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If you are interested in applying for participation with the Amerigroup Community Care network, please visit www.amerigroupcorp.com/providers and complete the online Provider Application Request. You may also call Provider Services at the National Customer Care Department at 1-800-454-3730.
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2 OVERVIEW

3 QUICK REFERENCE INFORMATION

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   Provider Specialties

   PCP On-site Availability

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INTRODUCTION

Welcome to the Amerigroup Community Care network provider family. Incorporated as Amerigroup New Jersey, Inc., we are pleased you have joined the network, which represents some of the finest health care providers in the state.

Amerigroup is a licensed Health Maintenance Organization (HMO). We bring the best expertise available nationally to operate local community-based health care plans with experienced local staff to complement our operations. We are committed to assisting you in providing quality health care.

Amerigroup believes that physicians, hospitals and other providers play a pivotal role in managed care. Amerigroup can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, quality provider network. All network providers are contracted with Amerigroup through a Participating Provider agreement.

If you are interested in participating in any of our quality improvement committees or learning more about specific policies, please contact us. Most committee meetings are prescheduled at times and locations intended to be convenient for you. Please call Provider Services at our National Customer Care Department at 1-800-454-3730 with any suggestions, comments or questions that you may have. Together, we can arrange for and provide an integrated system of coordinated, efficient and quality care for our members.
Who is Amerigroup?
Amerigroup is a wholly owned subsidiary of Amerigroup Corporation. As a leader in managed health care services for the public sector, the Amerigroup Corporation subsidiary health plans provide health care coverage exclusively to eligible low-income families, children, pregnant women and those in Medicaid managed care plans.

Mission
The Amerigroup mission is to operate a community-focused managed care company with an emphasis on the public sector health care market. Amerigroup will coordinate the members’ physical and behavioral health care, offering a continuum of education, access, care and outcome programs, resulting in improved quality, lower cost and better health status for these Americans.

Strategy
Our strategy is to:
- Improve access to preventive primary care services by ensuring the selection of a Primary Care Provider (PCP) who will serve as provider, case/care manager and coordinator for all basic medical services
- Improve the health status and outcomes of the members
- Educate members about their benefits, responsibilities and the appropriate use of health care services
- Encourage stable, long-term relationships between providers and members
- Discourage medically inappropriate use of specialists and emergency rooms
- Commit to community inappropriate use of specialists and emergency rooms
- Commit to community-based enterprises and community outreach
- Facilitate the integration of physical and behavioral health care
- Foster quality improvement mechanisms that actively involve providers in re-engineering health care delivery
- Encourage a customer service orientation with regular measurement of member and provider satisfaction

Summary
Escalating health care costs are driven in part by a pattern of fragmented, episodic care and unmanaged health problems of members. Amerigroup strives to educate members to encourage the appropriate use of the managed care system and to be involved in all aspects of their health care.
3 QUICK REFERENCE INFORMATION

Please call Provider Services at the National Customer Care department for precertifications and notifications, health plan network information, member eligibility, claims information, inquiries and recommendations you may have about improving our processes and managed care program.

<table>
<thead>
<tr>
<th>Amerigroup Telephone Numbers</th>
<th>Hours of Operation*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Services at the National Contact Center: 1-800-454-3730</td>
<td>Monday – Friday 8:00 a.m. to 6:00 p.m.</td>
</tr>
<tr>
<td>Notification/Precertification Fax: 1-800-964-3627</td>
<td>Available 24 hours a day/7 days a week</td>
</tr>
<tr>
<td>AT&amp;T Relay Service for English: 1-800-855-2880</td>
<td>Available 24 hours a day/7 days a week</td>
</tr>
<tr>
<td>AT&amp;T Relay Service for Spanish: 1-800-855-2884</td>
<td>Available 24 hours a day/7 days a week</td>
</tr>
<tr>
<td>Automated Provider Inquiry Line for Member Eligibility: 1-800-454-3730</td>
<td>Available 24 hours a day/7 days a week</td>
</tr>
<tr>
<td>Nurse HelpLine: 1-800-600-4441</td>
<td>Available 24 hours a day/7 days a week</td>
</tr>
<tr>
<td>Member Services: 1-800-600-4441</td>
<td>Monday – Friday 7:00 a.m. to 7:00 p.m.</td>
</tr>
<tr>
<td>Pharmacy Services: 1-800-454-3730</td>
<td>Monday – Friday 8:00 a.m. to 7:00 p.m. Saturday 10:00 a.m. to 2:00 p.m.</td>
</tr>
<tr>
<td>Electronic Data Interchange (EDI) Hotline: 1-800-590-5745</td>
<td>Available 24 hours a day/7 days a week; voice mail capability for after normal business hours</td>
</tr>
<tr>
<td>Dental Services: Healthplex 1-888-468-2183</td>
<td>Monday – Friday, 8:00 a.m. to 5:00 p.m.</td>
</tr>
<tr>
<td>Block Vision: 1-866-819-4298</td>
<td>Monday – Friday, 8:00 a.m. to 6:00 p.m.</td>
</tr>
<tr>
<td>National Imaging Associates, Inc. (Radiology Management): 1-800-642-7565</td>
<td>Monday – Friday, 8:00 a.m. to 8:00 p.m.</td>
</tr>
<tr>
<td>LabCorp (Laboratory Services): 1-888-LABCORP</td>
<td>Monday – Friday, 8:00 a.m. to 5:00 p.m.</td>
</tr>
</tbody>
</table>

*All hours of operation are Eastern Time.

www.amerigroupcorp.com/providers

Amerigroup provides access to a website that contains a full complement of online provider resources. The website features an online provider inquiry tool for real-time eligibility, claims status and precertification/notification status. In addition, the website provides general information that is helpful for the provider, such as forms, Preferred Drug List (PDL), drugs requiring a prior authorization, provider manuals, referral directories, provider newsletters, claims status, Electronic Remittance
Advice (ERA) and Electronic Funds Transfer (EFT) information, updates, clinical guidelines, and other information to assist providers in working with Amerigroup. The website may be accessed at: www.amerigroupcorp.com/providers.

**Ongoing Provider Communications**

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

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

<table>
<thead>
<tr>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Eligibility</strong></td>
</tr>
<tr>
<td>• Call the Provider Inquiry Line at 1-800-454-3730</td>
</tr>
<tr>
<td><strong>Enrollment/Disenrollment</strong></td>
</tr>
<tr>
<td>• For NJ FamilyCare enrollment, call the state of New Jersey at 1-800-701-0710</td>
</tr>
<tr>
<td>• NJ FamilyCare/Medicaid HelpLine: 1-800-356-1561</td>
</tr>
<tr>
<td><strong>Notification/Precertification</strong></td>
</tr>
<tr>
<td>• May be telephoned, faxed or submitted online to Amerigroup:</td>
</tr>
<tr>
<td>Telephone: 1-800-454-3730</td>
</tr>
<tr>
<td>Fax: 1-800-964-3627</td>
</tr>
<tr>
<td>Website: <a href="http://www.amerigroupcorp.com/providers">www.amerigroupcorp.com/providers</a></td>
</tr>
<tr>
<td>• Data required for complete notification/precertification:</td>
</tr>
<tr>
<td>o Member ID number</td>
</tr>
<tr>
<td>o Legible name of referring provider</td>
</tr>
<tr>
<td>o Legible name of individual referred to provider</td>
</tr>
<tr>
<td>o Number of visits and/or services</td>
</tr>
<tr>
<td>o Dates of service</td>
</tr>
<tr>
<td>o Diagnosis</td>
</tr>
<tr>
<td>• In addition, clinical information is required for precertification</td>
</tr>
<tr>
<td>• Referral and Authorization forms are located at</td>
</tr>
<tr>
<td><a href="http://www.amerigroupcorp.com/providers">www.amerigroupcorp.com/providers</a></td>
</tr>
<tr>
<td><strong>Claims Information</strong></td>
</tr>
<tr>
<td>• <strong>Submit paper claims to:</strong></td>
</tr>
<tr>
<td>Amerigroup Community Care</td>
</tr>
<tr>
<td>P.O. Box 61010</td>
</tr>
<tr>
<td>Virginia Beach, VA 23466-1010</td>
</tr>
<tr>
<td>• <strong>Electronic claims Payer ID:</strong></td>
</tr>
<tr>
<td>o Emdeon (formerly WebMD) is 27514</td>
</tr>
<tr>
<td>o Capario (formerly MedAvant) is 28804</td>
</tr>
<tr>
<td>o Avalidity (formerly THIN) is 26375</td>
</tr>
<tr>
<td>• Timely filing is within 180 days of the last date of service of the course of treatment, according to state law (N.J.A.C. 11:22-3.6).</td>
</tr>
<tr>
<td>• Amerigroup provides an online resource designed to significantly reduce the time your office spends on eligibility verification, claims</td>
</tr>
</tbody>
</table>
**Additional Information**


- If you are unable to access the Internet, you may receive claims, eligibility and precertification status over the telephone by calling our toll-free automated Provider Inquiry Line at 1-800-454-3730.

**Medical Appeal Information**

- Medical appeals must be filed within 60 days of the date of the adverse determination letter.
- Medical appeals require medical documentation and may be initiated with or without member consent.
- **File an appeal to:**
  
  Appeals Department  
  Amerigroup Community Care  
  399 Thornall St., Ninth Floor  
  Edison, NJ 08837

**Provider Payment Dispute**

- Provider Payment Disputes must be filed within 90 calendar days of the date of the EOP. Amerigroup will send a determination letter within 30 calendar days of receiving all necessary information. If the provider is dissatisfied with the resolution, the provider may submit a dispute regarding the resolution within 30 calendar days of receipt of the notification.
- **File a Payment Dispute to:**
  
  Payment Dispute Unite  
  Amerigroup Community Care  
  P.O. Box 61599  
  Virginia Beach, VA 23466-1599

**Provider Grievances**

- **Provider Grievances should be submitted to:**
  
  Amerigroup Community Care  
  P.O. Box 62509  
  Virginia Beach, VA 23466-2509

**Member Grievances**

- A member may telephone Amerigroup Member Services at 1-800-600-4441 or write to the following address:
  
  Quality Management Department  
  Amerigroup Community Care  
  399 Thornall Street, Ninth Floor  
  Edison, NJ 08837

- A member may receive assistance with a complaint by writing to the following address:
  
  NJ FamilyCare/Medicaid  
  P.O. Box 712  
  Trenton, NJ 08625-0712

**Case/Care Managers**

- Amerigroup case/care managers are available during normal business hours from 8:00 a.m. to 5:00 p.m. Eastern Time.
- For urgent issues, assistance is available after normal business hours, on weekends and on holidays through the Provider
<table>
<thead>
<tr>
<th><strong>Additional Information</strong></th>
<th>Services Line at 1-800-454-3730.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider Services Representatives</strong></td>
<td>Representatives are assigned to service areas based on New Jersey counties. For more information, contact Provider Services at the National Customer Care department at 1-800-454-3730.</td>
</tr>
</tbody>
</table>
4 PRIMARY CARE PROVIDERS

PCP Role

The Primary Care Provider (PCP) is a network provider who has the responsibility for the complete care of his or her patient, who is an Amerigroup member. The PCP serves as the entry point into the health care system for the member. The PCP is responsible for the complete care of his or her patient, including providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services, and maintaining the continuity of care. The PCP responsibilities shall include at a minimum:

- Managing the medical and health care needs of members to ensure all medically necessary services are made available in a timely manner
- Monitoring and follow-up on care provided by other medical service providers for diagnosis and treatment, to include services available under Medicaid Fee-For-Service (FFS)
- Maintaining a medical record of all services rendered by the PCP and other referral providers
- Advising and performing recommended preventive care screenings and routine well-care services

A PCP must be a physician or network provider/subcontractor who provides or arranges for the delivery of medical services, including case/care management, to ensure all services which are found to be medically necessary are made available in a timely manner. The PCP may practice in a solo or group setting or may practice in a clinic (e.g., a Federally Qualified Health Center [FQHC] or Rural Health Center [RHC]) or outpatient clinic.

Amerigroup encourages enrollees to select a PCP who provides preventive and primary medical care, as well as authorization and coordination of all medically necessary specialty services. Members are encouraged to make an appointment with their PCP within 90 calendar days of their effective date of enrollment.

FQHCs and RHCs may function as a PCP. Providers must arrange for coverage of the following services to assigned members:

- PCP is available 24 hours a day, 7 days a week in person or by an on-call physician
- Providers must answer emergency telephone calls from members within 15 minutes
- Each PCP must provide a minimum of 20 office hours per week of personal availability as a PCP within each county in which they have a practice.

The New Jersey Division of Medical Assistance and Health Services (DMAHS) administers the NJ Medicaid/FamilyCare program. This includes Medicaid recipients, NJ FamilyCare members, Supplemental Security Income (SSI) members and clients of the Division of Developmental Disabilities (DDD) in New Jersey. See Section 5 — Amerigroup Health Care Benefits and Copayments for a detailed list of covered services for each specific category.

Amerigroup requests that providers help identify members who qualify for coverage. If you know of or identify potential eligibles that may be entitled to NJ FamilyCare/Medicaid coverage, please ask them to call a state of New Jersey health benefits coordinator at 1-800-701-0710 or the Amerigroup NJ FamilyCare/Medicaid HelpLine at 1-877-453-4080.
Provider Specialties

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

- Family practitioner
- General practitioner
- General pediatrician
- General internist
- Nurse practitioners certified as specialists in family practice or pediatrics
- Certified nurse midwives
- OB/GYNs
- Specialist physicians
- Physician assistants

PCP On-site Availability

Amerigroup is dedicated to ensuring access to care for its members, and this depends upon the accessibility of network providers. Amerigroup network providers are required to abide by the following standards:

- PCPs must offer 24-hour-a-day, 7-day-a-week telephone access for members.
- A 24-hour telephone service may be used. The service may be answered by a designee such as an on-call physician or nurse practitioner with physician backup, an answering service or a pager system; however, this must be a confidential line for member information and/or questions. An answering machine is not acceptable. If an answering service or pager system is used, the call must be returned within 15 minutes if of an emergent nature.
- The PCP or another physician/nurse practitioner must be available to provide medically necessary services.
- Covering physicians are required to follow the precertification guidelines.
- It is not acceptable to automatically direct the member to the emergency room when the PCP is not available.
- We encourage our PCPs to offer after-hours office care in the evenings and on weekends.

Provider Disenrollment Process

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

Mandatory disenrollment occurs when a provider becomes unavailable due to immediate, unforeseen reasons. Examples of this include death and loss of license. Members are auto-assigned to another PCP to ensure continuous access to Amerigroup covered services, as appropriate. Amerigroup will notify members of any termination for PCPs or other providers from whom they receive ongoing care.

Amerigroup will provide notice to affected members when a provider disenrolls for voluntary reasons, such as retirement. Providers must provide written notice to Amerigroup within the time frames specified in the participating provider agreement with Amerigroup. Members who are linked to a PCP that has disenrolled for voluntary reasons will be notified to self-select a new PCP.
**Member Enrollment**

Amerigroup and network providers shall accept assignment of a member and will not discriminate against eligible enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, gender, or physical or mental handicap.

A member may request a new PCP, and Amerigroup will accommodate his or her request immediately. This means that PCPs may receive new members on any day of the month rather than just on the first of the month. Please note the member must initiate the PCP request change. PCPs will be reimbursed for services according to their contract. If PCPs are capitated, their reimbursement will be adjusted on a pro rata basis for those members who select or leave their PCP on any day other than the first of the month.

Newborn care is covered only if the mother was enrolled in Amerigroup at the time of the baby’s birth and subject to the following guidelines:

- Coverage of newborn infants will be the responsibility of Amerigroup from the date of birth and for a minimum of 60 days after the birth through the period ending at the end of the month in which the 60th day falls, unless the baby is determined eligible beyond that point. Any baby hospitalized during the first 60 days of life will remain the responsibility of Amerigroup until discharge. This includes hospital readmissions within 48 hours of discharge for the same diagnosis (other than liveborn infant). Amerigroup will notify DMAHS when a newborn who has been hospitalized and has not been added to its enrollment roster after 12 weeks from the date of birth. DMAHS will take action with the appropriate County Welfare Agency (CWA) to have the infant added to the eligibility file and subsequently the enrollment roster, following this notification. The mother’s Managed Care Entity (MCE) if it is Amerigroup will be responsible for the hospital stay for the newborn following delivery and for subsequent services based on enrollment.

