AMERIGROUP® Community Care

Provider Quick Reference Card

AMERIGROUP District of Columbia, Inc.

www.amerigroupcorp.com/providers

1-800-454-3730

LIVE WELL • VIVA BIEN

SERVICE, REQUIREMENTS, AND COMMENTS

ALLERGY SERVICES
No preauthorization required in office
Allergy testing does not require preauthorization if performed in a participating physician's office or participating hospital outpatient department.

BEHAVIORAL HEALTH/SUBSTANCE ABUSE
See comments
Primary mental healthcare may be furnished by the member's PCP. Preauthorization is required for coverage of inpatient admission, partial hospitalization and residential treatment. Coverage of initial outpatient treatment requires notification for initial 10 therapy sessions and medication management. Treatment plan completion is required for ongoing therapy sessions. **Coordination of physical and behavioral healthcare is essential.**

CARDIAC REHABILITATION
Preauthorization
Preauthorization is required for coverage of all services.

CHEMOTHERAPY
See comments
No preauthorization is required for coverage of chemotherapy procedures and medications when performed in the following outpatient settings by a participating facility or provider: office, outpatient hospital and ambulatory surgery center. **Note**: Preauthorization is required for coverage of inpatient services.

DENTAL SERVICES
Self-referral
- No preauthorization is required for coverage of procedure code 41899 when billed with diagnosis code 520-5239 or 525-5259. For TMJ services, see Plastic/Cosmetic/Reconstructive Surgery.
- Members under age 21, dental benefits include coverage of semiannual cleaning, fluoride treatment and exams. Members age 21 and older, dental benefits include coverage of oral exams, semiannual cleaning and X rays. Contact Doral Dental at 1-800-608-9542.

DERMATOLOGY SERVICES
No preauthorization required in office
Non-E&M level testing and procedures performed in a clinic/outpatient facility/ambulatory surgery center require preauthorization for coverage of services that may be considered cosmetic in nature. For cosmetic services, see Plastic/Cosmetic/Reconstructive Surgery.

DIAGNOSTIC TESTING
See comments
- No preauthorization is required for coverage of routine X rays, EKGs and ultrasounds performed in a network physician's office or a network facility or tests performed in conjunction with an inpatient stay.
- No preauthorization is required by the ordering physician for coverage of OB diagnostic testing for ultrasounds, Biophysical Profile (BPP) and Non-Stress Tests (NST).
- Preauthorization is required for coverage of MRA, MRI, CAT scans, nuclear cardiac, PET scans and sleep studies.
- Preauthorization is required for coverage of amniocentesis based on high-risk OB diagnosis.

DIALYSIS
See comments
Members have open access to Medicare approved dialysis centers. No preauthorization is required for coverage of dialysis procedures including medications when performed in a participating, end-stage renal disease treatment facility. **Note:** Preauthorization is required for coverage of services rendered in all other locations.

DURABLE MEDICAL EQUIPMENT (DME)
Preauthorization & Certificate of Medical Necessity
- No preauthorization is required for coverage of glucometers and nebulizers.
- Preauthorization is required for coverage of all prosthetics and orthotics and DME. See Medical Supplies for guidelines relating to disposable medical supplies.
- Preauthorization as well as a Certificate of Medical Necessity (CMN) is required for the following: hospital beds, support surfaces, motorized wheelchairs, manual wheelchairs, continuous positive airway pressure (CPAP), lymphedema pumps, osteogenesis stimulators, transcutaneous electrical nerve stimulator (TENS), seat lift mechanism, power operated vehicle (POV), external infusion pump, parenteral nutrition equipment, enteral nutrition equipment and oxygen. AMERIGROUP and provider must agree on HCPCS and/or other codes for billing covered services. All custom wheelchair preauthorizations require Medical Director's review.
- Preauthorization may be requested by completing a CMN– available at www.amerigroupcorp.com – or by submitting a physician order with an AMERIGROUP Referral and Authorization Request form.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) VISIT
Self-referral
Utilize EPSDT schedule and **document** visits/encounters on a CMS 1500 claim form.

