, stopping or reducing a service that was authorized, they may be able to continue to receive the service while we review their appeal. The member should contact Amerigroup within 10 days of receiving the denial notice at 1-800-600-4441 if they would like to continue receiving services while their appeal is reviewed. The service or benefit will continue until either the member withdraws the appeal or the appeal or fair hearing decision is adverse to the member. If the member does not win their appeal, they may have to pay for the services they received while the appeal was being reviewed.

Members or their designated representative may request to continue to receive benefits while the state fair hearing is pending. Benefits will continue if the request meets the criteria described above when the member receives the MCO's appeal determination notice and decides to file for a state fair hearing. If Amerigroup or the Maryland Fair Hearing officer does not agree with the member's appeal, the denial is upheld, **and the member continues to receive services**, the member may be responsible for the cost of services received during the review. If either rendering party overturns the Amerigroup denial, Amerigroup will authorize and cover the costs of the service within 72 hours of notification.

State Fair Hearing Rights
A state fair hearing is a review of the MCO's appeal decision by the Maryland Office of Administrative Hearings. Members have the right to ask for a state fair hearing within 120 days of the date of the MCO's appeal decision.

A HealthChoice member may exercise their state fair hearing rights, but the member must first file an appeal with Amerigroup. If Amerigroup upholds the denial, the member may appeal to the Office of Administrative Hearings (OAH) by contacting the HealthChoice Help Line at 1-800-284-4510. If the member decides to request a state fair hearing, we will continue to work with the member and the provider to attempt to resolve the issue prior to the hearing date.

If a hearing is held and the Office of Administrative Hearings decides in the member's favor, Amerigroup will authorize or provide the service no later than 72 hours of being notified of the decision. If the decision is adverse to the member, the member may be liable for services continued during our appeal and state fair hearing process. The final decision of the Office of Administrative Hearings is appealable to the Circuit Court and is governed by the procedures specified in *State Government Article, §10-201 et seq., Annotated Code of Maryland*.

State HealthChoice Help Lines

If a member has questions about the HealthChoice Program or the actions of Amerigroup, direct them to call the State's HealthChoice Help Line at 1-800-284-4510. Providers can contact the HealthChoice Provider Line at 1-800-766-8692.

Amerigroup Provider Complaint Process

The Provider Relations department will receive provider inquiries, suggestions and grievances directly from providers via email, provider satisfaction surveys, in person or by phone, mail or fax, as well as referrals from the Customer Service department, Credentialing department and the Complaint and Grievance department. The Provider Relations department will abide by all processing timelines as identified in regulatory standards. To submit a complaint, please contact your local Provider Relations Representative or call Provider Services at 1-800-454-3730.

HealthChoice Provider Hotline

The Provider Hotline provides HealthChoice providers access to MDH staff for grievances and inquiries.

Provider Hotline staff respond to general inquiries and resolves complaints from providers concerning member access and quality of care as well as educating providers about the HealthChoice Program. The telephone number for the Provider Hotline is 800-766-8692; TDD 800-735-2258. We will not take any punitive action against you for accessing the Provider Hotline.

As with the Amerigroup Provider Help Line, provider inquiries and complaints are tracked and analyzed monthly and quarterly to determine if specific intervention with particular MCOs is required or changes in state policies and procedures are necessary.

SECTION V. PHARMACY MANAGEMENT

Pharmacy Benefit Management

Amerigroup is responsible for most pharmacy services and will expand our drug formulary to include new products approved by the Food and Drug Administration in addition to maintaining drug formularies that are at least equivalent to the standard benefits of the Maryland Medical Assistance Program prescription medications and certain over-the-counter medicines. This requirement pertains to new drugs or equivalent drug therapies, routine childhood immunizations, vaccines prescribed for high-risk and special-needs populations, and vaccines prescribed to protect individuals against vaccine-preventable diseases. If a generic equivalent drug is not available, a new brand-name drug rated as P (priority) by the FDA will be added to the formulary.

Coverage may be subject to preauthorization to ensure medical necessity for specific therapies. For formulary drugs requiring preauthorization, a decision will be provided within 24 hours of request. For medical injectable drugs that are not included in "outpatient drugs", a decision will be provided within two business days of receipt of necessary clinical information, but no later than 14 calendar days from the date of the initial request for standard requests and no later than 72 hours after receipt of the request for expedited requests.

When a prescriber believes that a non-formulary drug is medically indicated, Amerigroup has procedures in place to consider nonformulary requests where documentation is provided indicating the formulary alternative is not medically appropriate. The State expects a non-formulary drug to be approved if documentation is provided indicating that the formulary alternative is not medically appropriate. Requests for non-formulary drugs will not be automatically denied or delayed with repeated requests for additional information.

Pharmaceutical services and counseling ordered by an in-plan provider, by a provider to whom the member has legitimately self-referred (if provided on-site), or by an emergency medical provider are covered, including:

- Legend (prescription) drugs
- Insulin
- All FDA-approved contraceptives (we may limit which brand drugs we cover)
- Latex condoms and emergency contraceptives (to be provided without any requirement for a provider's order)
- Nonlegend ergocalciferol liquid (Vitamin D)
- Hypodermic needles and syringes
- Enteral nutritional and supplemental vitamins and mineral products given in the home by nasogastric, jejunostomy or gastrostomy tube
- Enteric coated aspirin prescribed for treatment of arthritic conditions
- Nonlegend ferrous sulfate oral preparations
- Nonlegend chewable ferrous salt tablets when combined with vitamin C, multivitamins, multivitamins and minerals, or other minerals in formulation for members under age 12
- Formulas for genetic abnormalities
- Medical supplies for compounding prescriptions for home intravenous therapy
- Medical supplies or equipment used in the administration or monitoring of medication prescribed or ordered for a member by a qualifying provider

The following are not covered by the state or the MCO:

- Prescriptions or injections for central nervous system stimulants and anorectic agents when used for controlling weight

- Nonlegend drugs other than insulin and enteric aspirin ordered for treatment of an arthritic condition
- Medications for erectile dysfunction
- Ovulation stimulants

Amerigroup contracts with IngenioRx to provide the following services: pharmacy network contracting and network Point-of-Sale (POS) claim processing.

Mail-Order Pharmacy

We cannot require a member to use mail-order, but we do offer mail-order pharmacy services for certain drugs through IngenioRx's home delivery pharmacy. To obtain mail-order pharmacy services:

- Call our mail-order provider phone number: 1-833-203-1742
- Mail order provider fax number: 1-800-378-0323

Specialty Pharmacy

For specialty pharmacy services, Amerigroup contracts with IngenioRx Specialty Pharmacy Services as its exclusive supplier of high-cost, specialty and/or injectable drugs that treat a number of chronic or rare conditions. To obtain one of the listed specialty drugs, fax your prescription to IngenioRx Specialty at 1-833-263-2871 or call 1-833-255-0646.

Note: This is not a complete list and is subject to change, but represents the most commonly prescribed injectables. Call the Amerigroup Pharmacy department at 1-800-454-3730 for prior authorization of the drugs in the following table:

Medications Supplied by IngenioRx Specialty Pharmacy Services	
Disease or treatment	**Available drugs**
Allergic asthma	• Xolair®
Crohn's disease	• Avsola™ • Inflectra® • Remicade® • Renflexis®
Hemophilia, Von Willebrand disease and related bleeding disorders	• Advate™ • Alphanate® • Alphanine SD® • Amicar® • Autoplex T • Bebulin VH® • Benefix® • Feiba VH • Immuno® • Genarc™ • Helixate FS® • Hemofil-M® • Humate-P® • Koate-DVI® • Kogenate • FS® Monarc-M • Monoclate-P® • Mononine® • Novoseven® • Profilnine SD® • Proplex T® • Recombinate • Refacto® • Stimate®
Enzyme replacement for lysosomal storage disorders	• Aldurazyme® • Elaprase® • Fabrazyme® • Naglazyme™ • Myozyme®
Gaucher disease	• Cerezyme® • Ceredase
Growth hormone disorders	• Genotropin® • Nutropin®

Medications Supplied by IngenioRx Specialty Pharmacy Services		
Disease or treatment	**Available drugs**	
	• Humatrope® • Norditropin® • Norditropin • Nordiflex®	• Nutropin AQ® • Saizen® • Serostim® • Tev-Tropin™ • Zorbtive™
Hematopoietics	• Aranesp® • Epogen® • Leukine® • Neulasta®	• Neumega® • Neupogen® • Procrit
Hepatitis C	• Mavyret™ • Harvoni® • Vosevi™	• Zepatier™ • Epclusa®
Hormonal therapies	• Eligard™ • Lupron Depot® • Lupron Depot – Ped® • Trelstar Depot™	• Trelstar LA™ • Vantas™ • Viadur® • Zoladex®
Immune deficiencies	• Baygam® • Carimune® NF • Cytogam® • Flebogamma® • Gamimune® N • Gammagard® S/D • Gammar®– P I.V. • GammaSTAN®	• Gamunex® • Iveegam® EN • Octagam® • Panglobulin® • Polygam® SD • Vivaglobin® • WinRho® SDF
Multiple sclerosis	• Avonex® • Betaseron® • Copaxone®	• Novantrone® • Rebif® • Tysabri®
Oncology	• Gleevec® • Herceptin® • Nexavar® • Novantrone® • Revlimid® • Rituxan® • Sprycel™	• Sutent® • Tarceva ® • Temodar® • Thalomid® • Vidaza® • Xeloda® • Zolinza™
Pulmonary arterial hypertension	• Remodulin® • Revatio™	• Tracleer®
Pulmonary disease	• Aralast™ • Pulmozyme®	• TOBI®
Psoriasis	• Amevive® • Enbrel®	• Raptiva®
Respiratory syncytial virus	• Synagis®	
Rheumatoid arthritis	• Avsola™ • Enbrel® • Humira®	• Orencia® • Remicade® • Rituxan®

Medications Supplied by IngenioRx Specialty Pharmacy Services	
Disease or treatment	**Available drugs**
	• Kineret® • Inflectra® • Renflexis®
Other	• Actimmune NF® • Alferon N® • Apligraf® • Botox™ • Fuzeon® • Forteo® • Increlex™ • Lucentis™ • Macugen® • Mirena® • Myobloc® • Octreotide Acetate • Proleukin® • Rhogam® available at retail • Sandostatin® • Sandostatin LAR® • Somavert® • Thyrogen® • Visudyne®

Call the Amerigroup Pharmacy department at 1-800-454-3730 for prior authorization of the drugs in the following table:

Category	Examples
Erythropoiesis stimulating agents (ESA)	• Aranesp • Epogen • Procrit
Colony stimulating factors (CSF)	• Neupogen • Neulasta • Leukine
IVIG	• Carimune • Cytogam • Flebogamma • Gamastan • Gammagard • Gammar-P • Gamunex • Immune globulin • Iveegam • Octagam • Panglobulin • Polygam • Venoglobulin-S • Vivaglobin
Growth hormones	• Norditropin • Humatrope • Somatropin • Protropin • Genotropin • Nutropin • Saizen • Tev-Tropin • Zorbtive • Omnitrope
Biologic response modifiers	• Avsola • Inflectra • Remicade • Enbrel • Humira • Kineret • Amevive • Renflexis • Raptiva
Biologic oncology agents	• Erbitux • Avastin • Rituxan • Camptosar • Eloxatin • Gemzar • Ixempra • Tasigna • Taxol • Taxotere

Amerigroup is responsible for formulary development, drug utilization review and prior authorization. The Amerigroup Drug Utilization Review Program is subject to review and approval by MDH and is coordinated with the Drug Utilization Review Program of the Behavioral Health Service delivery system.

Prescription and Drug Formulary

The Amerigroup Pharmacy program utilizes a *Preferred Drug List* (*PDL*), which has been reviewed and approved by MDH. This is a list of the preferred drugs within the most commonly prescribed therapeutic categories. The medications included in the *PDL* are reviewed and approved by the Pharmacy and Therapeutics (P&T) committee. The P&T committee is comprised of practicing physicians and pharmacists from the Amerigroup provider community who evaluate safety, efficacy, adverse effects, outcomes and total pharmacoeconomic value for each drug product reviewed. The goal of the *PDL* is to provide cost-effective pharmacotherapy choices based on prospective, concurrent and retrospective review of medication therapies and utilization. Many over-the-counter (OTC) medications are also included in the *PDL* and should be considered for first-line therapy when appropriate. To access the *PDL*, go to https://provider.amerigroup.com/maryland-provider/home > Eligibility & Pharmacy > Pharmacy Information > Preferred Drug List (PDL).

Check the current Amerigroup formulary at https://provider.amerigroup.com/maryland-provider/home > Eligibility & Pharmacy > > Pharmacy Information > Medicaid Formulary, drug criteria and limitations (under Related information), before writing a prescription for either prescription or over-the-counter drugs. Amerigroup members must have their prescriptions filled at a network pharmacy.

The following are examples of covered items:

- Legend drugs
- Insulin
- Disposable insulin needles/syringes
- Disposable blood/urine glucose/acetone testing agents
- Contraceptives
- Latex condoms (to be provided without any requirement for a provider's order)
- Lancets and lancet devices
- Compounded medication of which at least one ingredient is a legend drug and listed on the Amerigroup *PDL*
- Any other drug that under applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber and is listed on the Amerigroup *PDL*
- *PDL*-listed legend contraceptives

Limitations – neither the state nor Amerigroup cover the following:

- Prescriptions or injections for central nervous system stimulants and anorectic agents when used for controlling weight
- Non-legend drugs other than insulin and enteric aspirin ordered for treatment of an arthritic condition

HIV/AIDS drugs previously covered by the state's Medicaid program are covered by Amerigroup effective January 1, 2020.

Most behavioral health medications are paid by Medicaid not the MCO. The state's Medicaid formulary can be found at: https://client.formularynavigator.com/Search.aspx?siteCode=9381489506.

Prescription Copays

Pharmacy copays are not applicable for the following:

- Family planning drugs and devices
- Individuals under age 21
- Pregnant women
- Institutionalized individuals who are inpatient in long-term care facilities or other institutions requiring spending all but a minimal amount of income for medical cost

HealthChoice members may not be charged copays, premiums or cost-sharing of any kind, except for the following:

- Up to a $3 copay for brand-name drugs
- Any other charge up to the fee-for-service limit as approved by MDH

Limitations on covered services do not apply to children under age 21 receiving medically necessary treatment under the EPSDT program.

The pharmacy cannot withhold services even if the member cannot pay the copay. The member's inability to pay the copay does not excuse the debt, and he or she can be billed for the copay at a later time.

Neither Amerigroup nor any subcontractors may solicit or accept copays or additional charges for services covered by the HealthChoice contract (per COMAR).

Over-the-Counter Products

Amerigroup offers an extra benefit for certain over-the-counter (OTC) drugs. Each member can receive up to $30 worth of these drugs each quarter. Quarters begin on the first day of January, April, July and October. The provider must write a prescription for these drugs. If the member reaches his or her maximum within the quarter, the pharmacy will notify the member. The following drugs are covered as part of this benefit (the brand names listed serve as a reference only):

OTC drug type	Brand name
Antacid	Tums, Alternagel, Maalox and Maalox Plus
Antidiarrheals	Kaopectate, Pepto-Bismol, Pedialyte and Imodium A-D
Antiemetics	Dramamine and Emetrol
Antihistamines	Chlor-Trimeton, Tavist-1 and Benadryl
Bacitracin	Polysporin, Neosporin
Cough and cold preparations	Dimetapp, Delsym, Vicks 44D, Robitussin, Robitussin DM, Robitussin-CF, Robitussin-PE, and Actifed Cold and Allergy
Decongestants	Sudafed
Ibuprofen	Advil
Laxatives	Dulcolax, Colace, Phillips' Milk of Magnesia, Fleet Phospho-Soda, Metamucil, Senokot and Senokot-S
Miscellaneous, oral	Cepastat, Gas-X and Mylicon
Miscellaneous, topical	Amlactin, Debrox, Cortizone and Naphcon-A

OTC drug type	Brand name
Nutritionals/ Supplements	Os-Cal, Niferex, Niferex-150, Fergon, Feosol, Fer-In-Sol, Strovite, Poly-Vi-Sol, Vi-Daylin, One-A-Day, Centrum, Slo-Niacin, Stuart Prenatal and Nephrovite
Pediculicide	RID, NIX
Respiratory	Broncho Saline

Injectables and Nonformulary Medications Requiring Prior Authorization

You can use the Prior authorization Lookup Tool to determine if outpatient services require authorization. To access the tool, log in at https://provider.amerigroup.com/maryland-provider/home and go to Resources > Prior Authorization Requirements > Prior Authorization Lookup Tool.

To request or check the status of a prior authorization request or decision, you must access our Interactive Care Reviewer (ICR) tool via Availity. To access ICR, log on) to Availity (www.availity.com) then select > Patient Registration> Authorizations and Referrals.

Examples of medications that require prior authorization are listed below (this list is not all-inclusive and is subject to change):

- Drugs not listed on the *PDL*
- Brand-name products for which there are therapeutically equivalent generic products available
- Self-administered injectable products
- Drugs that exceed certain limits (for information on these limits, please contact the Pharmacy department)
- Adapelene (Differin)
- Adefovir dipivoxil (Hepsera)
- Agalsidase beta (Fabrazyme)
- Antihemophilic factor, recombinant (Advate)
- Becaplermin gel 0.1% (Regranex)
- Botulinim toxin (Botox)
- Celecoxib (Celebrex)
- Ciclopirox (Penlac)
- Cyclosporine emulsion (Restasis)
- Dornase alfa (Pulmozyme)
- Doxercalciferol (Hectoral)
- Droperidol (Inapsine)
- Epoetin alfa (Procrit)
- Filgrastim (Neupogen)
- Imiquimod (Aldara)
- Interferon alfa-2a (Roferon-A)
- Interferon alfa-2b (Intron-A)
- Interferon alfacon-1 (Infergen)
- Laronidase (Aldurazyme)
- Leuprolide acetate (Lupron, Lupon Depot)
- Levalbuterol HCL solution (Xopenex)
- Midazolam injection/syrup (Versed)
- Omalizumab (Xolair)
- Orlistat (Xenical)
- Pegfilgrastim (Neulasta)

- Peginterferon alfa-2a (Pegasys)
- Peginterferon alfa-2b (PEG-Intron)
- Pimecrolimus (Elidel)
- Pramlintide (Symlin)
- Ribavirin + interferon alfa-2b (e.g., Rebetron)
- Sargramostim (Leukine)
- Sevelamer (Renagel)
- Sibutramine (Meridia)
- Somatropin (Nutropin, Nutropin AQ, Nutropin Depot, Saizen)
- Tegaserof (Zenorm)
- Teriparatide (Forteo)
- Thalidomide (Thalomid)
- Tobramycin inhalation soln (Tobi)

Excluded Drugs

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

- Weight control products (except Alli, which requires prior authorization)
- Antiwrinkle agents (e.g., Renova)
- Drugs used for cosmetic reasons or hair growth
- Experimental or investigational drugs
- Drugs used for experimental or investigational indication
- Immunization agents
- Infertility medications
- Erectile dysfunction drugs to treat impotence
- Nonlegend drugs other than insulin, those listed above or specifically listed under "Covered Nonlegend Drugs"

Prior Authorization Process

Providers are strongly encouraged to write prescriptions for preferred products as listed on the *PDL*. If for medical reasons a member cannot use a preferred product or preferred products requiring prior authorization, providers are required to contact Amerigroup Pharmacy Services to obtain prior authorization in one of the following ways:

- Call 1-800-454-3730 Monday-Friday from 8 a.m.-8 p.m. Eastern time, or 10 a.m.-2 p.m. on Saturdays
- Fax all information required and a prior authorization form (located at https://provider.amerigroup.com/maryland-provider/home > Eligibility & Pharmacy > Pharmacy Information > Pharmacy Prior Authorizations) to the following fax numbers:
  - For pharmacy outpatient drugs: 1-844-490-4871
  - For medical injectable drugs: 1-844-490-4873
- Submit prior authorization electronically through CoverMyMeds® at https://www.covermymeds.com
- Use the Availity Portal and select> Patient Registration > Authorization, then choose the Drug Prior Authorization (CoverMyMeds) link located on the lower portion of the Authorizations screen. CoverMyMeds allows you to:
  - Submit general pharmacy requests — medications dispensed directly to a member from retail pharmacy or shipped from a specialty pharmacy
  - Request medical injectables for those medications obtained by your office/facility for onsite infusion or administration

- Check prior authorization status
- Appeal denied requests
- Upload supporting documents and review appeal status

The information will be reviewed by a clinical pharmacist and/or medical director for medical necessity, and the provider will be notified within two business days of receipt of the necessary clinical information, and no later than seven calendar days from the date of the initial request.

If the service is denied, the prescriber and the member are notified in writing of the denial (per COMAR). All decisions are based on medical necessity and are determined according to certain established medical criteria. Amerigroup does not cover brand-name medications where there is an FDA-approved, therapeutically equivalent generic. Requests for brand-name medications when there is a generic available will follow the prior authorization process to determine medical necessity. Some drugs have daily quantity and/or dosage limits and are identified as such on the *PDL*. Requests for drugs exceeding the limits will require prior authorization to determine medical necessity.

Note: We follow the state's medical criteria for coverage of Hepatitis C drugs.

Step Therapy and Quantity Limits

Certain prescription medications may have additional requirements or limitations of coverage, which are outlined in the *Preferred Drug List*. Step therapy (ST) requires the use of a clinically recognized first-line drug before approval of a more complex and often more expensive medication where the safety, effectiveness and value has not been well established, before a second-line drug is authorized.

Quantity limits are in place per prescription or per month based on the maximum recommended dose or supply, according to the FDA approved package labeling or appropriate use and standards of quality care.

Maryland Prescription Drug Monitoring Program

Amerigroup complies with the Maryland Prescription Drug Monitoring Program. The Maryland Prescription Drug Monitoring Program (PDMP) is an important component of the Maryland Department of Health initiative to halt the abuse and diversion of prescription drugs. The Maryland Department of Health is a statewide database that collects prescription data on Controlled Dangerous Substances (CDS) and Human Growth Hormone (HGH) dispensed in outpatient settings. The Maryland Department of Health does not collect data on any other drugs.

Pharmacies must submit data to the Maryland Department of Health at least once every 15 days. This requirement applies to pharmacies that dispense CDS or HGH in outpatient settings in Maryland, and by out-of-state pharmacies dispensing CDS or HGH into Maryland. Patient information in the Maryland Department of Health is intended to help prescribers and pharmacists provide better-informed patient care. The information will help supplement patient evaluations, confirm patients' drug histories and document compliance with therapeutic regimens.

New registration access to the Maryland Department of Health database at https://crisphealth.org/services/prescription-drug-monitoring-program-pdmp/pdmp-registration is granted to prescribers and pharmacists who are licensed by the State of Maryland and in good standing with their respective licensing boards. Prescribers and pharmacists authorized to access the Maryland

Department of Health must certify before each search that they are seeking data solely for the purpose of providing health care to current patients. Authorized users agree that they will not provide access to the Maryland Department of Health to any other individuals, including members of their staff.

Corrective Managed Care Program/Lock-In Program

We restrict members to one pharmacy if they have abused pharmacy benefits. We must follow the state's criteria for corrective managed care. **The Corrective Managed Care (CMC) Program is an ongoing effort by the Maryland Medicaid Pharmacy Program (MMPP) to monitor and promote appropriate use of controlled substances.** Call 410-981-4569 if a member is having difficulty filling a prescription. **The CMC program is particularly concerned with appropriate utilization of opioids and benzodiazepines. Amerigroup will work with the state in these efforts and adhere to the state's opioid preauthorization criteria.**

Members who use multiple pharmacies and/or physicians in a short time period may incur serious drug interactions and have a greater potential for medication abuse and misuse; Amerigroup has a process to identify members who may not be utilizing the pharmacy benefit appropriately. The Corrective Managed Care Program is designed to encourage members to obtain prescription medications at a single pharmacy and to assist in coordination of care when there has been evidence of pharmacy benefit misuse. Members who consistently use multiple pharmacies and/or physicians to obtain multiple opiate medications will be evaluated for possible participation in the Corrective Managed Care Program. This program is designed to limit the providers and/or pharmacies authorized to write and/or fill prescriptions for members who are part of the program.

Members who meet criteria will be identified for possible inclusion in the program. The PCP and/or specialty care provider will be contacted by phone to clarify if there could be a documented and valid medical reason for the prescription pattern. The member is contacted by phone to gather clinical information about their condition and information about their prescription use. The Corrective Managed Care committee reviews the member's available medical claims history, provider comments, member comments and other relevant information to determine if the member should be enrolled in the Corrective Managed Care Program.

The member is contacted verbally to discuss concerns and is notified in writing of acceptable and unacceptable behavior. The primary care and/or specialty care providers and pharmacy are contacted to verify they are willing to participate in the member's Corrective Managed Care Program. Amerigroup follows a process to address behavior that has not changed.

Once a member is enrolled in the Corrective Managed Care Program, Amerigroup will only reimburse for prescriptions written by specific providers and/or filled at the specified pharmacy or pharmacy chain. Pharmacies can dispense a 72-hour supply of medication in an urgent or emergent situation. A member placed in the Corrective Managed Care program may appeal the decision within 20 days. Appeals shall be otherwise handled in accordance with COMAR. Members suspected of Medicaid fraud will be reported to the Medicaid Fraud Control Unit in accordance with COMAR.

Providers who want additional information about the Corrective Managed Care Program may contact their local Provider Relations representative.

Maryland Opioid Prescribing Guidance and Policies

The following policies apply to both Medicaid Fee-for-Service and all nine MCOs:

Policy

Prior authorization is required for long-acting opioids, fentanyl products, methadone for pain, and any opioid prescription that results in a patient exceeding 90 morphine milliequivalents (MME) per day.[1] **A standard 30-day quantity limit for all opioids is set at or below 90 MME per day.** The CDC advises, "clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥ 50 MME/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day." In order to prescribe a long-acting opioid, fentanyl products, methadone for pain and opioids above 90 MME daily, a prior authorization must be obtained every six months.