- A newborn whose mother is covered under SSI and does not apply or is not eligible for Aid to Families with Dependent Children (AFDC)/Temporary Assistance for Needy Families (TANF) will remain the responsibility of Amerigroup from the date of birth and for a minimum of 60 days after the birth, and for any readmits for the same diagnosis for 48 hours through the period ending at the end of the month in which the 60th day falls, unless the newborn is determined eligible beyond that point. Any newborn who is hospitalized during the first 60 days of life will remain the responsibility of Amerigroup until discharge, as well as for hospital readmissions within 48 hours of discharge for the same diagnosis (other than liveborn infant). Amerigroup will notify DMAHS when a newborn has been hospitalized and not added to its enrollment roster after 12 weeks from the date of birth.

- A newborn placed in Division of Youth and Family Services (DYFS) will remain the responsibility of Amerigroup from the date of birth for medically necessary newborn care. Once the child is medically stable and awaiting placement in a DYFS-approved home, the newborn is covered under Fee-For-Service (FFS) Medicaid.

- A newborn whose mother is enrolled in NJ FamilyCare B, C or D is the responsibility of Amerigroup from the date of birth through the end of the month in which the 60th day of coverage occurs unless the newborn is determined to be eligible beyond this period.

If a member relocates to another area and is otherwise still eligible for benefits, Amerigroup will continue to provide or arrange care to the member until DMAHS can disenroll him or her.
Members Eligibility Listing

The PCP will receive a list of his or her panel of assigned members monthly. If a member calls to change his or her PCP, the change will be effective the next business day. The PCP should verify that each Amerigroup member receiving treatment in his or her office is on said membership list. If a PCP does not receive the lists in a timely manner, he or she should contact a Provider Service representative. For questions regarding a member’s eligibility, providers may access www.amerigroupcorp.com/providers or call the automated Provider Inquiry Line at 1-800-454-3730.

Member Identification Cards

Each Amerigroup member will be provided an identification card, which identifies the member as a participant in the Amerigroup program, within 10 calendar days of notification of enrollment into Amerigroup or prior to the member’s enrollment effective date. To ensure immediate access to services, providers must accept the member’s Medicaid managed care ID card as proof of enrollment in the Amerigroup plan until the member receives the member ID card from Amerigroup, or providers may contact Amerigroup at 1-800-454-3730 to verify eligibility and benefits. The holder of the member ID card issued by Amerigroup is a member or guardian of the member.

Every Amerigroup member ID card lists the following:

- Effective date of Amerigroup membership
- Date of birth of member
- Member number
- Carrier and group number (RXGRP #) for injectables
- Amerigroup logo
- Health plan name – Amerigroup New Jersey, Inc.
- PCP name
- PCP telephone number
- Vision telephone number
- Amerigroup Member Services telephone number

Amerigroup member identification card sample:

SSI member under DDD
For members who are under DDD, behavioral health is billed to Amerigroup. For members who are not under DDD, behavioral health is billed to the FFS Medicaid program.

NJ FamilyCare ID Cards

- The NJ FamilyCare (A, B, C or D) is listed in the upper left-hand corner of the member’s ID card.

For NJ FamilyCare D members who are referred to an emergency room by their PCP for services normally rendered in the PCP’s office or are admitted, the emergency room copayment is waived. If the PCP refers the member to the emergency room for services normally rendered in the PCP’s office, the PCP must notify AMERIGROUP. This ensures appropriate adjudication of the claim.
For those NJ FamilyCare/Medicaid members who are not responsible for copayments or who are responsible for copayments and have met their copayment maximum, the member ID card will list $0 copayment.

Presentation of an Amerigroup member identification card does not guarantee eligibility; therefore, you should verify a member’s status by inquiring online or via telephone. Online support is available for provider inquiries at www.amerigroupcorp.com/providers, and telephonic verification may be obtained on the automated Provider Inquiry Line at 1-800-454-3730.

Americans with Disabilities Act Requirements

Amerigroup policies and procedures are designed to promote compliance with the Americans with Disabilities Act of 1990. Providers are required to take actions to remove an existing barrier and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes:

- Street-level access
- Elevator or accessible ramp into facilities
- Access to lavatory that accommodates a wheelchair
- Access to examination room that accommodates a wheelchair
- Clearly marked handicap parking, unless there is street-side parking

Communication Access

The Amerigroup policy is designed to ensure meaningful access to health care services for members with Limited English Proficiency (LEP). Amerigroup policy allows members with LEP to overcome language barriers and fully use services and benefits. Language assistance options are available at no cost to the member or provider.

Upon request, written member materials are available in Braille, in large print, on tape and in languages other than English (dependent upon the Amerigroup population). Member materials are written at the appropriate reading and grade level.

Oral interpretive services are available either in-office or telephonically. If you are serving an Amerigroup member with whom you cannot communicate, call our Member Services department 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. To arrange for in-office interpretive services, call Member Services at 1-800-600-4441.

For members who are deaf or hard of hearing, Amerigroup can also help you telephonically communicate with them via a translation device. Call the Member Services AT&T Relay Service line at 1-800-855-2880 for English and 1-800-855-2884 for Spanish. Also, in-office sign language assistance is available. Call Member Services at 1-800-600-4441 to arrange for the service.

The provider is required to offer interpretive services to members who may require services, document the offer and the member’s response, and reiterate that interpretive services are available at no cost to the member.
Below are a few guidelines that may result in better communication when using an interpreter:

- Keep your sentences short and concise. The longer and more complex your sentences, the less accurate the interpretation.
- Avoid use of medical terminology when possible, which is unlikely to translate well.
- Ask key questions in several different ways; this increases the chance you’ll get a response to exactly what you need to know.
- 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. This is an effective review of how well the member has understood what you told them.

Family members, especially minor children, should not be used as interpreters in assessments, therapy or other medical situations in which impartiality and confidentiality are critical, unless specifically requested by the member. The provider should help the member to use a nonfamilial interpreter and should help the member understand his or her concerns regarding the use of minor children as interpreters, even at the member’s request.

**Medically Necessary Services or Supplies**

Covered services or supplies must meet the New Jersey managed care contract definition of medically necessary. **Medically necessary** health services or supplies are necessary to:

- Prevent, evaluate, diagnose, correct, prevent the worsening of, alleviate, ameliorate or cure a physical or mental illness or condition
- Maintain health
- Prevent the onset of an illness, condition or disability
- Prevent or treat a condition that endangers life or causes suffering or pain, or results in illness or infirmity
- Prevent the deterioration of a condition
- Promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities appropriate for individuals of the same age
- Prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the member

The services provided, as well as the type of provider and setting must be:

- Reflective of the level of services that can be safely provided
- Consistent with the diagnosis of the condition
- Appropriate to the specific medical needs of the member and not solely for the convenience of the member or provider of service in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective

**Course of treatment** may include mere observation or, where appropriate, no treatment at all. Experimental services or services generally regarded by the medical profession as unacceptable treatment are not medically necessary. Medically necessary services provided must be based on peer-
reviewed publications, expert pediatric, psychiatric and medical opinion, and medical and/or pediatric community acceptance.

For **pediatric members**, medically necessary also means services that:
- Are needed by a member as a result of a comprehensive screening visit or an interperiodic encounter, whether or not they are ordinarily covered services for all other Medicaid members
- Are appropriate for the age and health status of the member
- Will aid in the overall physical and mental growth and development of the member
- Will assist in achieving or maintaining functional capacity

**Dental vs. Medical**: Network specialty dentists (oral surgeons) are required to submit a completed precertification request for surgical cases with appropriate diagnostic and medical and/or dental necessity rationales. These surgical procedures are considered either medical or dental in classification. Examples of such procedures are treatment of jaw fractures, removal of tumors, cysts and neoplasm. The dental medical director reviews surgical cases.

**Note**: Amerigroup does not cover the use of experimental procedures or experimental medications except under certain circumstances (e.g., clinical trials).
5 AMERIGROUP HEALTH CARE BENEFITS AND COPAYMENTS

Amerigroup Covered Services

The following are the health care services and benefits that Amerigroup covers for Medicaid and NJ FamilyCare members.

Note: Amerigroup does not cover use of experimental procedures or experimental medications except under certain circumstances (e.g., clinical trials).

For procedures that may be considered either medical or dental, such as surgical procedures for a fractured jaw or removal of cysts, Amerigroup has written policies and procedures that clearly and definitively indicate whether a physician specialist or oral surgeon may perform the procedure and when, where, and how authorization shall be promptly obtained if needed. Such policies and procedures can be found on the Amerigroup website and are available in hard copy upon request.

Cost-sharing Information

For Medicaid members or NJ FamilyCare A or B members, no copayment or deductible is required or may be collected for medically necessary covered services.

For NJ FamilyCare C and D members, a monthly premium may be required and is collected by the state. In addition, members may be responsible for a copayment or Personal Contribution to Care (PCC) for services dependent upon their state-assigned program status code. Native American Indians and Eskimos under age 19 in NJ FamilyCare C and D are not responsible for copays. Review the member ID card for copayment information.

The boxes below show the covered services and copay amounts for services that have copays. Copays are for NJ FamilyCare C and D members who have copays.

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>MEDICAID &amp; NJ FAMILYCARE A</th>
<th>NJ FAMILYCARE B</th>
<th>NJ FAMILYCARE C</th>
<th>NJ FAMILYCARE D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiology Services Include:</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
<td>• Covered for age 15 and younger • Limited to $1,000 per ear every 24 months</td>
</tr>
<tr>
<td>• Diagnostic services</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Screening services</td>
<td></td>
<td></td>
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<tr>
<td>• Preventive services</td>
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<td></td>
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<tr>
<td>• Corrective services</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>• Needed supplies and equipment</td>
<td></td>
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</tr>
</tbody>
</table>

Requires referral from physician or other licensed
<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>MEDICAID &amp; NJ FAMILYCARE A</th>
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<th>NJ FAMILYCARE D</th>
</tr>
</thead>
<tbody>
<tr>
<td>medical practitioner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractor Services</strong></td>
<td>No copay</td>
<td>No copay</td>
<td>$5 per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td>Includes manual manipulation of the spine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dental Services</strong></td>
<td>No copay</td>
<td>No copay</td>
<td>$5 per visit</td>
<td>No copay</td>
</tr>
<tr>
<td>Preventive dental services (exams, cleanings, space maintainers, sealants and fluoride):</td>
<td></td>
<td></td>
<td>Limited to children under the age of 19</td>
<td></td>
</tr>
<tr>
<td>- Every 6 months until age 18</td>
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<td></td>
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<tr>
<td>- Once a year for people 18 or older</td>
<td></td>
<td></td>
<td></td>
<td>Limited to children under the age of 19</td>
</tr>
<tr>
<td>- Fluoride is not covered for those 21 and over</td>
<td></td>
<td></td>
<td>Limited to children under the age of 19</td>
<td>Limited to children under the age of 19</td>
</tr>
<tr>
<td>Sealants:</td>
<td></td>
<td></td>
<td></td>
<td>Limited to children under the age of 19</td>
</tr>
<tr>
<td>- One time for those under age 17</td>
<td></td>
<td></td>
<td>Limited to children under the age of 19</td>
<td>Limited to children under the age of 19</td>
</tr>
<tr>
<td>- Not covered for those age 17 or older</td>
<td></td>
<td></td>
<td>Limited to children under the age of 19</td>
<td>Limited to children under the age of 19</td>
</tr>
<tr>
<td>Restorative (fillings and crowns):</td>
<td></td>
<td></td>
<td>Limited to children under the age of 19</td>
<td>Limited to children under the age of 19</td>
</tr>
<tr>
<td>- As medically appropriate to restore the natural tooth</td>
<td></td>
<td></td>
<td>Limited to children under the age of 19</td>
<td>Limited to children under the age of 19</td>
</tr>
<tr>
<td>- Prior authorization needed for crowns</td>
<td></td>
<td></td>
<td>Limited to children under the age of 19</td>
<td>Limited to children under the age of 19</td>
</tr>
<tr>
<td>Endodontic (root canal, etc.): Need prior authorization</td>
<td></td>
<td></td>
<td>Limited to children under the age of 19</td>
<td>Limited to children under the age of 19</td>
</tr>
<tr>
<td>Prosthodontic (removable dentures): Need prior authorization</td>
<td></td>
<td></td>
<td>Limited to children under the age of 19</td>
<td>Limited to children under the age of 19</td>
</tr>
<tr>
<td>Exodontic (extractions and oral surgery): For oral</td>
<td></td>
<td></td>
<td>Limited to children under the age of 19</td>
<td>Limited to children under the age of 19</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>MEDICAID &amp; NJ FAMILYCARE A</td>
<td>NJ FAMILYCARE B</td>
<td>NJ FAMILYCARE C</td>
<td>NJ FAMILYCARE D</td>
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<tr>
<td>surgery, prior authorization is required for inpatient and outpatient facilities</td>
<td></td>
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</tr>
<tr>
<td>Orthodontic: Limited to children under age 19 when medically necessary</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Periodontic (supporting structures, gums,)</td>
<td></td>
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</tr>
<tr>
<td>Fee-for-service Medicaid to provide and pay for certain dental services by a Medicaid non-Amerigroup provider that are started 60 to 120 days prior to a member’s first-time enrollment in managed care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME) &amp; Supplies</strong> Includes: Assistive technology devices, artificial aids, surgical implants, wheelchairs, beds</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
<td>Limited coverage</td>
</tr>
</tbody>
</table>
| **Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** Includes:  
  - Medical exams  
  - Dental services  
  - Vision services  
  - Hearing services | No copay  
  - Private duty nursing included only if approved by Amerigroup | No copay  
  - Coverage limited to screening and diagnosis | No copay  
  - Treatment services limited to those:  
    - Included in | No copay  
  - Coverage limited to well-child visits including immunizations, lead screening and treatments only |  |  |  |
<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>MEDICAID &amp; NJ FAMILYCARE A</th>
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<th>NJ FAMILYCARE C</th>
<th>NJ FAMILYCARE D</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lead screening</td>
<td>Amerigroup benefits, or</td>
<td>Private duty nursing included only if approved by Amerigroup</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Health care and treatment to correct or help improve any defects or conditions found in screenings</td>
<td>• Specified through fee-for-service Medicaid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes the following when indicated as a result of an EPSDT screening:</td>
<td>Private duty nursing included only if approved by Amerigroup</td>
<td>Medicaid</td>
<td>Medicaid</td>
<td></td>
</tr>
<tr>
<td>• Nonlegend drugs</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Ventilator services in the home</td>
<td>$10 per visit</td>
<td>$35 (no copayment required if member is referred to ER by Amerigroup)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Private duty nursing (provided by a registered nurse or licensed practical nurse under the guidance of the member’s physician in the member’s home or in a hospital)</td>
<td></td>
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<tr>
<td>Screening services are provided periodically:</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>• Neonatal exam</td>
<td></td>
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<tr>
<td>• Under 6 weeks</td>
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<tr>
<td>• 2 months</td>
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<td>• 4 months</td>
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<tr>
<td>• 6 months</td>
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<tr>
<td>• 9 months</td>
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<tr>
<td>• 12 months</td>
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<tr>
<td>• 15 months</td>
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<tr>
<td>• 18 months</td>
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<tr>
<td>• 24 months</td>
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<tr>
<td>• Annually through age 20</td>
<td></td>
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</tr>
<tr>
<td>Emergency Medical Care</td>
<td>No copay</td>
<td>No copay</td>
<td>$10 per visit</td>
<td>$35 (no copayment required if member is referred to ER by Amerigroup)</td>
</tr>
<tr>
<td>24 hours a day, 7</td>
<td></td>
<td></td>
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<tr>
<td>COVERED SERVICES</td>
<td>MEDICAID &amp; NJ FAMILYCARE A</td>
<td>NJ FAMILYCARE B</td>
<td>NJ FAMILYCARE C</td>
<td>NJ FAMILYCARE D</td>
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<tr>
<td>days a week</td>
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<td></td>
<td>PCP for services normally rendered in PCP office or if admitted to the hospital</td>
</tr>
</tbody>
</table>

**Family Planning Services**

Include:
- Services needed to delay or prevent pregnancy
- Pregnancy testing
- Genetic testing and counseling
- Contraceptives (including oral contraceptives)
- Follow-up care for complications linked with contraceptive methods issued by the family planning provider
- Sterilizations

Elective, induced abortions (and related services) are covered under the fee-for-service Medicaid program, including certain related office, laboratory, drugs, radiological and diagnostic services and surgical procedures.