EDUCATIONAL CONSULTATION
No notification or preauthorization is required.

EMERGENCY ROOM
Self-referral
Emergency care in the ER does not require notification. If emergency care results in an observation or admission, notification to AMERIGROUP is required within 24 hours or the next business day.

ENT SERVICES (OTOLARYNGOLOGY)
No preauthorization required in office
Non-E&M level testing and procedures performed in a clinic/ outpatient facility/ambulatory surgery center require preauthorization for coverage.

FAMILY PLANNING/STD CARE

Self-referral

Member may self-refer to any Qualified Family Planning provider regardless of whether the provider is a network or non-network provider for the following services:

- Prevention of pregnancy
- Pregnancy testing
- Counseling
- STD care
- Abortions as permitted under federal law

Additional services:

- No coverage for infertility treatment
- Depo-provera is covered with no preauthorization. A pregnancy test is required prior to administration of injectable contraceptives.
- Norplant insertion or removal is covered with no preauthorization.
- IUD requires preauthorization.
- Sterilization for members over age 21. Tubal ligation does not require notification and/or preauthorization, and member must sign approved sterilization form at least 30 days prior to the procedure. Vasectomy requires notification.

GASTROENTEROLOGY SERVICES

No preauthorization required in office

Non-E&M level testing and procedures performed in a clinic/outpatient facility/ambulatory surgery center require preauthorization for coverage.

GYNECOLOGY

No preauthorization required in office

Non-E&M level testing and procedures performed in a clinic/outpatient facility/ambulatory surgery center require preauthorization for coverage of hysterectomy by any approach, myomectomy by any approach, hysteroscopy or laparoscopy procedures.

HEARING AIDS

See comments

Hearing aids are available for members under age 21 as related to EPSDT services.

HEARING SCREENING/AUDIOLOGY

See comments

- No notification or preauthorization is required for the coverage of diagnostic and screening tests, hearing aid evaluations or counseling.
- No coverage for members age 21 and older unless medically necessary.

HOME HEALTHCARE

Preauthorization

Preauthorization is required for coverage of procedures and services.

HOSPICE CARE

See comments

Preauthorization is required for coverage of all procedures performed in a hospice. Preauthorization is required for Home Healthcare and DME.

HOSPITAL ADMISSIONS

Preauthorization

- Elective admissions require preauthorization for coverage.
- Emergency admissions require notification within 24 hours or next business day. If the insurance information was not communicated to the Hospital by the patient upon admission, then notification to AMERIGROUP is within 24 hours of the time when the hospital learned of the insurance information.
- Preadmission testing is a covered benefit and requires preauthorization. Preadmission testing must be performed by an AMERIGROUP preferred lab vendor. See Provider Referral Directory for a complete listing of participating vendors.
- Same-day admission is required for surgery.

LABORATORY SERVICES (OUTPATIENT)

See comments

- No notification or preauthorization is required if lab work (including RAST, Allergy testing and Genetic testing) is performed in a participating physician's office, participating hospital outpatient department or by an AMERIGROUP preferred lab vendor.
- All laboratory services furnished by non-participating providers require preauthorization by AMERIGROUP, except for hospital laboratory services in the event of an emergency medical condition.

MEDICAL SUPPLIES

See comments

No preauthorization is required for coverage of disposable medical supplies.

NEUROLOGY

Preauthorization

Non-E&M level testing and procedures require preauthorization for coverage.

OBSERVATION (OBSTETRICAL AND MEDICAL)

Notification

Notification within one business day is required for coverage of observation. A minimum observation period of six hours is required. If admission occurs, all charges for observation services "roll up" into the admission. Physician's order and submitted claim form must state "observation."

OBSTETRICAL CARE

See comments

- No preauthorization is required for coverage of obstetrical services when performed by a participating provider.
- Notification to AMERIGROUP is required at the FIRST prenatal visit.
- Notification of delivery is required with newborn information.
- Preauthorization is required for coverage of amniocentesis based on high-risk OB diagnosis.. OB case management programs are available.
- See Diagnostic Testing.