The prior authorization requires the following items: an attestation that the provider has reviewed Controlled Dangerous Substance (CDS) prescriptions in the Prescription Drug Monitoring Program (PDMP); an attestation of a Patient-Provider agreement; attestation of screening patient with random urine drug screen(s) before and during treatment; and attestation that a naloxone prescription was given/offered to the patient/patient's household member. Patients with cancer, sickle cell anemia or in hospice are excluded from the prior authorization process, but they should also be kept on the lowest effective dose of opioids for the shortest required duration to minimize risk of harm. *HealthChoice MCOs may choose to implement additional requirements or limitations beyond the state's policy.*

Naloxone should be prescribed to patients that meet certain risk factors. Both the CDC and Centers for Medicaid and Medicare Services have emphasized that clinicians should incorporate strategies to mitigate the risk of overdose when prescribing opioids.[2] We encourage providers to prescribe naloxone — an opioid antagonist used to reverse opioid overdose — if any of the following risk factors are present: history of substance use disorder; high dose or cumulative prescriptions that result in over 50 MME; prescriptions for both opioids and benzodiazepine or non-benzodiazepine sedative hypnotics; or other factors, such as drug-using friends/family.

Guidance

Non-opioids are considered the first line treatment for chronic pain. The CDC recommends expanding first line treatment options to non-opioid therapies for pain. In order to address this recommendation, the following evidence-based alternatives are available within the Medicaid program: NSAIDs, duloxetine for chronic pain; diclofenac topical; and certain first line non-pharmacological treatment options (e.g., physical therapy). Some MCOs have optional expanded coverage that is outlined in the attached document.

Providers should screen for substance use disorder. Before writing for an opiate or any controlled substance, providers should use a standardized tool(s) to screen for substance use. Screening, Brief Intervention and Referral to Treatment (SBIRT) is an example of a screening tool.[3] Caution should be used in prescribing opioids for any patients who are identified as having any type of or history of substance use disorder. Providers should refer any patient whom is identified as having a substance use disorder to a substance use treatment program.

Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidenced-based practice used to identify, reduce and prevent problematic use, abuse and dependence on alcohol and drugs. The practice has proved successful in hospitals, specialty medical practices, emergency departments and workplace wellness programs. SBIRT can be easily used in primary care settings and enables providers to

systematically screen and assist people who may not be seeking help for a substance use problem, but whose drinking or drug use may cause or complicate their ability to successfully handle health, work or family issues. The provision of SBIRT is a billable service under Medicaid. Information on billing may be accessed here: https://mmcp.health.maryland.gov/MCOupdates/Documents/pt_43_16_edicaid_program_updates_for_spring_2016.pdf

Patients identified with substance use disorder should be referred to substance use treatment. Maryland Medicaid administers specialty behavioral health services through a single administrative services organization — Optum. If you need assistance in locating a substance use treatment provider, Optum may be reached at 1-800-888-1965. If you are considering a referral to behavioral health treatment for one of your patients, additional resources may be accessed at http://dhmh.maryland.gov/ohcq/Pages/home.aspx.

Providers should use the PMDP every time they write a prescription for CDS. Administered by MDH, the PDMP gives health care providers online access to their patients' complete CDS prescription profile. Practitioners can access prescription information collected by the PDMP *at no cost* through the CRISP health information exchange, an electronic health information network connecting all acute care hospitals in Maryland and other health care facilities. Providers that register with CRISP get access to a powerful "virtual health record" that includes patient hospital admission, discharge and transfer records, laboratory and radiology reports and clinical documents, as well as PDMP data.

For more information about the PDMP, visit the MDH website: http://bha.health.maryland.gov/pdmp/Pages/Home.aspx. If you are not already a registered CRISP user, you can register for **free** at https://crisphealth.force.com/crisp2_login. PDMP usage is highly encouraged for all CDS prescribers and will become mandatory to check patients CDS prescriptions if prescribing CDS at least every 90 days (by law) on July 1, 2018.

If an MCO is implementing any additional policy changes related to opioid prescribing, the MCO will notify providers and beneficiaries.

1 Instructions on calculating MME is available at: https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf.
2 CDC guidance: https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm; and CMS guidance: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-02-02-16.pdf).
3 A description of these substance use screening tools may be accessed at: http://www.integration.samhsa.gov/clinical-practice/screening-tools.

SECTION VI. CLAIMS SUBMISSION, PROVIDER APPEALS, QUALITY INITIATIVES, PROVIDER PERFORMANCE DATA AND PAY FOR PERFORMANCE

Facts to Know Before You Bill

You must verify through the Eligibility Verification System (EVS) that participants are assigned to Amerigroup before rendering services. Prior to any appointment for a HealthChoice member, you must call EVS at 1-866-710-1447 to verify member eligibility and Amerigroup enrollment. This procedure will assist in ensuring payment for services. The Provider Inquiry Line is available 24 hours a day, 7 days a week at 1-800-454-3730. This is an automated telephone tool that enables providers to verify member eligibility, prior authorization and claims status. Providers can also log in to the self-service website at https://provider.amerigroup.com/MD to verify member eligibility or call a Provider Services representative at 1-800-454-3730 to answer eligibility questions.

- You are prohibited from balance billing anyone that has Medicaid, including MCO members.
- You may not bill Medicaid or MCO members for missed appointments.
- Medicaid regulations require that a provider accept payment by the Program as payment in full for covered services rendered and make no additional charge to any person for covered services.
- Any Medicaid provider that practices balance billing is in violation of their contract.
- For covered services, MCO providers may only bill us or the Medicaid program if the service is covered by the state but is not covered by the MCO.
- Providers are prohibited from billing any other person, including the Medicaid participant or the participant's family members, for covered services.
- HealthChoice participants may not pay for covered services provided by a Medicaid provider that is outside of their MCO provider network.
- If a service is not a covered service and the member knowingly agrees to receive a noncovered service, the provider MUST:
    - Notify the member in advance that the charges will not be covered under the program.
    - Require that the member sign a statement agreeing to pay for the services and place the document in the member’s medical record.
    - Note: We recommend you call us to verify that the service is not covered before rendering the service.

Submitting Claims to Amerigroup

Claims must be submitted in accordance with timely filing guidelines and must include all necessary information as outlined in the following sections. In addition, all codes used in billing must be supported by appropriate medical record documentation.

Electronic Claim Submission

Amerigroup has partnered with Availity to become our designated EDI gateway. All Amerigroup EDI transactions currently flowing through our internal legacy EDI gateway will be required to transition to the Availity EDI gateway.

All Amerigroup EDI claims should still be submitted for adjudication the same way; it’s just the entry point (EDI gateway) for them that is changing to Availity. Availity is a no-cost EDI submission option for Amerigroup providers willing to submit directly, in lieu of a clearinghouse.

Transmitting 837 Claims

If you currently transmit 837 claims using a clearinghouse, you should contact your clearinghouse as soon as possible to confirm your EDI submission path for Amerigroup transactions has not changed.

If your clearinghouse notifies you of changes regarding connectivity, workflow or the financial cost of EDI transactions, providers can submit claims directly through Availity.

Existing direct submitters of our legacy EDI gateway can now connect directly to the Availity gateway for Amerigroup 837 transmissions.

Registering with Availity
If you choose to submit directly through Availity but are not yet a registered user, go to https://www.availity.com and select **Register**.

The registration wizard will lead you through the enrollment process. Once complete, you will receive an email with your login credentials and next steps for getting started.

If you have any questions or concerns, please contact Availity at 1-800-AVAILITY (282-4548).

Paper Claim Submission
Amerigroup encourages electronic claim submission; however, providers have the option to submit paper claims. Amerigroup utilizes optical character recognition (OCR) technology as part of its front-end claims processing procedures. The benefits of this technology include:

- Faster turnaround times and adjudication.
- Claims status availability within five days of receipt.
- Immediate image retrieval by Amerigroup staff for claims information, enabling more timely and accurate responses to provider inquiries.

To use OCR technology, claims must be submitted on original, red claim forms (not black and white or photocopied forms) that are laser-printed or typed (not handwritten) in large, dark font. Providers must submit a properly completed *UB-04* or *CMS-1500 (08-05)* claim form within 180 days from the date of discharge for inpatient services or from the date of service for outpatient services except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date the third-party documents resolution of the claim. For cases of retroactive eligibility, the time frames for filing a claim will begin on the date Amerigroup receives notification from MDH of the member's eligibility/enrollment.

In accordance with the implementation timelines set by CMS, the National Uniform Claim Committee (NUCC) and the National Uniform Billing Committee (NUBC), Amerigroup requires the use of the new *CMS-1500* (*08-05*) form for the purpose of accommodating the NPI.

CMS-1500 (08-05) and *UB-04 CMS-1450* claim forms must include the following information prior to the state of Maryland becoming compliant with the NPI federal rule. Amerigroup has aligned its NPI and taxonomy code requirements with the state of Maryland (HIPAA-compliant where applicable):

- Member's name
- Member's ID number
- Member's date of birth
- Provider name according to contract
- Provider tax ID number and state Medicaid ID number
- Amerigroup provider number
- NPI of billing provider when applicable
- Date of service

- Place of service
- ICD-10 diagnosis code/revenue codes
- Procedures, services or supplies rendered, CPT-4 codes/HCPCS codes/diagnosis-related groups (DRGs) with appropriate modifiers, if necessary
- Itemized charges
- Days or units
- Modifiers as applicable
- Coordination of benefits (COB) and/or other insurance information
- The prior authorization number or copy of the prior authorization
- Name of referring provider
- NPI of referring provider when applicable
- Any other state-required data

Amerigroup cannot accept claims with alterations to billing information. Amerigroup does not accept computer-generated or typewritten claims with information that has been marked through, handwritten, or appears to have been covered by correction fluid or tape. Claims that have been altered will be returned to the provider with an explanation of the reason for the return.

Paper claims must be submitted within 180 days of the date of service, and emergency room claims must be submitted within nine months of the date of service, except in cases of COB/subrogation or in cases where a member has retroactive eligibility. For cases of COB/subrogation, the time frame for filing a claim will begin on the date the third-party documents resolution of the claim. For cases of retroactive eligibility, the time frames for filing a claim will begin on the date Amerigroup receives notification from MDH of the member's eligibility/enrollment. Paper claims must be submitted to:

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

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

Encounter Data
Providers must submit encounter data within the timely filing periods outlined in the Claims Adjudication section of this manual through EDI submission methods or *CMS-1500 (08-05)* or *1450/UB-40* claim forms. Include the following information in submissions:

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

Amerigroup will not reimburse providers for items received free of charge or items given to members free of charge.
Providers must use HIPAA-compliant billing codes when billing or submitting encounter data. This applies to both electronic and paper claims. When billing codes are updated, providers are required to use appropriate replacement codes for submitted claims or covered services.

Providing after-hours care in an office setting helps reduce inappropriate emergency room use and encourages members to receive appropriate follow-up care. To promote greater access for members, Amerigroup provides additional reimbursement to PCPs who provide after-hours care. Additionally, Amerigroup encourages PCPs to provide efficient quality care in an office setting and will reimburse wellness visits and sick visits billed on the same day. For more information, visit the provider self-service website at https://provider.amerigroup.com/MD.

Claims Adjudication
Amerigroup is dedicated to providing timely adjudication of claims. Amerigroup processes all claims according to generally accepted claims coding and payment guidelines defined by the CPT-4 and ICD-10 manuals. Providers must use HIPAA-compliant billing codes when billing by paper or electronically. When billing codes are updated, providers are required to use appropriate replacement codes for submitted claims. Amerigroup will reject claims submitted with noncompliant billing codes. Amerigroup uses code-editing software to determine which services are considered part of, incidental to, or inclusive of the primary procedure.

Timely Filing
Paper and electronic claims must be filed within 180 calendar days. Timely filing periods begin from the date of discharge for inpatient services and from date of service for outpatient/physician services. Timely filing requirements are defined in the provider agreement. Amerigroup will deny claims submitted after the filing deadline.

Documentation of Timely Claim Receipt
Claims will be considered timely if submitted:
- By United States mail first class, return receipt requested or by overnight delivery service — you must provide a copy of the claim log that identifies each claim included in the submission.
- Electronically — you must provide the clearinghouse-assigned receipt date from the reconciliation reports.
- By hand delivery — you must provide a claim log identifying each claim included in the delivery and a copy of the signed receipt acknowledging the hand delivery.

The claims log maintained by providers must include the following information:
- Name of claimant
- Address of claimant
- Telephone number of claimant
- Claimant's federal tax identification number
- Name of addressee
- Name of carrier
- Designated address
- Date of mailing or hand delivery
- Subscriber name
- Subscriber ID number
- Patient name

- Date(s) of service/occurrence
- Total charge
- Delivery method

Good Cause
If a claim or claim dispute was filed untimely, you have the right to include an explanation and/or evidence explaining the reason for delayed submission. Amerigroup will contact you for clarification or additional information necessary to make a good cause determination.

Good cause may be found when a physician or supplier claim filing is delayed due to:
- Administrative error due to incorrect or incomplete information furnished by official sources (e.g., carrier, intermediary, CMS) to the physician or supplier.
- Incorrect information furnished by the member to the physician or supplier resulting in erroneous filing with another care management organization plan or with the state.
- Unavoidable delay in securing required supporting claim documentation or evidence from one or more third parties despite reasonable efforts by the physician/supplier to secure such documentation or evidence.
- Unusual, unavoidable or other circumstances beyond the service provider's control that demonstrate the physician or supplier could not reasonably be expected to file timely.
- Destruction or other damage of the physician's or supplier's records, unless such destruction or other damage was caused by the physician's or supplier's willful act of negligence.

Coordination of Benefits
Amerigroup follows state-specific guidelines and all federal regulations when coordination of benefits is necessary with other health insurance (OHI), third party liability (TPL), medical subrogation or estate recovery. Amerigroup uses covered medical and hospital services whenever available or other public or private sources of payment for services rendered to members.

OHI and TPL refer to any individual, entity or program that may be liable for all or part of a member's health coverage. The state is required to take all reasonable measures to identify legally liable third parties and treat verified OHI and TPL as a resource of each plan member.

Amerigroup takes responsibility for identifying and pursuing OHI and TPL for members and puts forth best efforts to identify and coordinate with all third parties against whom members may have claims for payments or reimbursements for services. These third parties may include Medicare or any other group insurance, trustee, union, welfare, employer organization or employee benefit organization, including preferred provider organizations or similar type organizations, any coverage under governmental programs, and any coverage required to be provided for by state law.

When OHI or TPL resources are available to cover the costs of trauma-related claims and medical services provided to Medicaid members, Amerigroup will reject the claim and redirect providers to bill the appropriate insurance carrier (unless certain pay-and-chase circumstances apply — see below). Or, if Amerigroup does not become aware of the resource until after payment for the service was rendered, Amerigroup will pursue post-payment recovery of the expenditure. Providers must not seek recovery in excess of the Medicaid payable amount.
Pay-and-chase circumstances include:
- When the services are for preventive pediatric care (EPSDT).

The Amerigroup subrogation vendor handles the filing of liens and settlement negotiations both internally and externally.
For questions regarding paid, denied or pended claims, call Provider Services at 1-800-454-3730.

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 the term ICD-10 is often used 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.

Encounter Data Reporting Requirements
Amerigroup maintains a system to collect member encounter data. All capitated providers and/or sites must report all member encounters. This is a key component of the Amerigroup information system, and electronic reporting is encouraged. Failure to submit accurate and timely reports may result in corrective action up to and including termination of the *Participating Provider Agreement*.

If a provider is capitated, the provider will receive a monthly check based on a number of factors (e.g., member's age, gender, number of members in provider's panel) that includes payment for all capitated services rendered.

Due to reporting needs and requirements, Amerigroup network providers reimbursed by capitation must send encounter data to Amerigroup for each member encounter. This is performed through use of the *CMS-1500 (08-05)* claim form. Data must be submitted in a timely manner. Failure to provide information can result in delayed capitation payment. The encounter data must include the following:
- Member ID number
- Member's first and last name
- Date of member's birth
- Provider name according to contract
- Amerigroup provider ID number
- Coordination of benefit information
- Date of encounter
- Diagnosis code
- Types of services provided (utilizing current procedure codes and modifiers, if applicable)
- Provider's tax ID number and state Medicaid ID number
- NPI

Submit encounter data to:

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

HEDIS® outcomes are also collected through claim and encounter data submissions. This includes but is not limited to:

- Preventive services (e.g., childhood immunization, mammography and Pap smears).
- Prenatal care (e.g., the number and frequency of prenatal visits).
- Acute and chronic illness (e.g., ambulatory follow-up and hospitalization for major disorders).

Compliance is monitored by the Amerigroup Utilization and Quality Improvement staff, coordinated with the medical director and reported to the quality management committee on an annual basis. The PCP is monitored for compliance with reporting of utilization. Lack of compliance will result in training and follow-up audits and may result in termination.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Claims Adjudication

Amerigroup 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. Hospital facility claims should be submitted using the *UB-04* form, and provider services claims should be submitted using the *CMS-1500 (08-05)* form.

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

- Submit claims within 180 days of the date of service (for inpatient claims filed by a hospital, within 180 days from the date of discharge)
- In the case of other insurance, submit the claim within 180 days of 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 180 days from the date the eligibility is added

Claims submitted after the 180-day filing deadline will be denied.

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

Health care practitioners and other persons entitled to reimbursement must use the *CMS-1500 (08-05)* form and instructions provided by CMS for use of the *CMS-1500 (08-05)* as the sole instrument for filing claims with Amerigroup for professional services. This does not apply to dental services billed by dentists using the *J 512 Form* or its equivalent or pharmacists or pharmacies filing claims for prescription drugs.

Except for parties to a global contract, Amerigroup may not require a health care practitioner or other person entitled to reimbursement to use any code or modifier to file claims for health care services different from, or in addition to, what is required under the applicable standard code set for the professional services provided.

Except as noted, Amerigroup may not use and may not require a health care practitioner or other person entitled to reimbursement to use another descriptor with a code or to furnish additional

information with the initial submission of a *CMS-1500 (08-05)* that is different from, or in addition to, the applicable standard code set for the professional services provided.

A health care practitioner or other person entitled to reimbursement whose billing is based on the amount of time involved will indicate the start and stop time or number of minutes in Field 24G, currently titled Day or Units, of the *CMS-1500 (08-05)* if it is not used to specify the number of days of treatment. This form is available at www.cms.hhs.gov.

***CMS-1500 (08-05)* Claim Form Instructions**
The *CMS-1500 (08-05)* form and instructions are used by noninstitutional providers and suppliers to bill for covered services. Under Amerigroup, claims may be submitted electronically. To initiate the electronic claims submission process or obtain additional information, contact the Amerigroup EDI Hotline at 1-800-590-5745. In addition, Amerigroup utilizes optical character recognition (OCR) technology as part of its claims processing procedures. In order to use OCR, claims must be submitted on original, red claim forms (not black and white or photocopied forms), and laser printed or typed (not handwritten) in large, dark font.

Amerigroup may not use or require a health care practitioner or a person entitled to reimbursement to use any field for purposes inconsistent with these essential data elements or in addition to the applicable standard code set. A provider may elect to include additional data elements.

Field 1 – Type of Plan – Required
Place an X in the box to indicate the type of insurance.

Field 1a – Insured's ID Number – Required
Enter the member's ID number from their Amerigroup ID card.

Field 2 – Patient's Name – Required
Enter the member's last name, first name and middle initial, if any, as shown on his or her member ID card. Do not use abbreviations or nicknames.

Field 3 – Patient's Birth Date – Required
Enter the patient's eight-digit birth date in MM/DD/CCYY format and check the box that indicates the gender of the patient.

Field 4 – Insured's Name – Required
If there is insurance primary to Amerigroup, enter the name of the insured here. When the insured and the patient are the same, enter the word same.

Field 5 – Patient's Address and Telephone Number – Required
Enter the patient's address (i.e., street, city, state and ZIP code) and telephone number. If the patient lives in a nursing home or other extended care facility, provide the facility's address.

Field 6 – Patient Relationship to Insured – Required
Enter the item indicating the patient's relationship to the primary insured individual. The choices are self, spouse, child and other. Complete this item only if Item 4 is completed; otherwise, leave this item blank. If there are payers of higher priority, enter the appropriate relationship code.

Field 7 – Insured's Address – Required
Enter the insured's address (i.e., street, city, state and ZIP code) and telephone number. If the address of the insured and the patient are the same, enter the word same. If the insured's address is in care of someone else, enter the c/o reference in the first three positions on the first line of the insured's address.

Field 8 – Patient Status – Required if Applicable
Enter the patient's marital status and whether employed or a student if the services are provided by a laboratory issued a license pursuant to Health-General §17-205, Annotated Code of Maryland. The choices for the patient's marital status are single, married and other. The choices for employment status are employed, full-time student and part-time student. Check all applicable boxes.

Field 9 – Other Insured's Name – Required if Applicable
Enter the last name, first name and middle initial of other insured or member who is enrolled in any other policy if the name is different from that shown for Item 2. Enter the word same if the name is the same for Item 2. If no other policy benefits are assigned, leave this item blank.

Field 9a – Other Insured's Policy or Group Number – Required if Applicable
Enter the policy or group number if the member is covered by more than one health plan. If the patient does not have other insurance coverage, leave this item blank.

Field 9b – Other Insured's Date of Birth – Required if Applicable
Enter the other insured's or member's date of birth and the gender of the member identified in Field 9. If the patient does not have other coverage, leave this item blank.

Field 9c – Employer's Name or School Name – Required if Applicable
Enter the other insured's or member's plan name (e.g., employer, school, etc.) if the member is covered by more than one health plan.

Field 9d – Insurance Plan Name or Program Name – Required if Applicable
Enter the other insured's or member's HMO or insurer name if the member is covered by more than one health plan.

Field 10a, b and c – Employment Related Condition – Required
Indicate whether the patient's condition is related to his or her employment and is applicable to one or more of the services described in Item 24. If the patient's condition is related to employment, put an X in the yes box and indicate whether it is related to the patient's current or previous employment by circling the appropriate term. If the injury or illness is related to an automobile accident, place an X in the yes box. Enter the date of the accident in Item 14 in an eight-digit format. If the patient's condition is related to another accident, place an X in the yes box. Enter the date of the accident in Item 14. File the claims with the other insurer as the primary payer (Item 11). Once a response (i.e., a payment or denial notice) is received from the primary insurer, file the secondary claims with Amerigroup. Field 10d is reserved for local use. Identify the insurance in Field 11.

Field 11 – Insured's Policy Group or FECA Number – Required
Enter the subscriber's policy, group or Federal Employees' Compensation Act (FECA) identification number of any insurer primary to Amerigroup. By completing this item, the physician or supplier acknowledges having made a good faith effort to determine whether Amerigroup is the secondary payer. Do not leave this item blank. If there is no insurance primary to Amerigroup, enter the word none

and proceed to Field 12. If there is insurance primary to Amerigroup, enter the insured policy or group number and complete Item 11a. Amerigroup is always the payer of last resort.

Field 11a – Insured's Date of Birth – Required
Enter the subscriber's birth date and gender, except in the case of a laboratory issued a license pursuant to Health-General Article, §17-205, Annotated Code of Maryland.

Field 11b – Employer's Name or School Name –Required
Enter the employer name, if applicable. If there has been a recent change in the insured's insurance status, enter the date of the change preceded by a brief description of the change.

Field 11c – Insurance Plan Name or Program Name – Required
Enter the complete name of the third party payer, except in the case of a laboratory issued a license pursuant to Health-General Article, §17-205, Annotated Code of Maryland.

Field 11d – Is There Another Health Benefit Plan? – Required
Disclose any other health plan.

Field 12 – Patient's or Authorized Person's Signature (Information Release/Government Authorization) – Required
This item contains the signature of the patient or the patient's authorized representative and the date in eight-digit format. The signature authorizes release of medical information necessary to process the claim and the payment of benefits to the physician or supplier if the physician and/or supplier accepts assignment. In lieu of a signature on the claim, enter SOF if there is a Signature On File agreement with the provider. (For additional information, see instructions). Signature on file will also be accepted here.

Field 13 – Insured's or Authorized Person's Signature (Payment Authorization) – Required
For nongovernment programs, an assignment of benefits separate from the information release (Field 12) is required if benefits are to be sent to the provider. The patient must sign in the block if payment to the provider is desired, or the patient's/insured's signature on a separate document must be maintained in the patient's file (enter On File). Some provider agreements (e.g., PPOs, HMOs, etc.) specifically address how payments are to be handled, in which case leave the block blank. However, it is still advisable to obtain an assignment of benefits from the patient or patient's representative if payment is to go to your office. Do not make any notation in this space if payment is to go to the patient. Signature on file will also be accepted here.

Field 14 – Date of Current Illness, Injury or Pregnancy – Required
Enter the current illness (first symptom), injury (accident) or pregnancy (Last Menstrual Period LMP) in eight-digit format, except in the case of a laboratory-issued license pursuant to Health-General Article, §17-205, Annotated Code of Maryland. If an accident date is provided, complete Field 10b or 10c. For chiropractic services, enter the date of the initiation of the course of treatment and the eight-digit X-ray date in Field 19.

Field 15 – If Patient Has Had Same or Similar Illness – Required
Enter (if applicable) the date the patient has had the same or similar illness, except in the case of a health care practitioner for emergency services or a laboratory issued a license pursuant to Health-General Article, §17-205, Annotated Code of Maryland.

Field 16 – Dates Patient Unable to Work in Current Occupation – Required
This item identifies the dates the patient was employed and unable to work in his or her current occupation and may indicate employment-related insurance coverage. The eight-digit format must be used in this item. Completion of this field is important for worker's compensation cases. Any entry in this field may indicate employment-related insurance coverage.

Field 17 – Name of Referring Physician or Other Source and ID Number of Referring Physician – Required
This field contains the complete name of the physician who requests or orders a service or item. Except in the case of a health care practitioner for emergency services, enter the name of the referring physician if the service or item was ordered by a physician. A referring physician is a physician who requests an item or service for the member. An ordering physician is a physician who orders nonphysician services or items for the member, such as diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services or Durable Medical Equipment (DME).