Infertility and sterilization reversals are not covered.

**Hearing Aid**

No copay

No copay

No copay

$5 per visit (no copay for preventive care services)

 '*. Covered for age'
<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>MEDICAID &amp; NJ FAMILYCARE A</th>
<th>NJ FAMILYCARE B</th>
<th>NJ FAMILYCARE C</th>
<th>NJ FAMILYCARE D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Services</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Include:</td>
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<td></td>
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<td></td>
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<tr>
<td>• Hearing aids and accessories</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>• Ear mold impressions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Routine follow-up and adjustments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Repairs</td>
<td></td>
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</tbody>
</table>
| Requires hearing screening, resulting in prescription for hearing aid services | | | | 15 and younger
<p>|                       |                            |                |                | • Limited to $1,000 per ear every 24 months |
| <strong>Home Health Agency Services</strong> | No copay | No copay | No copay | No copay |
| Include:         | Covered by fee-for-service Medicaid for all ABD members | Covered by Amerigroup for all other NJ FamilyCare B members | Covered by Amerigroup for all other NJ FamilyCare C members | Coverage provided by Amerigroup limited to skilled nursing for homebound members provided or supervised by a registered nurse, home health aides for skilled care and medical social services that are medically necessary |
| • Services given at member’s home (excludes a hospital, nursing facility or intermediate care facility) | | | | |
| • Nursing services by a registered nurse or licensed practical nurse | | | | |
| • Home health aide services | | | | |
| • Medical supplies and equipment | | | | |
| • Appliances | | | | |
| • Audiology services | | | | |
| Services must be ordered by member’s physician | | | | |
| <strong>Hospice Agency Services</strong> | No copay | No copay | No copay | No copay |
| Hospice services covered in community and institutional settings | | | | |
| Room and board services covered | | | | |</p>
<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>MEDICAID &amp; NJ FAMILYCARE A</th>
<th>NJ FAMILYCARE B</th>
<th>NJ FAMILYCARE C</th>
<th>NJ FAMILYCARE D</th>
</tr>
</thead>
<tbody>
<tr>
<td>only when services are delivered in an institutional (nonprivate residence) setting</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
</tr>
<tr>
<td><strong>Inpatient Hospital</strong> (includes Rehabilitation Hospitals and special hospitals)</td>
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<tr>
<td>Includes services normally given in a hospital that are under the guidance of a physician</td>
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</tr>
<tr>
<td>Except for a DDD member for an acute psychiatric hospital admission, coverage provided by traditional Medicaid for members when primary diagnosis is mental health/substance abuse-related</td>
<td></td>
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</tr>
<tr>
<td>Requires prior authorization for nonemergency care and care following stabilization of an emergency condition</td>
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<tr>
<td>Not covered:</td>
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</tr>
<tr>
<td>- Cosmetic surgery</td>
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<td></td>
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<tr>
<td>- Rest cures</td>
<td></td>
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<tr>
<td>- Personal comfort and convenience items</td>
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<tr>
<td>- Services and supplies not directly related to the care of the patient</td>
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<td></td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>MEDICAID &amp; NJ FAMILYCARE A</td>
<td>NJ FAMILYCARE B</td>
<td>NJ FAMILYCARE C</td>
<td>NJ FAMILYCARE D</td>
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<td>----------------------------------</td>
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</tr>
<tr>
<td>Telephone charges</td>
<td>No copay</td>
<td>$5 per visit for each visit that is not part of an office visit</td>
<td></td>
<td>$5 per visit for each visit that is not part of an office visit</td>
</tr>
<tr>
<td>Take-home supplies</td>
<td>No copay</td>
<td>$5 per visit for each visit that is not part of an office visit</td>
<td></td>
<td>$5 per visit for each visit that is not part of an office visit</td>
</tr>
<tr>
<td>Laboratory Services</td>
<td>No copay</td>
<td>$5 per visit for each visit that is not part of an office visit</td>
<td></td>
<td>$5 per visit for each visit that is not part of an office visit</td>
</tr>
<tr>
<td>Must be ordered by a physician or other licensed practitioner</td>
<td>Routine testing related to administration of certain psychotropic drugs is covered for DDD members only</td>
<td></td>
<td>No copay for prenatal care visits</td>
<td>$10 copay for services rendered during nonoffice hours and for home visits</td>
</tr>
<tr>
<td>Members will be notified of results within 24 hours for urgent and emergent cases and within 10 business days for routine cases</td>
<td>No copay for prenatal care visits</td>
<td></td>
<td>$5 copay for first prenatal visit</td>
<td>$10 copay for services rendered during nonoffice hours and for home visits</td>
</tr>
<tr>
<td>Maternity and Related Newborn Care</td>
<td>No copay</td>
<td>No copay for prenatal care visits</td>
<td>No copay</td>
<td>$5 copay for first prenatal visit</td>
</tr>
<tr>
<td>Includes diagnosis-specific disposable medical supplies</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>Covered by Amerigroup to members who are clients of the Division of Developmental Disabilities (DDD &amp; DDD/CCW)</td>
<td>No copay for prenatal care visits</td>
<td>No copay</td>
<td>No copay</td>
</tr>
<tr>
<td>Include:</td>
<td>Covered by fee-for-service Medicaid</td>
<td>No copay for prenatal care visits</td>
<td>No copay</td>
<td>No copay</td>
</tr>
<tr>
<td>Intake evaluation</td>
<td>Covered by fee-for-service Medicaid</td>
<td>No copay for prenatal care visits</td>
<td>No copay</td>
<td>No copay</td>
</tr>
<tr>
<td>Off-site crisis intervention</td>
<td>(see Services Provided under Fee-For-Service for NJ FamilyCare/Medicaid members for more information, limits and limits)</td>
<td>No copay for prenatal care visits</td>
<td>No copay</td>
<td>No copay</td>
</tr>
<tr>
<td>Family therapy</td>
<td>Covered by fee-for-service Medicaid (see Services Provided under Fee-For-Service for NJ FamilyCare/Medicaid members for more information, limits and limits)</td>
<td>No copay for prenatal care visits</td>
<td>No copay</td>
<td>No copay</td>
</tr>
<tr>
<td>Family meetings</td>
<td>Covered by fee-for-service Medicaid (see Services Provided under Fee-For-Service for NJ FamilyCare/Medicaid members for more information, limits and limits)</td>
<td>No copay for prenatal care visits</td>
<td>No copay</td>
<td>No copay</td>
</tr>
<tr>
<td>Psychological testing</td>
<td>Covered by fee-for-service Medicaid (see Services Provided under Fee-For-Service for NJ FamilyCare/Medicaid members for more information, limits and limits)</td>
<td>No copay for prenatal care visits</td>
<td>No copay</td>
<td>No copay</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>MEDICAID &amp; NJ FAMILYCARE A</td>
<td>NJ FAMILYCARE B</td>
<td>NJ FAMILYCARE C</td>
<td>NJ FAMILYCARE D</td>
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</tr>
<tr>
<td>• Medication management  Services for conditions that alter mental states that are of an organic nature covered by Amerigroup Partial hospitalization and partial care covered under the fee-for-service Medicaid program</td>
<td>Mental health day care programs at Adult Partial Care Centers covered by fee-for-service Medicaid for all products  Covered by fee-for-service Medicaid for all other members (see Services Provided under Fee-for-Service for NJ FamilyCare/ Medicaid Members for more information, limits and exclusions)</td>
<td>limits and exclusions)</td>
<td>exclusions)</td>
<td>and exclusions)</td>
</tr>
<tr>
<td></td>
<td>Inpatient hospital services for mental health, including psychiatric hospitals, limited to 35 days per year</td>
<td>Outpatient benefits for short-term, outpatient evaluative and crisis intervention, or home health mental health services, limited to 20 visits per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Facility Services  Limited to the first 30 days of admission to a nursing facility</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Limited to rehabilitation services</td>
<td>Limited to rehabilitation services</td>
<td>Limited to rehabilitation services</td>
<td>Limited to rehabilitation services</td>
</tr>
<tr>
<td>Optical Appliances  (artificial eyes, eyeglasses, contact lenses and other visual aids prescribed)  Optical appliances must be prescribed by a participating ophthalmologist or optometrist  For members age 0-18 and age 60 or older: Members can</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td>Limited to one pair of glasses (or contact lenses) per 24-month period or as medically necessary</td>
</tr>
</tbody>
</table>
get one pair of frames and eyeglass lenses chosen from Medicaid-approved materials once every year, or sooner in some cases, when meeting Medicaid-approved criteria for changes in prescription.

**For members age 19-59:** Members can get one pair of frames and eyeglass lenses chosen from Medicaid-approved materials once every two years, or sooner in some cases, when meeting Medicaid-approved criteria for changes in prescription.

Talk to your vision provider to see if you need a new eyeglass prescription. Members have a choice of covered frames.

Contact lenses may be covered for:
- Members with certain ocular pathological conditions
- Members whose vision cannot be improved to at least 20/70 with regular lenses but
<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>MEDICAID &amp; NJ FAMILYCARE A</th>
<th>NJ FAMILYCARE B</th>
<th>NJ FAMILYCARE C</th>
<th>NJ FAMILYCARE D</th>
</tr>
</thead>
<tbody>
<tr>
<td>can be improved to 20/70 or better with contact lenses</td>
<td></td>
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</tr>
<tr>
<td>Contact lenses may be replaced once every two years, or more often, if there is a significant change in a member’s prescription.</td>
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<tr>
<td>If members do not meet any of the above medical necessity criteria, but choose contact lenses anyway, up to a $100 credit may be given toward the cost of the contact lenses.</td>
<td></td>
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</tr>
<tr>
<td><strong>Optometrist Services</strong></td>
<td>No copay</td>
<td>No copay</td>
<td>$5 per visit</td>
<td>$5 per visit</td>
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<tr>
<td></td>
<td>One routine eye exam covered every 12 months</td>
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</tbody>
</table>