OPHTHALMOLOGY

No preauthorization required in office

Non-E&M level testing and procedures performed in a clinic/outpatient facility/ambulatory surgery center require preauthorization for coverage. See Vision Care.

ORAL MAXILLOFACIAL

See comments

See Plastic/Cosmetic/Reconstructive Surgery.

OTOLARYNGOLOGY (ENT) SERVICES

No preauthorization required in office

Non-E&M level testing and procedures performed in a clinic/outpatient facility/ambulatory surgery center require preauthorization for coverage.

OUT-OF-AREA/OUT-OF-PLAN CARE

Preauthorization

Preauthorization is required except for emergency care (including self-referral) and OB delivery. However, a woman in active labor is covered under EMTALA and is not subject to preauthorization requirements.

OUTPATIENT/AMBULATORY SURGERY

Preauthorization and Plan of Care

Preauthorization and plan of care are required for coverage of the following service types regardless of the specialty of the provider: chiropractic, dermatology, ENT (otolaryngology), gastroenterology, neurology, ophthalmology, oral maxillofacial, pain management, plastic/cosmetic, podiatry and any out-of-area/out-of-plan outpatient or ambulatory surgery.

PAIN MANAGEMENT

Preauthorization

Non-E&M level testing and procedures require preauthorization for coverage.

PERINATOLOGY

See comments

Notification to AMERIGROUP is required. See Diagnostic Testing.

PHARMACY

See comments

Closed formulary. Prescribed drugs limited to legend drugs approved as safe and effective by the FDA and over-the-counter medications in the District specified categories. Those over-the-counter drugs that fall into the following categories are covered if they are prescribed on a written prescription by a healthcare professional:

- Oral analgesics
- Ferrous sulfate
- Antacids
- Diabetic preparations
- Pediatric and prenatal vitamin formulations
- Selma extract, single dose preparations when required for diagnostic radiological procedures performed under the supervision of a participating provider
- Family planning drugs and supplies
- Psychotropic medications approved by the Dixon Transitional Receiver

Additionally, there is an OTC Enhanced Benefit which is limited to $15 per quarter for each member (includes acetaminophen, antifungal vaginal products, ibuprofen and pediculicides). The OTC Enhanced Benefit requires a written prescription.

PHYSIATRY

See comments

Preauthorization is required for coverage of all services and procedures related to pain management.

PHYSICAL MEDICINE & REHABILITATION

See comments

Preauthorization is required for coverage of all services and procedures related to pain management.

PLASTIC/COSMETIC/RECONSTRUCTIVE SURGERY (INCLUDING ORAL MAXILLOFACIAL SERVICES)

See comments

- No preauthorization is required for coverage of E&M codes.
- All other services require preauthorization for coverage. Services considered cosmetic in nature are not covered. Services related to previous cosmetic procedures are not covered (i.e., scar revision, keloid removal resulting from pierced ears). Reduction mammoplasty requires Medical Director's review.
- No preauthorization is required for coverage of oral maxillofacial E&M services.
- Preauthorization is required for coverage of trauma to the teeth and oral maxillofacial medical and surgical conditions.

PODIATRY

See comments

- No preauthorization for E&M visits is required when provided by a participating podiatrist.
- Non-E&M level testing and procedures require preauthorization for coverage.
- Notification is required for coverage of annual diabetic foot exam.
- Preauthorization is required for coverage of all other services.

RADIATION THERAPY

See comments

No preauthorization is required for coverage of radiation therapy procedures when performed in the following outpatient settings by a participating facility or provider: office, outpatient hospital and ambulatory surgery center. **Please note that CAT scans, nuclear cardiology, MRA, MRI and PET scans will continue to require preauthorization for coverage.**

RADIOLOGY

See comments

See Diagnostic Testing.