Field 17a – Other ID # – Required
This field is used to report supplementary identification numbers for the referring or ordering physician listed in Field 17. Field 17a's first segment should include one of the following qualifiers, which identify the type of number being reported immediately to the right:

- 1D – Medicaid provider number
- G2 – Provider commercial number
- N5 – Provider plan network identification number
- ZZ – Provider taxonomy

Field 17b – NPI #
This field is used to submit the NPI number of the Referring, Ordering or Other source.

Field 18 – Hospitalization Dates Related to Current Services – Required if Applicable
Enter the applicable month, day and year of the hospital admission and discharge using an eight-digit date format. This item is to be completed when medical services are rendered as a result of, or subsequent to, a related hospitalization. If services were rendered in a facility other than the patient's home or a physician's office, provide the name and address of that facility in Field 32.

Field 19 – Reserved for Local Use – Not Required
This information is not collected.

Field 20 – Outside Laboratory – Required
Indicate whether any diagnostic tests subject to purchase price limitations were performed outside the physician's office and enter the charges for those purchased services. Place an X in the Yes box when a provider other than the provider billing for the service performed the diagnostic test. When Yes is checked, Field 32 must be completed with the name and address of the clinical laboratory or other supplier that performed the service. If billing for multiple purchased diagnostic tests, each test must be submitted on a separate claim form. Enter the purchase price of the tests in the charges column. Show dollars and cents, omitting the dollar sign. Place an X in the no box when diagnostic tests are performed in the physician's office or supervised by the physician (i.e., no purchased tests are included on the claim).

Field 21 – Diagnosis or Nature of Illness or Injury – Required
Enter the member's diagnosis and/or condition using an ICD-10-CM code number and code to the highest level of specificity for the encounter or visit. All physician specialties must use an ICD-10-CM

code number and code up to the highest level of specificity. Report at least one diagnosis code on the claim. Enter up to four codes in priority order (e.g., primary condition, secondary condition, etc.) to accurately describe the reason for the encounter. List the first code for the diagnosis, condition, problem, etc., shown in the medical record to be chiefly responsible for the service provided. Then, list codes that describe the coexisting conditions. For all narrative diagnoses for nonphysician specialties, use a separate attachment to the claim form.

Field 22 – Medicaid Resubmission Code – Not Required
This item contains the acronym CC denoting it as a Corrected Claim. When billing Medicare, leave this item blank.

Field 23 – Prior authorization Number – Required if Applicable
Enter the prior authorization number, if applicable for appropriate procedures.

Field 24a – Dates of Service – Required
Enter the appropriate from and to dates of service for the entire period reflected by the procedure code using an eight-digit date format and excluding all punctuation. Do not use slashes between dates. If the date or month is a single digit, precede it with a zero. Make sure the dates shown are no earlier than the date of the current illness shown in Field 14. If the same service is furnished on different dates, each date should be listed on the claim. For services performed on a single day, the from and to dates are the same. (For additional information see instructions).

Field 24b – Place of Service – Required
This item indicates the site where services were rendered or an item was utilized. Enter the appropriate two-digit numeric code pertaining to the place of service. If services were provided in the emergency department, use code 23. If services were provided in an urgent care center, use code 22. If services were rendered in a hospital, clinic, laboratory or other facility, show the name and the address of the facility in Field 32.

Field 24c – EMG – Required
This item represents an emergency indicator. You can either enter Y, N or leave blank.

Field 24d – Procedures, Services or Supplies – Required
Enter the appropriate CPT or HCPCS code to define the procedure, service or supply rendered. CPT is Current Procedural Terminology and was developed by the American Medical Association. The codes and modifiers selected must be supported by medical documentation in the patient's record. Link each CPT code with the appropriate ICD-10-CM code listed in Fields 21 and 24e. In the absence of an applicable CPT code, enter the HCPCS code applicable to the services, procedure or supplies rendered. The codes and modifiers selected must be supported by medical documentation in the patient's record. Link each HCPCS code with the appropriate ICD-10-CM code listed in Fields 21 and 24e. Enter the specific procedure code without a descriptive narrative. If no specific procedure codes are available that fully describe the procedure performed and an unlisted or not otherwise classified procedure code must be used, include the narrative description in Field 19. Enter a code established by the Medicaid program if the claim is for services rendered pursuant to Health-General Article, §15-103(b)(2), Annotated Code of Maryland.

Field 24e – Diagnosis Code Pointer – Required
Indicate reference numbers linking the ICD-10-CM codes listed in Field 21 to the dates of service and CPT codes listed in Fields 24a and 24d. The information is used to document that the patient's diagnosis warranted the physician's services. Enter only one reference number per line item. When multiple

services are performed, enter the primary reference number for each service. In a situation where two or more diagnoses are required for a procedure code, you must reference only one of the diagnoses in Field 21.

Field 24f – Charges – Required
Enter the amount charged by the physician for each of the services or procedures listed on the claim. If multiple occurrences of the same procedure are being billed on the same line, indicate the inclusive dates of service in Field 24a. List the separate charge for each service in this item and the number of units or days in Field 24g. Do not bill a flat fee for multiple dates of service on one line.

Field 24g – Days or Units – Required
Enter the number of days, time (i.e., minutes), start and stop time or units (without decimal points) of procedures, services or supplies listed in Field 24d. This Field is commonly used to report multiple visits, units of supplies, anesthesia minutes or oxygen volume. If only one service is performed, enter the number one (1). For some services (e.g., hospital visits, test, treatments, doses of an injectable drug, etc.), indicate the actual quantity provided. When the number of days is reported, it is compared with the inclusive dates of service listed in Field 24a. Days usually are reported when the patient has been hospitalized. When billing radiology services, do not provide the number of X-ray views in this column. Use the appropriate procedure code to report the number of views. However, when the same radiology procedure is performed more than once on the same day, the number of times should be shown in this item. Anesthesia claims must be reported in minutes.

Field 24h – EPSDT – Required
Enter Y for Yes and N for No to indicate Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services were provided. EPSDT applies only to children under age 21 who receive medical benefits through public assistance.

Field 24i – ID Qual – Not Required
This field is used to report supplementary identification numbers for the rendering physician.

In 24i, line 1, the shaded area includes one of the following qualifiers, which identify what type of number is being reported immediately to the right in 24j:

- 1D – Medicaid provider number
- G2 – Provider commercial number
- N5 – Provider plan network identification number
- ZZ – Provider taxonomy when required

In 24i, line 1, the unshaded area of the qualifier contains the value of NPI, and the NPI of the rendering provider should be submitted immediately to the right in 24j.

In 24j, the individual rendering the service is reported in 24j. The Rendering Provider is the person or company (e.g., laboratory or other facility) that rendered or supervised the care. Report the Identification Number in Items 24i and 24j only when different from data recorded in items 33a and 33b.

Field 25 – Federal Tax ID Number or Social Security Number – Required
Enter the provider's or supplier's Federal Tax ID (e.g., employer identification number). The number may be the Social Security Number (SSN) or the federal tax ID number/Employee Identification Number (EIN). Designate whether number listed is SSN or EIN by placing an X in the appropriate box.

Field 26 – Patient's Account Number – Required
Enter the member's account number assigned by the provider's accounting system. The patient's account number is used by the provider for retrieving individual patient accounts and case records and for posting payment. If included on the claim form, the member's account number is displayed on the Provider's Explanation of Payment for that claim.

Field 27 – Accept Assignment – Required if Applicable
If the physician or supplier agrees to accept the amount allowed by HealthChoice as the full payment for the service, place an X in the yes box. This establishes this claim as an assigned claim.

Field 28 – Total Charge – Required
Enter the dollars and cents, omitting the dollar sign. Also, verify this amount equals the total of the charges listed in Field 24f. To bill a Medicare Secondary Payer (MSP) claim, bill the full amount of the charges in this item. Do not report the difference between what the primary payer paid and the total charges or the allowed amounts. Attach a copy of the primary payer's Explanation of Benefits (EOB) that contains the payment information.

Field 29 – Amount Paid – Required if Applicable
Enter the amount paid by the patient for covered services only using dollars and cents, omitting the dollar sign.

Field 30 – Balance Due – Required if Applicable
Enter the difference between Field 28 and Field 29.

Field 31 – Signature of Physician or Supplier – Required
Enter the signature of the physician, supplier or representative, and the date the claim form was signed in eight-digit format. The provider or his or her authorized representative must sign the provider's name. An approved facsimile stamp may also be used. Type the provider's full name below the signature or stamp. Do not enter the name of an association or corporation in this field. (Computer generated and/or printed provider's name of Signature on file will also be accepted here.)

Field 32 – Name and Address of Facility Where Services Were Rendered – Required if Applicable
Enter the name and address of the facility where services were rendered if they were furnished in a hospital, clinic, laboratory, or any facility other than the patient's home or physician's office. A complete address includes the ZIP code, which allows carriers to determine the correct pricing locality for purposes of claims payment. When the name and address of the facility is the same as the biller name and address in Field 33, enter the word Same. For additional information see instruction.

Field 32a – NPI # – Required
This field is used to report the NPI number for the service facility location.

Field 32b – Other ID # – Required
This field is used to report a supplementary identification number for the service facility location. In 32b, include one of the following qualifiers to identify the type of number being reported immediately following the qualifier value:

- 1D – Medicaid provider number
- G2 – Provider commercial number
- N5 – Provider plan network identification number
- ZZ – Provider taxonomy when required

Field 33 – Physician's, Supervising Physician's and Supplier's Billing Name, Address – Required
Enter the billing name and billing address of the individual providing the claimed services. Enter the individual provider number and/or the group provider, or if appropriate, the Amerigroup assigned provider number to whom the services are being billed.

Field 33a –NPI # – Required
This field is used to report the NPI number for the Billing Provider.

***UB-04* Claim Form**
Hospitals or persons entitled to reimbursement must use the *UB-04*, and instructions provided by CMS for use of the *UB-04*, as the sole instrument for filing claims with Amerigroup for hospital and other health care services.

Except for parties to a global contract, Amerigroup may not use and may not require a hospital or other person entitled to reimbursement to use any code or modifier for the filing of claims for hospital and other health care services that is different from, or in addition to, what is required under the applicable standard code set for hospital or other health care services provided.

Except as noted, Amerigroup may not use and may not require a hospital or other person entitled to reimbursement to furnish additional information with the initial submission of a *UB-04* that is different from, or in addition to, the applicable standard code set for the hospital or other health care services provided. This form is available at www.cms.hhs.gov.

***UB-04* Claim Form Instructions**
The *UB-04* form and instructions are used by institutional and other selected providers. Under Amerigroup, claims may be submitted electronically. To initiate the electronic claims submission process or obtain additional information, contact the Amerigroup Electronic Data Interchange (EDI) Hotline at 1-800-590-5745. In addition, Amerigroup utilizes optical character recognition (OCR) technology as part of its claims processing procedures. In order to use OCR, claims must be submitted on original claim forms with drop-out red ink, and printed or typed (not handwritten) in large, dark font.

Amerigroup may not use or require a hospital or other person entitled to reimbursement to use any field for purposes inconsistent with these essential data elements or in addition to the applicable standard code set. A provider may elect to include additional data elements.

Field 1 – Provider Name, Address and Telephone Number – Required
Enter the provider's name, city, state, ZIP code and telephone number.

Field 2 – Untitled – Not Required
This information is not collected.

Field 3 – Patient Control Number – Required
Enter the patient's unique alphanumeric identification code assigned by the provider to facilitate retrieval of individual financial records and post of payment.

Field 4 – Type of Bill – Required
Enter the three-digit alphanumeric code. The first digit of the code indicates the type of facility, the second digit of the code indicates the type of care and the third digit of the code indicates the frequency of care.

Field 5 – Federal Tax Number – Required
Enter the provider's federal tax ID number.

Field 6 – Statement Covers Period – Required
Enter the beginning and ending dates of the period of care. The from date is used to determine timely filing.

Field 7 – Covered Days – Required if Applicable
Enter the information if Medicare is a primary or secondary payer.

Field 8 – Noncovered Days – Required if Applicable
Enter the information if Medicare is a primary or secondary payer.

Field 9 – Coinsurance Days – Required if Applicable
Enter the information if Medicare is a primary or secondary payer.

Field 10 – Lifetime Reserve Days – Required if Applicable
If the patient received inpatient care, enter the information if Medicare is a primary or secondary payer.

Field 11 – Untitled – Not Required
This information is not collected.

Field 12 – Patient's Name – Required
Enter the patient's full name in last name, first name and middle initial order.

Field 13 – Patient's Address – Required
Enter the patient's address (street, city, state and ZIP code).

Field 14 – Patient's Birth Date – Required
Enter the patient's birth date in MM/DD/CCYY format.

Field 15 – Patient Sex – Required
Enter the patient's gender (M or F).

Field 16 – Patient's Marital Status – Required
Enter the patient's marital status.

Field 17 – Admission Date – Required if Applicable
This information is required for an inpatient admission or home health service only. Enter the patient's admission date in MM/DD/YY format.

Field 18 – Admission Hour – Required
Enter the patient's admission hour using military time format.

Field 19 – Type of Admission – Required if Applicable
This information is required for an inpatient admission or swing bed services only.
1. Emergency
2. Urgent
3. Elective
4. Newborn

5. Trauma center
6. Information not available

Field 20 – Source of Admission – Required if Applicable
This information is required for an inpatient admission only. Enter the source of admission.
1. Physician referral
2. Clinic referral
3. HMO referral
4. Transfer from a hospital
5. Transfer from a SNF
6. Transfer from another health care facility
7. Emergency room
8. Court/law enforcement
9. Information not available
10. Transfer from a critical access hospital
11. Transfer from another home health agency
12. Readmission to same home health agency

Field 21 – Discharge Hour – Required if Applicable
Enter the patient's discharge hour using military time format.

Field 22 – Patient Status – Required if Applicable
This information is required for an inpatient admission only. Enter the patient's discharge status code as outlined below:
01 Discharged to home or self-care (routine discharge)
02 Discharged/transferred to another short-term general hospital
03 Discharged/transferred to Skilled Nursing Facility (SNF) – see Code 61 below
04 Discharged/transferred to an Intermediate Care Facility (ICF)
05 Discharged/transferred to another type of institution (including distinct parts) or referred for outpatient services to another institution
06 Discharged/transferred to home under care of organized home health service organization
07 Left against medical advice or discontinued care
08 Discharged/transferred to home under care of a home intravenous drug therapy provider
09 Admitted as an inpatient to this hospital
20 Expired
30 Still patient or expected to return for outpatient services
40 Expired at home (hospice claims only)
41 Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (hospice claims only)
42 Expired – place unknown (hospice claims only)
43 Discharged/transferred to a federal hospital
50 Discharged/transferred to hospice – home
51 Discharged/transferred to hospice – medical facility
61 Discharged/transferred within this institution to a hospital-based Medicare-approved swing bed
62 Discharged/transferred to an inpatient rehabilitation facility, including distinct units of a hospital
63 Discharged/transferred to long-term care hospital
64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65 Discharged/transferred to a psychiatric hospital or psychiatric distinct unit of a hospital

71 Discharged/transferred to another institution for outpatient services as specified by the discharge plan of care
72 Discharged/transferred to this institution for outpatient services as specified by the discharge plan of care

Field 23 – Medical Record Number – Required
Enter the number assigned to the patient's medical/health record. If the provider enters a number, Amerigroup will carry the number through its system and return it to the provider.

Fields 24 through 30 – Condition Code – Required
Enter code(s) identifying conditions related to the bill which may affect processing.

Field 31 – Untitled – Not Required
This information is not collected.

Fields 32 through 35 – Occurrence Codes and Dates – Required if Applicable
Up to four codes and dates may be entered.

Field 36 – Occurrence Span Code and Dates – Required
Enter code(s) and from and to date span of the occurrence.

Field 37 – Internal Control Number (ICN)/Document Control Number (DCN) – Not Required
This information is not collected.

Field 38 – Responsible Party Name and Address – Required
If there are payers of higher priority, enter the name of the individual in whose name the insurance is carried. If that person is the patient, enter Patient.

Fields 39 through 41 – Value Codes and Amounts – Required
Enter the code(s) and related dollar amount(s) to identify data of a monetary nature necessary for the processing of the claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00).

Field 42 – Revenue Code – Required
Enter the applicable revenue code of the Health Services Cost Review Commission for hospitals located in the state or the National or State Uniform Billing Data Elements Specifications for hospitals not located in the state. The appropriate revenue code is entered on the adjacent line in Field 42 to explain each charge in Field 47. To assist in bill review, revenue codes should be listed in ascending numeric sequence to the extent possible. There is no fixed total field in this area. Instead, revenue code 0001 is entered last in Field 42.

X refers to an appropriate subcategory within the general category/description. To limit the number of line items on each bill, revenue codes are summed at the zero level to the extent possible.

Code	Description
001	Total charge
Accommodation revenue codes (10X–21X)	
10X	All-inclusive rate
11X	Room and board – private (medical or general)

Code	Description
12X	Room and board – semi-private two beds (medical or general)
13X	Semi-private – three and four beds (medical or general)
14X	Private – deluxe (medical or general)
15X	Room and board – ward (medical or general)
16X	Other room and board (medical or general)
17X	Nursery
18X	Leave of absence
19X	Subacute care
20X	Intensive care
21X	Coronary care
Ancillary Revenue Codes (22X–99X)	
22X	Special charges
23X	Incremental nursing care charges
24X	All-inclusive ancillary
25X	Pharmacy
26X	Intravenous therapy
27X	Medical/surgical supplies
28X	Oncology
29X	Durable medical equipment (DME) (other than rental)
30X	Laboratory
31X	Laboratory pathological
32X	Radiology – diagnostic
33X	Radiology – therapeutic
34X	Nuclear medicine
35X	Computed tomographic (CT) scan
36X	Operating room services
37X	Anesthesia
38X	Blood
39X	Blood storage and processing
40X	Other imaging services
41X	Respiratory services
42X	Physical therapy
43X	Occupational therapy
44X	Speech language pathology
45X	Emergency room
46X	Pulmonary function
47X	Audiology
48X	Cardiology
49X	Ambulatory surgical care
50X	Outpatient services
51X	Clinic
52X	Freestanding clinic
53X	Osteopathic services
54X	Ambulance
55X	Skilled nursing

Code	Description
56X	Medical social services
57X	Home health aide (home health)
58X	Other visits (home health)
59X	Units of service (home health)
60X	Oxygen (home health)
61X	Magnetic resonance imaging (MRI)
62X	Medical/surgical supplies
63X	Drugs requiring specific identification
64X	Home intravenous therapy services
65X	Hospice services
66X	Respite care (home health only)
67X	Outpatient special residence charges
68X	Trauma response
70X	Cast room
71X	Recovery room
72X	Laboratory or room/delivery
73X	Electrocardiogram (EKG/ECG)
74X	Electroencephalogram (EEG)
75X	Gastrointestinal services
76X	Treatment or observation room
77X	Preventive care services
78X	Telemedicine
79X	Extra-corporeal shock wave therapy (formerly Lithotripsy)
80X	Inpatient renal dialysis
81X	Organ acquisition
82X	Hemodialysis – outpatient or home dialysis
83X	Peritoneal dialysis – outpatient or home
84X	Continuous ambulatory peritoneal dialysis (CAPD) – outpatient
85X	Continuous cycling peritoneal dialysis (CCPD) – outpatient
88X	Miscellaneous dialysis
90X	Behavioral health treatments/services
91X	Behavioral health treatment/services – extension of 90X
92X	Other diagnostic services
93X	Medical rehabilitation day program
94X	Other therapeutic services
95X	Other therapeutic services – extension of 94X
96X	Professional fees
97X	Professional fees – extension of 96X
98X	Professional fees – extension of 96X and 97X
99X	Patient convenience items
100X	Behavioral health accommodations
210X	Alternative therapy services
310X	Adult care

Field 43 – Revenue Description – Required
Enter the appropriate description.

Field 44 – HCPCS/Rates – Required if Applicable
Enter the appropriate CPT, HCPCS or global code if required by contract.

Field 45 – Service Date – Required if Applicable
Enter the date of service if Field 6 is not completed.

Field 46 – Service Units – Required
Enter the quantity of services.

Field 47 – Total Charges – Required
Enter the total charges by line item. Each line allows entry of up to nine digits.

Field 48 – Noncovered Charges – Required
Enter the total noncovered charges pertaining to the related revenue code in Field 42.

Field 49 – Untitled – Not Required
This information is not collected.

Fields 50A, B and C – Payer – Required if Applicable
Enter the primary insurance payer in Field 50A.

Fields 51A, B and C – Provider Number – Required if Applicable
Enter the primary insurance payer's number in Field 51A.

Fields 52A, B and C – Release of Information – Required
The back of the UB-04 form contains a certification that all necessary release statements are on file.

Y	Code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.
R	Code indicates the release is limited or restricted.
N	Code indicates no release on file.

Fields 53A, B and C – Assignment of Benefits Certification Indicator – Required
Enter the appropriate assignment indicator.

Fields 54A, B and C – Prior Payments – Required if Applicable
For all services other than inpatient hospital and SNF services, the sum of any amount(s) collected by the provider from the patient are entered on the patient (fourth/last) line of this column.

Fields 55A, B and C – Estimated Amount Due – Required if Applicable
Enter the estimated amount due, if applicable.

Field 56 – Untitled – Not Required
This information is not collected.

Field 57 – Untitled – Not Required
This information is not collected.

Fields 58A, B and C – Insured's Name – Required
If there are payers of higher priority, enter the name of the individual in whose name the insurance is carried. If that person is the patient, enter Patient.

Fields 59A, B and C – Patient's Relationship to Insured – Required
If there are payers of higher priority, enter the appropriate relationship code.

Fields 60A, B and C – Certificate/Social Security Number/HI Claim/Identification Number – Required
Enter the appropriate number.

Fields 61A, B and C – Group Name – Not Required
This information is not collected.

Fields 62A, B and C – Insurance Group Number – Not Required
This information is not collected.

Field 63 – Treatment Authorization Code – Required
Enter the authorization number, if applicable.

Field 64 – Employment Status Code – Required if Applicable
Enter the employment status code if there are primary payers.

Field 65 – Employer Name – Required if Applicable
Enter the employer's name if there are primary payers.

Field 66 – Employer Location – Required if Applicable
If there are payers of higher priority, enter the specific location of the employer of the individual identified on the same line in Field 58. A specific location is the city, plant, etc., in which the employer is located.

Field 67 – Principal Diagnosis Code – Required
Enter the five-digit diagnosis code shown to be chiefly responsible for the services.

Fields 68 through 75 – Other Diagnosis Codes – Required if Applicable
Enter the diagnosis codes describing the patient's signs or presenting symptoms, or both, for services provided in a hospital emergency department. Enter the five-digit diagnosis codes shown to coexist at the time of the principal diagnosis. Up to eight additional diagnosis codes may be entered.

Field 76 – Admitting Diagnosis – Required
This information is required for an inpatient admission. Enter the admission diagnosis. This is the condition identified by the physician at the time of the patient's admission requiring hospitalization.

Field 77 – E Code – Not Required
This information is not collected.

Field 78 – Untitled – Required if Applicable
Enter the appropriate diagnosis-related group (DRG) code if required by contract.

Field 79 – Procedure Coding Method – Required
Enter the appropriate code.

Field 80 – Principal Procedure Code and Date – Required if Applicable
This information is required for an inpatient or outpatient surgical procedure. Enter the principal procedure. This is the principal procedure performed for definitive treatment rather than for diagnostic or exploratory purposes.

Field 81 – Other Procedure Codes and Dates – Required if Applicable
Enter the other significant procedures (up to five procedures), if applicable.

Field 82 – Attending/Referring Physician ID – Required
Enter the appropriate provider code of the referring physician.

Fields 83A and B – Other Physician ID – Required if Applicable
Enter the appropriate provider code of the physician if a procedure was performed on an inpatient basis. Enter the appropriate provider code of the physician if a reported HCPCS code is subject to the ambulatory surgical center (ASC) payment limitation or a reported HCPCS code is on the list of codes Amerigroup furnishes and that require approval. Other services do not require this information to be collected.

Field 84 – Remarks – Not Required
This information is not collected.

Field 85 – Provider Representative Signature – Required
Enter the signature of the provider representative or notation that the signature is on file with Amerigroup.

Field 86 – Date – Required
Enter the date the bill was submitted.

Claim Form Attachments
Amerigroup requires the following attachments for a claim to qualify as a clean claim:

- Explanation of benefits statement from the primary payer to the secondary payer, unless an electronic remittance notice has been sent by the primary payer to the secondary payer
- Medicare remittance notice if the claim involves Medicare as a primary payer, and Amerigroup provides evidence it does not have a crossover agreement to accept an electronic remittance notice
- Description of the procedure or service, which may include the medical record if a procedure or service rendered has no corresponding CPT or HCPCS code
- Operative notes if the claim is for multiple surgeries or includes modifier 22, 58, 62, 66, 78, 80, 81 or 82
- Anesthesia records documenting time spent on the service if the claim for anesthesia services rendered includes modifiers P4 or P5
- Documents referenced as contractual requirements in a global contract (if applicable)
- Ambulance trip report if the claim is for ambulance services submitted by an ambulance company licensed by the Maryland Institute for Emergency Medical Services Systems
- Office visit notes if the claim includes modifiers 21 or 22
- Information related to an audit as specified in writing by Amerigroup if the Amerigroup audit demonstrated a pattern of fraud, improper billing or improper coding
- Admitting notes, except in the case of services rendered in accordance with *Health-General Article, §§19-701(d) and 19-712.5, Annotated Code of Maryland*, if the claim is for inpatient services provided outside of the time or scope of the authorization

- Physician notes, except in the case of services rendered in accordance with *Health-General Article, §§19-701(d) and 19-712.5, Annotated Code of Maryland*, if the claim for services provided is outside of the time or scope of the authorization or if the authorization is in dispute
- Itemized bills, except in the case of services rendered in accordance with *Health-General Article, §§19-701(d) and 19-712.5, Annotated Code of Maryland,* if the claim is for services rendered in a hospital, and the hospital claim has no prior authorization for admission or the claim is for services inconsistent with the Amerigroup concurrent review determination rendered before the delivery of services regarding the medical necessity of the service
- Adjunct claims documentation, pursuant to Health-General Article, §19-710.1(b)(3), Annotated Code of Maryland

The following are permissible categories of disputed claims for which Amerigroup may request additional information:

- Except in cases of services rendered in accordance with *Health-General Article, §§19-701(d) and 19-712.5, Annotated Code of Maryland*, if there is no authorization or there was a prior authorization and Amerigroup disputes the claim consistent with the Amerigroup basis for denial or because the claim is for services provided outside the time or scope of the authorization and the applicable attachment was not submitted with the claim
- Eligibility for benefits or coverage
- Necessity of a service, procedure or DME rendered or provided by a specialist and not requested by a network PCP on a referral form or consultant treatment plan
- Information necessary to adjudicate the claim consistent with the global contract
- Reasonable belief of incorrect billing
- Additional information not obtained by Amerigroup from the member within 30 days of receipt of the claim
- Legibility of the claim in a material manner
- Reasonable belief of fraudulent or improper coding, consistent with the Amerigroup retroactive denial
- Reasonable belief that a claim for emergency service may not meet the standards for an emergency service
- Category approved by the commissioner by regulation

If an attachment containing the same type of information was submitted with the claim, Amerigroup may not request additional information.