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<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>MEDICAID &amp; NJ FAMILYCARE A</th>
<th>NJ FAMILYCARE B</th>
<th>NJ FAMILYCARE C</th>
<th>NJ FAMILYCARE D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organ Transplants</strong></td>
<td>No copay</td>
<td>Donor and recipient inpatient costs covered up to two months after disenrollment to fee-for-service Medicaid for members placed on a transplant list or who become eligible for a transplant while enrolled in Amerigroup</td>
<td>Donor and recipient inpatient costs covered up to two months after disenrollment to fee-for-service Medicaid for members placed on a transplant list or who become eligible for a transplant while enrolled in Amerigroup</td>
<td>No copay</td>
</tr>
<tr>
<td>Includes liver, lung, heart, heart-lung, pancreas, kidney, cornea, intestine and bone marrow, including autologous bone marrow transplants</td>
<td>Donor and recipient inpatient costs covered up to two months after disenrollment to fee-for-service Medicaid for members placed on a transplant list or who become eligible for a transplant while enrolled in Amerigroup</td>
<td>Donor and recipient inpatient costs covered up to two months after disenrollment to fee-for-service Medicaid for members placed on a transplant list or who become eligible for a transplant while enrolled in Amerigroup</td>
<td>Donor and recipient inpatient costs covered up to two months after disenrollment to fee-for-service Medicaid for members placed on a transplant list or who become eligible for a transplant while enrolled in Amerigroup</td>
<td>No copay</td>
</tr>
<tr>
<td>Experimental organ transplants excluded</td>
<td>Donor and recipient inpatient costs covered up to two months after disenrollment to fee-for-service Medicaid for members placed on a transplant list or who become eligible for a transplant while enrolled in Amerigroup</td>
<td>Donor and recipient inpatient costs covered up to two months after disenrollment to fee-for-service Medicaid for members placed on a transplant list or who become eligible for a transplant while enrolled in Amerigroup</td>
<td>Donor and recipient inpatient costs covered up to two months after disenrollment to fee-for-service Medicaid for members placed on a transplant list or who become eligible for a transplant while enrolled in Amerigroup</td>
<td>No copay</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Outpatient Hospital Services</strong></th>
<th>No copay</th>
<th>No copay</th>
<th>$5 for each outpatient visit (no copay for preventive care)</th>
<th>$5 for each outpatient visit (no copay for preventive care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include:</td>
<td>Preventive services</td>
<td>Diagnostic services</td>
<td>Therapeutic services</td>
<td>Palliative services</td>
</tr>
<tr>
<td>Examples</td>
<td>Physical therapy, occupational therapy, and speech therapy covered by fee-for-service Medicaid; mental health visits covered by fee-for-service Medicaid with the</td>
<td>May require prior authorization for nonemergency care and physician referral</td>
<td>Excludes mental health visits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No copay</td>
<td>No copay</td>
<td>$5 for each outpatient visit (no copay for preventive care)</td>
<td>$5 for each outpatient visit (no copay for preventive care)</td>
</tr>
<tr>
<td></td>
<td>No copay</td>
<td>No copay</td>
<td>$5 for each outpatient visit (no copay for preventive care)</td>
<td>$5 for each outpatient visit (no copay for preventive care)</td>
</tr>
<tr>
<td></td>
<td>$5 for each outpatient visit (no copay for preventive care)</td>
<td>$5 for each outpatient visit (no copay for preventive care)</td>
<td>$5 for each outpatient visit (no copay for preventive care)</td>
<td>$5 for each outpatient visit (no copay for preventive care)</td>
</tr>
<tr>
<td></td>
<td>Excludes mental health visits</td>
<td>Excludes mental health visits</td>
<td>Excludes mental health visits</td>
<td>Excludes mental health visits</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>MEDICAID &amp; NJ FAMILYCARE A</td>
<td>NJ FAMILYCARE B</td>
<td>NJ FAMILYCARE C</td>
<td>NJ FAMILYCARE D</td>
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<tr>
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</tr>
<tr>
<td>exception of the DD population (see section Services Provided under Fee-For-Service for NJ FamilyCare/ Medicaid Members for details)</td>
<td>No copay</td>
<td>No copay</td>
<td>$5 per visit</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Podiatrist Services</td>
<td>No copay</td>
<td>No copay</td>
<td>$5 per visit</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Excludes routine hygienic care of the feet, such as treatment of corns, calluses, nail trimming, foot soaking or other services, in the absence of a pathological condition</td>
<td>No copay</td>
<td>No copay</td>
<td>$5 per visit</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>No copay</td>
<td>No copay</td>
<td>$1 copay for generic</td>
<td>$5 copay for brand-name</td>
</tr>
<tr>
<td>May require prior authorization for selected drugs</td>
<td>For all ABD members and all members who are covered by both Medicaid and Medicare: prescription drugs covered under fee-for-service Medicaid</td>
<td>Over-the-counter drugs covered for children (see Extra Amerigroup Benefits for NJ FamilyCare/Medicaid Members for more information on over-the-counter drugs)</td>
<td>Over-the-counter drugs covered for children (see Extra Amerigroup Benefits for NJ FamilyCare/Medicaid Members for more information on over-the-counter drugs)</td>
<td>$5 copay — if greater than 34-day supply, then $10 copay</td>
</tr>
<tr>
<td>Amerigroup uses a formulary — a list of drugs your doctor can choose from to treat your illnesses; prior authorization is required for consideration of drugs outside the formulary when medically necessary</td>
<td>Over-the-counter drugs covered for children (see Extra Amerigroup Benefits for NJ FamilyCare/Medicaid Members for more information on over-the-counter drugs)</td>
<td>Over-the-counter drugs covered for children (see Extra Amerigroup Benefits for NJ FamilyCare/Medicaid Members for more information on over-the-counter drugs)</td>
<td>Over-the-counter drugs are not covered</td>
<td></td>
</tr>
<tr>
<td>Legend (prescription) drugs and nonlegend drugs approved by the Medicaid program are covered</td>
<td></td>
<td></td>
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<tr>
<td>Preventive Health</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>MEDICAID &amp; NJ FAMILYCARE A</td>
<td>NJ FAMILYCARE B</td>
<td>NJ FAMILYCARE C</td>
<td>NJ FAMILYCARE D</td>
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<tr>
<td>---------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Care, Counseling and Health Promotion</td>
<td></td>
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<tr>
<td>Includes referrals to WIC programs</td>
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<tr>
<td><strong>For all female members:</strong> If your PCP is not a women’s health specialist,</td>
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<tr>
<td>covered services include direct access to an Amerigroup network woman’s health</td>
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<tr>
<td>specialist for covered care that is needed to provide women’s routine and</td>
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<tr>
<td>preventive health care services, such as annual gynecological exams, mammograms.</td>
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</tr>
<tr>
<td>Primary Care and Physician Services</td>
<td>No copay</td>
<td>No copay</td>
<td>$5 per visit</td>
<td>$5 per visit during normal office hours</td>
</tr>
<tr>
<td>(24 hours a day, 7 days a week)</td>
<td></td>
<td></td>
<td>No copay for wellness visits, lead screenings and treatments, age-appropriate immunizations, prenatal care and Pap smears, when appropriate</td>
<td>$10 per visit for nonoffice hours and home visits</td>
</tr>
<tr>
<td>Include:</td>
<td></td>
<td></td>
<td>$5 for first prenatal care visit only — no copay thereafter</td>
<td>$5 for first prenatal care visit only — no copay thereafter</td>
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<tr>
<td>• Primary and specialty care</td>
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<tr>
<td>• Certified nurse midwives</td>
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<tr>
<td>• Certified nurse practitioners</td>
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<tr>
<td>• Clinical nurse specialists</td>
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<tr>
<td>• Physician assistant services</td>
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<tr>
<td>• Independent clinic services (includes preventive, diagnostic, therapeutic,</td>
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<tr>
<td>rehabilitative or palliative services)</td>
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<tr>
<td>COVERED SERVICES</td>
<td>MEDICAID &amp; NJ FAMILYCARE A</td>
<td>NJ FAMILYCARE B</td>
<td>NJ FAMILYCARE C</td>
<td>NJ FAMILYCARE D</td>
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<tr>
<td>--------------------------------------------------</td>
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</tbody>
</table>
| Services provided by nonparticipating providers are not covered, unless:  
  • Referred by a participating provider  
  • Referred in error by a participating provider | No copay                   | No copay        | No copay        | No copay        |
| Prosthetic and Orthotic Devices  
  (includes certified shoe provider)  
  Prosthetic devices include corrective or supportive devices that:  
  • Replace a missing part of the body  
  • Prevent or correct physical deformity or malfunction  
  • Support a weak or deformed part of the body  
  Orthotic devices include devices or braces that provide support, more function and help to overcome physical impairment or defects; prosthetic and orthotic devices must be prescribed by a physician or other licensed practitioner | No copay                   | No copay        | No copay        | No copay        |
| Radiology Services  
  (X-rays)  
  Diagnostic and therapeutic services mean professional and technical | No copay                   | No copay        | No copay        | $5 per visit for each visit not part of an office visit |
<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>MEDICAID &amp; NJ FAMILYCARE A</th>
<th>NJ FAMILYCARE B</th>
<th>NJ FAMILYCARE C</th>
<th>NJ FAMILYCARE D</th>
</tr>
</thead>
<tbody>
<tr>
<td>radiology services</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
</tr>
<tr>
<td>Members will be</td>
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<tr>
<td>notified of results</td>
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<tr>
<td>within 24 hours for</td>
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<tr>
<td>urgent and emergent</td>
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<tr>
<td>cases and within 10</td>
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<tr>
<td>business days for routine cases</td>
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<tr>
<td>Transportation Services</td>
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<tr>
<td>Includes ambulance,</td>
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<tr>
<td>Mobile Intensive Care</td>
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<tr>
<td>Units (MICUs) and</td>
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<tr>
<td>invalid coach services</td>
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<tr>
<td>Transportation by invalid coach for SSI members choosing to see a provider outside their county of residence is not covered</td>
<td>No copay</td>
<td>Lower-mode transportation, such as taxi or bus, to medical appointments covered by fee-for-service Medicaid</td>
<td>No copay</td>
<td>Lower-mode transportation is not covered</td>
</tr>
<tr>
<td>Lower-mode transportation is covered by Amerigroup if a member must travel 30 miles or more to a nonhospital provider when a network or alternative provider is not available; this covers medically necessary benefits through Amerigroup or fee-for-service Medicaid</td>
<td>No copay</td>
<td>Lower-mode transportation is covered by Amerigroup if a member must travel 30 miles or more to a nonhospital provider when a network or alternative provider is not available; this covers medically necessary benefits through Amerigroup or fee-for-service Medicaid</td>
<td>No copay</td>
<td>Lower-mode transportation is covered by Amerigroup if a member must travel 30 miles or more to a nonhospital provider when a network or alternative provider is not available; this covers medically necessary benefits through Amerigroup or fee-for-service Medicaid</td>
</tr>
<tr>
<td>Transportation limited to ambulance for medical emergency only</td>
<td>No copay</td>
<td>Lower-mode transportation is not covered</td>
<td>No copay</td>
<td>Lower-mode transportation is not covered</td>
</tr>
<tr>
<td>Transportation is</td>
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<tr>
<td>covered if a member</td>
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</tr>
<tr>
<td>must travel 30 miles or more for medically necessary benefits covered by Amerigroup when a network or alternative provider is not available</td>
<td>No copay</td>
<td>Lower-mode transportation is not covered</td>
<td>No copay</td>
<td>Lower-mode transportation is not covered</td>
</tr>
<tr>
<td>is not available</td>
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</tbody>
</table>
SERVICES PROVIDED UNDER MEDICAID FEE-FOR-SERVICE FOR NJ FAMILYCARE/MEDICAID MEMBERS

The following are not covered by Amerigroup, but are covered by New Jersey FFS Medicaid. These services may require medical orders by the member’s PCP. Providers should contact NJ FamilyCare at 1-800-701-0710.

<table>
<thead>
<tr>
<th>FEE-FOR-SERVICE</th>
<th>MEDICAID &amp; NJ FAMILYCARE A</th>
<th>NJ FAMILYCARE B</th>
<th>NJ FAMILYCARE C</th>
<th>NJ FAMILYCARE D</th>
</tr>
</thead>
<tbody>
<tr>
<td>DYFS Residential Treatment Center Care</td>
<td>Covered</td>
<td>Covered through fee-for-service</td>
<td>Covered through fee-for-service</td>
<td>Not covered</td>
</tr>
<tr>
<td>Treatment centers to provide medical and social services to ensure the safety and well-being of children who may be abused or neglected; includes critical diagnostic and treatment services, and timely and needed access to all covered benefits</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Elective, Induced Abortions and Related Services</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>Can be covered through any Amerigroup provider or any state-approved Medicaid provider</td>
<td>Can be covered through and Amerigroup provider or any state-approved Medicaid provider</td>
<td>Can be covered through any Amerigroup provider or any state-approved Medicaid provider</td>
<td>For certain NJ FamilyCare D members: Can be covered through any Amerigroup provider or any state-approved Medicaid provider; call Member Services to learn more</td>
</tr>
<tr>
<td>Home Health</td>
<td>Covered for all</td>
<td>See Amerigroup</td>
<td>See Amerigroup</td>
<td>See Amerigroup</td>
</tr>
<tr>
<td>FEE-FOR-SERVICE</td>
<td>MEDICAID &amp; NJ FAMILYCARE A</td>
<td>NJ FAMILYCARE B</td>
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<td>NJ FAMILYCARE D</td>
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<td>---------------------------------------</td>
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</tr>
<tr>
<td>Services</td>
<td>members with the exception of ABD; home health for ABD covered by Medicaid fee-for-service</td>
<td>Covered Services for NJ FamilyCare/ Medicaid Members</td>
<td>Covered Services for NJ FamilyCare/ Medicaid Members</td>
<td>Covered Services for NJ FamilyCare/ Medicaid Members</td>
</tr>
<tr>
<td>Inpatient and Outpatient Mental Health Services</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>$25 per visit</td>
</tr>
<tr>
<td></td>
<td>Inpatient hospital services limited to 35 days per year</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>Members under age 19 covered through Children’s Health Insurance Program are not limited to 35 days per year</td>
<td></td>
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<tr>
<td></td>
<td>Outpatient benefits for short-term, outpatient evaluation and crises intervention or home health mental health services limited to 20 visits per year</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Inpatient Psychiatric Hospital Services</td>
<td>Covered for members under 21 or 65 and over</td>
<td>Covered for members under 21 or 65 and over</td>
<td>Covered for members under 21 or 65 and over</td>
<td>Not covered</td>
</tr>
<tr>
<td>Intermediate Care Facilities/Mental Retardation</td>
<td>Covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Medical Day Care Services</td>
<td>Covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse Services</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td></td>
<td>• Partial Hospitalization</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Partial Care</td>
<td></td>
<td></td>
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</tbody>
</table>

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<table>
<thead>
<tr>
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<th>NJ FAMILYCARE C</th>
<th>NJ FAMILYCARE D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Facility Services</td>
<td>HMO coverage limited to the first 30 days, after which member will be disenrolled from Amerigroup</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Outpatient Rehabilitation Services</td>
<td>Covered</td>
<td>Therapy limited to 60 days per therapy per year</td>
<td>$5 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td></td>
<td>Include:</td>
<td></td>
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<tr>
<td></td>
<td>Physical therapy</td>
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<tr>
<td></td>
<td>Occupational therapy</td>
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<td></td>
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<tr>
<td></td>
<td>Speech therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Care Assistant Services</td>
<td>Covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Legend (prescription) and nonlegend drugs are covered for all ABD and other dual-eligible members, including those</td>
<td>Covered by Amerigroup</td>
<td>Covered by Amerigroup</td>
<td>Covered by Amerigroup</td>
</tr>
<tr>
<td>FEE-FOR-SERVICE</td>
<td>MEDICAID &amp; NJ FAMILYCARE A</td>
<td>NJ FAMILYCARE B</td>
<td>NJ FAMILYCARE C</td>
<td>NJ FAMILYCARE D</td>
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<tr>
<td>clients of DDD Fee-for-service Medicaid coverage also includes atypical antipsychotic drugs and generic versions</td>
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<tr>
<td>Sex Abuse Exams (at DYFS-contracted Child Abuse Regional Diagnostic Centers or by DYFS-contracted physicians)</td>
<td>Covered by Medicaid Program with case management</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Substance Abuse Services Includes:</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>• Diagnosis, treatment and detoxification services</td>
<td></td>
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<tr>
<td>• Methadone and its administration</td>
<td>Inpatient and outpatient services limited to detoxification</td>
<td></td>
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<tr>
<td></td>
<td>No service limit for members under age 19 covered through Children’s Health Insurance Program</td>
<td></td>
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<tr>
<td></td>
<td>Costs for methadone maintenance and administration are not covered</td>
<td></td>
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<tr>
<td>Transportation Services – livery</td>
<td>Routine transportation, such as a taxi, is covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Waiver and Demonstration Program Services</td>
<td>Covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
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<tr>
<td></td>
<td>Member is disenrolled from</td>
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</table>
SERVICES NOT COVERED BY AMERIGROUP OR FEE-FOR-SERVICE FOR NJ FAMILYCARE/MEDICAID MEMBERS

There are other services that are not part of your Amerigroup benefits. These services are not covered by Medicaid, either. These services are listed below:

- All services your family doctor or Amerigroup says are not medically necessary
- Cosmetic surgery, except when medically necessary and with prior approval
- Experimental organ transplants and investigational services
- Infertility diagnosis and treatment services, including sterilization reversals and related office (medical or clinic), drugs, lab, radiological and diagnostic services, and surgical procedures
- Rest cures, personal comfort and convenience items, services, and supplies not directly related to the care of the patient, including guest meals and lodging, telephone charges, travel expenses, take home supplies and similar costs
- Respite care
- Services that involve the use of equipment in facilities when the purchase, rental or construction of the equipment has not been approved by New Jersey law
- All claims that come directly from services provided by or in federal institutions
- Services provided in an inpatient psychiatric institution that is not an acute-care hospital to members under 65 and over 21 years old
- Free services — free services provided by public programs or voluntary agencies should be used when possible
- Services or items furnished for any sickness or injury that occurs while the covered member is on active duty in the military
- Services provided outside of the United States and territories
- Services or items furnished for any condition or accidental injury that arises out of and during employment where benefits are available (worker’s compensation law, temporary disability benefits law, occupational disease law or similar laws); this applies whether or not the member claims or receives benefits and whether or not a third-party gets a recovery for resulting damages
- Any benefit that is covered or payable under any health, accident or other insurance policy
- Any services or items furnished that the provider normally provides for free
- Services furnished by an immediate relative or member of the Medicaid beneficiary’s household
- Services billed when the health care records do not correctly reflect the provider’s procedure code
- Services or items reimbursed based on a cost study or other evidence acceptable to the state of New Jersey
For NJ FamilyCare D members, these additional services are not included:

- Intermediate Care Facilities/ Intellectual Disability
- Private duty nursing, unless authorized by Amerigroup
- Personal care assistant services
- Medical day care services
- Chiropractic services
- Orthotic devices
- Targeted case management for the chronically ill
- Residential treatment center psychiatric programs
- Religious nonmedical institutions care and services
- EPSDT (except for well-child care, including immunizations and lead screening and treatments)
- Transportation services, including nonemergency ambulance, invalid coach and lower-mode transportation such as taxi or bus except in those instances where the member is referred by the health plan to a provider 30 or more miles from the member’s home.
- Hearing aid services, except for children age 15 and younger
- Blood and blood plasma (except administration of blood, processing of blood, processing fees and fees related to autologous blood donations are covered)
- Cosmetic surgery (except when medically necessary and with prior approval)
- Custodial care
- Special remedial and educational services
- Experimental and investigational services
- Medical supplies (except diabetic supplies)
- Rehabilitative services for substance abuse
- Weight reduction programs or dietary supplements (except surgical operations, procedures or treatment of obesity when approved by the contractor)
- Acupuncture and acupuncture therapy (except when performed as a form of anesthesia in connection with covered surgery)
- Temporomandibular joint disorder (TMJ) treatment, including treatment performed by prosthesis placed directly in the teeth
- Recreational therapy
- Sleep therapy
- Court-ordered services
- Thermograms and thermography
- Biofeedback
- Radial keratotomy
- Nursing facility services, except when the admission is for rehabilitative services
- Audiology services, except for children age 15 and younger
- Postacute care except for 30 days of inpatient occupational, physical or speech therapy
Vision Services

Amerigroup members have enhanced vision service benefits. Facilities and providers are listed in the Provider Referral Directory. If a member needs assistance in obtaining care, the member should contact Block Vision (Block) at the telephone number listed on his or her member ID card. Providers may contact Block provider services support at 1-866-819-4298 for routine vision services. Providers may contact Amerigroup at 1-800-454-3730 regarding medical vision services.