REHABILITATION THERAPY (SHORT TERM): OT, PT, RT & ST

See comments

Notification is required upon initial visit. Preauthorization is required for coverage of subsequent visits from AMERIGROUP. No speech therapy services are covered for members age 21 and older unless medically necessary. ECI program for members' age 0 to 3, no preauthorization required for PT, OT and ST.

SKILLED NURSING FACILITY

Preauthorization

Preauthorization is required for coverage.

SERVICE, REQUIREMENT AND COMMENTS

STERILIZATION

See comments

- Sterilization services are a covered benefit for members age 21 and older.
- No preauthorization or notification is required for coverage of sterilization procedures including tubal ligation and member must sign an approved sterilization form at least 30 days prior to the procedure. Vasectomy requires notification.
- **Sterilization consent form is required for claims submission.**
- Reversal of sterilization is not a covered benefit.

TERMINATION OF PREGNANCY

Preauthorization

AMERIGROUP is required to provide coverage of abortions as permitted under federal law and District of Columbia rules and regulations which includes:

- None of the funds appropriated under this Act shall be expended for any abortion except where the life of the mother would be endangered if the fetus were carried to term or where the pregnancy is the result of rape or incest.

TRANSPORTATION

Self-referral

Members can contact AMERIGROUP Member Services at 1-800-600-4441 or contact Logisticare at 1-800-894-8124 for assistance in scheduling transportation with five days prior notice. EPSDT and/or urgent care services do not require five days prior notice for transportation.

URGENT CARE CENTER

See comments

No notification or preauthorization is required for participating facility.

VISION CARE (MEDICAL)

See comments

See Ophthalmology.

VISION CARE (ROUTINE)

Self-referral

Members may contact Block Vision at 1-800-428-8789.

WELL-WOMAN EXAM

Self-referral

See benefit limitation in Provider Manual.

OTHER SPECIALTY CARE SERVICES COVERAGE GUIDELINES

ENDOCRINOLOGY

No notification/preauthorization required

Provider may refer to specialty without notification/preauthorization from AMERIGROUP.

GENETICS

No notification/preauthorization required

Provider may refer to specialty without notification/preauthorization from AMERIGROUP.

GERIATRIC MEDICINE

No notification/preauthorization required

Provider may refer to specialty without notification/preauthorization from AMERIGROUP.

HIV SPECIALIST/INFECTIOUS DISEASES

No notification/preauthorization required

Provider may refer to specialty without notification/preauthorization from AMERIGROUP.

NEPHROLOGY

No notification/preauthorization required

Provider may refer to specialty without notification/preauthorization from AMERIGROUP.

ONCOLOGY/HEMATOLOGY

No notification/preauthorization required

Provider may refer to specialty without notification/preauthorization from AMERIGROUP.

PULMONOLOGY

No notification/preauthorization required

Provider may refer to specialty without notification/preauthorization from AMERIGROUP.

RHEUMATOLOGY

No notification/preauthorization required

Provider may refer to specialty without notification/preauthorization from AMERIGROUP.

DEFINITIONS

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

NOTIFICATION: Prior to rendering covered medical services, the provider must notify AMERIGROUP by telephone, fax or email of the intent to do so. There is no review against medical necessity criteria. However, member eligibility and provider status (network and non-network) are verified. Additionally, primary care physicians must coordinate all specialist referrals in accordance with managed care principles. Members may self-refer for obstetrical, gynecological, family planning and outpatient behavioral health services without PCP coordination or prior authorization. Participating specialists are not required to submit referral forms with claims.

ADMINISTRATIVE SERVICES

PROVIDER SERVICES
TELEPHONE: 1-800-454-3730
AMERIGROUP Provider Services offers preauthorization, case management, health education materials, outreach and more to providers Monday through Friday from 8:00 a.m. to 6:00 p.m. Eastern Time.

PREAUTHORIZATION / NOTIFICATION
TELEPHONE: 1-800-454-3730
FAX: 1-800-964-3627
Preauthorization/notification may be called in or faxed to AMERIGROUP. AMERIGROUP's process is designed to provide you with the results orally or by fax within two business days. **Note:** Behavioral Health information may be faxed to a dedicated fax number at 1-800-505-1193.