Amerigroup may not request medical records if the claim is for services set forth in *Title 31, Subtitle 10, Chapter 11* of the Maryland Insurance Administration and an itemized bill was submitted with the claim.

We may not request additional information for the following categories of disputed claims:

- Except for global contracts, a description of the procedure or service that is inconsistent with the applicable standard code set
- Reimbursement for hospital services in accordance with the rates approved by the Health Services Cost Review Commission
- Services that were precertified by Amerigroup

Encounter Data Format

Amerigroup uses the *CMS-1500 (08-05)* claim form to obtain encounter data. See the Encounter Data Reporting Requirements section for more information.

Claim Forms
The terms below are defined in accordance with the Maryland Insurance Administration, *Title 31, Subtitle 10, Chapter 11*.

A **clean claim** is defined as a claim for reimbursement submitted to Amerigroup by a health care practitioner, pharmacy or pharmacist, hospital or person entitled to reimbursement that contains the required data elements and any attachments requested by Amerigroup.

An **applicable code set** is defined as the most recent version, as of the date of service, of the following:

- For services rendered by health care practitioners, the Current Procedural Terminology (CPT) maintained and distributed by the American Medical Association, including its codes and modifiers and codes for anesthesia services
- For dental services, the Code on Dental Procedures and Nomenclature (CDT), maintained and distributed by the American Dental Association
- For all professional and hospital services, the International Classification of Diseases, Clinical Modification (ICD-10 CM)
- For all other health-related services, the CMS' HCPCS levels I and II and modifiers, maintained and distributed by the U.S. Department of Health and Human Services
- For prescribed drugs, the National Drug Codes (NDC), maintained and distributed by the U.S. Department of Health and Human Services
- For anesthesia services, the codes maintained and distributed by the American Society of Anesthesiologists
- For psychiatric services, the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) codes, distributed by the American Psychiatric Association
- For hospital and other applicable health care services, including home health services, the state *UB-04 Uniform Billing Data Elements Specification Manual*
- For hospital services pursuant to a Maryland contract or insurance policy, a revenue code approved by the Health Services Cost Review Commission for a hospital located in the state or by the *National or State Uniform Billing Data Elements Specifications* for a hospital not located in the state
- For services rendered pursuant to *Health-General Article, §15-103(b)(2), Annotated Code of Maryland*, a code established by the Medicaid program

An **auto code** is defined as an ICD-10 code designed by Amerigroup as a diagnosis that is an emergency service.

A **modifier** is defined as a code appended to a CPT or HCPCS code to provide more specific information about a medical procedure.

For a paper claim, Amerigroup will date-stamp the claim with the date received or assign a batch number to the electronic claim that includes the date received. Amerigroup will maintain a written or electronic record of the date of the receipt of a claim. If a provider requests verification, Amerigroup will provide verification of the date of claim receipt within five working days. The claim is presumed to have been received by Amerigroup within three working days from the date the provider placed the claim in the U.S. mail if the provider maintains the stamped certificate of mailing for the claim or on the date recorded by the courier, if the claim was delivered by courier.

Amerigroup utilizes auto codes to determine emergency services and provides them to all network practitioners or hospitals rendering emergency services and to all health care practitioners or hospitals

rendering emergency services that request the auto codes. If the auto codes are updated, the codes will be distributed 30 days prior to implementation.

Billing Inquiries
After filing a claim with Amerigroup, providers should review the weekly *Explanation of Payment* (*EOP*). If the claim does not appear on an *EOP* within 15 business days as adjudicated or you have no other written indication the claim has been received, check the status of your claim using the Provider Inquiry Line at 1-800-454-3730 or the Amerigroup website. If the claim is not on file with Amerigroup, resubmit your claim within 180 days from the date of service. If filing electronically, check for acceptance of the claim via the confirmation reports you receive from your EDI or practice management vendor.

The Interactive Voice Response System
Amerigroup provides an automated interactive voice response (IVR) system to better serve members and participating providers. This IVR technology allows Amerigroup to provide more detailed enrollment, claims and authorization status information along with self-service features for members. These features allow each member to:

- Update his or her address and telephone number.
- Request a new member ID card.
- Search for and/or change his or her PCP name.

Amerigroup recognizes that in order for you to provide the best service to members, accurate, up-to-date information must be shared. As a result, Amerigroup offers an automated inquiry line for accessing claims status, member eligibility and prior authorization determination status 24 hours a day, 365 days a year.

The toll-free automated Provider Inquiry Line (1-800-454-3730) can be used to verify member status, claim status and prior authorization determination. This tool also offers the ability to be transferred to the appropriate department for other needs such as requesting new prior authorization, ordering forms or directories, seeking advice in case management, or obtaining a member roster. Detailed instructions for use of the Provider Inquiry Line are outlined below.

To access member eligibility information:

1. Dial 1-800-454-3730. After saying your NPI or provider ID and TIN for the prompt, you can say, “member status,” “eligibility” or “enrollment status.”
2. Be prepared to say the member’s Amerigroup ID number, ZIP code and date of service.
3. You can search by Medicaid ID, Medicare ID or Social Security number.
    a. Say, “I don’t have it” when asked to say the member’s Amerigroup ID number, then say the ID type you would like to use when prompted.
4. The system will verify the member’s eligibility and PCP name.

To review claim status:

1. Dial 1-800-454-3730 and listen for the prompt.
    a. At the main menu, say, “claims.”
    b. You can get the status of a single claim or the five most recent claims.
    c. You can speak to someone about a Payment Appeal Form or an *EOP*.
2. Be prepared to say the claim number.
    a. If you don’t have it, you can hear the five most recent claims by saying recent claims.

To review authorization status:

1. Dial 1-800-454-3730 and listen for the prompt.
    a. At the main menu, say, “authorizations”.
    b. Say “authorization status” to hear up to 10 outpatient or one inpatient authorization determination.
    c. Say “new authorization” to be transferred to the correct department based on the authorization type.
2. Be prepared to say the member’s Amerigroup ID number, ZIP code, date of birth and date of service.
    a. Say the admission date or the first date for the start of service in MM/DD/YYYY format.

Provider Appeal of Amerigroup Claim Denial

Denial of claims is considered a contractual issue between the MCO and the provider. Providers must contact the MCO directly. The Maryland Insurance Administration refers MCO billing disputes to MDH. MDH may assist providers in contacting the appropriate representative at Amerigroup, but MDH cannot compel Amerigroup to pay claims that Amerigroup administratively denied.

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

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

- **Claim inquiry:** A question about a claim but not a request to change a claim payment.
- **Claims correspondence:** When Amerigroup requests further information to finalize a claim. Typically, these requests include medical records, itemized bills or information about other insurance a member may have.
- **Medical necessity appeals:** A pre-service appeal for a denied service; for these, a claim has not yet been submitted.

For more information on each of these, please refer to the appropriate section in this provider manual.

Payment Disputes

A claim payment dispute may be submitted for multiple reason(s), including:

- Contractual payment issues.
- Disagreements over reduced or zero-paid claims.
- Post-service authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues.*

* Amerigroup will consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

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

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

Claim Payment Reconsideration

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

We accept reconsideration requests in writing, verbally and through our secure provider website within 90 business days from the date on the *EOP* (see below for further details on how to submit). Reconsiderations filed more than 90 business days from the *EOP* will be considered untimely and upheld unless good cause can be established.

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

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

We will send you our decision in a determination letter, which will include:

- A statement of the provider's reconsideration request.
- A statement of what action Amerigroup intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes or provider manual references.
- An explanation of the provider’s right to request a claim payment appeal within 30 business days of the date of the reconsideration determination letter.
- An address to submit the claim payment appeal.
- A statement that the completion of the Amerigroup claim payment appeal process is a necessary requirement before requesting a state fair hearing.

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

Claim Payment Appeal

If you are dissatisfied with the outcome of a reconsideration determination, you may submit a claim payment appeal. Please note, we cannot process a claim payment appeal without a reconsideration on file.

We accept claim payment appeals through our provider website or in writing within 30 business days of the date on the reconsideration determination letter. Claim payment appeals received more than 30 business days from the reconsideration determination letter will be considered untimely and will be upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. If a claim payment appeal requires clinical expertise, the appropriate clinical Amerigroup professionals will review it.

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

We will send you our decision in a determination letter, which will include:

- A statement of the provider's claim payment appeal request.
- A statement of what action Amerigroup intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes or provider manual references.

How to Submit a Claim Payment Dispute

We have several options to file a claim payment dispute:

- Preferred method to submit a dispute: Online (reconsiderations and claim payment appeals): Use the secure Appeals tool accessed through Availity. https://www.availity.com. (Select **Claims & Payments** > **Appeals**) Through the Availity Appeals tool, you can upload supporting documentation and will receive acknowledgement of your submission.
- Verbally (reconsiderations only): Call Provider Services at 1-800-454-3730.
- Written (reconsiderations and claim payment appeals): Mail all required documentation (see below for more details), including the *Claim Payment Appeal Form* or the *Reconsideration Form* to:
  Payment Dispute Unit
  Amerigroup Community Care
  P.O. Box 61599
  Virginia Beach, VA 23466-1599

Required Documentation for Claims Payment Disputes

Amerigroup requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

- Your name, address, phone number, email, and either your NPI or TIN
- The member's name and his or her Amerigroup or Medicaid ID number
- A listing of disputed claims, which should include the Amerigroup claim number and the date(s) of service(s)
- All supporting statements and documentation

Administrative Appeals vs. Medical Necessity Appeals

Both administrative and medical necessity appeals must be received within 90 business days of the date on the denial letter.

Administrative Appeals
An administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of prior authorization or failure by the provider to submit clinical information when requested.

Appeals for administrative denials must address the reason for the denial (i.e., why prior authorization was not obtained or why clinical information was not submitted).

If Amerigroup overturns its administrative decision, the case is reviewed for medical necessity and, if approved, the claim will be reprocessed or the requestor will be notified of the action that needs to be taken.

Medical Necessity Appeals
A medical necessity appeal is the request for a review of an adverse decision. An appeal encompasses requests to review adverse decisions of care denied before services are rendered (pre-service) and care denied after services are rendered (postservice), such as medical necessity decisions, benefit determination related to coverage, rescission of coverage or the provision of care or service.

Amerigroup offers a medical necessity appeal process that provides members, member representatives and providers the opportunity to request and participate in the re-evaluation of adverse actions. The member, member representatives and providers will be given the opportunity to submit written comments, medical records, documents or any other information relating to the appeal. Amerigroup will investigate each appeal request, gathering all relevant facts for the case before making a decision.

How to Submit a Medical Necessity Appeals
Amerigroup encourages electronic appeals submission; however, providers have the option to submit paper appeals.
Preferred method to submit an appeal Online via Availity

- Request an appeal using Interactive Care Reviewer (ICR), our online authorization tool for any eligible denied authorization affiliated with your tax id / organization at https://www.availity.com
    - To request an appeal through ICR you need to have the Authorization Referral Request role assignment on Availity. Your organization's Availity administrator can give you access to this role.
- Through Availity, you can upload supporting documentation and will receive acknowledgement of your submission.
- To be eligible the case must be in a denied status. You can also request a clinical appeal through ICR for cases submitted by phone and fax.
- Verbally: Call Provider Services at 1-800-454-3730.
- Written: Mail all required documentation
    - Appeal letters and other related clinical information should be sent to:

Centralized Appeals Processing
Amerigroup Community Care
P.O. Box 61599
Virginia Beach, VA 23466-1599

State's Independent Review Organization (IRO)

The Department contracts with an IRO for the purpose of offering providers another level of appeal for providers who wish to appeal ***medical necessity denials*** only. Providers must first exhaust all levels of the MCO appeal process. By using the IRO, you agree to give up all appeal rights (e.g., administrative hearings, court cases). The IRO only charges **after** making the case determination. If the decision upholds the MCO's denial, you must pay the fee. If the IRO reverses the MCO's denial, the MCO must pay the fee. The web portal will walk you through submitting payments. The review fee is $425. More detailed information on the IRO process can be found at https://mmcp.MDH.maryland.gov/SitePages/IRO%20Information.aspx. The IRO does not accept cases for review which involve disputes between the Behavioral Health ASO and Amerigroup.

MCO Quality Initiatives

Quality Management Program Purpose and Goals

The Amerigroup QM program is designed to improve the quality and safety of health care and services delivered to our members. It's a comprehensive and integrated system whose purpose is to:

- Objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical and behavioral health care and services.
- Identify and implement strategies including a population health approach to improve the quality, appropriateness and accessibility of member health care.
- Facilitate organization-wide integration of quality management principles.

The overall goal of the QM program is to improve the quality and safety of clinical care and services provided to members through the Amerigroup network of providers, programs and services. The QM program is also committed to the satisfaction of our network providers. Specific goals, which are reviewed annually and revised as needed, are established to support the purpose of the QM program.

The goals of the QM program are to:

- Develop and maintain QM resources, structure and processes that support the organization's commitment to quality health care for our members.
- Continuously improve the quality of care and service provided to members.
- Improve or maintain positive member and provider experiences through data analysis and implementation of effective interventions.
- Ensure full compliance with all applicable state, federal and accreditation requirements.
- Implement a comprehensive population health strategy that addresses:
    - Keeping members healthy.
    - Managing members with emerging risk.
    - Patient safety or outcomes across settings.
    - Managing chronic illness programs.
- Ensure patient safety and promote safe clinical practices.
- Ensure vulnerable and special needs populations have access to appropriate care management programs, including complex case management, case management and disease management, and if available, long-term services and support (LTSS) programs.
- Maintain the Cultural and Linguistically Appropriate Services (CLAS) and Health Disparities Program and NCQA Multicultural Healthcare Distinction.
- Ensure effective credentialing and recredentialing processes for providers that comply with state, federal and accreditation requirements.

- Ensure the provision of appropriate access to care by monitoring practitioner and provider access and availability reports.
- Ensure the development of action plans to address gaps in access and availability.
- Provide oversight of all delegated activities to ensure compliance with all state, federal and accrediting organizations.

The QM program identifies and acts on opportunities for improvement, reflecting a continuous quality improvement (CQI) philosophy. Continuous quality improvement processes and activities are identified in the *QM Program Description*, *Work Plan*, and *Annual Evaluation* and are implemented to accomplish identified goals. The *QM Program Description* describes the essential structure, resources and processes through which the QM program is implemented. The annual *QM Work Plan* identifies specific activities and projects to be undertaken by Amerigroup and the performance measures to be evaluated throughout the year. *Work Plan* activities align with contractual, accreditation and/or regulatory requirements and identify measurements to accomplish goals. The *Annual Evaluation* describes the level of success achieved in realizing set clinical and service performance goals through quantitative and qualitative analysis and prior years trending as appropriate.

Quality Management Program Methodology
The QM program methodology involves a review of the complete range of health services provided to members as categorized by all demographic groups, including those with special health care needs, clinically related groups, and service settings for clinical and nonclinical measures. Quality initiatives are developed and implemented as indicated by data analysis for outcome and process improvements.

Initiatives are reassessed on an ongoing and annual basis to evaluate intervention effectiveness and compare year-to-year performance. The QM program uses the latest available research to track and trend quality indicators to ensure measures are reported, outcomes are analyzed, and goals are attained. Contractual standards, evidence-based practice guidelines and other nationally recognized sources (NCQA, AHRQ and NQF) may be utilized to identify performance/metric indicators, standards, and benchmarks that are objective, measurable, and based on current knowledge and clinical experience.

Data sources utilized to monitor performance and advance the QM program include: enrollment information, claims, encounters, authorizations, appeals, complaints, disease/case management documentation, access and availability survey findings, member medical records within provider offices and facilities, surveys by external bodies such as accreditation entities or CMS, quality improvement studies, state data files, CAHPS®, and HEDIS® results. Data collection follows protocols established in approved policies and/or programs with standardized data collection tools ensuring consistent and accurate data abstraction. As a part of our continued efforts to monitor quality improvement program and activities, all practitioners and providers must allow Amerigroup to utilize performance data.

Quantitative and qualitative analyses are conducted to evaluate the effectiveness of activities in achieving Amerigroup clinical and service performance goals. These analyses will take into account potential barriers for achieving desired outcomes and recommend interventions or strategies to address them. Data is aggregated to track and trend over time for identification of optimal and suboptimal plan performance.

Quality Management Committee
The quality management committee (QMC) establishes the strategic direction and monitors the QM program. Included among the QMC's responsibilities are:

- Review and approve the annual quality management program description and work plan.
- Analyze, review and make recommendations regarding the planning, implementation, measurement and outcomes of clinical/service quality improvement studies.
- Coordinate communication of quality management activities throughout Amerigroup.
- Review HEDIS and CAHPS data and action plans for improvement.
- Review, monitor and evaluate program compliance against state, federal and accreditation standards.
- Measure compliance to medical and behavioral health practice guidelines.
- Monitor continuity of care between medical and behavioral health services.

Data results related to QM studies and other activities are presented to the QMC, which reports to the Amerigroup governing body. At the direction of the QMC, Amerigroup posts information on progress towards QM program goals on the dedicated provider and member pages on the Amerigroup website.

Medical Advisory Committee
The Amerigroup medical advisory committee (MAC) is comprised of network providers, which provides input to the QMC as follows:

- Utilize ongoing peer review system to assess levels of care and quality of care provided.
- Monitor practice patterns to identify appropriateness of care and for improvement/risk prevention activities.
- Review and provide input, based upon the characteristics of the local delivery system; approve evidence-based clinical protocols/guidelines to facilitate the delivery of quality care and appropriate resource utilization.
- Review clinical study design and results.
- Develop and approve action plans/recommendations regarding clinical quality improvement studies.
- Consider/recommend actions with regard to physician quality of care issues review, and provide input on clinically oriented QM policies and procedures, UM policies and procedures and disease/case management policies and procedures.
- Review and provide feedback regarding new technologies.
- Oversee compliance of delegated services.

The MAC also advises Amerigroup on aspects of our QM program including policies and/or operations affecting network providers and/or members.

Health Promotion Programs
Amerigroup provides health promotion programs to encourage members to use health services appropriately and lead healthier lives. These programs include education about prenatal care, prevalent chronic conditions and preventive screenings. To assist your Amerigroup patients in accessing these programs, contact your Provider Relations representative or call Provider Services at 1-800-454-3730.

Appointment Scheduling and Outreach Requirements
To ensure HealthChoice members have every opportunity to access needed health-related services, PCPs must develop collaborative relationships with the following entities to bring members into care:

- Amerigroup
- Specialty care providers
- The local health departments' administrative care coordination units (ACCUs)

Contact your Provider Relations representative or call Provider Services at 1-800-454-3730 for information on how Amerigroup can help you bring your patients into care.

Prior to any appointment for a HealthChoice member, you must call EVS at 1-866-710-1447 to verify member eligibility and Amerigroup enrollment. This procedure will assist in ensuring payment for services. A member's health coverage may also be verified via the Availity Portal. For help using Availity, please call Availity Client Services at 1-800-Availity (1-800-282-4548).

CMS prohibits providers from billing Medicaid participants whatsoever, including for missed appointments.

Taking Care of Baby and Me®

When it comes to our pregnant members, we are committed to keeping both mom and baby healthy. That's why we encourage all of our moms-to-be to take part in our Taking Care of Baby and Me program — a comprehensive case management and care coordination program for all expectant mothers and their newborns. It identifies pregnant women as early in their pregnancies as possible through review of state enrollment files, claims data, lab reports, hospital census reports, provider notification of pregnancy and delivery notification forms, and self-referrals.

Once pregnant members are identified, we act quickly to mitigate obstetrical risk and ensure the appropriate levels of care and case management services are provided. We offer:

- Individualized, one-on-one case management support for women at the highest risk.
- Care coordination for moms who may need a little extra support.
- Educational materials and information on community resources.
- Incentives to keep up with prenatal and postpartum checkups and well-child visits after the baby is born.

Experienced case managers work with members and providers to establish a care plan for our highest risk pregnant members. Case managers also collaborate with community agencies to ensure mothers have access to necessary services, including transportation, home visitor programs, breastfeeding support and counseling, and the Women, Infants and Children (WIC) program.

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

Amerigroup requires notification of pregnancy after the first prenatal visit and notification of delivery following birth. You may choose to complete the notification of pregnancy and delivery in the online Interactive Care Reviewer or fax the forms to Amerigroup at 1-800-964-3627.

You should also complete the Availity platform's Maternity Module.

- Perform an Eligibility and Benefits request on an Amerigroup member and choose one of the following benefit service types: Maternity, Obstetrical, Gynecological, or Obstetrical/Gynecological.
- Before you see the benefit results screen you will be asked if the member is pregnant and given a Yes or No option. If you indicate "Yes" you will be asked what the estimated due date is and can fill that date out if you have an estimate or leave it blank if you do not.
- After you submit your answer you will be taken to the benefits page like normal. In the background a Maternity Module will have been generated for this patient in the Maternity application in the Payer Spaces for the Amerigroup plan.

NICU Care Management Program

The NICU Care Management program is committed to ensuring that all high risk infants have a well-defined plan for quality and cost effective NICU care and a safe and successful transition to the home environment. We provide a seamless, integrated approach, including early identification of members for NICU Care Management referral, enrollment, engagement and continued oversight and assistance through case closure. This program encourages parent/caregiver involvement in their infant's care while hospitalized in the NICU. We focus on parents of infants expected to be in the hospital greater than two weeks who were born at 34 or fewer weeks gestation, born weighing 2000 grams or less, born with major congenital anomalies, require ventilator care, or require major surgery. NICU Care Management provides education and support to help parents/caregivers cope with the day-to-day stress of having a baby in the NICU, encourage them to stay involved in the care of their babies, and help them to prepare themselves and their homes for discharge.

The stress of having a critically ill infant in the NICU can potentially result in Post-Traumatic Stress Disorder (PTSD) symptoms among parents and loved ones. In an effort to reduce the impact of PTSD among members, assistance is provided by:

- Guiding parent(s) into hospital-based support programs, if available, as well as to target support services and referrals to providers
- Screening parent(s) for PTSD approximately one month after the date of birth
- Referring parent(s) to behavioral health program resources, if indicated
  Reconnecting with families with a one-month follow-up call to assess if the parent(s) received benefit from initial contact and PTSD awareness

Dental Care for Children and Pregnant Members

Dental services for children under age 21 and pregnant women are provided by the Maryland Healthy Smiles Dental Program, administered by Scion. Contact Maryland Healthy Smiles Provider Services at 1-844-275-8753 with questions about dental benefits.

Coverage of hospital anesthesia services for dental services performed in a hospital setting are covered by the medical assistance fee-for-service program pursuant to *Dental Transmittal #45*.

Patient Safety

Amerigroup provides information and resources for providers regarding health care safety and standards. An example of a resource is www.hospitalcompare.hhs.gov, a CMS website providing specific information on hospitals. This user-friendly site compiles quality indicators for all Medicare-certified hospitals and provides a comparison of quality indicators for services rendered by the selected hospital.

Quarterly Complaint Reporting
Amerigroup is responsible for gathering and reporting information about members' appeals and grievances as well as the interventions and resolution of these appeals and grievances to the state. The reports contain data on appeals and grievances in a standardized format and are submitted on a quarterly basis. To accomplish this, Amerigroup is required to operate a consumer services hotline and internal complaint process.

Amerigroup Member Hotline
The Member Hotline can be reached at 1-800-600-4441, Monday-Friday from 8 a.m.- 6 p.m. Eastern time. This unit handles, resolves and/or properly refers members' inquiries and complaints to other agencies. Additionally, Amerigroup provides members with information about how to access the Member Services department and Consumer Services Hotline to obtain information and assistance.

Provider Performance Data

Healthcare Effectiveness Data and Information Set (HEDIS) & Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Amerigroup uses HEDIS data as a central monitor of provider performance. Amerigroup distributes HEDIS measure results to providers and consults with them on how to improve their performance.

Amerigroup has dedicated nursing staff in the Quality department who perform site visits to provider offices to train both providers and their office staff in the following areas:

- Information about the year's selected HEDIS studies
- How data for those measures will be collected
- Codes associated with each measure
- Tips for smooth coordination of medical record data collection

HEDIS measures are also included in the Amerigroup Provider Quality Incentive Program (PQIP), our pay-for-performance program (see the Pay for Performance section for more information).

Amerigroup also closely monitors performance on the CAHPS member satisfaction surveys. CAHPS results are reviewed and analyzed by the QMC to compare performance against national benchmarks and state performance goals to identify opportunities for improvement and develop strategies and interventions to increase member satisfaction. Input is also sought from the MAC on how Amerigroup can improve member experience with the plan.

Pay for Performance

The Amerigroup Provider Quality Incentive Program (PQIP, or "the program") rewards PCPs for the quality of care they provide to our members. The PQIP uses a system of quality measures — primarily HEDIS — and based on pay-for-performance principles, encourages efficient, preventive and cost-effective health care practices.

The programs objectives are to:

- Improve targeted clinical quality results.
- Promote quality, safe and effective patient care across the health delivery system.
- Improve provider operational efficiency.

- Improve medical cost management, by providing incentives for improving quality care and providing tools for providers to reduce medically unnecessary utilization and costs.