Under Medicaid and NJ FamilyCare A, B and C, the following services are covered:

- One exam is covered once every 12 months for members up to age 18; one pair of frames and eyeglass lenses selected from Medicaid allowable materials are covered once every 12 months or more frequently as medically necessary
- One exam is covered once every 12 months for members ages 19 through 59; one pair of frames and eyeglass lenses selected from Medicaid allowable materials are covered once every 24 months or more frequently as medically necessary
- One exam is covered once every 12 months for members age 60 or older; one pair of frames and eyeglass lenses selected from Medicaid allowable materials are covered once every 12 months or more frequently as medically necessary

Under NJ FamilyCare D, one exam is covered once every 12 months for members. One pair of frames and eyeglass lenses selected from Medicaid allowable materials are covered once every 24 months or more frequently as medically necessary.

Under NJ FamilyCare C and D, the vision exam requires a $5 copayment. No copayment is required for Native Americans and Eskimos under age 19 enrolled in NJ FamilyCare C and D.

Frames and eyeglass lenses are covered in full if the member chooses from Medicaid allowable materials. There is no allowance if the member does not choose from the selected Medicaid allowable materials. Repairs and replacements are covered with prior authorization if they are within the New Jersey Medicaid guidelines for repairs and/or replacements.

Contact lenses are covered as medically necessary:

- Specific ocular pathological conditions (e.g., Keratoconus, monocular surgical aphakia to effect binocular vision, anisometropia of 3.0 diopters or more)
- Members whose vision cannot be improved to at least 20/70 with regular lenses but improvement of vision can be accomplished to 20/70 or better with contact lenses
- Replacement of contact lens within two years only if there has been a significant change in basic lens parameters (e.g., design or prescription), and prior authorization is required

In addition, Block will provide the following Amerigroup value-added benefit to the extent the medical necessity criteria for contact lenses are not met, and the member elects to receive contact lenses. Block will allow an amount equal to the lesser of the member PCP’s billed charges, usual and customary or $100 for the cost of contact lenses, whichever is less.
Taking Care of Baby and Me® Program

Amerigroup offers Taking Care of Baby and Me® to all expectant mothers. The program objective is to provide coordinated, comprehensive prenatal management with the intent of identifying members prior to an adverse health event and provide them with care management, education and incentive gift rewards to promote healthy outcomes.

Notification to the Amerigroup National Customer Care department at 1-800-454-3730 is required at the first prenatal visit. Taking Care of Baby and Me provides care management to:

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

Health education is provided and encouraged through prenatal and postpartum health promotion packets that also include information on foster program participation and gift incentives. Information about available health-related community services is provided to members as appropriate. All identified pregnant members will automatically receive information on Taking Care of Baby and Me®.

Early and Periodic Screening, Diagnosis and Treatment

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated comprehensive child-health program for Medicaid recipients from birth through age 20. It is designed to identify physical and mental defects and provide treatment (or referral when indicated) to correct or ameliorate defects and chronic conditions. EPSDT screening must include:

- A comprehensive health and developmental history, including assessment of both physical and mental health development and provision of all diagnostic and treatment services that are medically necessary to correct or ameliorate a physical or mental condition identified during a screening visit
- A comprehensive, unclothed physical examination, including:
  - Vision and hearing screening
  - Dental inspection
  - Nutritional assessment
- Age-appropriate immunizations, health history and the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines; Amerigroup and network providers will adjust for periodic changes in recommended types and schedule of vaccines; immunizations must be reviewed at each screening examination as well as during acute care visits, and necessary immunizations must be administered when not contraindicated; deferral of administration of a vaccine for any reason must be documented
- Appropriate laboratory tests; the following list of screening tests is not all-inclusive:
  - Hemoglobin/hematocrit/EP
  - Urinalysis
  - Tuberculin test — intradermal, administered annually and when medically indicated
  - Lead screening using blood lead-level determinations must be performed for every Medicaid-eligible and NJ FamilyCare/Medicaid child:
    - Between 9 and 18 months, preferably at 12 months of age
    - Between 18 – 26 months, preferably at 24 months of age
Between 27 – 72 months of age for any child not previously tested
- Additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and will be obtained as necessary
- Health education and/or anticipatory guidance
- Referral for further diagnosis and treatment or follow-up of all abnormalities which are treatable/correctable or require maintenance therapy, uncovered or suspected (referral may be to the provider conducting the screening examination or to another provider as appropriate)
- Amerigroup has a referral process to be used by our providers that shall include providing a copy of the medical consultation and diagnostic results to the MH/SA provider. We have procedures to allow for notification of an enrollee’s MH/SA provider regarding the findings of his/her physical examination and laboratory/radiological tests within 24 hours of receipt for urgent cases and within five business days in nonurgent cases. This notification shall be made by phone with follow up in writing when feasible. Our policies and procedures can be found on our website and are available in hard copy upon request.

EPSDT screening services should reflect the age of the child and are provided periodically according to the following schedule:
- Neonatal exam
- Under 6 weeks of age
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- Annually through age 20

Vision services, at a minimum, include diagnosis and treatment for defects in vision and the provision of eyeglasses when medically necessary. Vision screening in an infant means, at a minimum, eye examination and observation of responses to visual stimuli. Screening for distant visual acuity and ocular alignment will be done for each child beginning at age 3.

Dental services may not be limited to emergency services. Dental screening in this context means, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries or oral infection. Referral to a dentist after one year of age is mandatory and at a minimum an annual dentist visit thereafter through the age of 20 years.

Hearing services, at a minimum, include diagnosis and treatment for defects in hearing, including hearing aids. For infants identified as at-risk for hearing loss through the New Jersey Newborn Hearing Screening Program, hearing screening should be conducted prior to three months of age, using professionally recognized audiological assessment techniques. For all other children, hearing screening means, at a minimum, observation of an infant’s response to auditory stimuli and audiogram for a child age three and older. Speech and hearing assessment will be a part of each preventive visit for an older child.

Mental Health (MH)/Substance Abuse (SA) includes a MH/SA assessment documenting pertinent findings. When there is an indication of a possible MH/SA issue, the Well-being Screening Tool or a DHS-approved equivalent will be used to evaluate the member. Such other necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects, and physical and mental/substance abuse illnesses and conditions discovered by the screening services.
For NJ FamilyCare B and C members, coverage includes all preventive screening and diagnostic services, medical examinations, immunizations, dental, vision, lead screening and hearing services. It includes only those treatment services identified through the examination that are included under the Amerigroup covered benefits or specified services through the FFS program.

For NJ FamilyCare D members, coverage is limited. For coverage information, please refer to Section 5 — Amerigroup Health Care Benefits and Copayments.

For all EPSDT visits, use the HMO — EPSDT Worksheet located in Appendix A — Forms.

Since Medicaid members may be less likely to seek preventive care than other populations, it is important for Amerigroup and its network physicians to arrange for a high level of EPSDT and immunization services for members. Amerigroup encourages members to receive EPSDT visits through the member handbook, new member welcome calls, a yearly member newsletter and written notices to all members who have missed an EPSDT appointment.

Amerigroup requires participating PCPs to encourage child members to receive EPSDT and adult members to receive an annual physical. If members miss an EPSDT appointment, the providers must document the missed appointments in the medical records and try to reach the members to reschedule. Amerigroup will send each PCP a list of his or her Amerigroup members who have missed an EPSDT visit or failed to have an encounter. The physician’s office staff must contact the members on this list to set up an appointment for a well visit. The provider must document efforts to contact members in the medical record. Although the EPSDT worksheet is not submitted with the claim for payment, the EPSDT worksheet must be submitted to Amerigroup upon request to confirm EPSDT has been performed.

**EPSDT Reminder Program**

A list of Amerigroup members who, based on Amerigroup claims data, may not have received EPSDT services according to the periodicity schedule is sent to their PCP each month. Additionally, Amerigroup mails information to these members encouraging them to contact their PCP’s office to set up appointments for needed services.

Please note that:

- The specific services needed for each member are listed on the report. Reports are based only on services received during the time the member has been enrolled with Amerigroup.
- Services must be rendered within due date span in accordance with federal EPSDT guidelines, the State Department of Health guidelines and the Centers for Disease Control and Prevention (CDC) Childhood and Adolescent Immunization Guide. In accordance with these guidelines, services received prior to the specified periodicity date do not fulfill EPSDT requirements.
- The list is based on Amerigroup claims data received prior to the date printed on the list. In some instances, the appropriate services may have been provided after the report run date.
- To ensure accuracy in tracking preventive services, please submit a completed claim form for those dates of service to:
Prenatal Care

Amerigroup provides a comprehensive package of maternity care and educational outreach services, which addresses the areas of a woman’s life likely to affect pregnancy outcomes and the health of her infant. Taking Care of Baby and Me® is the educational and incentive gift component provided to all pregnant members. Each member is automatically enrolled in this program through the maternal notification process.

Maternal and child case/care managers are available to:
• Improve pregnancy outcomes
• Coordinate services
• Provide outreach to members

Amerigroup believes preventive and early prenatal care will reduce infant morbidity and mortality rates. Early prenatal care can help reduce the care required by low birth weight, which would otherwise be compromised in low-birth-weight infants.

Blood Lead Screening

Providers will furnish a screening program for the presence of lead toxicity in children that consists of two components: verbal risk assessment and blood lead testing.

During every well-child visit for children between the ages of six months and six years old, the PCP will screen each child for lead poisoning. A blood test will be performed at 12 months and 24 months of age to determine lead exposure and toxicity. In addition, children over the age of 24 months and up to 72 months should receive blood lead-screening tests if there is no past record of a test. Please see blood lead-risk forms located in Appendix A — Forms.

Providers will perform an oral risk assessment for lead toxicity at every periodic visit between the ages of 6 months and 72 months (6 years). For further information, see the Verbal Blood Lead Risk Assessment form located in Appendix A — Forms. Generally, a child’s level of risk for exposure to lead depends upon the answers to the Verbal Blood Lead Risk Assessment form. If the answers to all questions are negative, a child is considered at a low risk for high doses of lead exposure. If the answers to any question are affirmative or I don’t know, a child is considered at a high risk for high doses of lead exposure. Regardless of risk, each child must be tested between 9 months and 18 months, preferably at 12 months and between 18 months and 26 months, preferably at 24 months. Further, any child between 27 months and 72 months who has not previously been tested should be tested. A child’s risk category can change with each administration of the oral risk assessment.

All screenings must be performed through a blood lead-level determination. Amerigroup has policies and procedures in place to identify and treat high-risk children for lead exposure and toxicity. The procedures include blood-level screening, diagnostic evaluation and treatment with follow-up care of children whose blood lead levels are elevated. The erythrocyte protoporphyrin test is no longer
acceptable as a screening test for lead poisoning; however, it is still valid as a screening test for iron deficiency anemia. Blood-level screening may be performed by a capillary sample (i.e., finger stick), venous sample or the use of a filter paper method. However, all elevated blood levels (e.g., equal to or greater than 10 micrograms per one deciliter) obtained through a capillary sample and filter paper must be confirmed by a venous sample.

The blood lead test must be performed by a New Jersey Department of Health and Senior Services licensed laboratory. The frequency with which the blood test is to be administered depends upon the results of the verbal risk assessment. For children determined to be at a low risk for high doses of lead exposure, a blood lead-screening test must be performed once between the ages of 9 months and 18 months, preferably at 12 months, between 18 months and 26 months, preferably at 24 months. Further, any child between 27 months and 72 months who has not previously been tested should be tested. For children determined to be at a high risk for high doses of lead exposure, a blood level screening must be performed at the time a child is determined to be at high risk beginning at six months of age if there is pertinent information or evidence that the child may be at risk at a younger age.

Amerigroup will send letters to our network PCPs who have lead screening rates less than 80 percent for two consecutive six-month periods. The letter will educate the PCPs on their need and responsibility to provide lead-screening services. PCPs who do not meet the 80 percent screening rate will be placed on corrective action plans. Amerigroup will monitor these PCPs to document improvement.

Amerigroup encourages use of the filter paper lead-screening method. A finger stick collection can be readily performed in the office with minimal clinical expertise required, and MEDTOX supplies are provided at no charge. In-office lead screening will serve to remove one of the patient’s largest barriers to obtaining the service — locating and securing an appointment at a lab. Contact your Provider Relations representative for more information on how to get started.

Amerigroup has policies and procedures in place regarding a Lead Case/Care Management (LCM) program. Children with blood lead levels ≥ 10 µg/dl and members of the same household who are between six months and six years of age are enrolled in the Amerigroup LCM program. The LCM program consists of the following:

- Follow-up of a child in need of lead screening or who has been identified with an elevated blood lead level of ≥ 10 µg/dl. At a minimum the follow-up includes:
  - For a child with an elevated blood lead level ≥ 10 µg/dl, the LCM will ascertain if the blood lead level has been confirmed with a venous blood sample; in the absence of confirmatory test results, the LCM will arrange for a test
  - For a child with a confirmed blood (venous) lead level of ≥ 10 µg/dl, the LCM will notify and provide to the local health department the child’s name, PCP’s name, the confirmed blood lead level and any other pertinent information
- Education for the family regarding all aspects of lead hazard and toxicity. The LCM will provide the family with materials that explain the sources of lead exposure, the consequences of elevated blood levels and preventive measures, including housekeeping, hygiene and appropriate nutrition. The reason it is necessary to follow a prescribed medical regimen will also be explained.
- Communication to all interested parties
• Development of a written case/care management plan with the PCP and the child’s family and other interested parties. The case/care management plan will be reviewed and updated on a regular basis.
• Coordination of the various aspects of the affected child’s care (e.g., Women, Infants and Children [WIC] Program, support groups, community resources)
• Pursuit of noncompliant members for follow-up tests/appointments and documentation of these activities in the LCM program


**Obstetrical and Gynecological Services**

**Well-woman Exam – Direct Access**
Members may self-refer to an Amerigroup network OB/GYN provider for routine and preventive women’s health care services when their PCP is not a women’s health specialist. Routine and preventive health care services will not require a referral from the PCP under this type of circumstance. A well-woman examination includes:
• Pelvic exam
• Pap smear
• STD screen
• Blood work and/or lab
• Pregnancy test, if medically indicated
• Breast exam
• Mammogram (Amerigroup follows the recommendations of the U.S. Preventive Services Task Force guidelines, which are supported by the U.S. Office of Disease Prevention and Health Promotion. However, Amerigroup will cover the cost of mammograms ordered by network providers for members of any age.) The physician may send the member to any of the network imaging facilities for the mammogram.

**Noninterference**
Amerigroup will not prohibit or restrict a provider from engaging in medical communication with the provider’s patient, either explicitly or implied. In addition, the Amerigroup Provider Manual, newsletters, directives, letters, oral instructions or any other forms of communication will not prohibit medical communication between the provider and the provider’s patient. Providers are free to communicate with their patients about their health status, medical care or treatment options, including any alternative treatment that may be self-administered, and the risks, benefits and consequences of treatment or nontreatment regardless of whether benefits for that care or treatment are provided under Amerigroup, if the provider is acting within the lawful scope of practice. Providers are free to practice their respective professions in providing the most appropriate treatment required by their patients and will provide informed consent within the guidelines of the law, including possible positive and negative outcomes of the various treatment modalities.

**Obstetrical Care**
At the member’s first obstetrical (OB) visit, the obstetrician must notify Amerigroup at 1-800-454-3730. This is the maternal notification process. The provider must complete the Maternity OB Notification
form and submit to Amerigroup to facilitate appropriate case/care management. Amerigroup offers a wide variety of educational classes for its members.

After notification, the obstetrician may act as the member’s PCP throughout the entire pregnancy, including six weeks postpartum. Additional medically necessary, covered test procedures may be ordered without precertification from the member’s general PCP. The obstetrician may also refer the member to other network physicians, as necessary, to provide nonobstetrical care. To ensure continuity of care, any referral for nonobstetrical-related care should first be discussed with the member’s general PCP.