ADMINISTRATIVE COMPLAINTS
Administrative complaints/appeals must be filed within 90 business days of the adjudication date of the Explanation of Payment. Forms for provider appeals are located on our web site at www.amerigroupcorp.com and should be sent to the following address: AMERIGROUP CENTRALIZED APPEALS TEAM • POST OFFICE BOX 61599 • VIRGINIA BEACH, VA 23466-1599.

CLAIMS SERVICES

ELECTRONIC DATA INTERCHANGE (EDI)
TELEPHONE: 1-800-590-5745
AMERIGROUP is requiring all submitters of Institutional claims to use the new UB-04 form. The same submission requirement applies to Professional claims to use the new CMS-1500 (08-05) form that has been approved by the National Uniform Claim Committee (NUCC) effective July 2, 2007. If a claim is received after July 2, 2007 on any other form but the UB-04 or the CMS-1500 (08-05) form, the claim will be returned to the submitter for reprocessing.

To provide faster and more accurate claims adjudication, AMERIGROUP offers electronic claims submission through electronic data interchange (EDI). AMERIGROUP accepts claims electronically through two clearinghouses: Emdeon (formerly WebMD) and MedAvant (formerly ProxyMed). The clearinghouse and appropriate payor number is 27517 for Emdeon and 28807 for MedAvant.

PAPER CLAIMS
AMERIGROUP utilizes optical character recognition (OCR) technology as part of its front-end claims processing procedures. Timely filing is within 180 days from the date of service. In order to use OCR technology, your claims must be submitted on original claim forms (CMS 1500 or UB 92) with "dropout" red ink, printed or typed (not handwritten) in large, dark font. Mail paper claims to the following address: **Medical/Surgical** AMERIGROUP COMMUNITY CARE • POST OFFICE BOX 61697 • VIRGINIA BEACH, VA 23466-1697 • **Substance Abuse** AMERIGROUP COMMUNITY CARE • POST OFFICE BOX 61737 VIRGINIA BEACH, VA 23466-1737 • **Please note: AMA & CMS-approved modifiers must be used appropriately based on the type of service and procedure code.**

MEDICAL APPEALS
Medical appeals can be initiated by the member or the provider on behalf of the member and must be submitted within 30 calendar days from receipt of an adverse determination. Medical appeals can be submitted in writing to the following address: AMERIGROUP CENTRALIZED APPEALS PROCESSING • POST OFFICE BOX 61599 • VIRGINIA BEACH, VA 23466-1599 • A provider submitting on behalf of a member can provide a letter or complete a provider appeals form located on our web site at www.amerigroupcorp.com.

HEALTH SERVICES

CARE MANAGEMENT SERVICES
TELEPHONE: 1-800-454-3730
AMERIGROUP offers care management services to members who are likely to have extensive healthcare needs. The Nurse Care Manager works with you to develop individualized care plans. This includes identifying community resources, providing health education, monitoring compliance, assisting with transportation, etc.

24/7/365 NURSE HELPLINE
TELEPHONE: 1-800-600-4441
Members may call our 24-hour Nurse HelpLine for nursing advice, seven days a week, 365 days a year. When a member accesses this service, a report will be faxed to your office within 24 hours of receipt of the call.

AMERIGROUP ASSIST AND PROVIDER INQUIRY LINE

AVAILABLE 24/7/365

AMERIGROUP now provides an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status and referral authorization status. Visit our web site at **www.amerigroupcorp.com/providers**.

TELEPHONE: 1-800-454-3730

For those times when you can't access the internet, you can receive claims, eligibility and referral authorization status over the telephone anytime by calling us toll free. Using your telephone keypad, enter your AMERIGROUP participating provider number when prompted by the recorded voice. It's easy! The recording guides you through a menu of options, allowing you to select the information or materials you need.