The incentives offered to PCPs by PQIP, which are awarded annually, seek to encourage them to meet the quality measure targets for member care designed by the program. Thus, these additional payments incentivize good performance. PCPs are prohibited from encouraging member selection or deselection and from discriminating against members based on location, ethnicity, culture, race, religion, disability, political belief, sex, age, socioeconomic status, health status or medical history. PQIP providers are also prohibited from withholding or preventing medically necessary services from being delivered to Amerigroup members. PQIP is not intended to limit PCPs' exercise of professional judgment in treating members or to limit their ability to discuss available treatment options with members.

PQIP providers are subject to a quality scorecard, which is calculated using administrative (claims) data for their assigned members on the PQIP quality measures. Amerigroup makes care opportunities reports available monthly to PQIP PCPs, identifying members who are included in quality measures for whom the required physician visit, test, screening and any other services have not yet taken place. Amerigroup also makes a quarterly performance scorecard available to PCPs, detailing whether quality threshold levels for incentives are being met. To determine annual incentives, provider performance on the PQIP quality measures are compared against those of their peers and for year-over-year performance improvement.

SECTION VII. PROVIDER SERVICES AND RESPONSIBILITIES

Overview of Amerigroup Provider Services

The Amerigroup Provider Solutions Department is here to help. Our Provider Solutions staff serves the following functions:

- Perform outreach to providers
- Offer provider education and training
- Engage providers in quality initiatives
- Deliver provider customer service
- Build and maintain the provider network

Contact Provider Services at 1-800-454-3730 for information on how Amerigroup can help you bring your patients into care.

Provider Web Portal

Amerigroup offers a public provider website and a secure sign-in website located at https://provider.amerigroup.com/MD. Both public and secure sites offer tools to assist in meeting our members' needs, including:

- Claim forms
- Prior authorization Lookup Tool
- Provider manual
- Clinical practice guidelines
- News and announcements
- Provider directory
- Fraud, waste and abuse information
- Pharmacy formulary

Registering for the secure sign-in website allows additional tools through Availity such as:

- Prior authorization submission and status lookup
- Pharmacy prior authorization
- PCP panel listings
- Member eligibility
- Claims status
- Claim payment appeal submission/status
- New for 2021 – Chat with Payer

Information Changes

Please report any status changes either via fax to 1-866-920-1873 or mail to:

Provider Services
Amerigroup Community Care
7550 Teague Road, Suite 500
Hanover, MD 21076

Provider Inquiries

The Provider Inquiry Line is available 24 hours a day, 7 days a week at 1-800-454-3730. This is an automated telephone tool that enables providers to verify member eligibility, prior authorization and claims status. Providers can also log in to the self-service website at

https://provider.amerigroup.com/MD to verify member eligibility or call a Provider Services representative at 1-800-454-3730 to answer eligibility questions.

Recredentialing

The recredentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Amerigroup Community Care credentialing standards.

Currently Participating Applicants (Recredentialing)

2. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
3. Re-credentialing application signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;
4. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a Practitioner participates in Amerigroup Community Care programs or provider Network(s), federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the Practitioner will become immediately ineligible for participation in the applicable government programs or provider Network(s) as well as Amerigroup Community Care other credentialed provider Network(s).
5. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
6. No new history of licensing board reprimand since prior credentialing review;
7. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
8. Current DEA/CDS registration and/or state controlled substance certification without new (since prior credentialing review) history of or current restrictions;
9. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; OR for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Members needing hospitalization;
10. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism;
11. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
12. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
13. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five (5) years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
14. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
15. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    a. voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    b. voluntary surrender of state license related to relocation or nonuse of said license;
    c. an NPDB report of a malpractice settlement or any report of a malpractice settlement that does

not meet the threshold criteria;
   d. nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
   e. previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window;
   f. actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
   g. history of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
16. No QI data or other performance data including complaints above the set threshold.
17. Recredentialed at least every three (3) years to assess the practitioner's continued compliance with Amerigroup Community Care standards.

*It is expected that these findings will be discovered for currently credentialed Network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Network practitioners and HDOs that do not meet one or more of the criteria for recredentialing.

Recredentialing of HDOs occurs every three (3) years unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in Networks or Plan Programs must submit all required supporting documentation.

On request, HDOs will be provided with the status of their credentialing application. Amerigroup Community Care may request, and will accept, additional information from the HDO to correct incomplete, inaccurate, or conflicting credentialing information. The CC will review this information and the rationale behind it, as presented by the HDO, and determine if a material omission has occurred or if other credentialing criteria are met.

Overview of Provider Responsibilities

Affirmative Statement
Amerigroup ensures utilization management decisions are fair, independent and according to approved criteria and available benefits. Utilization management decisions are based only upon appropriateness of care and service and the existence of coverage. Amerigroup does not specifically reward providers or other individuals for issuing denials of coverage of care, and financial incentives for utilization management decision-makers do not encourage decisions that result in utilization.

Nondiscrimination Statement
Amerigroup does not engage in, aid or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color or national origin in providing aid, benefits or services to beneficiaries. Amerigroup does not utilize or administer criteria having the effect of discriminatory practices on the basis of gender or gender identity. Amerigroup does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of or subjecting them to discrimination on the basis of gender or gender identity. In addition, in compliance with the Age Act, Amerigroup may not discriminate against any person on the basis of age, or aid or perpetuate age discrimination by providing significant assistance to any agency, organization or person that discriminates on the basis of age. Amerigroup provides health coverage to members on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender

identity, race, color, age, religion, national origin, physical or mental disability, or type of illness or condition.

Members who contact Amerigroup with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when an Amerigroup representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and is assisted in doing so, if the member requests assistance. Amerigroup documents, tracks and trends all alleged acts of discrimination.

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

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

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

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

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

- Mail: 1300 Amerigroup Way (SC1/2), Virginia Beach, VA
- Phone: 757-473-2737, ext. 31028

Equal Program Access on the Basis of Gender

Amerigroup provides individuals with equal access to health programs and activities without discriminating on the basis of gender. Amerigroup must also treat individuals consistently with their gender identity, and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association with, a member of a protected class (i.e., race, color, national origin, gender, gender identity, age or disability).

Amerigroup may not deny or limit health services that are ordinarily or exclusively available to individuals of one gender, to a transgender individual based on the fact that a different gender was assigned at birth, or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.

Primary Care Providers

The primary care provider (PCP) is a network provider who is responsible for providing or arranging for the complete care of his or her patients. PCPs may include the following specialties:

- General practitioners
- Family practitioners
- Internists
- Pediatricians

- Obstetricians/gynecologists (OB/GYNs) (for pregnant women only)
- Certified nurse midwife (for pregnant women only)
- Nurse practitioner
- Specialists designated as PCPs (with the approval of the Amerigroup)

The PCP serves as the entry point for access to health care services. The PCP is responsible for providing members with medically necessary covered services, or for recommending a member to a specialty care provider to furnish the needed services. The PCP is also responsible for maintaining medical records and coordinating comprehensive medical care for each assigned member. Members can choose a physician, nurse practitioner or physician's assistant as their PCP. The PCP will act as a coordinator of care and has the responsibility to provide accessible, comprehensive, and coordinated health care services covering the full range of benefits.

The PCP is required to:
- Address the member's general health needs.
- Treat illnesses.
- Coordinate the member's health care.
- Promote disease prevention and maintenance of health.
- Maintain the member's health records.
- Recommend specialty care when necessary.

If a woman's PCP is not a women's health specialist, Amerigroup will allow her to see a women's health specialist **within the MCO network**, without a referral, for covered services necessary to provide women's routine and preventive health care services. Prior authorization is required for certain treatment services.

Services Provided by the PCP
The PCP manages or arranges for all the health care needs of Amerigroup members who select him or her as their PCP. Each PCP must provide a minimum of 20 hours per week of personal availability. In this capacity as a designated PCP, all baseline physical, emergency, urgent, routine and follow-up care within the PCP's scope of medical training and practice are provided. In addition to managing all services for office care, coordination of care with appropriate specialty care (both network and non-network), coordination of hospital admissions and maintenance of the member's complete medical record, PCPs are responsible for providing a wide range of services generally accepted in the community as primary care, including screening and referral as needed for behavioral health and substance abuse services. This also includes the responsibility to educate members about the appropriate use of emergency services. PCPs must make their best effort to contact each new member to schedule an appointment for a baseline physical that is age- and gender-specific.

PCPs are also required to provide members with telephone access 24 hours a day, 7 days a week. The telephone service may be answered by a designee, such as an on-call physician or a nurse practitioner with physician backup. All automated after-hours messages must offer the option to either speak to a live party or respond to patient inquiries within 30 minutes.

Arrangements for coverage while off-duty or on vacation are to be made with other network PCPs. Covering PCPs must be able to provide medically necessary services and follow Amerigroup prior authorization guidelines. It is not acceptable to automatically direct the member to the emergency room when the PCP is not available.

PCP Contract Terminations

If you are a PCP and we terminate your contract for any of the following reasons, the member assigned to you may elect to change to another MCO in which you participate by calling the enrollment broker within 90 days of the contract termination:

- For reasons other than the quality of care or your failure to comply with contractual requirements related to quality assurance activities
- Amerigroup reduces your reimbursement to the extent that the reduction in rate is greater than the actual change in capitation paid to Amerigroup by the Department, and Amerigroup and you are unable to negotiate a mutually acceptable rate.

Specialty Providers

Specialty providers are responsible for providing services in accordance with the accepted community standards of care and practices. MDH requires Amerigroup to maintain a complete network of adult and pediatric providers adequate to deliver the full scope of benefits. If a PCP cannot locate an appropriate specialty provider, call Member Services at 1-800-600-4441 for assistance.

Obligations of the specialist include the following:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program
- Meeting eligibility requirements to participate in the Medicaid program
- Accepting all members for specialty services within the scope of the specialist's practice
- Submitting required claims information
- Arranging for coverage with other network providers while off-duty or on vacation
- Verifying member eligibility and prior authorization of services (when required) at each visit
- Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis following a routinely scheduled consultative visit
- Notifying both the PCP and Amerigroup, as well as requesting prior authorization from Amerigroup as appropriate, when scheduling a hospital admission or any other procedure requiring Amerigroup approval

Specialist as PCP Referral

Under certain circumstances, a specialist may be approved by Amerigroup to serve as a member's PCP when a member requires the regular care of the specialist. The criteria for a specialist to serve as a member's PCP include the existence of a chronic, life-threatening illness or condition of such complexity whereby:

- The need for multiple hospitalizations exists.
- The majority of care must be provided by a specialist.
- The administrative requirements of arranging for care exceed the capacity of the PCP.
    - This would include members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis, etc.

The specialist must meet the requirements for PCP participation (including contractual obligations and credentialing), provide access to care 24 hours a day, 7 days a week and coordinate the member's health care, including preventive care. When such a need is identified, the member or specialist must contact the Amerigroup Case Management department and complete a *Specialist as PCP Request Form*. An Amerigroup case manager will review the request and submit it to the Amerigroup medical director. Amerigroup will notify the member and the provider of the determination in writing within 30 days of receiving the request. Should Amerigroup deny the request, Amerigroup will provide written notification

to the member and provider of the reason(s) for the denial of the request. Specialists serving as PCPs will continue to be paid under fee-for-service while serving as the member's PCP. The designation cannot be retroactive. For further information, see the *Specialist as PCP Request Form* in Appendix A – Forms.

Out-of-Network Providers and Single Case Agreements

Amerigroup may approve a single case agreement on a case-by-case basis. For more information, call Provider Services at 1-800-454-3730.

Appointment Scheduling and Outreach Requirements

To ensure HealthChoice members have every opportunity to access needed health-related services, PCPs must develop collaborative relationships with the following entities to bring members into care:

- Amerigroup
- Specialty care providers
- The local health departments' administrative care coordination units (ACCUs)

Contact your Provider Relations representative or call Provider Services at 1-800-454-3730 for information on how Amerigroup can help you bring your patients into care.

Prior to any appointment for a HealthChoice member, you must call EVS at 1-866-710-1447 to verify member eligibility and Amerigroup enrollment. This procedure will assist in ensuring payment for services.

CMS prohibits providers from billing Medicaid participants whatsoever, including for missed appointments.

Routine and Urgent Appointments for HealthChoice Members

To ensure members receive care in a timely manner, PCPs and specialists must maintain the following COMAR appointment availability standards:

Type of visit	Availability standard
Urgent care visits	Within 48 hours of request
Routine and preventive care visits	Within 30 days of request
Routine specialist follow-up appointments	Within 30 days or sooner as deemed necessary by the PCP (Note: The PCP's office staff will make the appointment directly with the specialist's office staff).
Initial newborn visits	Within 14 days of discharge from the hospital (if no home visit)

Second Opinions

If a member requests a second opinion, Amerigroup will provide for a second opinion from a qualified health care professional within our network. If necessary we will arrange for the member to obtain one outside of our network.

A member or the member's PCP may request a second opinion for serious medical conditions or elective surgical procedures at no cost to the member. Also, a member of the health care team and/or the member's parents or guardians may also request a second opinion. These conditions and/or procedures include but are not limited to the following:

- Treatment of serious medical conditions such as cancer
- Elective surgical procedures such as hernia repair (simple) for adults (age 18 or older), hysterectomy (elective procedure), spinal fusion (except for children under age 18 with a diagnosis of scoliosis) and laminectomy (except for children under age 18 with a diagnosis of scoliosis)
- Other medically necessary conditions as circumstances dictate

The second opinion must be obtained from a network provider (see the *Provider Referral Directory* at https://provider.amerigroup.com/MD). A second opinion can be obtained from a non-network provider if there is not a network provider with the expertise required for the condition. Once approved, the PCP will notify the member of the date and time of the appointment and will forward copies of all relevant records to the consulting provider. The PCP will notify the member of the outcome of the second opinion.

Amerigroup may also request a second opinion at its own discretion. This includes but is not limited to the following scenarios:

- There is concern about care expressed by the member or the provider.
- Potential risks or outcomes of recommended or requested care are discovered by the plan during its regular course of business.
- Before initiating denial of coverage of service.
- Denied coverage is appealed.
- An experimental or investigational service is requested.

When Amerigroup requests a second opinion, Amerigroup will make the necessary arrangements for the appointment, payment and reporting. Once the second opinion is completed, Amerigroup will inform the member and the PCP of the results and the consulting provider's conclusion and recommendation(s) regarding further action.

Provider Requested Member Transfer

When persistent problems prevent an effective provider-patient relationship, a participating provider may ask a member to leave their practice. Such requests cannot be based solely on the member filing a grievance; an appeal; a request for a fair hearing; or other action by the patient related to coverage, high utilization of resources by the patient or any reason that is not permissible under applicable law.

The following steps must be taken when requesting a specific provider-patient relationship termination:

- The provider must send a letter informing the member of the termination and the reason(s) for the termination. A copy of this letter must also be faxed to our Provider Relations department at 1-866-920-1873.
- The provider must support continuity of care for the member by giving sufficient notice and opportunity to make other arrangements for care. Upon request, the provider will provide resources or recommendations to the member to help locate another participating provider and offer to transfer records to the new provider upon receipt of a signed patient authorization.

Medical Records Requirements

Amerigroup requires medical records to be maintained in a manner that is current, detailed and organized and permits effective and confidential patient care and quality review.

Providers are required to maintain medical records that conform to good professional medical practice and appropriate health management. A permanent medical record must be maintained at the primary care site for every member and be available to the PCP and other providers. Medical records must be kept in accordance with Amerigroup and state standards as outlined below.

Medical Record Standards

The records reflect all aspects of patient care, including ancillary services. Documentation of each visit must include:

1. Date of service
2. Purpose of visit
3. Diagnosis or medical impression
4. Objective finding
5. Assessment of patient's findings
6. Plan of treatment, diagnostic tests, therapies and other prescribed regimens
7. Medications prescribed
8. Health education provided
9. Signature and title or initials of the provider rendering the service
    a. If more than one person documents in the medical record, there must be a record on file as to which signature is represented by which initials.

These standards shall, at a minimum, meet the following medical record requirements:

1. Patient identification information: Each page or electronic file in the record must contain the patient's name or ID number.
2. Personal/biographical data: The record must include the patient's age, gender, address, employer, home and work telephone numbers and marital status.
3. All entries must be dated and the author identified.
4. Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one provider reviewer.
5. Allergies: Medication allergies and adverse reactions must be prominently noted on the record. The note of No Known Allergies (i.e., the absence of allergies) must be noted in an easily recognizable location.
6. Past medical history (for members seen three or more times): Past medical history must be easily identified, including serious accidents, operations and illnesses. For children, past medical history relates to prenatal care and birth.
7. Immunizations: For pediatric records of children age 13 and under, a completed immunization record or a notation of prior immunization must be recorded, including vaccines and dates given when possible.
8. Diagnostic information
9. Medication information: Medication information and/or instructions to member are included.
10. Identification of current problems: Significant illnesses, medical and behavioral health conditions, and health maintenance concerns must be identified in the medical record.
11. The member must be provided with basic teaching and instruction regarding physical and/or behavioral health conditions.
12. Smoking/alcohol/substance abuse: A notation concerning cigarette and/or alcohol use or substance abuse must be stated if present for members age 12 and older. Abbreviations and symbols may be appropriate.
13. Consultations, referrals and specialist reports: Notes from consultations must be included in the record. Consultation, laboratory and X-ray reports filed in the chart must have the ordering provider's initials or other documentation signifying review. Consultation and any abnormal laboratory and imaging study results must have an explicit notation in the record of follow-up plans.

14. All emergency care provided directly by the contracted provider or through an emergency room and the hospital discharge summaries for all hospital admissions while the member is enrolled.
15. Hospital discharge summaries: Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the member is enrolled with the provider's panel and for prior admissions as necessary. Prior admissions pertain to admissions which may have occurred prior to the member being enrolled and are pertinent to the member's current medical condition.
16. Advance directive: For medical records of adult members, the medical record must document whether the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.
17. Documentation of evidence and results of medical, preventive and behavioral health screenings must be included.
18. The record must include documentation of all treatment provided and the results of such treatment.
19. The record must include documentation of the team of providers involved in the multidisciplinary team of a member needing specialty care.
20. The record must include documentation in both the physical and behavioral health records of integration of clinical care. Documentation should include:
    a. Screening for behavioral health conditions, including those which may affect physical health care and vice versa, and referral to behavioral health providers when problems are indicated
    b. Screening and referral by behavioral health providers to PCPs when appropriate
    c. Receipt of behavioral health referrals from physical medicine providers and the disposition and/or outcome of those referrals
    d. A summary of the status and/or progress from the behavioral health provider to the PCP at least quarterly or more often if clinically indicated
    e. A written release of information permitting specific information sharing between providers
    f. Documentation that behavioral health professionals are included in the primary and specialty care service teams described in this contract when a member with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder

Member Visit Data

Documentation of individual encounters must provide adequate evidence of, at a minimum:

1. History and physical exam: Appropriate subjective and objective information must be obtained for the presenting complaints.
2. For members receiving behavioral health treatment, documentation must include at-risk factors (e.g., danger to self and/or others, ability to care for self, affect, perceptual disorders, cognitive functioning, and significant social health) and efforts to coordinate care with all behavioral health providers after obtaining the appropriate release(s) of information.
3. Admission or initial assessment must include current support systems or lack of support systems.
4. For members receiving behavioral health treatment, an assessment must be completed for each visit relating to client status and/or symptoms of the treatment process. Documentation may indicate initial symptoms of the behavioral health condition as decreased, increased or unchanged during the treatment period.
5. Plan of treatment must include the activities, therapies and goals to be carried out.
6. Diagnostic tests
7. Therapies and other prescribed regimens: For members who receive behavioral health treatment, documentation must include evidence of family involvement as applicable and include evidence that family was included in therapy sessions when appropriate.
8. Follow-up: Encounter forms or notes must have a notation when indicated concerning follow-up care, calls or visits. The specific time to return must be noted in weeks, months or as needed. Unresolved problems from previous visits are addressed in subsequent visits.

9. Referrals, results thereof and all other aspects of member care, including ancillary services.

Amerigroup will systematically review medical records to ensure compliance with standards and will institute actions, as appropriate, for improvement when standards are not met.

Amerigroup policies are designed to maintain an appropriate record-keeping system for services to members. This system will collect all pertinent information related to the medical management of each member and make that information readily available to appropriate health professionals and state agencies. All records will be retained in accordance with the record retention requirements of *45 CFR 74.164* (i.e., records must be retained for seven years from the date of service). Records will be made accessible upon request to agencies of the state of Maryland and the federal government.

Confidentiality and Accuracy of Member Records
Providers must safeguard/secure the privacy and confidentiality of and verify the accuracy of any information that identifies an Amerigroup member. Original medical records must be released only in accordance with federal or Maryland laws, court orders, or subpoenas.

Providers must follow both required and voluntary provision of medical records must be consistent with the Health Insurance Portability and Accountability Act (HIPAA) privacy statute and regulations (http://www.hhs.gov/ocr/privacy).

Reporting Communicable Disease

Providers must ensure that all cases of reportable communicable disease that are detected or suspected in a member by either a clinician or a laboratory are reported to the LHD as required by *Health — General Article, §§18-201 to 18-216, Annotated Code of Maryland* and *COMAR 10.06.01 Communicable Diseases*. Any health care provider with reason to suspect that a member has a reportable communicable disease or condition that endangers public health, or that an outbreak of a reportable communicable disease or public health-endangering condition has occurred, must submit a report to the health officer for the jurisdiction where the provider cares for the member.

- The provider report must identify the disease or suspected disease and demographics on the member including the name, age, race, sex and address of residence, hospitalization, date of death, etc. on a form provided by the Department (*DHMH1140*) as directed by *COMAR 10.06.01*.
- With respect to patients with tuberculosis, you must:
  - Report each confirmed or suspected case of tuberculosis to the LHD within 48 hours.
  - Provide treatment in accordance with the goals, priorities and procedures set forth in the most recent edition of the *Guidelines for Prevention and Treatment of Tuberculosis*, published by MDH.

Other Reportable Diseases and Conditions
A single case of a disease of known or unknown etiology that may be a danger to public health, as well as unusual manifestation(s) of a communicable disease, are reportable to the LHD. An outbreak of a disease of known or unknown etiology that may be a danger to the public health is reportable immediately by telephone.

Reportable Communicable Diseases — Laboratory Providers
Providers of laboratory services must report positive laboratory results as directed by *Health General Article §18-205, Annotated Code of Maryland*. To remain in compliance with the Maryland HIV/AIDS Reporting Act of 2007, laboratory providers must report HIV-positive members and all CD4 testing results to the LHD by using the member's name. The state of Maryland *HIV/CD4 Laboratory Report Form*

DHMH 4492 must be used. The reporting law and the revised reporting forms may be found at http://phpa.dhmh.maryland.gov/SitePages/reportable-diseases.aspx.

A laboratory located within Maryland that performs mycobacteriology services must report all positive findings to the health officer of the jurisdiction in which the laboratory is located. For an out-of-state laboratory licensed in Maryland and performing tests on specimens from Maryland, the laboratory may report to the health officer of the county of residence of the member or to the MDH, Division of Tuberculosis Control within 48 hours by telephone at 410-767-6698 or fax at 410-669-4215. Amerigroup cooperates with the LHDs in investigations and control measures for communicable diseases and outbreaks.

Advance Directives

Providers are required to comply with federal and state law regarding advance directives for adult members. Maryland advance directives include a *Living Will*, *Health Care Power Of Attorney*, and *Mental Health Treatment Declaration Preferences* and are written instructions relating to the provision of health care when the individual is incapacitated. The advance directive must be prominently displayed in the adult member's medical record. Requirements include:

- Providing written information to adult members regarding each individual's rights under Maryland law to make decisions regarding medical care and any provider written policies concerning advance directives (including any conscientious objections).
- Documenting in the member's medical record, whether or not the adult member has been provided the information and whether an advance directive has been executed.
- Not discriminating against a member because of his or her decision to execute or not execute, an advance directive and not making it a condition for the provision of care.
- Educating staff on issues related to advance directives, as well as communicating the member's wishes to attending staff at hospitals or other facilities.
- Educate patients on advance directives (durable power of attorney and living wills)

Advance directive forms and frequently asked questions can be found at www.marylandattorneygeneral.gov/Pages/HealthPolicy/advancedirectives.aspx.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has many provisions affecting the health care industry, including transaction code sets, privacy and security provisions. HIPAA impacts what is referred to as covered entities; specifically, providers, health plans and health care clearinghouses that transmit health care information electronically. HIPAA has established national standards addressing the security and privacy of health information as well as standards for electronic health care transactions and national identifiers. All providers are required to adhere to HIPAA regulations. For more information about these standards, please visit www.hhs.gov/ocr/hipaa. In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within hearing range of other patients.

Cultural Competency

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs, and activities receiving federal financial assistance, such as Medicaid. Cultural competency is the ability of individuals, as reflected in personal and organizational responsiveness, to

understand the social, linguistic, moral, intellectual and behavioral characteristics of a community or population and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay, or ability to speak English. Amerigroup expects providers to treat all members with dignity and respect as required by federal law, including honoring member's beliefs, being sensitive to cultural diversity, and fostering respect for member's cultural backgrounds. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance, such as Medicaid.

Amerigroup members come from diverse cultural backgrounds. Sensitivity to cultural differences allows Amerigroup to recognize and avoid situations that may discourage a member from using services or following treatment plans.

The culture of poverty may also create lifestyle issues such as inability to afford telephone service, frequent residential moves, homelessness and attributes like low literacy or language barriers that make it difficult to effectively interact with members. Amerigroup believes positive member interactions may encourage members to use services more appropriately.

Health Literacy — Limited English Proficiency (LEP) or Reading Skills

Amerigroup is required to verify that limited-English proficient (LEP) members have meaningful access to health care services. Because of language differences and inability to speak or understand English, LEP persons are often excluded from programs they are eligible for, experience delays, denials of services, receive care, services based on inaccurate or incomplete information. Providers must deliver services in a culturally effective manner to all members, including those with LEP or reading skills.

The Amerigroup provider directory includes a list of languages spoken by participating primary and specialty care providers. Translation assistance options are available at no cost to the member or provider. Upon request, written materials are available in large print, on tape and in languages other than English (dependent upon the plan's population). Member materials are written at a fifth-grade reading level per state requirement.