Obstetrical care includes the following:

- All office visits during pregnancy, including additional office visits for treatment of non-OB related issues such as urinary tract infections
- Routine office hemoglobin and urinalysis tests, unless the tests are being performed for non-OB related conditions
- Initial serology for syphilis
- Ultrasounds, prenatal lab tests, other lab tests such as alpha-fetoprotein, RFP, Rhogam and nonstress tests
- Member care for delivery, including induction of labor by pitocin, episiotomy and delivery with or without forceps
- Physician’s services during normal hospital stay for uncomplicated cesarean section or vaginal deliveries
- Prenatal Pap smears
- Postpartum services during the six-week period following delivery, including all office visits and postpartum Pap smear

After delivery, the member may remain in the hospital for a period of no less than 48 hours for a vaginal birth and no less than 96 hours for a C-section birth.

The Amerigroup Comprehensive Maternity Services

The Amerigroup Comprehensive Maternity Services provides a package of care which addresses all areas that affect pregnancy outcomes and the health of infants. Coordination and continuity of care over time are part of the program requirements and guidelines. Coordination includes care coordination, comprehensive initial, periodic and postpartum assessment, development and implementation of a written plan of care, and an initial orientation for all members concerning the process and content of prenatal care, and their rights and responsibilities. Care coordination refers to activities designed to provide the member with care that is continuous, well integrated and tailored to the member’s individual needs. This includes active follow-up activities designed to ensure the plan of care is being followed and revised as needed.

The Amerigroup Comprehensive Maternity Services contains two major components: medical and health support services. The medical component includes obstetrical prenatal, intrapartum and postpartum care services. The health support services include care coordination, health education, nutrition, social and/or psychological services and home visits.

Prenatal care notification must be provided to Amerigroup. Delivery precertification will be obtained at the time of notification of pregnancy. Amerigroup requires providers to submit the Amerigroup New
Jersey Maternity Notification form found in Appendix A. This form may be faxed to Amerigroup at 1-800-964-3627. The following is a summary of information required:

- Outreach (notify Amerigroup if assistance with outreach is needed)
- Prenatal care (provided at the time of notification)
  - OB high-risk conditions
  - Prior pregnancy
  - Current pregnancy
  - Psychological risk factors
- Fetal risk factors in current pregnancy
- Delivery services (obtained by Amerigroup case/care managers during concurrent review)
- Postpartum services

**Infertility Services**

Only the diagnosis of infertility is considered a preventive health service. Treatment for such a diagnosis is not considered a preventive health service and is not covered by Amerigroup.

**Hysterectomy and Sterilization**

Federal law requires providers to provide hysterectomies and sterilizations to Medicaid members in ways designed to ensure those members consider their options and make informed choices. Amerigroup covers sterilizations only under the following conditions:

- The individual is at least 21 years old at the time of consent to be sterilized
- The individual is not mentally incompetent
- The individual has voluntarily given informed consent
- At least 30 days, but not more than 180 days have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. Informed consent must have been given at least 30 days before the expected date of delivery. For emergency abdominal surgery, at least 72 hours must have passed since the member gave informed consent.

The informed consent must meet the following requirements. The person who obtained consent must have offered to answer all questions and provided the following information:

- Advice that the individual is free to withhold or withdraw consent to the procedure at any time before sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled
- A description of available alternative methods of family planning and birth control
- Advice that the sterilization procedures are considered irreversible
- A thorough explanation of the specific sterilization procedure to be performed
- A full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used
- A full description of the benefits or advantages that may be expected as a result of the sterilization
- Advice that the sterilization will not be performed for at least 30 days, except under certain circumstances described above
The above information must be effectively communicated to all individuals, including persons who are blind, deaf or otherwise handicapped. An interpreter must be provided if the individual does not understand the language on the consent form or the language used by the person who is obtaining consent. The individual must be permitted to have a witness of his or her choice when consent is given. The Medicaid consent form must be completed and signed.

The Hysterectomy Receipt of Information form and Sterilization Consent form – 7473 MED are located in Appendix A — Forms. The forms take the provider through the entire consent process. A copy of the consent form must be placed in the member’s medical record. Another copy must be attached to the claim for the hysterectomy or sterilization procedure in order for the claim to be adjudicated. Both Amerigroup and the Michigan Peer Review Organization (MPRO) review such forms during medical chart audits.

**HIV Testing and Voluntary Counseling**

Amerigroup collaborates with community-based agencies that educate, test and treat pregnant women with HIV/AIDS to reduce perinatal transmission of HIV from the mother to the infant. All pregnant women will receive HIV education and counseling and HIV testing with their consent as part of their regular prenatal care. A refusal of testing must be documented in the member’s medical record. Additionally, counseling and education regarding perinatal transmission of HIV and available treatment options (e.g., the use of Zidovudine or the most current treatment accepted by the medical community for treating the disease) for the mother and newborn infant will be made available during the pregnancy and/or to the infant within the first months of life. Amerigroup arranges for treatment for HIV-positive pregnant women in collaboration with the member’s obstetrician in accordance with the CDC and NJ State Department of Human Services, Division of Epidemiology and AIDS Program. The following forms are located in Appendix A – Forms: Counsel for HIV Antibody Blood Test, Consent for HIV Antibody Blood Test and Results of HIV Antibody Blood Test.

**Outpatient Laboratory and Radiology Services**

Amerigroup allows laboratory testing in the office. PCPs and specialists will be reimbursed according to their contract.

For those offices with limited or no office laboratory facilities, laboratory tests should be referred to a network reference laboratory or network hospital that functions as an Amerigroup participating lab vendor. Please refer to the provider referral directory for a complete listing of participating laboratory vendors. In addition, Amerigroup allows members to access network hospital outpatient departments for blood drawing and/or specimen collection only when a convenient alternative is not available. Request forms for laboratory services should be obtained from the network laboratory, completed appropriately and forwarded with the specimen to the laboratory chosen.

All laboratory services furnished by nonparticipating providers require precertification by Amerigroup, except for hospital laboratory services in the event of an emergency medical condition.

For offices with limited or no office laboratory facilities, lab tests should be referred to an Amerigroup preferred lab vendor.
Preadmission laboratory tests must be ordered and completed within 72 hours of admission.

Below are tests that will not be recognized as stat (i.e., immediate) tests:

- Fecal occult blood
- Dip-stick or tablet reagent urinalysis for the following: bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen
- Ovulation tests
- Erythrocyte sedimentation rate, nonautomated
- Hemoglobin, copper sulfate, nonautomated
- Blood glucose by glucose monitoring device, specifically
- Spun hematocrit
- Hemoglobin by single analyte instruments with self-contained features to perform specimens’ reagents interaction, providing direct measurement and readout (e.g., Hemocue)

**Clinical Laboratory Improvement Amendment Reporting**

The federal Clinical Laboratory Improvement Amendment (CLIA) requires that all laboratories servicing Medicaid recipients must have a certificate of waiver or a certificate of registration.

The laboratories with a certificate of waiver may only provide the following nine tests:

1. Dip-stick or tablet reagent urinalysis for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity and urobilinogen
2. Fecal occult blood
3. Ovulation tests
4. Urine pregnancy tests
5. Erythrocyte sedimentation rate — nonautomated
6. Hemoglobin-copper sulfate — nonautomated
7. Blood glucose by glucose monitoring devices cleared by the U.S. Food and Drug Administration (FDA) specifically for home use
8. Spun microhematocrit
9. Hemoglobin by single analyte instruments with self-contained or component features to perform specimen/reagent interaction, providing direct measurement and readout

**Radiology Services**

Physicians will use National Imaging Associates, Inc. (NIA) for the management of certain diagnostic imaging studies. NIA will perform precertification services for Magnetic Resonance Imaging (MRI)/Magnetic Resonance Angiogram (MRA), Positron Emission Tomography (PET) scan, Computed Tomography (CT) and nuclear cardiology performed in an outpatient setting. Physicians who order any of the tests listed above must obtain precertification by contacting NIA at 1-800-642-7565, Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern Time. In addition to reviewing clinical appropriateness and issuing precertifications for these studies, NIA will locate a preferred imaging facility from the Amerigroup network of radiology service providers. Any of these tests performed in conjunction with an inpatient stay are not subject to precertification by NIA.
Reading of X-rays

When both a PCP and a radiologist read an X-ray, only the radiologist will be reimbursed for reading the film. If the PCP feels there is a concern with the reading diagnosis, he or she should contact the radiological facility to discuss the concern.

Urgent/Emergent Results: Providers are required to notify enrollees of laboratory and radiology results within 24 hours of receipt of results in urgent or emergent cases. Providers may arrange an appointment to discuss laboratory/radiology results within 24 hours of receipt of results when it is deemed face-to-face discussion with the enrollee/authorized person may be necessary. Urgent/emergency appointment standards must be followed. Rapid strep test results must be available to the enrollee within 24 hours of the test.

Routine Results: Providers are required to establish a mechanism to notify enrollees of non-urgent or non-emergent laboratory and radiology results within 10 business days of receipt of the results.

Pharmacy Services

The Amerigroup pharmacy benefit provides coverage for medically necessary medications from licensed prescribers for the purpose of saving lives in emergency situations or during short-term illness, sustaining life in chronic or long-term illness or limiting the need for hospitalization. Members have access to most national pharmacy chains and many independent retail pharmacies.

Monthly Limits
All prescriptions are limited to a 34-day supply per fill.

Covered drugs
The Amerigroup Pharmacy Program uses a Preferred Drug List (PDL). This is a list of the preferred drugs within the most commonly prescribed therapeutic categories. The PDL comprises drug products reviewed and approved by the Amerigroup Pharmacy and Therapeutics (P&T) Committee. The P&T Committee is comprised of network physicians, pharmacists and other health care professionals who evaluate safety, efficacy, adverse effects, outcomes and total pharmacoeconomic value for each drug product reviewed. The PDL also includes several Over-The-Counter (OTC) products recommended as first-line treatment where medically appropriate. To prescribe medications that do not appear on the PDL, please contact Pharmacy Services at 1-800-454-3730.

The following are examples of covered items:
- Formulary legend drugs
- Insulin
- Disposable insulin needles and syringes
- Disposable blood, urine glucose and acetone testing agents (e.g., Chemstrips, Clinitest tablets, Diastix Strips, Tes-Tape)
- Lancets and lancet devices
- Compounded medication of which at least one ingredient is a legend drug and is listed on the Amerigroup Medication Formulary
• Any other drug, which under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber and is listed on the Amerigroup Medication Formulary
• Formulary legend contraceptives; Exception: Injectable contraceptives may be dispensed up to a 90-day supply

Under the New Jersey Medicaid program (P.L. 1996, c.42, the State Fiscal Year 1997 Appropriations Act), unless the provider writes in ink in his own handwriting at the bottom of the prescription Brand Medically Necessary, the prescription will be filled with a generic substitution in every case. When a prescriber writes Brand Medically Necessary, these prescriptions will require prior authorization.

Amerigroup shall provide for a 72-hour supply of medication, on or off the formulary, while awaiting a prior authorization determination. Amerigroup will allow members to continue with a medication that has been removed from the Amerigroup formulary when, in the opinion of the provider, changing medications would not be safe for the member. Amerigroup shall only restrict or require a prior authorization for prescriptions or pharmacy services prescribed by MH/SA providers if one of the following exceptions is demonstrated:
1. The drug prescribed is not related to the treatment of substance abuse, dependency, addiction or mental illness or to any side effects of the psychopharmacological agents. These drugs are to be prescribed by Amerigroup PCPs or specialists in the Amerigroup network.
2. The prescribed drug does not conform to standard rules of the Amerigroup pharmacy plan.
3. Amerigroup, at its option, may require a Prior Authorization (PA) process if the number of prescriptions written by the MH/SA provider for MH/SA-related conditions exceeded four per month per member. For drugs that require weekly prescriptions, these prescriptions shall be counted as one per month and not as four separate prescriptions.

Prior Authorization Drugs
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, providers are required to contact Amerigroup Pharmacy Services to obtain prior authorization. Prior authorization may be requested by calling Pharmacy Services at 1-800-454-3730 (24 hours per day, 7 days per week). Providers must be prepared to provide relevant clinical information regarding the member’s need for a nonpreferred product or a medication requiring prior authorization. Decisions are based on medical necessity and are determined according to certain established medical criteria. Examples of medications that require authorization are listed below (Note: This list is subject to change and not all inclusive):
• 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)
• Adapaline (Differin)
• Adefovir dipivoxil (Hepsera)
• Agalsidase beta (Fabrazyme)
• Antihemophilic factor, recombinant (Advate)
• Becaplermin gel 0.1 percent (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, Lupron Depot)
• Levalbuterol hcl soln (Xopenex)
• Midazolam inj/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 (Rebetron)
• Saragliomostim (Leukine)
• Sevelamer (Renagel)
• Sibutramine (Meridia)
• Somatropin (Nutropin, Nutropin AQ, Nutropin Depot, Saizen)
• Tegaserod (Zelnorm)
• Terbinfine hcl tabs (Lamisil)
• Teriparatide (Forteo)
• Thalidomide (Thalomid)
• Tizanidine (Zanaflex)
• Tobramycin inhalation soln (Tobi)

**OTC Drugs**

Amerigroup has an enhanced benefit for members. The member may obtain a prescription for OTC or nonlegend drugs.

- For members of all categories age 21 and older, the benefit limit is $15 per quarter per member
- For members of all categories under age 21 (except NJ FamilyCare D), there is no benefit limit
- For NJ FamilyCare D members, OTC drugs are not a covered benefit

The Amerigroup PDL includes coverage of several OTC drugs when accompanied by a prescription. The following are examples of OTC medication classes covered:

- Analgesics and Antipyretics
Antacids
Antibacterials, topical
Antidiarrheals
Antiemetics
Antifungals, topical
Antifungals, vaginal
Anti-inflammatory, topical
Antihistamines
Contraceptives
Cough and cold preparations
Decongestants
Laxatives
Pediculocides
Respiratory agents (including spacing devices)

Excluded Drugs
The following drugs are examples of medications that are excluded from the pharmacy benefit:

- Anti-wrinkle agents (e.g., Renova)
- Drugs used for cosmetic reasons or hair growth
- Drugs used for experimental or investigational indication
- Erectile dysfunction drugs to treat impotence
- Experimental or investigational drugs
- Immunizing agents
- Implantable drugs and devices (Norplant, Mirena IUD)
- Infertility medications
- Weight control products (except Meridia and Alli which require prior authorization)

Specialty Drug Program

Amerigroup contracts with Caremark Specialty Pharmacy Services to be its exclusive supplier of high cost, specialty and injectable drugs that treat a number of chronic or rare conditions including:

- Anemia
- Crohn’s Disease
- Cystic Fibrosis
- Gaucher Disease
- Growth Hormone Deficiency
- Hemophilia
- Hepatitis C
- Immunologic Disorders
- Multiple Sclerosis
- Neutropenia
- Primary Pulmonary Hypertension
- Respiratory Syncytial Virus (RSV) Disease
- Rheumatoid Arthritis

A full listing of the medications supplied by Caremark Specialty Pharmacy Services is included here in this manual and is current at the time of printing. Because new specialty drugs continually become available, you should check with Amerigroup before providing any specialty and/or injectable drugs.

To obtain one of the listed specialty drugs, fax your request to CaremarkConnect at 1-800-323-2445; or call CaremarkConnect at 1-800-237-2767.
Because this is an exclusive arrangement with Caremark Specialty Pharmacy Services, you should not provide these drugs without first obtaining prior authorization from Amerigroup:

<table>
<thead>
<tr>
<th>Allergic Asthma</th>
<th>Intron® -A</th>
<th>Novantrone®</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Xolair®</td>
<td>Pegasys® **</td>
<td>Revlimid®</td>
<td>Actimmune NF®</td>
</tr>
<tr>
<td>Crohn’s Disease</td>
<td>Rebetol®</td>
<td>Rituxan®</td>
<td>Alferon N®</td>
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<tr>
<td>Remicade®</td>
<td>Rebetron®</td>
<td>Sprycel™™</td>
<td>Apligraf®</td>
</tr>
<tr>
<td>Enzyme Replacement</td>
<td>Ribavirin</td>
<td>Sutent®</td>
<td>Botox™</td>
</tr>
<tr>
<td>For Lysosomal Storage</td>
<td>Roferon® -A</td>
<td>Tarceva®</td>
<td>Fuzeon®</td>
</tr>
<tr>
<td>Disorders</td>
<td></td>
<td>Temodar®</td>
<td>Forteo®</td>
</tr>
<tr>
<td>Aldurazyme®</td>
<td></td>
<td>Thalomid®</td>
<td>Increlex™</td>
</tr>
<tr>
<td>Hormonal Therapies</td>
<td></td>
<td>Vidaza®</td>
<td>Lucentis™</td>
</tr>
<tr>
<td>Lupron Depot®</td>
<td></td>
<td>Xeloda®</td>
<td>Macugen®</td>
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<tr>
<td>Lupron Depot - Ped®</td>
<td></td>
<td>Zolinza®</td>
<td>Myobloc®</td>
</tr>
<tr>
<td>Gaucher Disease</td>
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<td></td>
<td>Octreotide Acetate</td>
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<tr>
<td>Ceredase</td>
<td></td>
<td></td>
<td>Proleukin®</td>
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<tr>
<td>Cerezyme®</td>
<td>Trelstar Depot™</td>
<td></td>
<td>Rhogam® available at</td>
</tr>
<tr>
<td>Growth Hormone Disorders</td>
<td></td>
<td>Trelstar LA</td>
<td>retail</td>
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<tr>
<td>Drotropin®</td>
<td></td>
<td>Vantas®</td>
<td>Sandostatin®</td>
</tr>
<tr>
<td>Humatrope</td>
<td></td>
<td>Viadur®</td>
<td>Sandostatin LAR°</td>
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<tr>
<td>Norditropin**</td>
<td></td>
<td>Zoladex®</td>
<td>Somavert®</td>
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<tr>
<td>Norditropin - Nordiflex**</td>
<td></td>
<td></td>
<td>Thyrogen®</td>
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<tr>
<td>Nutropin®</td>
<td></td>
<td></td>
<td>Visudyne®</td>
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<tr>
<td>Nutropin AQ®</td>
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<td></td>
<td>Vivitrol®</td>
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<tr>
<td>Saizen®</td>
<td>Fabrazyme®</td>
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<tr>
<td>Serostim®</td>
<td>Myozyme®</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tev-Tropin™</td>
<td>Naglazyme™</td>
<td></td>
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<tr>
<td>Zorbitive™</td>
<td>Myozyme™</td>
<td></td>
<td></td>
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<tr>
<td>Immune Deficiencies</td>
<td></td>
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<tr>
<td>Baygam®</td>
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<tr>
<td>Carimune® NF</td>
<td>Cytogam®</td>
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<tr>
<td>Cyrogamma™</td>
<td>Flebogamma®</td>
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<tr>
<td>Gamimune® N</td>
<td>Gamimune® S/D</td>
<td></td>
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</tr>
<tr>
<td>Nordotropin**</td>
<td>Gammar® -P I.V.</td>
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</tr>
<tr>
<td>Nordopin - Nordiflex**</td>
<td>GammaSTAN®</td>
<td></td>
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<tr>
<td>Nutropin®</td>
<td>Gamunex®</td>
<td></td>
<td></td>
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<tr>
<td>Nutropin AQ®</td>
<td>Ivecag EN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saizen®</td>
<td>Octagam®</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serostim®</td>
<td>Panglobulin®</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tev-Tropin™</td>
<td>Polygam® SD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zorbitive™</td>
<td>Vivaglobin®</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hematopoietics*</td>
<td></td>
<td>WinRho® SDF</td>
<td></td>
</tr>
<tr>
<td>Aranesp®</td>
<td>Multiple Sclerosis</td>
<td></td>
<td>Respiratory</td>
</tr>
<tr>
<td>Epogen®</td>
<td>Avonex®</td>
<td>Syncytial Virus</td>
<td>Synagis®</td>
</tr>
<tr>
<td>Leukine</td>
<td>Betaseron®</td>
<td>Rheumatoid</td>
<td></td>
</tr>
<tr>
<td>Neulasta®</td>
<td>Copaxone®</td>
<td>Arthritis</td>
<td></td>
</tr>
<tr>
<td>Neumega®</td>
<td>Novantrone®</td>
<td>Enbrel®</td>
<td></td>
</tr>
<tr>
<td>Neupogen®</td>
<td>Rebif®</td>
<td>Humira®</td>
<td></td>
</tr>
<tr>
<td>Procrit®</td>
<td>Tysabri®</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The drugs below require notification for treatment:

**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

**Behavioral Health Services**

Behavioral health services are covered for members who are clients of the Division of Developmental Disabilities (DDD). Non-DDD members are covered under the Medicaid FFS program for behavioral health services. Behavioral health services are available for DDD members as follows:

- PCPs can call the toll-free number on the member’s identification card. A behavioral health care manager will be available for consultation and/or to furnish the name of an appropriate provider.
- Amerigroup members can call the toll-free number on their identification card to access services.
- Behavioral health providers can call the toll-free number on the member’s identification card and request precertification for an Amerigroup member who has requested services from the provider directly.

In addition, coverage of those diagnoses which are categorized as altering the mental status of a member but are of organic origin will be covered by Amerigroup for all categories of members. These include the diagnoses in the following International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) series:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>290.0</td>
<td>Senile dementia, simple type</td>
</tr>
<tr>
<td>290.1</td>
<td>Presenile dementia</td>
</tr>
<tr>
<td>290.10</td>
<td>Presenile dementia, uncomplicated</td>
</tr>
<tr>
<td>290.11</td>
<td>Presenile dementia with delirium</td>
</tr>
<tr>
<td>290.12</td>
<td>Presenile dementia with delusional features</td>
</tr>
<tr>
<td>290.13</td>
<td>Presenile dementia with depressive features</td>
</tr>
<tr>
<td>290.2</td>
<td>Senile dementia with delusional or depressive features</td>
</tr>
<tr>
<td>290.20</td>
<td>Senile dementia with delusional features</td>
</tr>
<tr>
<td>290.21</td>
<td>Senile dementia with depressive features</td>
</tr>
<tr>
<td>290.3</td>
<td>Senile dementia with delirium</td>
</tr>
<tr>
<td>290.4</td>
<td>Arteriosclerotic dementia</td>
</tr>
<tr>
<td>290.40</td>
<td>Arteriosclerotic dementia, uncomplicated</td>
</tr>
<tr>
<td>290.41</td>
<td>Arteriosclerotic dementia with delirium</td>
</tr>
<tr>
<td>290.42</td>
<td>Arteriosclerotic dementia with delusional features</td>
</tr>
<tr>
<td>290.43</td>
<td>Arteriosclerotic dementia with depressive features</td>
</tr>
<tr>
<td>290.8</td>
<td>Other specific senile psychotic conditions</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>290.9</td>
<td>Unspecified senile psychotic condition</td>
</tr>
<tr>
<td>291.1</td>
<td>Alcohol amnestic syndrome</td>
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<tr>
<td>291.2</td>
<td>Other alcoholic dementia</td>
</tr>
<tr>
<td>292.82</td>
<td>Drug-induced dementia</td>
</tr>
<tr>
<td>292.83</td>
<td>Drug-induced amnestic syndrome</td>
</tr>
<tr>
<td>292.9</td>
<td>Unspecified drug-induced mental disorders</td>
</tr>
<tr>
<td>293.0</td>
<td>Acute delirium</td>
</tr>
<tr>
<td>293.1</td>
<td>Subacute delirium</td>
</tr>
<tr>
<td>293.8</td>
<td>Other specific transient organic mental disorders</td>
</tr>
<tr>
<td>293.81</td>
<td>Organic delusional syndrome</td>
</tr>
<tr>
<td>293.82</td>
<td>Organic hallucinosis syndrome</td>
</tr>
<tr>
<td>293.83</td>
<td>Organic affective syndrome</td>
</tr>
<tr>
<td>293.84</td>
<td>Organic anxiety syndrome</td>
</tr>
<tr>
<td>294.0</td>
<td>Amnestic syndrome</td>
</tr>
<tr>
<td>294.1</td>
<td>Dementia in conditions classified elsewhere</td>
</tr>
<tr>
<td>294.8</td>
<td>Other specified organic brain syndromes (chronic)</td>
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<tr>
<td>294.9</td>
<td>Unspecified organic brain syndrome (chronic)</td>
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<tr>
<td>305.1</td>
<td>Nondependent abuse of drugs – tobacco</td>
</tr>
<tr>
<td>310.0</td>
<td>Frontal lobe syndrome</td>
</tr>
<tr>
<td>310.2</td>
<td>Postconcussion syndrome</td>
</tr>
<tr>
<td>310.8</td>
<td>Other specified nonpsychotic mental disorder following organic brain damage</td>
</tr>
<tr>
<td>310.9</td>
<td>Unspecified nonpsychotic mental disorder following organic brain damage</td>
</tr>
</tbody>
</table>

PCPs and other providers must use the Well-being Screening Tool, which is located in Appendix A – Forms for all members.

In the case of an admission, members should receive an outpatient follow-up encounter within seven days of hospital discharge. Amerigroup will contact members who have been discharged within the same seven-day period to monitor and facilitate access to follow-up care.

The following atypical antipsychotic agents are covered by New Jersey FFS Medicaid program:

- Abilify (aripiprazole)
- Clozapine
- Generically-equivalent drug products of the drugs listed in this section
- Invega (paliperidone)
- Olanzapine
- Quetiapine
- Risperidone
- Symbyax (olanzapine and fluoxetine)
- Ziprasidone
- All other atypical antipsychotic drugs within the specific therapeutic drug classes H7T and H7X not listed above

The goals of the precertification process are to avoid unreasonably restricted access to medications and to ensure that the prescribed drug is related to the treatment of a behavioral health condition or
to any side effect of the psychopharmacological medication. Precertification for medications will occur in very limited circumstances whether for DDD members or non-DDD members. Precertification is required where the prescribed drug does not conform to the standard rules of the Amerigroup pharmacy plan as described in Amerigroup Drug Utilization Review program description and in this manual.

Amerigroup will only restrict or require a precertification for prescriptions or pharmacy services prescribed by MH/SA providers if one of the following exceptions is demonstrated:

- The drug prescribed is not related to the treatment of substance abuse, dependency, addiction or mental illness or to any side effects of the psychopharmacological agents. These drugs are to be prescribed by the Amerigroup PCP or specialists in the Amerigroup network.
- The prescribed drug does not conform to standard rules of the Amerigroup pharmacy plan.
- Amerigroup at its option may require a precertification process if the number of prescriptions written by the MH/SA provider for MH/SA-related conditions exceed four per month per member. For drugs that require weekly prescriptions, these prescriptions will be counted as one per month and not as four separate prescriptions. The Amerigroup prior authorization process for the purposes of this section will require review and prior approval by DMAHS.

**Behavioral Health Precertification**

Amerigroup requires precertification for all elective behavioral health inpatient admissions and certain outpatient services. Amerigroup uses Milliman Criteria, InterQual® Behavioral Health Criteria, as well as the American Society of Addiction Medicine’s Patient Placement Criteria. The following all-inclusive list of services must be precertified:

- Inpatient admission
- Outpatient detoxification
- Intensive outpatient and partial hospital programs
- Electroconvulsive therapy
- Psychological and neuropsychological testing

**Coordination of Physical and Behavioral Care**

Amerigroup has designed systems to ensure the coordination of physical and behavioral care for DDD members and non-DDD members who are currently receiving services.

Amerigroup recognizes that treatment and recovery can be complicated by comorbid conditions. Additionally, Amerigroup believes that essential ambulatory care should continue unabated while a member is hospitalized; therefore, PCPs and behavioral health providers are required to communicate directly to ensure continuity of care.

- When a member who is being treated for a comorbid behavioral health condition is admitted for treatment of a physical health condition, the attending physician will attempt to secure a release of information and review the admission with the PCP. This is necessary to ensure that essential treatment will continue unabated.
- When a member who is being treated for a comorbid physical health condition is admitted for treatment of a behavioral health condition, the attending physician will attempt to secure a release
of information and review the admission with the behavioral health provider. This is necessary to ensure that essential treatment will continue unabated.

Amerigroup requires that physical and behavioral health providers share relevant case information in a timely, useful and confidential manner. Amerigroup requires that the behavioral health provider be notified of the member’s physical examination and laboratory and radiological tests within 24 hours of receipt for urgent cases and within five business days in nonurgent cases. This notification will be made by telephone with follow-up in writing. The provider will obtain a release of information from any member or his or her legal representative (e.g., parent, guardian or conservator) before releasing confidential health information. The release of information must contain, at a minimum, the following:

- Name and identification number of the member whose health information is being released
- Name of provider releasing the information
- Name of provider receiving the information
- Information to be released
- Period for which the authorization is valid
- Statement informing the signatory that he or she can cancel the authorization at any time
- Printed name of the signatory
- Signature or mark of the signatory
- Date of signature

A physical health provider who recognizes concomitant behavioral health needs requiring treatment by a behavioral health provider will facilitate the member’s access to a behavioral health service by following the Amerigroup specialty referral procedures for DDD members. For non-DDD members, the physical health provider needs only to facilitate a referral to a behavioral health service.

A non-network provider who recognizes concomitant physical health needs requiring treatment by a physical health provider is expected to facilitate the member’s access to a primary provider by contacting Amerigroup.

For both DDD and non-DDD members who are hospitalized and receive both behavioral and physical health services, primacy (i.e., the form of care that is primary) will be determined by the principle diagnosis, type of attending physician and location of service. Either type of provider may initiate consultation with the other and coordinate further and/or ongoing care.

A physical and behavioral health provider should exchange health information at the following junctures:

- When the member first accesses a physical or behavioral health service
- When a change in the member’s health or treatment plan requires an alteration of the other provider’s treatment plan (e.g., when a member who has been taking lithium becomes pregnant)
- When the member is admitted to or discharged from the hospital
- When the member discontinues care
- When a member is admitted and a consultation is warranted
- Once a quarter if not otherwise required

Information should contain at a minimum:

- Provider’s name and contact information
- Member’s name, date of birth, gender, ID number and contact information
- Reason for referral (initial contact only)
- Current diagnosis
- History of the presenting illness and other relevant medical and social histories (initial contact only)
- Level of suicide, homicide, physical harm or threat
- Current treatment plan
- Special instructions (e.g., diagnostic questions to be answered, treatment recommendations)

The provider will maintain a copy of the release of information form and document care coordination in the member’s medical record.

For members who are not DDD clients, Amerigroup will coordinate inpatient behavioral health consultations and services, as well as discharge planning and follow-up with the member’s behavioral health provider (both network and non-network).

**Transportation Services**

Some counties have agencies that help Medicaid families get transportation to and from their medical appointments. This transportation is for members who cannot take public transportation and have no other way to get to appointments. Routine transportation to medical appointments for NJ FamilyCare B, C and D members is not covered.

For transportation to medical appointments, the member may call the following telephone numbers for transportation.
- Atlantic County – Division of Economic Assistance at 609-645-7700, ext. 5910
- Bergen County – Bergen County Board of Social Services at 201-368-4360
- Burlington County – Burlington County Board of Social Services at 609-261-1000
- Camden County – Camden County Board of Social Services at 856-225-8800
- Cape May County – Cape May County Welfare Board at 609-886-6200
- Cumberland County – Cumberland County Board of Social Services at 856-691-4600
- Essex County – Essex Medicaid Assistance Customer Center at 1-800-315-5278
- Gloucester County – Gloucester County Board of Social Services at 856-256-2281
- Hunterdon County – Hunterdon County Division of Social Services at 908-788-1300
- Mercer County – Mercer County Board of Social Services at 609-394-6666
- Middlesex County – Middlesex County Board of Social Services at 732-745-3500
- Monmouth County – Monmouth County Division of Social Services at 732-431-6000
- Morris County – Offices of Temporary Assistance at 973-326-7860
- Ocean County – Ocean County Board of Social Services at 732-349-1500
- Passaic County – Passaic County Board of Social Services at 973-881-0100
- Salem County – Salem County Board of Social Services at 856-299-7200
- Somerset County – Somerset County Board of Social Services at 732-418-3400
- Sussex County – Sussex County Division of Social Services at 973-383-3600
- Union County – Union County Division of Social Services at 908-965-2700
- Warren County – Warren County Division of Temporary Assistance and Social Services at 908-475-6301
The member must call for transportation several days before the provider appointment to schedule a reservation. If he or she cannot get transportation to his or her medical care, he or she may also call Member Services at 1-800-600-4441. Member Services may be able to locate other transportation.