Oral interpretive services are available either in-office or telephonically at no cost to you or the member. If you serve an Amerigroup member with whom you cannot communicate, call Member Services at 1-800-600-4441 to access an interpreter. For immediate needs, Amerigroup has Spanish-language interpreters available without delay and can provide access to interpreters of other languages within minutes.

Amerigroup recommends that requests for in-office interpreter services be arranged at least one business day in advance of the appointment. If a member with special needs requires an interpreter to accompany him or her to a clinic appointment, a case manager/care coordinator can make arrangements for the interpreter to be present.

Providers are required to offer interpretive services to members who may require assistance. Providers should document the offer and the members' response and reiterate that interpretive services are available at no cost. Family and friends should not be used to provide interpretation services, except at a member's request.

Access for Individuals with Disabilities

Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a physician's office, be accessible and flexible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs or activities of a public entity or be subjected to discrimination by any such entity. Provider offices must be accessible to persons with disabilities. Providers must also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways.

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. These actions include:

- Street-level access.
- Elevator or accessible ramp into facilities.
- Access to a lavatory that accommodates a wheelchair.
- Access to an examination room that accommodates a wheelchair.
- Clearly marked handicapped parking in the absence of street-side parking.
- Large print materials.

SECTION VIII. QUALITY ASSURANCE MONITORING PLAN AND REPORTING FRAUD, WASTE AND ABUSE

Quality Assurance Monitoring Plan

The quality assurance monitoring plan for the HealthChoice program is based on the philosophy that the delivery of health care services, both clinical and administrative, is a process that can be continuously improved. The state of Maryland's quality assurance plan structure and function support efforts to deal efficiently and effectively with any identified quality issue. On a daily basis and through a systematic audit of MCO operations and health care delivery, the Department identifies both positive and negative trends in service delivery. Quality monitoring and evaluation and education through member and provider feedback are an integral part of the managed care process and help to ensure that cost containment activities do not adversely affect the quality of care provided to members.

The Department's quality assurance monitoring plan is a multifaceted strategy for assuring that the care provided to HealthChoice members is high quality, complies with regulatory requirements, and is rendered in an environment that stresses continuous quality improvement. Components of the Department's quality improvement strategy include: establishing quality assurance standards for MCOs; developing quality assurance monitoring methodologies; and developing, implementing and evaluating quality indicators, outcome measures and data reporting activities, including:

- *Health Service Needs Information* form completed by the participant at the time they select an MCO to assure that the MCO is alerted to immediate health needs (e.g., prenatal care service needs).
- A complaint process administered by MDH staff.
- A complaint process administered by Amerigroup.
- A systems performance review of each MCO's quality improvement processes and clinical care performed by an External Quality Review Organization (EQRO) selected by the Department. The audit assesses the structure, process and outcome of each MCO's internal quality assurance program.
- Annual collection, validation and evaluation of the Healthcare Effectiveness Data and Information Set (HEDIS), a set of standardized performance measures designed by the National Committee for Quality Assurance and audited by an independent entity.
- Other performance measures developed and audited by MDH and validated by the EQRO.
- An annual member satisfaction survey using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), developed by NCQA for the Agency for Healthcare Research and Quality.
- Monitoring of preventive health, access and quality of care outcome measures based on encounter data.
- Development and implementation of an outreach plan.
- A review of services to children to determine compliance with federally required EPSDT standards of care.
- Production of a Consumer Report Card.
- An *Annual Technical Report* that summarizes all quality activities.

In order to report these measures to MDH, Amerigroup must perform chart audits throughout the year to collect clinical information on our members. Amerigroup truly appreciates the provider offices' cooperation when medical records are requested.

In addition to information reported to MDH, Amerigroup collects additional quality information. Providers may need to provide records for standard medical record audits that ensure appropriate record documentation. Our Quality Improvement staff may also request records or written responses if quality issues are raised in association with a member complaint, chart review or referral from another source.

Fraud, Waste and Abuse Activities

We are committed to protecting the integrity of our health care program and the effectiveness of our operations by preventing, detecting and investigating fraud, waste and abuse. Combating fraud, waste and abuse begins with knowledge and awareness.

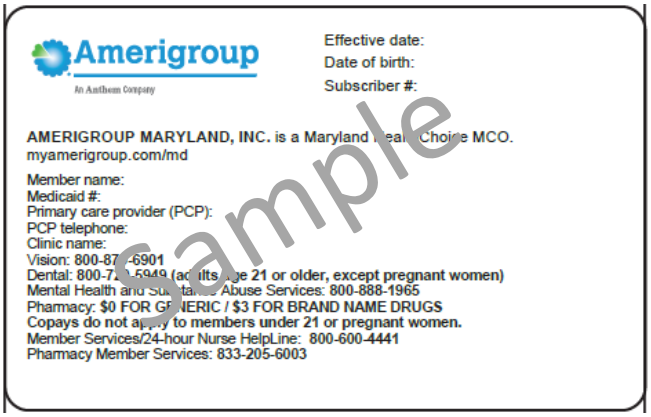
- Fraud: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it — or any other person. The attempt itself is fraud, regardless of whether or not it is successful.
- Waste: Includes overusing services or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions but rather occurs when resources are misused.
- Abuse: When health care providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

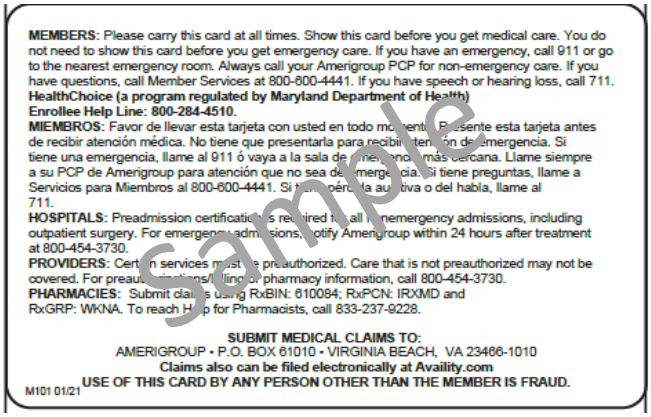
To help prevent fraud, waste and abuse, providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card. It is the first line of defense against possible fraud. Our company may not accept responsibility for the costs incurred by providers supplying services to a person who is not a member, even if that person presents an Amerigroup member identification card. Providers should take measures to ensure the cardholder is the person named on the card.

Every Amerigroup member identification card lists the following:

- Effective date of Amerigroup membership
- Member date of birth
- Subscriber number (Amerigroup identification number)
- Carrier and group number (RXGRP number) for injectables
- Amerigroup logo and health plan name (Amerigroup Community Care.)
- PCP name, telephone number and address
- Copays for office visits, emergency room visits and pharmacy services (if applicable)
- How to access behavioral health services
- Vision service plan telephone number and dental service plan telephone number
- Amerigroup Member Services and 24-hour Nurse HelpLine telephone numbers

Amerigroup member ID card sample:





Presentation of an Amerigroup member identification card (ID) does not guarantee eligibility; providers should verify a member's status by inquiring online or via telephone. Online support is available for provider inquiries on the website, and telephonic verification may be obtained through the automated Provider Inquiry Line at 1-800-454-3730.

Providers should encourage members to protect their ID cards as they would a credit card, to carry their Amerigroup card at all times, and report any lost or stolen cards to Amerigroup as soon as possible. Understanding the various opportunities for fraud and working with members to protect their Amerigroup ID card can help prevent fraudulent activities. If you suspect fraud, call the Amerigroup Compliance Hotline at 757-518-3633. Providers should instruct their patients who suspect ID theft to watch the *Explanation of Benefits* (*EOB*s) for any errors and then contact member services if something is incorrect.

No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so.

Reporting Suspected Fraud and Abuse

Participating providers are required to report to Amerigroup all cases of suspected fraud, waste and abuse; inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

If you suspect a provider (e.g., provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste or abuse, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators.

You can report your concerns by:

- Visiting our website and completing the *Report Waste, Fraud and Abuse* form.
- Calling Provider Services.
- Calling our Special Investigations Unit fraud hotline at 1-866-847-8247.

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud, but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

You can also report provider fraud to the MDH Office of the Inspector General at 410-767-5784 (1-866-770-7175), the Maryland Medicaid Fraud Control Division of the Office of the Maryland Attorney General at 410-576-6521 (1-888-743-0023), or to the Federal Office of Inspector General in the U.S. Department of Health and Human Services at 1-800-HHS-TIPS (1-800-447-8477).

The Maryland Medicaid Fraud Control Division of the Office of the Maryland Attorney General created by statute to preserve the integrity of the Medicaid program by conducting and coordinating fraud, waste and abuse control activities for all Maryland agencies responsible for services funded by Medicaid.

Examples of Provider Fraud, Waste and Abuse (FWA):

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling – when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding – when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a provider (a doctor, dentist, counselor, medical supply company, etc.) include:

- Name, address and phone number of provider.
- Name and address of the facility (hospital, nursing home, home health agency, etc.).
- Medicaid number of the provider and facility, if you have it.
- Type of provider (doctor, dentist, therapist, pharmacist, etc.).
- Names and phone numbers of other witnesses who can help in the investigation.
- Dates of events.
- Summary of what happened.

Examples of Member Fraud, Waste and Abuse

- Forging, altering or selling prescriptions
- Letting someone else use the member's ID (Identification) card
- Obtaining controlled substances from multiple providers
- Relocating to out-of-service Plan area
- Using someone else's ID card

When reporting concerns involving a member include:

- The member's name
- The member's date of birth, Social Security Number or case number if you have it
- The city where the member resides
- Specific details describing the fraud, waste or abuse

Investigation Process

We investigate all reports of fraud, abuse and waste for all services provided under the contract, including those that subcontracted to outside entities. If appropriate, allegations and the investigative findings are reported to all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste or abuse, which may include but is not limited to:

- Written warning and/or education: We send certified letters to the provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries, or may advise of further action.

- Medical record audit: We review medical records to substantiate allegations or validate claims submissions.
- Special claims review: A certified professional coder or investigator evaluates claims and places payment or system edits on file. This type of review prevents automatic claim payment in specific situations.
- Recoveries: We recover overpayments directly from the provider. Failure of the provider to return the overpayment may result in reduced payment of future claims or further legal action.

Acting on Investigative Findings
We refer all criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

If a provider appears to have committed fraud, waste or abuse, the provider:
- Will be referred to the Special Investigations Unit.
- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination.

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan. If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily disenrolled from our health care plan, with state approval.

Relevant Laws

There are several relevant laws that apply to fraud, waste and abuse:

The Federal False Claims Act (FCA) (*31 U.S.C. §§ 3729-3733*) was created to combat fraud and abuse in government health care programs. This legislation allows the government to bring civil actions to recover damages and penalties when health care providers submit false claims. Penalties can include up to three times actual damages and an additional $5,500 to $11,000 per false claim. The False Claims Act prohibits, among other things:
- Knowingly presenting a false or fraudulent claim for payment or approval.
- Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government.
- Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid.

The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program. Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

The Self-Referral Prohibition Statute (Stark Law) prohibits providers from referring members to an entity with which the provider or provider's immediate family member has a financial relationship, unless an exception applies.

The Red Flag Rule (Identity Theft Protection) requires "creditors" to implement programs to identify, detect and respond to patterns, practices or specific activities that could indicate identity theft.

The Health Insurance Portability and Accountability Act (HIPAA) requires:

- Transaction standards.
- Minimum security requirements.
- Minimum privacy protections for protected health information.
- National Provider Identification (NPIs) numbers.

The Federal Program Fraud Civil Remedies Act (PFCRA), codified at *31 U.S.C. §§ 3801-3812*, provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are $5,500 for each false claim or statement, and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which the government makes a payment. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula.

Under the Federal Anti-Kickback statute (AKA), codified at *42 U.S.C. § 1320a-7b*, it is illegal to knowingly and willfully solicit or receive anything of value directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual or ordering or arranging for any good or service for which payment may be made in whole or in part under a federal health care program, including programs for children and families accessing Amerigroup services through Maryland HealthChoice.

Under Section 6032 of the Deficit Reduction Act of 2005 (DRA), codified at *42 U.S.C. § 1396a(a)(68)*, Amerigroup providers will follow federal and Maryland laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs, including programs for children and families accessing Amerigroup services through Maryland HealthChoice.

Under the Maryland False Claims Act, *Md. Code Ann., Health General §2-601 et. seq*., administrative sanctions can be imposed, as follows:
- Denial or revocation of Medicare or Medicaid provider number application (if applicable)
- Suspension of provider payments
- Being added to the OIG List of Excluded Individuals/Entities database
- License suspension or revocation

Remediation may include any or all of the following:
- Education
- Administrative sanctions
- Civil litigation and settlements
- Criminal prosecution
- Automatic disbarment
- Prison time

Exclusion Lists and Death Master Report
Amerigroup is required to check the Office of the Inspector General (OIG), the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), the Social Security Death Master Report, and any other such databases as the Maryland MMA Providers and other Entities Sanctioned List may prescribe.

Amerigroup does not participate with or enter into any provider agreement with any individual, or entity that has been excluded from participation in federal health care programs, who have a relationship with excluded providers or who have been terminated from Medicaid, or any programs by Maryland Department of Health for fraud, waste, or abuse. The provider must agree to assist

Amerigroup as necessary in meeting our obligations under the contract with the Maryland Department of Health to identify; investigate; and take appropriate corrective action against fraud, waste and abuse (as defined in *42 C.F.R. 455.2*) in the provision of health care services.

Additional Resources
To access the current list of Maryland sanctioned providers, follow this link:
https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

APPENDIX A. ATTACHMENTS

Attachment 1: Rare and Expensive Case Management (REM) Program

The Maryland Department of Health (MDH) administers a Rare and Expensive Case Management (REM) program as an alternative to the MCO for certain HealthChoice eligible individuals diagnosed with rare and expensive medical conditions.

Medicaid Benefits and REM Case Management
To qualify for the REM program, the HealthChoice enrollee must have one or more of the diagnoses specified in the *Rare and Expensive Disease List* below. The enrollee may elect to enroll in the REM program or to remain in Amerigroup if the Department agrees that it is medically appropriate. REM participants are eligible for all fee-for-service benefits currently offered to Medicaid-eligible beneficiaries who not eligible to enroll in MCOs. In addition, REM participants may receive additional services, which are described in *COMAR 10.09.69*.

The participant's REM case manager will:
- Gather all relevant information needed to complete a comprehensive needs assessment.
- Assist the participant select an appropriate PCP, if needed.
- Consult with a multi-disciplinary team that includes providers, participants and family/care givers, and develop the participant's plan of care.
- Implement the plan of care, monitor service delivery and modify the plan as warranted by changes in the participant's condition.
- Document findings and maintain clear and concise records.
- Assist in the participant's transfer out of the REM program, when and if appropriate.

Care Coordination
REM case managers are also expected to coordinate care and services from other programs and/or agencies to ensure a comprehensive approach to REM case management services. Examples of these agencies and programs include the following:
- MDH; Healthy Start program newborn follow-up assessments
- Maternal Child Health Division on EPSDT; guidelines, benchmarks and other special-needs children's issues
- Developmental Disability Administration; service coordination for those also in the Home and Community-Based Services Waiver
- AIDS Administration; consults on pediatric AIDS
- DHR coordinates:
  - Medical assistance eligibility issues
  - With Child Protective Services and Adult Protective Services
  - With foster care programs
- Department of Education; coordinates with the Infants and Toddlers Program and other special education programs
- Mental Hygiene Administration; referrals for behavioral health services to the Specialty Mental Health System as appropriate and coordination of these services with somatic care

Referral and Enrollment Process
Candidates for REM are generally referred by their PCP, specialty providers or MCOs but may also self-identify. The referral must include a physician's signature and the required supporting documentation for the qualifying diagnosis(es). A registered nurse reviews the medical information in order to determine the member's eligibility for REM. If the intake nurse determines there is no

qualifying REM diagnosis, the application is sent to the REM physician advisor for a second-level review before a denial notice is sent to the member and referral source. If the member does not meet the REM criteria, they will remain enrolled in the MCO.

If the intake nurse determines the enrollee has an REM-qualifying diagnosis, the nurse approves the member for enrollment in REM. Before the enrollment is completed, the Intake Unit contacts the PCP to see if he/she will continue providing services through the Medicaid fee-for service program. If the PCP is unwilling to continue to care for the member, the case is referred to a case manager to select a PCP in consultation with the member. If the PCP will continue providing services, the Intake Unit explains the program and gives the member an opportunity to refuse REM enrollment. If enrollment is refused, the member remains in the MCO. The MCO is responsible for providing the member's care until the REM enrollment process is complete.

For questions and referral forms, call 1-800-565-8190. Instructions for completing and accessing the *REM Intake and Referral Form* are located at: https://mmcp.dhmh.maryland.gov/longtermcare/SiteAssets/SitePages/REM/REM%20Intake%20Packet%20Oct%207%202015%20Corrected%2010%2007%2015.pdf. Referral forms may be faxed to the REM Intake Unit at 410-333-5426 or mailed to:

REM Intake Unit
Maryland Department of Health
201 W. Preston St., Room 210
Baltimore, MD 21201-2399

Table of Rare and Expensive Diagnosis

ICD-10	ICD-10 Description	AGE LIMIT
B20	Human immunodeficiency virus (HIV) disease	0—20
C96.0	Multifocal and multisystemic Langerhans-cell histiocytosis	0—64
C96.5	Multifocal and unisystemic Langerhans-cell histiocytosis	0—64
C96.6	Unifocal Langerhans-cell histiocytosis	0—64
D61.01	Constitutional (pure) red blood cell aplasia	0—20
D61.09	Other constitutional aplastic anemia	0—20
D66	Hereditary factor VIII deficiency	0—64
D67	Hereditary factor IX deficiency	0—64
D68.0	Von Willebrand's disease	0—64
D68.1	Hereditary factor XI deficiency	0—64
D68.2	Hereditary deficiency of other clotting factors	0—64
E70.0	Classical phenylketonuria	0—20
E70.1	Other hyperphenylalaninemias	0—20
E70.20	Disorder of tyrosine metabolism, unspecified	0—20
E70.21	Tyrosinemia	0—20
E70.29	Other disorders of tyrosine metabolism	0—20
E70.30	Albinism, unspecified	0—20
E70.40	Disorders of histidine metabolism, unspecified	0—20
E70.41	Histidinemia	0—20
E70.49	Other disorders of histidine metabolism	0—20
E70.5	Disorders of tryptophan metabolism	0—20
E70.8	Other disorders of aromatic amino-acid metabolism	0—20
E71.0	Maple-syrup-urine disease	0—20
E71.110	Isovaleric acidemia	0—20
E71.111	3-methylglutaconic aciduria	0—20
E71.118	Other branched-chain organic acidurias	0—20
E71.120	Methylmalonic acidemia	0—20
E71.121	Propionic acidemia	0—20
E71.128	Other disorders of propionate metabolism	0—20
E71.19	Other disorders of branched-chain amino-acid metabolism	0—20
E71.2	Disorder of branched-chain amino-acid metabolism, unspecified	0—20
E71.310	Long chain/very long chain acyl CoA dehydrogenase deficiency	0—64
E71.311	Medium chain acyl CoA dehydrogenase deficiency	0—64
E71.312	Short chain acyl CoA dehydrogenase deficiency	0—64
E71.313	Glutaric aciduria type II	0—64
E71.314	Muscle carnitine palmitoyltransferase deficiency	0—64
E71.318	Other disorders of fatty-acid oxidation	0—64
E71.32	Disorders of ketone metabolism	0—64
E71.39	Other disorders of fatty-acid metabolism	0—64
E71.41	Primary carnitine deficiency	0—64
E71.42	Carnitine deficiency due to inborn errors of metabolism	0—64
E71.50	Peroxisomal disorder, unspecified	0—64
E71.510	Zellweger syndrome	0—64
E71.511	Neonatal adrenoleukodystrophy	0—64

ICD-10	ICD-10 Description	AGE LIMIT
E71.518	Other disorders of peroxisome biogenesis	0—64
E71.520	Childhood cerebral X-linked adrenoleukodystrophy	0—64
E71.521	Adolescent X-linked adrenoleukodystrophy	0—64
E71.522	Adrenomyeloneuropathy	0—64
E71.528	Other X-linked adrenoleukodystrophy	0—64
E71.529	X-linked adrenoleukodystrophy, unspecified type	0—64
E71.53	Other group 2 peroxisomal disorders	0—64
E71.540	Rhizomelic chondrodysplasia punctata	0—64
E71.541	Zellweger-like syndrome	0—64
E71.542	Other group 3 peroxisomal disorders	0—64
E71.548	Other peroxisomal disorders	0—64
E72.01	Cystinuria	0—20
E72.02	Hartnup’s disease	0—20
E72.03	Lowe’s syndrome	0—20
E72.04	Cystinosis	0—20
E72.09	Other disorders of amino-acid transport	0—20
E72.11	Homocystinuria	0—20
E72.12	Methylenetetrahydrofolate reductase deficiency	0—20
E72.19	Other disorders of sulfur-bearing amino-acid metabolism	0—20
E72.20	Disorder of urea cycle metabolism, unspecified	0—20
E72.21	Argininemia	0—20
E72.22	Arginosuccinic aciduria	0—20
E72.23	Citrullinemia	0—20
E72.29	Other disorders of urea cycle metabolism	0—20
E72.3	Disorders of lysine and hydroxylysine metabolism	0—20
E72.4	Disorders of ornithine metabolism	0—20
E72.51	Non-ketotic hyperglycinemia	0—20
E72.52	Trimethylaminuria	0—20
E72.53	Primary hyperoxaluria	0—20
E72.59	Other disorders of glycine metabolism	0—20
E72.81	Disorders of gamma aminobutyric acid metabolism	0—20
E72.89	Other specified disorders of amino-acid metabolism	0—20
E74.00	Glycogen storage disease, unspecified	0—20
E74.01	von Gierke disease	0—20
E74.02	Pompe disease	0—20
E74.03	Cori disease	0—20
E74.04	McArdle disease	0—20
E74.09	Other glycogen storage disease	0—20
E74.12	Hereditary fructose intolerance	0—20
E74.19	Other disorders of fructose metabolism	0—20
E74.21	Galactosemia	0—20
E74.29	Other disorders of galactose metabolism	0—20
E74.4	Disorders of pyruvate metabolism and gluconeogenesis	0—20
E75.00	GM2 gangliosidosis, unspecified	0—20
E75.01	Sandhoff disease	0—20
E75.02	Tay-Sachs disease	0—20

ICD-10	ICD-10 Description	AGE LIMIT
E75.09	Other GM2 gangliosidosis	0—20
E75.10	Unspecified gangliosidosis	0—20
E75.11	Mucolipidosis IV	0—20
E75.19	Other gangliosidosis	0—20
E75.21	Fabry (-Anderson) disease	0—20
E75.22	Gaucher disease	0—20
E75.23	Krabbe disease	0—20
E75.240	Niemann-Pick disease type A	0—20
E75.241	Niemann-Pick disease type B	0—20
E75.242	Niemann-Pick disease type C	0—20
E75.243	Niemann-Pick disease type D	0—20
E75.248	Other Niemann-Pick disease	0—20
E75.25	Metachromatic leukodystrophy	0—20
E75.26	Sulfatase deficiency	0—20
E75.29	Other sphingolipidosis	0—20
E75.3	Sphingolipidosis, unspecified	0—20
E75.4	Neuronal ceroid lipofuscinosis	0—20
E75.5	Other lipid storage disorders	0—20
E76.01	Hurler's syndrome	0—64
E76.02	Hurler-Scheie syndrome	0—64
E76.03	Scheie's syndrome	0—64
E76.1	Mucopolysaccharidosis, type II	0—64
E76.210	Morquio A mucopolysaccharidoses	0—64
E76.211	Morquio B mucopolysaccharidoses	0—64
E76.219	Morquio mucopolysaccharidoses, unspecified	0—64
E76.22	Sanfilippo mucopolysaccharidoses	0—64
E76.29	Other mucopolysaccharidoses	0—64
E76.3	Mucopolysaccharidosis, unspecified	0—64
E76.8	Other disorders of glucosaminoglycan metabolism	0—64
E77.0	Defects in post-translational mod of lysosomal enzymes	0—20
E77.1	Defects in glycoprotein degradation	0—20
E77.8	Other disorders of glycoprotein metabolism	0—20
E79.1	Lesch-Nyhan syndrome	0—64
E79.2	Myoadenylate deaminase deficiency	0—64
E79.8	Other disorders of purine and pyrimidine metabolism	0—64
E79.9	Disorder of purine and pyrimidine metabolism, unspecified	0—64
E80.3	Defects of catalase and peroxidase	0—64
E84.0	Cystic fibrosis with pulmonary manifestations	0—64
E84.11	Meconium ileus in cystic fibrosis	0—64
E84.19	Cystic fibrosis with other intestinal manifestations	0—64
E84.8	Cystic fibrosis with other manifestations	0—64
E84.9	Cystic fibrosis, unspecified	0—64
E88.40	Mitochondrial metabolism disorder, unspecified	0—64
E88.41	MELAS syndrome	0—64
E88.42	MERRF syndrome	0—64
E88.49	Other mitochondrial metabolism disorders	0—64

ICD-10	ICD-10 Description	AGE LIMIT
E88.89	Other specified metabolic disorders	0—64
F84.2	Rett's syndrome	0—20
G11.0	Congenital nonprogressive ataxia	0—20
G11.1	Early-onset cerebellar ataxia	0—20
G11.2	Late-onset cerebellar ataxia	0—20
G11.3	Cerebellar ataxia with defective DNA repair	0—20
G11.4	Hereditary spastic paraplegia	0—20
G11.8	Other hereditary ataxias	0—20
G11.9	Hereditary ataxia, unspecified	0—20
G12.0	Infantile spinal muscular atrophy, type I (Werdnig-Hoffman)	0—20
G12.1	Other inherited spinal muscular atrophy	0—20
G12.21	Amyotrophic lateral sclerosis	0—20
G12.22	Progressive bulbar palsy	0—20
G12.29	Other motor neuron disease	0—20
G12.8	Other spinal muscular atrophies and related syndromes	0—20
G12.9	Spinal muscular atrophy, unspecified	0—20
G24.1	Genetic torsion dystonia	0—64
G24.8	Other dystonia	0—64
G25.3	Myoclonus	0—5
G25.9	Extrapyramidal and movement disorder, unspecified	0—20
G31.81	Alpers disease	0—20
G31.82	Leigh's disease	0—20
G31.9	Degenerative disease of nervous system, unspecified	0—20
G32.81	Cerebellar ataxia in diseases classified elsewhere	0—20
G37.0	Diffuse sclerosis of central nervous system	0—64
G37.5	Concentric sclerosis (Balo) of central nervous system	0—64
G71.00	Muscular dystrophy, unspecified	0—64
G71.01	Duchenne or Becker muscular dystrophy	0—64
G71.02	Facioscapulohumeral muscular dystrophy	0—64
G71.09	Other specified muscular dystrophies	0—64
G71.11	Myotonic muscular dystrophy	0—64
G71.2	Congenital myopathies	0—64
G80.0	Spastic quadriplegic cerebral palsy	0—64
G80.1	Spastic diplegic cerebral palsy	0—20
G80.3	Athetoid cerebral palsy	0—64
G82.50	Quadriplegia, unspecified	0—64
G82.51	Quadriplegia, C1-C4 complete	0—64
G82.52	Quadriplegia, C1-C4 incomplete	0—64
G82.53	Quadriplegia, C5-C7 complete	0—64
G82.54	Quadriplegia, C5-C7 incomplete	0—64
G91.0	Communicating hydrocephalus	0—20
G91.1	Obstructive hydrocephalus	0—20
I67.5	Moyamoya disease	0—64
K91.2	Postsurgical malabsorption, not elsewhere classified	0—20
N03.1	Chronic nephritic syndrome with focal and segmental glomerular lesions	0—20
N03.2	Chronic nephritic syndrome w diffuse membranous glomrlneph	0—20

ICD-10	ICD-10 Description	AGE LIMIT
N03.3	Chronic neph syndrome w diffuse mesangial prolif glomrlneph	0—20
N03.4	Chronic neph syndrome w diffuse endocaplry prolif glomrlneph	0—20
N03.5	Chronic nephritic syndrome w diffuse mesangiocap glomrlneph	0—20
N03.6	Chronic nephritic syndrome with dense deposit disease	0—20
N03.7	Chronic nephritic syndrome w diffuse crescentic glomrlneph	0—20
N03.8	Chronic nephritic syndrome with other morphologic changes	0—20
N03.9	Chronic nephritic syndrome with unsp morphologic changes	0—20
N08	Glomerular disorders in diseases classified elsewhere	0—20
N18.1	Chronic kidney disease, stage 1	0—20
N18.2	Chronic kidney disease, stage 2 (mild)	0—20
N18.3	Chronic kidney disease, stage 3 (moderate)	0—20
N18.4	Chronic kidney disease, stage 4 (severe)	0—20
N18.5	Chronic kidney disease, stage 5	0—20
N18.6	End stage renal disease	0—20
N18.9	Chronic kidney disease, unspecified	0—20
Q01.9	Encephalocele, unspecified	0—20
Q02	Microcephaly	0—20
Q03.0	Malformations of aqueduct of Sylvius	0—20
Q03.1	Atresia of foramina of Magendie and Luschka	0—20
Q03.8	Other congenital hydrocephalus	0—20
Q03.9	Congenital hydrocephalus, unspecified	0—20
Q04.3	Other reduction deformities of brain	0—20
Q04.5	Megalencephaly	0—20
Q04.6	Congenital cerebral cysts	0—20
Q04.8	Other specified congenital malformations of brain	0—20
Q05.0	Cervical spina bifida with hydrocephalus	0—64
Q05.1	Thoracic spina bifida with hydrocephalus	0—64
Q05.2	Lumbar spina bifida with hydrocephalus	0—64
Q05.3	Sacral spina bifida with hydrocephalus	0—-64
Q05.4	Unspecified spina bifida with hydrocephalus	0—64
Q05.5	Cervical spina bifida without hydrocephalus	0—64
Q05.6	Thoracic spina bifida without hydrocephalus	0—64
Q05.7	Lumbar spina bifida without hydrocephalus	0—64
Q05.8	Sacral spina bifida without hydrocephalus	0—64
Q05.9	Spina bifida, unspecified	0—64
Q06.0	Amyelia	0—64
Q06.1	Hypoplasia and dysplasia of spinal cord	0—64
Q06.2	Diastematomyelia	0—64
Q06.3	Other congenital cauda equina malformations	0—64
Q06.4	Hydromyelia	0—64
Q06.8	Other specified congenital malformations of spinal cord	0—64
Q07.01	Arnold-Chiari syndrome with spina bifida	0—64
Q07.02	Arnold-Chiari syndrome with hydrocephalus	0—64
Q07.03	Arnold-Chiari syndrome with spina bifida and hydrocephalus	0—64
Q30.1	Agenesis and underdevelopment of nose, cleft or absent nose only	0—5
Q30.2	Fissured, notched and cleft nose, cleft or absent nose only	0—5

ICD-10	ICD-10 Description	AGE LIMIT
Q31.0	Web of larynx	0—20
Q31.8	Other congenital malformations of larynx, atresia or agenesis of larynx only	0—20
Q32.1	Other congenital malformations of trachea, atresia or agenesis of trachea only	0—20
Q32.4	Other congenital malformations of bronchus, atresia or agenesis of bronchus only	0—20
Q33.0	Congenital cystic lung	0—20
Q33.2	Sequestration of lung	0—20
Q33.3	Agenesis of lung	0—20
Q33.6	Congenital hypoplasia and dysplasia of lung	0—20
Q35.1	Cleft hard palate	0—20
Q35.3	Cleft soft palate	0—20
Q35.5	Cleft hard palate with cleft soft palate	0—20
Q35.9	Cleft palate, unspecified	0—20
Q37.0	Cleft hard palate with bilateral cleft lip	0—20
Q37.1	Cleft hard palate with unilateral cleft lip	0—20
Q37.2	Cleft soft palate with bilateral cleft lip	0—20
Q37.3	Cleft soft palate with unilateral cleft lip	0—20
Q37.4	Cleft hard and soft palate with bilateral cleft lip	0—20
Q37.5	Cleft hard and soft palate with unilateral cleft lip	0—20
Q37.8	Unspecified cleft palate with bilateral cleft lip	0—20
Q37.9	Unspecified cleft palate with unilateral cleft lip	0—20
Q39.0	Atresia of esophagus without fistula	0—3
Q39.1	Atresia of esophagus with tracheo-esophageal fistula	0—3
Q39.2	Congenital tracheo-esophageal fistula without atresia	0—3
Q39.3	Congenital stenosis and stricture of esophagus	0—3
Q39.4	Esophageal web	0—3
Q42.0	Congenital absence, atresia and stenosis of rectum with fistula	0—5
Q42.1	Congen absence, atresia and stenosis of rectum without fistula	0—5
Q42.2	Congenital absence, atresia and stenosis of anus with fistula	0—5
Q42.3	Congenital absence, atresia and stenosis of anus without fistula	0—5
Q42.8	Congenital absence, atresia and stenosis of other parts of large intestine	0—5
Q42.9	Congenital absence, atresia and stenosis of large intestine, part unspecified	0—5
Q43.1	Hirschsprung's disease	0—15
Q44.2	Atresia of bile ducts	0—20
Q44.3	Congenital stenosis and stricture of bile ducts	0—20
Q44.6	Cystic disease of liver	0—20
Q45.0	Agenesis, aplasia and hypoplasia of pancreas	0—5
Q45.1	Annular pancreas	0—5
Q45.3	Other congenital malformations of pancreas and pancreatic duct	0—5
Q45.8	Other specified congenital malformations of digestive system	0—10
Q60.1	Renal agenesis, bilateral	0—20
Q60.4	Renal hypoplasia, bilateral	0—20
Q60.6	Potter's syndrome, with bilateral renal agenesis only	0—20
Q61.02	Congenital multiple renal cysts, bilateral only	0—20
Q61.19	Other polycystic kidney, infantile type, bilateral only	0—20
Q61.2	Polycystic kidney, adult type, bilateral only	0—20
Q61.3	Polycystic kidney, unspecified, bilateral only	0—20

ICD-10	ICD-10 Description	AGE LIMIT
Q61.4	Renal dysplasia, bilateral only	0—20
Q61.5	Medullary cystic kidney, bilateral only	0—20
Q61.9	Cystic kidney disease, unspecified, bilateral only	0—20
Q64.10	Exstrophy of urinary bladder, unspecified	0—20
Q64.12	Cloacal extrophy of urinary bladder	0—20
Q64.19	Other exstrophy of urinary bladder	0—20
Q75.0	Craniosynostosis	0—20
Q75.1	Craniofacial dysostosis	0—20
Q75.2	Hypertelorism	0—20
Q75.4	Mandibulofacial dysostosis	0—20
Q75.5	Oculomandibular dysostosis	0—20
Q75.8	Other congenital malformations of skull and face bones	0—20
Q77.4	Achondroplasia	0—1
Q77.6	Chondroectodermal dysplasia	0—1
Q77.8	Other osteochondrodysplasia with defects of growth of tubular bones and spine	0—1
Q78.0	Osteogenesis imperfecta	0—20
Q78.1	Polyostotic fibrous dysplasia	0—1
Q78.2	Osteopetrosis	0—1
Q78.3	Progressive diaphyseal dysplasia	0—1
Q78.4	Enchondromatosis	0—1
Q78.6	Multiple congenital exostoses	0—1
Q78.8	Other specified osteochondrodysplasias	0—1
Q78.9	Osteochondrodysplasia, unspecified	0—1
Q79.0	Congenital diaphragmatic hernia	0—1
Q79.1	Other congenital malformations of diaphragm	0—1
Q79.2	Exomphalos	0—1
Q79.3	Gastroschisis	0—1
Q79.4	Prune belly syndrome	0—1
Q79.59	Other congenital malformations of abdominal wall	0—1
Q89.7	Multiple congenital malformations, not elsewhere classified	0—10
R75	Inconclusive laboratory evidence of HIV	0—12 months
Z21	Asymptomatic human immunodeficiency virus infection status	0—20
Z99.11	Dependence on respirator (ventilator) status	1-64
Z99.2	Dependence on renal dialysis	21-64

Attachment 2: *School-Based Heath Center Health Visit Form* (*DHMH 2015*)

SCHOOL-BASED HEALTH CENTER HEALTH VISIT REPORT FORM

☐ **Well child exam only (see attached physical exam form)**

SBHC Name & Address: **SBHC Provider Number:** **Contact Name:** **Telephone:** **Fax:**	**MCO Name & Address:** **Contact Name:** **Telephone:** **Fax:** **Date Faxed:**	
Student Name: **DOB:** **MA Number:** **SS Number:**	**Date of Visit:** **Type of Visit:** ☐ **Acute/Urgent** ☐ **Follow Up** ☐ **Health Maintenance**	**ICD-10 Codes**
Provider Name/Title:		**CPT Codes**
T: P: RR: BP: PF: PaO2: Hgt: Wgt: BMI: Rapid Strep Test: - Hgb: BGL: U/A:	**Drug Allergy:** ☐ **NKDA**	
	Current Medications:	**Immunization review:** ☐ **UTD** **Given today:** **Needs:**

Age: **Chief Complaint:**
HPI:

Past Medical History: ☐ **Unremarkable** ☐ **See health history** ☐ **Pertinent:**

Physical Findings:

General: ☐ Alert/NAD
☐ Pertinent:

Head: ☐ Normal
☐ Pertinent:

Ears: ☐ TMs: pearly, + landmarks , + light reflex
☐ Cerumen removed curette/lavage
☐ Pertinent:

Eyes: ☐ PERRLA, sclerae clear, no discharge/crusting
☐ Pertinent:

Nose: ☐ Turbinates: pink, without swelling
☐ Pertinent:

Mouth: ☐ Pharynx without erythema, swelling, or exudate
☐ Normal dentition without caries
☐ Pertinent:

Neck: ☐ Full ROM. No tenderness
☐ Pertinent:

Lymph Nodes: ☐ No lymphadenopathy
☐ Pertinent:

Cardiac: ☐ RRR, normal S1 S2, no murmur
☐ Pertinent:

Lungs: ☐ CTA bilaterally, no retractions, wheezes, rales, ronchi
☐ Pertinent:

Abdomen: ☐ Soft, non-tender, no HSM, no masses,
☐ Bowel sounds present
☐ Pertinent:

Genitalia: ☐ Normal female/normal male Tanner Stage
☐ Pertinent:

Extremities: ☐ FROM
☐ Pertinent:

Neurologic: ☐ Grossly intact
☐ Pertinent:

Skin: ☐ Intact, no rashes
☐ Pertinent:

ASSESSMENT: **PLAN:**

Rx Ordered:

Labs Ordered:

Radiology Services Ordered:

PCP F/U Required:
☐ **Yes** ☐ **No**

Provider Signature: _____

DHMH 2015 **For MCO formulary info, find MCO website at:** https://mmcp.dhmh.maryland.gov/healthchoice/SitePages/Home.aspx

SCHOOL-BASED HEALTH CENTER HEALTH VISIT REPORT FORM

☐ **Well child exam only (see attached physical exam form)**

SBHC Name & Address: **SBHC Provider Number:** **Contact Name:** **Telephone:** **Fax:**	**MCO Name & Address:** **Contact Name:** **Telephone:** **Fax:** **Date Faxed:**

Student Name: **DOB:** **MA Number:** **SS Number:**	**Date of Visit:** **Type of Visit:** ☐ **Acute/Urgent** ☐ **Follow Up** ☐ **Health Maintenance**	**ICD-10 Codes**
Provider Name/Title:		**CPT Codes**
T: P: RR: BP: PF: PaO2:	**Drug Allergy:** ☐ **NKDA**	
Hgt: Wgt: BMI:	**Current Medications:**	**Immunization review:** ☐ **UTD** **Given today:** **Needs:**
Rapid Strep Test: - Hgb: BGL: U/A:		

Age: **Chief Complaint:**
HPI:

Past Medical History: ☐ **Unremarkable** ☐ **See health history** ☐ **Pertinent:**

Physical Findings:

General: ☐ Alert/NAD
☐ Pertinent:

Head: ☐ Normal
☐ Pertinent:

Ears: ☐ TMs: pearly, + landmarks , + light reflex
☐ Cerumen removed curette/lavage
☐ Pertinent:

Eyes: ☐ PERRLA, sclerae clear, no discharge/crusting
☐ Pertinent:

Nose: ☐ Turbinates: pink, without swelling
☐ Pertinent:

Mouth: ☐ Pharynx without erythema, swelling, or exudate
☐ Normal dentition without caries
☐ Pertinent:

Neck: ☐ Full ROM. No tenderness
☐ Pertinent:

Lymph Nodes: ☐ No lymphadenopathy
☐ Pertinent:

Cardiac: ☐ RRR, normal S1 S2, no murmur
☐ Pertinent:

Lungs: ☐ CTA bilaterally, no retractions, wheezes, rales, ronchi
☐ Pertinent:

Abdomen: ☐ Soft, non-tender, no HSM, no masses,
☐ Bowel sounds present
☐ Pertinent:

Genitalia: ☐ Normal female/normal male Tanner Stage
☐ Pertinent:

Extremities: ☐ FROM
☐ Pertinent:

Neurologic: ☐ Grossly intact
☐ Pertinent:

Skin: ☐ Intact, no rashes
☐ Pertinent:

ASSESSMENT: **PLAN:**

Rx Ordered:

Labs Ordered:

Radiology Services Ordered:

PCP F/U Required:
☐ **Yes** ☐ **No**

Provider Signature: _____

DHMH 2015 **For MCO formulary info, find MCO website at:** https://mmcp.dhmh.maryland.gov/healthchoice/SitePages/Home.aspx

Attachment 3: Local Health ACCU and NEMT Transportation — Contact List

County	Main phone number	Transportation phone number	Administrative Care Coordination Unit (ACCU) phone number	Website
Allegany	301-759-5000	301-759-5123	301-759-5094	http://www.alleganyhealthdept.com
Anne Arundel	410-222-7095	410-222-7152	410-222-7541	http://www.aahealth.org
Baltimore City	410-396-3835	410-396-6422	410-649-0521	http://health.baltimorecity.gov
Baltimore County	410-887-2243	410-887-2828	410-887-4381	http://www.baltimorecountymd.gov/agencies/health
Calvert	410-535-5400	410-414-2489	410-535-5400, ext. 360	http://www.calverthealth.org
Caroline	410-479-8000	410-479-8014	410-479-8023	https://health.maryland.gov/carolinecounty/Pages/NewHome.aspx
Carroll	410-876-2152	410-876-4813	410-876-4940	http://cchd.maryland.gov
Cecil	410-996-5550	410-996-5171	410-996-5145	http://www.cecilcountyhealth.org
Charles	301-609-6900	301-609-7917	301-609-6803	http://www.charlescountyhealth.org
Dorchester	410-228-3223	410-901-2426	410-228-3223	http://www.dorchesterhealth.org
Frederick	301-600-1029	301-600-1725	301-600-3341	http://health.frederickcountymd.gov
Garrett	301-334-7777	301-334-9431	301-334-7695	http://garretthealth.org
Harford	410-838-1500	410-638-1671	410-942-7999	http://harfordcountyhealth.com
Howard	410-313-6300	877-312-6571	410-313-7567	https://www.howardcountymd.gov/Departments/Health
Kent	410-778-1350	410-778-7025	410-778-7035	http://kenthd.org
Montgomery	311 or 240-777-0311	240-777-5899	240-777-1648	http://www.montgomerycountymd.gov/hhs
Prince George's	301-883-7879	301-856-9555	301-856-9550	http://www.princegeorgescountymd.gov/1588/Health-Services
Queen Anne's	410-758-0720	443-262-4462	443-262-4481	www.qahealth.org
St. Mary's	301-475-4330	301-475-4296	301-475-6772	http://www.smchd.org
Somerset	443-523-1700	443-523-1722	443-523-1766	http://somersethealth.org
Talbot	410-819-5600	410-819-5609	410-819-5654	https://health.maryland.gov/talbotcounty/Pages/home.aspx
Washington	240-313-3200	240-313-3264	240-313-3290	https://health.maryland.gov/washhealth/Pages/home.aspx
Wicomico	410-749-1244	410-548-5142 Option # 1	410-543-6942	https://www.wicomicohealth.org
Worcester	410-632-1100	410-632-0092	410-632-9230	http://www.worcesterhealth.org

Attachment 4: Local Health Service Request Form (DHMH 4682) — Fillable Form

Date: / / To: Attention: Address: City/State/Zip: Phone:

HealthChoice
LOCAL HEALTH SERVICES REQUEST FORM

Client Information	
Client Name: Address: City/State/Zip: Phone: County: DOB: / / SS#: - - Sex: ☐M ☐F Hispanic: ☐Y ☐N MA#: Private Ins.: ☐ No ☐Yes Martial Status: ☐Single ☐Married ☐Unknown If Interpreter is needed specific language:	Race: ☐African-American/Black ☐Alaskan Native ☐American Native ☐Asian ☐Native Hawaiian ☐Pacific Islander ☐White ☐More than one race ☐Unknown Caregiver/Emergency Contact: Relationship: Phone:
FOLLOW-UP FOR: (Check all that apply) ☐Child under 2 years of age ☐Child 2 – 21 years of age ☐Child with special health care needs ☐ Pregnant EDD: ____ / ____ /____ ☐Adults with disability(mental, physical, or developmental) ☐Substance use care needed ☐Homeless (at-risk)	RELATED TO: (Check all that apply) ☐Missed appointments: ___ #missed ☐Adherence to plan of care ☐Immunization delay ☐Preventable hospitalization ☐Transportation ☐Other:
Diagnosis:	
Comments:	
MCO:	Date Received: / /
Document Outreach: # Letter(s) _____# Phone Call(s) _____ # Face to Face _____	☐Unable to Locate ☐Contact Date: / / ☐Advised ☐Refused
Comments:	
Contact Person: Phone: Fax:	Provider Name: Provider Phone:
Local Health Department (County)	Date Received: / /
Document Outreach: # Letter(s) _____ # Phone Call(s) _____ # Face to Face _____	☐No Action (returned) Reason for return:
Contact Person: Contact Phone:	Disposition: ☐Contact Complete: Date: / / ☐Unable to Locate: Date: / / ☐Referred to: Date: / /
Comments:	

DHMH 4582 8/14

Attachment 5: Maryland Prenatal Risk Assessment Form (DHMH 4850)

MARYLAND PRENATAL RISK ASSESSMENT

REFER TO INSTRUCTIONS ON BACK BEFORE STARTING

Date of Visit: _____/ _____/ ___

Provider Name:_____ Provider Phone Number: _____- _____- __ Provider NPI#: Site NPI#: _____

__ __ __ __ __ __ __ __ __ __

Client Last Name: First Name: Middle:

House Number: Street Name: Apt: City: County (If patient lives in Baltimore City, leave blank): State: Zip Code: Home Phone #: -_-__Cell Phone#: -__-__Emergency Phone#: - -_

SSN: - - DOB: / / Emergency Contact:

Name/Relationship

Race: **Language Barrier?** Yes No **Payment Status (Mark all that apply):**

_African-American or Black Specify Primary Language Private Insurance, Specify:

_Alaskan Native American Native **Hispanic?** Yes No MA/HealthChoice

_Asian More than 1 race MA #:

_Native Hawaiian or other Pacific Islander **Marital Status:**

Name of MCO (if applicable): ___

_Unknown White Married Unmarried Unknown

Educational Level Applied for MA Specify Date: /_/

Highest grade completed: GED? Yes No Uninsured

Currently in school? Yes No Unknown

Transferred from other source of prenatal care ? Yes No

If YES, date care began: _/___/ _____

Other source of prenatal care: _____ Trimester of

1st prenatal visit: ____1st __2nd __3rd

LMP: __/ ___/ ___Initial EDC: _/ ___/ ___

Complete all that apply **Check all that apply**

___# Full-term live births __History of pre-term labor

___# Pre-term live births __History of fetal death (> 20 weeks)

___# Prior LBW births ___History of infant death w/in 1 yr of age

___# Spontaneous abortions _____History of multiple gestation

___# Therapeutic abortions _____History of infertilitly treatment

___# Ectopic pregnancies __First pregnancy

___# Children now living

Psychosocial Risks: Check all that apply.

___Current pregnancy unintended

___Less than 1 year since last delivery

___Late registration (more than 20 weeks gestation)

___Disability (mental/physical/developmental), Specify _____

___History of abuse/violence within past 6 months

___Tobacco use, Amount _

___Alcohol use, Amount _

___Illegal substances within past 6 months

___Resides in home built prior to 1978, ___Rent _____Own

___Homelessness

___Lack of social/emotional support

___Exposure to long-term stress

___Lack of transportation

___Other psychosocial risk (specify in comments box)

___None of the above

COMMENTS ON PSYCHOSOCIAL RISKS:

Medical Risks: Check all that apply.

Current Medical Conditions of this Pregnancy:

___Age ≤15

___Age ≥ 45

___BMI < 18.5 or BMI > 30

___Hypertension (> 140/90)

___Anemia (Hgb < 10 or Hct < 30

___Asthma

___Sick cell disease

___Diabetes: Insulin dependent _Yes _____No

___Vaginal bleeding (after 12 weeks)

___Genetic risk: specify __

___Sexually transmitted disease, Specify ___

___Last dental visit over 1 year ago

___Prescription drugs

___History of depression/mental illness, Specify_____

Depression assessment completed? _Yes __No

___Other medical risk (specify in comment box)

___None of the above

COMMENTS ON MEDICAL RISKS:

Form Completed By: _____ Date

Form Completed: _____/ _____/ _____

MDH 4850 revised March 2014

DO NOT WRITE IN THIS SPACE 9005

Maryland Prenatal Risk Assessment Form Instructions

Purpose of Form: **Identifies pregnant woman who may benefit from local health department Administrative Care Coordination (ACCU) services and serves as the referral mechanism. ACCU services complement medical care and may be provided by public health nurses and social workers through the local health departments. Services may include resource linkage, psychosocial/environmental assessment, reinforcement of the medical plan of care, and other related services.**

Form Instructions: On the initial visit the provider/staff will complete the demographic and assessment sections for ALL pregnant women enrolled in Medicaid at registration and those applying for Medicaid. Within ten (10) days of completing the prenatal risk assessment, forward this instrument to the local health department in the jurisdiction in which the pregnant enrollee lives.

NEW - Enter both the provider and site/facility NPI numbers.
Print clearly; use black pen for all sections.
Press firmly to imprint.
White-out previous entries on original completely to make corrections.
If client does not have a social security number, indicate zeroes.
Indicate the person completing the form.
Review for completeness and accuracy.

Faxing and Handling Instructions:

Do not fold, bend, or staple forms. **Only punch holes at top of form if necessary**. Store forms in a dry area. **Fax the MPRAF to the local health department in the client's county of residence.** To reorder forms call the local **ACCU**.

Definitions (selected): Data may come from self-report, medical records, provider observation or other sources.

DEFINITIONS	
Alcohol use	Is a "risk-drinker" as determined by a screening tool such as MAST, CAGE, TACE OR 4Ps
Current history of abuse/violence	Includes physical, psychological abuse or violence within the client's environment within the past six months
Exposure to long-term stress	For example: partner-related, financial, safety, emotional
Genetic risk	At risk for a genetic or hereditary condition
Illegal substances	Used illegal substances within the past 6 months (e.g. cocaine, heroin, marijuana, PCP) or is taking methadone/buprenorphine
Lack of social/emotional support	Absence of support from family/friends. Isolated
Language barrier	In need of interpreter, e.g. Non-English speaking, auditory processing disability, deaf
Oral Hygiene	Presence of dental caries, gingivitis, tooth loss
Preterm live birth	History of preterm birth (prior to the 37th gestational week)
Prior LBW birth	Low birth weight birth (under 2,500 grams)
Sickle cell disease	Documented by medical records
Tobacco use	Used any type of tobacco products within the past 6 months

Client's Local Health Department Addresses (rev 03/2014) (FAX to the ACCU in the jurisdiction where the client resid

Mailing Address	Phone Number
Allegany County ACCU 12501 Willowbrook Rd S.E. Cumberland, MD 21502	301-759-5094 Fax: 301-777-2401
Anne Arundel County ACCU 1 Harry S. Truman Parkway, Ste 200 Annapolis, MD 21401	410-222-7541 Fax: 410-222-4150
Baltimore City ACCU HealthChare Access Maryland 201 E. Baltimore St, Ste. 1000 Baltimore, MD 21202	410-649-0526 Fax: 1-888-657-8712
Baltimore County ACCU 6401 York Rd., 3rd Floor Baltimore, MD 21212	410-887- 4381 Fax: 410-828-8346
Calvert County ACCU 975 N. Solomon's Island Rd, P.O. Box 980 Prince Frederick, MD 20678	410-535-5400 Fax: 410-535-1955
Caroline County ACCU 403 S. 7th St., P.O. Box 10 Denton, MD 21629	410-479-8023 Fax: 410-479-4871
Carroll County ACCU 290 S. Center St, P. O. Box 845 Westminster, MD 21158-0845	410-876-4940 Fax: 410-876-4959
Cecil County ACCU 401 Bow Street Elkton, MD 21921	410-996-5145 Fax: 410-996-0072
Charles County ACCU 4545 Crain Highway, P.O. Box 1050 White Plains, MD 20695	301-609-6803 Fax: 301-934-7048
Dorchester County ACCU 3 Cedar Street Cambridge, MD 21613	410-228-3223 Fax: 410-228-8976
Frederick County ACCU 350 Montevue Lane Frederick, MD 21702	301-600-3341 Fax: 301-600-3302
Garrett County ACCU 1025 Memorial Drive Oakland, MD 21550	301-334-7692 Fax: 301-334-7771
Harford County ACCU 34 N. Philadelphia Blvd. Aberdeen, MD 21001	410-273-5626 Fax: 410-272-5467
Howard County ACCU 7180 Columbia Gateway Dr. Columbia, MD 21044	410-313-7323 Fax: 410-313-5838
Kent County ACCU 125 S. Lynchburg Street Chestertown, MD 21620	410-778-7039 Fax: 410-778-7019
Montgomery County ACCU 1335 Piccard Drive, 2nd Floor Rockville, MD 20850	240-777-1635 Fax: 240-777-4645
Prince George's County ACCU 9201 Basil Court, Room 403 Largo, MD 20774	301-883-7231 Fax: 301-856-9607
Queen Anne's County ACCU 206 N. Commerce Street Centreville, MD 21617	443-262-4481 Fax: 443-262-9357
St Mary's County ACCU 21580 Peabody St., P.O. Box 316 Leonardtown, MD 20650-0316	301-475-4951 Fax: 301-475-4350
Somerset County ACCU 7920 Crisfield Highway Westover, MD 21871	443-523-1740 Fax: 410-651-2572
Talbot County ACCU 100 S. Hanson Street Easton, MD 21601	410-819-5600 Fax: 410-819-5683
Washington County ACCU 1302 Pennsylvania Avenue Hagerstown, MD 21742	240-313-3229 Fax: 240-313-3222
Wicomico County ACCU 108 E. Main Street Salisbury, MD 21801	410-543-6942 Fax: 410-543-6568
Worcester County ACCU 9730 Healthway Dr. Berlin, MD 21811	410-629-0164 Fax: 410-629-0185

Request for Fair Hearing Form

To: Susan J. Tucker, Executive Director
In Care of Dina Smoot
Office of Health Services
210 W. Preston St., Room 127
Baltimore, MD 21201

Name: _____

Address: _____

_____

Telephone number: _____

Medical assistance number (found on your Medicaid card): _____

I disagree with my Managed Care Company's decision because: _____

_____

_____

_____

_____

_____

_____

Please schedule my fair hearing within 20 days of the date you receive this request.

Thank you,

Signature

Screening Tools

CAGE-AID

Directions: Please answer “yes” or “no” to each of the following questions.

Question	Yes	No
Have you ever felt you ought to cut down on your alcohol or drug use?	____	____
Have people annoyed you by criticizing your alcohol or drug use?	____	____
Have you ever felt bad or guilty about your alcohol or drug use?	____	____
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover? (Eye opener)	____	____

A yes response to any question suggests alcohol/drug abuse and warrants further assessment.

CRAFFT

Directions: Please answer “yes” or “no” to each of the following questions.

Question	Yes	No
Have you ever ridden in a car driven by someone (including yourself) that was “high” or had been using alcohol or drugs?	____	____
Do you ever use alcohol or drugs to relax, feel better about yourself or fit in?	____	____
Do you ever use alcohol or drugs while you are by yourself, alone?	____	____
Do you ever forget things you did while using alcohol or drugs?	____	____
Do your friends or family ever tell you that you should cut down on your drinking or drug use?	____	____
Have you ever gotten into trouble while using alcohol or drugs?	____	____

A yes response to two or more questions suggests alcohol/drug abuse and warrants further assessment.

Women, Infants and Children Referral Form

This is a referral to a Women, Infants and Children (WIC) provider agency. Medicaid participants eligible for WIC benefits include the classifications listed below. Please check the category that most appropriately describes the individual being referred for services.

- Pregnant woman
- Woman who is breast-feeding her infant(s) up to one year postpartum
- Woman who is not breast-feeding up to six months postpartum
- Infant under age 1
- Child under age 5

Name of individual being referred: _____
Address: _____

_____
Telephone number: _____

I, the undersigned, give permission for my provider to give the WIC program any required medical information.

_____
Signature of the patient being referred or in the case of children and infants, signature and printed name of the parent and/or guardian.

Physician's name: _____
Telephone number: _____
Date of referral: _____
Send completed form to:
Local WIC program center: _____
Address: _____

_____
Telephone number: _____

Maryland Uniform Consultation and Referral Form

Date of Referral:	**Carrier Information:** Name: Address: Phone Number: ( ) Facsimile/Data #: ( )
Patient Information	
Name: (Last, First, MI)	
Date of Birth: (MM/DD/YY)	
Phone Number: ( )	
Member ID #:	
Site #:	

Primary or Requesting Provider:

Name: (Last, First, MI)	Specialty:	
Institution/Group Name:	Provider ID #:1	Provider ID #: 2 (If Required)
Address: (Street #, City, State, ZIP)		
Phone Number: ( )	Facsimile/Data Number: ( )	

Consultant/Facility Provider:

Name: (Last, First, MI)	Specialty:	
Institution/Group Name:	Provider ID #:1	Provider ID #: 2 (If Required)
Address: (Street #, City, State, ZIP code)		
Phone Number: ( )	Facsimile/Data Number: ( )	

Referral Information:

Reason for referral:
Brief History, Diagnosis and Test Results:

<table>
<tr><td colspan="2">Services Desired: Provide Care as Indicated ☐ Initial Consultation Only: ☐ Diagnostic Test (specify)
_____

☐ Consultation with Specific Procedures: (specify)
_____
_____
☐ Specific Treatment_____
☐ Global OB Care and Delivery
☐ Other: (Explain)
_____</td><td>Place of Service:
☐ Office
☐ Outpatient Medical/Surgical Center*
☐ Radiology
☐ Laboratory
☐ Inpatient Hospital*
☐ Extended Care Facility*
☐ Other: (Explain) * (Specific Facility Must be Named)</td></tr>
<tr><td>Number of Visits: _____ If Blank, One Visit is Assumed</td><td>Authorization #:</td><td>Referral is Valid Until:
(Date) _____
(See Carrier Instructions)</td></tr>
<tr><td></td><td>(If Required)</td><td></td></tr>
<tr><td colspan="2">Signature: (Individual Completing This Form)</td><td>Authorizing Signature: (If Required)</td></tr>
</table>

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member's eligibility on the date the service is rendered and to any other contractual provisions of the plan and/or carrier.

White: Carrier; Yellow: Primary or Requesting Provider; Pink: Consultant/Facility Provider; Goldenrod: Patient

See Carrier/Plan Manual for Specific Instructions.

Specialist as PCP Request Form

Date: _____

Member name: _____

Member ID number: _____

PCP name (if applicable): _____

Specialist/specialty: _____

Member diagnosis: _____

Describe the medical justification for selecting a specialist as the PCP for this member.

_____

_____

_____

_____

_____

The signatures below indicate agreement by the specialist, Amerigroup and the member that the specialist will function as this member's PCP, including providing to the member 24 hours a day, 7 days a week access.

Specialist signature: _____ Date: _____

Medical director signature: _____ Date: _____

Member signature: _____ Date: _____

Living Will Form

You can make a living will by completing this form. You can choose another form or use the one your doctor gives you. If you make a living will, give it to your Amerigroup network provider. If you need help to understand or complete this form, call Member Services at 1-800-600-4441.

I, (*Print your name here*) _____, am of sound mind. I want to have what I indicate here followed. I am writing this in the event something happens to me and I cannot make decisions about my medical care. These instructions are to be used if I am not able to make decisions. I want my family and doctors to honor what I say here. These instructions will tell what I want to have done if 1) I am in a terminal condition (going to die), or 2) I am permanently unconscious and have brain damage that is not going to get better. If I am pregnant and my doctor knows it, then my instructions here will not be followed during the time I am still pregnant and the baby is living.

TREATMENT I DO **NOT** WANT
I do not want (put your initials by the services you do not want):
_____Cardiac resuscitation (start my heart pumping after it has stopped)
_____Mechanical respiration (machine breathing for me if my lungs have stopped)
_____Tube feeding (a tube in my nose or stomach that will feed me)
_____Antibiotics (drugs that kill germs)
_____Hydration (water and other fluids)
_____Other (indicate what it is here)

TREATMENT I **DO** WANT
I want (put your initial by the services you do want):
_____Medical services
_____Pain relief
_____All treatment to keep me alive as long as possible
_____Other (indicate what it is here)
_____

What I indicate here will happen, unless I decide to change it or decide not to have a living will at all. I can change my living will anytime I wish. I just have to let my doctor know I want to change it or forgo a living will entirely.
Signature: _____
Date: _____
Address: _____

Statement of witness
I am not related to this person by blood or marriage. I know that I would not get any part of the person's estate when he or she dies. I am not a patient in the health care facility where this person is a patient. I am not a person who has a claim against any part of this person's estate when he or she dies. Furthermore, if I am an employee of a health facility in which this person is a patient, I am not involved in providing direct patient care to him or her. I am not directly involved in the financial affairs of the health facility.

Witness: _____
Date: _____
Address: _____

Durable Power of Attorney Form

You can name a durable power of attorney by filling out this form. You can use another form or use the one your doctor gives you. If you name a durable power of attorney, give it to your Amerigroup network provider. If you need help to understand or complete this form, call Member Services at 1-800-600-4441.

I, (*Name*) **_____, want**
_____ _____,
(*Name of person I want to carry out my wishes*) (*Person's address*)

to make treatment decisions for me if I cannot. This person can make decisions when I am in a coma, not mentally able to or so sick I just cannot tell anyone. If the person I named is not able to do this for me, then I name another person to do it for me. This person is
_____ _____.
(*Name of second person I want to carry out my wishes*) (*Second person's address*)

TREATMENT I DO **NOT** WANT
I do not want (put your initials by the services you do not want):
_____Cardiac resuscitation (start my heart pumping after it has stopped)
_____Mechanical respiration (machine breathing for me if my lungs have stopped)
_____Tube feeding (a tube in my nose or stomach that will feed me)
_____Antibiotics (drugs that kill germs)
_____Hydration (water and other fluids)
_____Other (indicate what it is here)
_____

TREATMENT I **DO** WANT
I want (put your initial by the services you do want):
_____Medical services
_____Pain relief
_____All treatment to keep me alive as long as possible
_____Other (indicate what it is here)

What I indicate here will happen, unless I decide to change it or decide not to have a durable power of attorney at all. I can change my durable power of attorney anytime I wish. I just have to let my doctor know I want to change it or not have it at all.
Signature: _____
Date: _____
Address: _____

Statement of witness
I am not related to this person by blood or marriage. I know that I would not get any part of the person's estate when he or she dies. I am not a patient in the health care facility where this person is a patient. I am not a person who has a claim against any part of this person's estate when he or she dies. Furthermore, if I am an employee of a health facility in which this person is a patient, I am not involved in providing direct patient care to him or her. I am not directly involved in the financial affairs of the health facility.

Witness: _____ Date: _____
Address: _____

Provider Payment Dispute and Correspondence Submission Form

This form should be completed by providers for payment disputes and claim correspondence only.

Member first/last name _____ Date of birth _____

Member Amerigroup, Medicaid or Medicare ID (circle one) _____

Provider first/last name_____ NPI #_____
☐ Participating ☐ Nonparticipating*

* If filing for a Medicare member and the member has potential financial liability, you must include a completed CMS Waiver of Liability form.

Provider contact first/last name_____ Contact phone (____) _____

Provider street address_____

City_____ State_____ ZIP_____ Phone (_____) _____

Claim #_____ Billed amount $_____ Amount received $_____

Start date of service _____ End date of service _____ Auth #_____

To ensure timely and accurate processing of your request, please complete the payment dispute or claim correspondence section below by checking (✓) the applicable determination or request reason provided on the Amerigroup determination letter or Explanation of Payment (EOP).

PAYMENT DISPUTE: Check (✓) One → ☐ **First-level dispute** ☐ **Second-level dispute**
A payment dispute is defined as a dispute between the provider and Amerigroup in reference to a claim determination where the member cannot be held financially liable. All disputes with member liability must follow the applicable appeals process. Please refer to the EOP to ensure you are following the correct process.

Clearly and completely indicate the payment dispute reason(s). You may attach an additional sheet if necessary. **Please include appropriate medical records**.

CLAIM CORRESPONDENCE: Check (✓) appropriate box below.
Claim correspondence is defined as a request for additional and/or needed information for a claim to be considered clean, to be processed correctly or for a payment determination to be made.

☐ **Itemized bill/medical records** (In response to an Amerigroup claim denial or request)

☐ **Corrected claim** ☐ **Other insurance/third-party liability information** ☐ **Other correspondence**

Clearly and completely indicate the reason(s) for your correspondence. You may attach an additional sheet, if necessary. Mail this form and supporting documentation to:

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

Practitioner Office Site Evaluation Tool

AMERIGROUP PRACTITIONER SITE VISIT ASSESSMENT TOOL

INFORMATION BELOW MUST BE DOCUMENTED AT TOP OF EACH PAGE OF SITE VISIT FORM! ALL QUESTIONS MUST BE ANSWERED.

Physician/Practitioner Name(s): Last First

Last First

Last First

Last First

Office Address

Specialty(ies) **Date**

Phone Number:

Office Manager: Last First

Physician/Practitioner Name(s):

Last First

Last First

Last First

Reviewer Name Last First

		Point Value	Y	N	N/A	Point Score	
A.	**Physical Accessibility:**	**10**				0.00%	
1	Is there accessibility for people with disabilities? (First floor access, ramps or elevator access) If not, does staff have an alternative plan of action? Access throughout the office including bathroom(s)?	2					
2	Is accessible parking clearly marked? (Sign/painted symbol on pavement) Only applies to off-street parking; N/A if parking is street-side only.	1					
3	Are doorways and stairways that provide access free from obstructions at all times and allow easy access by wheelchair or stretcher?	2					
4	**FL Only:** If applicable, are stairwells protected by fire doors? Applies to facilities only	2					
5	Are exits clearly marked and is there emergency lighting in instances of power failure?	2					
6	Are building and office suite clearly identifiable (clearly marked office sign)?	1					0
B.	**Physical Appearance:**	**10**				0.00%	
1	Is the office clean, well kept and smoke free? (Neat appearance, no trash on floor, furniture in good repair, no significant spills on floors / furnishings)	2					
2	Is treatment area clean and well kept? (No significant spills on floors, counters or furnishings, no trash on floor)	2					
3	Does office have smoke detector(s)?	2					
4	Easy access to a clean, supplied bathroom? (Soap, toilet paper, hand towels and hand washing instructions)	1					
5	**FL Only:** If available, is the facility/office inspected annually by the local or state fire control agency?	1					
6	Is waiting room well lit?	1					
7	Fire extinguishers clearly present and fully charged and recently inspected (even if office has sprinkler system)?	1					0
C.	**Adequacy of Waiting and Examining Room Space:**	**10**				0.00%	
1	Is there adequate seating in the waiting area (based on number of physicians/practitioners)? *	1					
2	Does the staff provide extra seating when the waiting room is full?	1					
3	Is there a minimum of 2 exam rooms per scheduled provider? (2 consultation rooms for Behavioral Health (BH) Provider	1					
4	Is there privacy of exam/consultation rooms? (Doors or curtain closures; rooms cannot be visualized from waiting room)	1					
5	Are exam/consultation rooms reasonably sound proof? (Conversations cannot be heard from waiting room or other exam rooms)	2					
6	**FL Only:** Are all areas well lighted and well ventilated?	1					
7	An otoscope, ophthalmoscope, blood pressure cuff and scale readily accessible? N/A for BH Providers	1					
8	For OB/GYNs only or any physician/practitioner providing OB Care:						
	Does the office have the following readily accessible: (If not OB/GYN, check N/A)						
8a	- A fetalscope (DeLee and/or Dopler) and a measuring tape for fundal height measurement?	1					
8b	- Supplies for dipstick urine analysis (glucose, protein)?	1					0
	* 1 Provider = 6 seats, 2 Providers = 8 seats, 3 Providers = 11 seats, 4 Providers = 14 seats, 5 Providers = 17 seats						
D.	**Adequacy of Medical Records:**	**20**				0.00%	
1	Are there individual patient records?	2					
2	Are records stored in a manner which ensures confidentiality - are they kept in an area not accessible by patients?	2					
3	Are all items secured in the chart?	2					
4	Are medical records readily available? (Within 15 minutes of request) Ask them if they are.	2					
5	**Medical Recordkeeping practices:**						
5a	Is there a place to document allergies?	2					
5b	Is there a place to document current medication list?	2					
5c	Is there a place to document current chronic problems list?	2					
5d	Is there an immunization record on pediatric charts? N/A for BH Providers	2					
5e	Is there a growth chart on pediatric charts? N/A for BH Providers	2					
5f	Is there a place to document presence/absence and discussion of a patient self-determination / advance directive?	2					0
	(If not appropriate, check N/A)						

E.	**Appointment Availability**: Is the physician/practitioner available:	**13**				0.00%	
1	Routinely within a wait time of 45 minutes or less? (Ask office manager)	1					
2	At least 4 days or 20 hours per week? **NY:** At least 16 hours per week at this office location or has waiver been granted?	1					
3	**GA Only-All other Plans N/A:** PCP adult sick visits w/n 72 hrs. and/or PCP pediatric sick visits w/n 24 hrs.?	1					
4	**GA Only-All other Plans N/A:** Specialist visits w/n 30 calendar days of request?	1					
5	**GA Only-All other Plans N/A:** Mental Health Providers w/n 14 calendar days of request?	1					
6	**GA Only-All other Plans N/A:** Initial visit for pregnant women w/n 14days of request?	1					
7	24 hour call coverage for emergencies? (By themselves or by covering provider) Crisis Hotline **Yes/No (BH Providers only)**	1					
8	Urgent care within 24 hours?	1					
9	Routine/problem care within 2 weeks **FL, NM, NY, OH, TN,TX;** 10 days-**VA**, **MD/DC ;** 3 weeks-**GA**; 28 days-**NJ**	1					
10	All except GA - including first visit after pregnancy determination (excludes home pregnancy test)]? Please circle appropriate Health Plan						
11	Are phone lines adequate to handle volume of total patient population?	1					
12	Physical/wellness exams for adults within 30 days-**VA**, **MD/DC, FL, NM**, **NY, OH, TN;** 10 weeks **TX**; baseline physical for new members w/n 180 days of enrollment-NJ? Please circle appropriate Health Plan - N/A for BH Providers	1					
13	Physical/wellness exams for children within 30 days-**VA, MD/DC**, **FL, GA, NM, NY, OH, TN**; 2 months.-**TX and NJ**; from the date of contract/request? Please circle appropriate Health Plan - N/A for BH Providers	1					
14	**NJ Only:** Baseline physicals for new child members/adult members of DDD w/n 90 days of enrollment or according to EPSDT guidelines? - N/A for BH Providers and for all Plans except NJ	1					0
F.	**Documentation Evaluation:** Does the office have the following:	**17**				0.00%	
1	No-show follow-up procedure/policy? (If not written, can the staff verbally explain the process?)	2					
2	A chaperone policy? (If provider does not have written chaperone policy, office must provide statement on letterhead indicating chaperone will be in the exam room.) **THIS ELEMENT IS A MUST HAVE TO PASS SITE VISIT & PARTICIPATE**	2					
3	Is the Patient Bill of Rights posted? Are copies available upon request?	1					
4	Is Medical License/Occupational License displayed? Are the hours of operation posted?	1					
5	**TX and FL only:** Is there a posted notice of member complaint process?	1					
6	**FL Only:** Is the Statewide Consumer Call Center Number Posted? 1-800-962-2873	1					
7	**FL Only:** If Provider does not carry malpractice insurance, is required patient notification statement posted in prominent place in reception area?	1					
8	Is there a written policy for hand washing, gloved procedures, and disposal of sharps, etc.? May not be applicable for BH Providers in private practice setting.	2					
9	Is there a written OSHA Exposure Control Plan which includes Universal Precautions & Blood Born Pathogen exposure procedures for staff? May not be applicable for BH Providers	2					
10	**FL & TX Only:** Posted copy of CLIA Certificate or Certificate of Waiver, if applicable? **(Attach a copy to site evaluation tool)**	1					
	TX Only: PCPs providing TX HealthSteps services MUST have CLIA, CLIA Waiver or lab services on site within same bldg.						
11	**FL & TX Only:** Posted copy of current radiology services certification or licensure, if applicable? **(Attach a copy to site**	1					
12	If Provider employs NPs, PAs or other mid-level providers that will assesses health care needs of members, do they have written policies that describe duties and supervision of such providers?	2					0
G.	**HIPAA Requirements/Regulations**	**8**				0.00%	
1	Is there a written P & P addressing permitted uses/disclosures and required disclosures of patient PHI/IIHI?	2					
2	Does Provider have authorization forms available to designate Personal Representative(s) to which PHI/IIHI may be released and/or disclosed?	2					
3	Are there physical safeguards in place to protect the privacy of patient PHI/IIHI?	2					
4	Is there a designated Compliance & Privacy person? **Name:**_____	2					0
H.	**Office Evaluation**	**12**				0.00%	
1	Is there an approved process for bio-hazardous disposal (solid, liquid or gas) to ensure protection of members, staff & the environment?	2					
2	Are pharmaceutical supplies and medication stored in a locked area that is not readily accessible to patients?	2					
3	Is there a plan/procedures for narcotic inventory, control and disposal?	1					
4	Are vaccines and other biologicals refrigerated, as appropriate?	1					
5	**FL Only:** Facilities only - Is alternate power source available in operative, treatment & recovery areas to ensure life and safety of members?	1					
6	**FL Only:** Facilities only: Are food snacks handled & maintained within a clean environment to support patients with special nutritional needs?	1					
7	**FL Only:** Is there documentation of periodic instruction of personnel in proper use of safety, emergency and fire extinguishing equipment?	1					
8	Is emergency equipment available (an oral airway and ambu bag)? If not, note how staff accommodates emergency situations. Physician or Physician Extender trained in CPR?	1					
9	Observe 2-3 office staff interactions: Are they professional and helpful?	2					0
	To complete the form, answer every question, then total the number of points and record here.	**100**			**TOTAL**	**0**	

A copy of this complete profile was received by:

_____ Office Manager / Physician/Practitioner **(please circle one)**

Office Manager/Physician/Practitioner Signature

REMINDER - DO NOT DEDUCT POINTS FOR THOSE QUESTIONS THAT ARE ANSWERED N/A
INCLUDE THOSE POINTS FOR N/A ANSWERS IN TOTAL SCORE

REMINDER - IF PROVIDER HAS A CLIA CERTIFICATE/CERTIFICATE OF WAIVER AND/OR RADIOLOGY LICENSURE
YOU MUST ATTACH A COPY OF THE DOCUMENTS TO THIS SITE VISIT FORM

APPENDIX B. CLINICAL GUIDELINES

As part of its quality improvement process, Amerigroup adopts nonpreventive and preventive clinical practice guidelines for acute and chronic medical and behavioral health conditions that are scientific and evidenced-based. This is determined by scientific evidence, review of government research sources, review of clinical or technical literature, involvement of board-certified practitioners from appropriate specialties or professional standards. Recognized sources of the evidenced-based guidelines include national organizations such as the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH), professional medical-specialty organizations such as the American Academy of Pediatrics (AAP), American College of Obstetrics and Gynecologists (ACOG), American Academy of Family Practice (AAFP) and voluntary health organizations as the American Diabetes Association (ADA) and American Cancer Society (ACS). The American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), Texas Implementation of Medication Algorithm (TIMA) and Texas Medicaid Algorithm Project (TMAP) are currently more specific sources recognized for behavioral health guidelines. Other sources that may be referenced in developing or updating behavioral health guidelines include organizations such as the Substance and Mental Health Services Administration (SMHSA) and National Institute of Mental Health (NIMH). The guidelines are based on valid and reliable clinical evidence, a consensus of health care professionals in a particular field and the needs of the members. The guidelines are adopted and approved in consultation with network health care professionals. They are reviewed and updated periodically as appropriate, but at a minimum of every two years. Amerigroup will disseminate the guidelines to all affected providers and, upon request, to members and potential members. The Amerigroup decisions regarding disease management, case management, utilization management, member education, coverage of services and other areas included in the guidelines, will be consistent with Amerigroup guidelines. Data is gathered and monitored using HEDIS, ad hoc medical records review and other sources to measure performance against the guidelines and improve the clinical care process.

Visit https://provider.amerigroup.com/MD and select **Resources** and then **Provider policies, guidelines & manuals**. On this page you will find the *Clinical Practice Guidelines Matrix*. A copy of the guidelines can be printed from the website or you can contact Provider Services at 1-800-454-3730 to receive a copy.