If the member does not need emergency care but needs an ambulance, mobile intensive care unit or an invalid coach to receive medical service, he or she should call Member Services at 1-800-600-4441. Paratransit is covered for members with precertification from an Amerigroup case/care manager.

For an emergency medical condition, members are instructed to call 911 for an ambulance. For NJ FamilyCare D members, ambulance service is covered for medically necessary emergent services.

Transportation services are covered if a member must travel 30 miles or more for medically necessary benefits when a network or alternative provider is not available.

### Out-of-area Coverage

Amerigroup will provide or arrange for out-of-area coverage of covered benefits in emergency situations and nonemergency situations when travel back to the service area is not possible or practical or when medically necessary services can only be provided elsewhere.

- Amerigroup is not responsible for out-of-state coverage for routine care if the member resides out of the state for more than 30 days.
- For full-time students attending school and residing out of the country, Amerigroup is not responsible for health care benefits while the member is in school.
- Amerigroup is not responsible for services provided outside of the United States or its territories.

### Domestic Violence Services

It is especially important that network providers be vigilant in identifying members who may have been subjected to domestic violence. Domestic Violence — Framing Questions, Domestic Violence — Direct Verbal Questions and Domestic Violence — New Member screening tools are included on the next page of this manual. Member Services can help members identify resources to protect themselves from further domestic violence. Providers should report all suspected domestic violence.

State law requires reporting of child abuse. Such reporting can be done anonymously. Report any injuries from firearms and other weapons to the police. Report suspected child abuse or neglect immediately to the DYFS at 1-800-792-8610. They receive calls at this number 24 hours a day, 7 days a week. To report abuse that occurred in an institution, call the DYFS at 1-800-215-6853.

State law encourages individuals to report suspected cases of elder or partner abuse, neglect or exploitation that occurs in the community. Report suspected elder or partner abuse immediately to the State’s Division of Aging and Community Services at 1-800-792-8820 or to the particular county Adult Protective Services office. An individual can access the National Domestic Violence Hotline number by calling 1-800-799-7233; or for text telephone assistance, call 1-800-787-3224.

State law provides immunity from any criminal or civil liability as a result of good faith reports of child abuse or neglect. Any person who knowingly fails to report suspected abuse or neglect may be subject to a fine up to $1,000 or imprisonment up to six months.
Domestic Violence Screening Tools

Domestic Violence - Framing Statements

1. Because violence is so common in many people’s lives, I have begun to ask all my members about it.
2. I am concerned that someone hurting you may have caused your symptoms.
3. I do not know if this is a problem for you, but many of the people I see as members are dealing with abusive relationships.

Domestic Violence - Direct Verbal Questions

1. Are you in a relationship with a person who physically hurts or threatens you?
2. Did someone cause these injuries? Was it your partner or spouse?
3. Has your partner or ex-partner ever hit you or physically hurt you? Has he or she ever threatened to hurt you or someone close to you?
4. Do you feel controlled or isolated by your partner?
5. Do you ever feel afraid of your partner? Do you feel you are in danger? Is it safe for you to go home?
6. Has your partner ever forced you to have sex when you did not want to? Has your partner ever refused to practice safe sex?

Domestic Violence - New Member

Option 1:
1. Have you ever been hurt or threatened by your friend, spouse or partner?
   -Or-
2. Have you ever been hit, kicked, slapped, pushed or shoved by your friend, spouse or partner?
   -Or-
3. Have you ever been hit, kicked, slapped, pushed or shoved by your friend, spouse or partner during this pregnancy?
   -Or-
4. Have you ever been raped or forced to engage in sexual activity against your will?

Option 2:
1. Are you currently or have you ever been in a relationship where you were physically hurt, threatened or made to feel afraid?
Option 3:
1. Have you ever been forced or pressured to have sex when you did not want to?
   -Or-
2. Have you ever been hit, kicked, slapped, pushed or shoved by your friend, spouse or partner?

Sexual Abuse

It is required that each provider cooperate with the DYFS at 1-800-792-8610 in contacting that agency when sex abuse is suspected. Referrals should be made to the DYFS designated sex abuse specialty centers. If a suspected abuse case arises and a referral is required, the provider or member may call a specialty center directly or may call Amerigroup Member Services at 1-800-600-4441 for a list of the specialty centers near them.

Amerigroup in the Community

Amerigroup is a community-focused managed health care company that works to improve the lives of uninsured and low-income parents, children and persons with disabilities. Through our Medicaid and NJ FamilyCare programs, we ensure access to quality health care for those who otherwise might go without medical coverage. Amerigroup works with respected, community-based organizations to sponsor outreach events across the service area, including:

- Sponsoring summer technology camps for youth
- Holding free Summer Family Fun Nights to help strengthen family bonds
- Providing free hats and mittens to keep children warm in the winter
- Offering a free, safe, violence-free and fun environment for local teens to learn life skills, job training and alcohol and drug prevention
- Supporting the health of elderly community members
- Curtailing the effects diabetes and asthma have on our community’s people through education and support

Amerigroup also provides health education workshops in the community on a variety of topics to children, parents and staff members.

Amerigroup strives to contribute to the community’s overall quality of life for substantial and long-lasting impact by forming networks in which community organizations, health care professionals and community members work together.

Head Start Program

Head Start is a national program that provides comprehensive developmental services for preschool children ages three to five from low-income families and under the Early Head Start program for infants, toddlers and pregnant women. Amerigroup collaborates with the community Head Start programs to provide timely and age-appropriate health screening and referrals for routine health services.

- Amerigroup assigns each member a community-based PCP.
- Head Start staff encourages members to see their PCP for screenings and health services.
- Amerigroup supports timely and complete immunization of all children.
Amerigroup supports routine dental, vision and hearing exams for members.
Physical exams are encouraged according to the EPSDT periodicity schedule.
Amerigroup supports personal hygiene as part of the child’s daily routine through age-appropriate educational programs.
The Amerigroup Member Services staff, nurse case/care managers and Health Promotion staff coordinate the delivery of services for the children and work with their caretakers to eliminate barriers to timely health care.
Amerigroup Health Educators provide staff education programs and parent workshops focused on disease prevention and the importance of childhood screenings.

**School-based Youth Services Programs and Local Health Departments**

Amerigroup works collaboratively with School-based Youth Service Programs and Local Health Departments.

**New Jersey School-based Youth Services Program**
The School-based Youth Services Program (SBYSP), developed by the New Jersey Department of Human Services, provides adolescents and children with the opportunity to complete their education, to obtain skills that lead to employment or additional education and to lead a mentally and physically healthy life.

SBYSP sites primarily serve adolescents between ages 13 to 19, many of whom are at risk of dropping out of school, becoming pregnant, using drugs, developing mental illness or being unemployed. SBYSP sites also serve those most at risk of being dependent for long periods on state assistance programs.

Each site offers a comprehensive range of services, including:
- Crisis intervention
- Individual and family counseling
- Primary and preventive health services
- Drug and alcohol abuse counseling
- Employment counseling, training and placement
- Summer and part-time job development
- Referrals to health and social services
- Recreation

Some sites offer day care, teen parenting, training, special vocational programs, family planning, transportation and hotlines. Parental consent is required for all SBYSP services.

Amerigroup provides health education workshops to SBYSP participants on a variety of topics, including:
- Adolescent health
- Nutrition
- Conflict resolution
- Personal hygiene
- Healthy relationships
For an updated list of SBYSP and program directors, please visit www.state.nj.us/dcf/prevention/school.

Local Health Departments
For an updated list of Local Health Departments in New Jersey, please visit www.state.nj.us/health/lh/lhdirectory.pdf.

New Technology Assessments
Amerigroup continues to keep pace with change and to ensure that members have access to safe and effective care. Amerigroup has a formal process to evaluate and address new developments in medical technology, including medical therapies and procedures, drugs, and equipment.

Coordination of Benefits
If a member is covered by more than one health care plan, Amerigroup will administer Coordination Of Benefits (COB). Under COB, the primary payer of benefits is identified in order to eliminate duplication of reimbursement.

If Amerigroup is identified as the primary payer of benefits, Amerigroup will reimburse the provider up to the contracted fee. If Amerigroup is identified as the secondary payer of benefits and the primary coverage is Medicare, Amerigroup will cover the full deductible for in-Patient services and Out-Patient Hospital Services. For Out-Patient services, Amerigroup will cover the primary health plan’s deductible, coinsurance and noncovered services if those services are covered under the Amerigroup scope of benefits up to the Medicare/Medicaid contracted fee, not to exceed the amount Amerigroup would have paid if it had been the primary carrier. In addition, providers and members must abide by all Amerigroup policies and procedures, including notification or precertification of services.

Amerigroup will notify the state within 30 days after it learns a member has health insurance coverage that is not reflected in the state’s file or casualty insurance coverage or if there is a change in a member’s health insurance coverage. In addition, Amerigroup requires its providers to notify Amerigroup of this information.

Any questions or inquiries regarding paid, denied or pended claims should be directed to Provider Services at 1-800-454-3730.

Third-party Liability
Providers must use and report any other public or private third-party sources of payment for services rendered to members.

If a provider is aware of third-party coverage, the provider must submit a claim first to the appropriate third party before submitting a claim to Amerigroup.
In the following situations, a provider may bill Amerigroup first and then coordinate with the liable third party, unless Amerigroup has received prior approval from the state to take other action:
- The coverage is derived from a parent whose obligation to pay support is being enforced by the Department of Human Services.
- The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the Medicaid program.
- The claim is for labor, delivery and postpartum care and does not involve hospital costs associated with the inpatient hospital stay.
- The claim is for a child who is in a DYFS support out-of-home placement.
- The claim involves coverage or services mentioned above in combination with another service.

If a provider knows that the third party will neither pay for nor provide the covered service and the service is medically necessary, the provider may bill Amerigroup without having received a written denial from the third party.

Sharing of Third-party Liability Information by a Provider
A provider must notify Amerigroup within 30 days after he or she learns that a member has health insurance coverage not reflected in the health insurance provided by Amerigroup or casualty insurance coverage or of any change in a member’s health insurance coverage.

When a provider becomes aware that a member has retained counsel who either may institute or has instituted a legal cause of action for damages against a third party, he or she must notify Amerigroup in writing, including the member’s name and Medicaid identification number, date of accident and/or incident, nature of injury, name and address of the member’s legal representative, copies of pleadings, and any other documents related to the action in the provider’s possession or control. This will include but not be limited to (for each service date on or subsequent to the date of the accident and/or incident) the member’s diagnosis and the nature of the service provided to the member.

A provider must notify Amerigroup within 30 days of the date he or she became aware of the death of one of his or her patients age 55 or older, giving the member’s full name, Social Security Number, Medicaid identification number, and date of birth.

Providers must agree to cooperate with Amerigroup and the state’s efforts to maximize the collection of third-party payments by providing Amerigroup updates to the information required by this section.

Self-referral Services (Services That Do Not Need a Referral from a PCP)
Members may self-refer for a limited number of services:
- A service provided by the member’s assigned PCP or an approved Amerigroup provider for special needs care
- Specialty care services provided by a network specialist
- Emergency room care provided in a medical emergency
- Annual well-woman exam, routine and preventive women’s health care services when the PCP is not a women’s health specialist; services can be received from a network obstetrician/gynecologist, certified nurse midwife or PCP
- Care provided by the provider’s nurse or physician assistant
- Dental care provided by a network family dentist
• Family planning services provided by a network or non-network Medicaid-approved family planning provider
• Medicaid services that are not covered by Amerigroup
• Prenatal care provided by a network obstetrician or certified nurse midwife
• Members with HIV and other chronic conditions may select a specialist who has been approved by Amerigroup; the provider may provide specialty services and primary care to the member without precertification
• Routine vision care provided by a Block Vision provider

The Member Handbook details the self-referral process, and members can call Member Services for explanation of the self-referral process.
6 MEMBER RIGHTS AND RESPONSIBILITIES

Members have rights and responsibilities when participating with a Managed Care Organization (MCO). Our Member Services representatives serve as advocates for Amerigroup members. The following lists the rights and responsibilities of members:

**Members have the right to:**

- Receive a current directory of doctors within the Amerigroup network that includes addresses, telephone numbers and a list of providers that accept members who speak languages other than English
- Choose any of our Amerigroup network specialists; members need to get a referral from their Primary Care Provider (PCP) first; the referral is based on whether the specialist can take new patients; some services do not need a referral
- Be referred by their PCP to get care from a specialist who has treated chronic disabilities
- Be able to get in touch with their PCP or a backup PCP 24 hours a day, 365 days a year for urgent care; this information is on the member ID card
- Call 911 without getting an OK from Amerigroup if they have an emergency medical condition; this information is on the member ID card
- Talk with their doctors about all medical treatments they can have, even if they are not covered; they may also get information on treatment they can have or other care options; this includes anything listed in the clinical guidelines
- File a complaint or appeal with Amerigroup or the State
- Be treated with respect and dignity
- Have information about Amerigroup, our services, policies and procedures, network providers, member rights and responsibilities, and any changes made
- Refuse treatment to the extent of the law and be aware of the results; this includes the right to refuse to be part of research.
- Have an advance directive in effect
- Expect their records and communications will be kept confidential; they will not be given to anyone unless they allow it
- Choose their own PCP in the Amerigroup network, choose a new network PCP and have privacy when seeing their providers
- Have a choice of specialists and receive information on how to obtain referral to a specialist or other provider, like an eye doctor
- Have their medical information given to a person they choose, or have it given to a person who is legally authorized, when concern for their health makes it inadvisable to give such information to them
- Get help from someone who speaks their language or through a TTY line
- Be free from being billed by providers for covered services that are medically necessary and were authorized by Amerigroup, unless there is a copayment
- Offer suggestions for changes in the way Amerigroup does business
- Be free of hazardous procedures
• Be fully informed by their PCP, Care/Case Manager or other Amerigroup network providers and help make decisions about their health care
• Take part in developing and implementing a plan of care that promotes the best results for them and encourages independence
• Have services that promote quality of life and independence; Amerigroup wants to help keep and encourage their natural support systems
• Have a doctor be the one to decide if their coverage is to be denied or limited
• Voice complaints about Amerigroup or the care provided and recommend changes to policies and services to Amerigroup staff, providers and outside representatives of their choice free of limits, interference, force, discrimination or attack by Amerigroup or our providers
• Right to refuse care from specific providers
• Have access to their medical records in accordance with federal and state laws
• Be free from harm, including unnecessary physical restraints or isolation, excessive medication, physical or mental abuse, or neglect
• Make recommendations regarding the member rights and responsibilities policy

Amerigroup shall not discriminate against an enrollee or attempt to disenroll a member for filing a complaint or grievance/appeal against the HMO.

Members have the right to receive the following information each year:
• Member rights and responsibilities
• Amerigroup benefits and services and how to get these benefits and services
• Provisions for after-hours and emergency coverage
• Charges to members, if charges apply, including:
  ◦ How to pay charges
  ◦ Copayments and fees
  ◦ What to do if they get a bill for services
• Termination of or changes in benefits, services, health care facilities or providers
• How to appeal decisions that affect their coverage, benefits or relationship with Amerigroup
• How to change PCPs
• How to disenroll from Amerigroup
• How to file a complaint or grievance and how to recommend changes they think Amerigroup should make
• The percentage of Amerigroup network providers who are board-certified
• A description of:
  ◦ How to get services, including authorization requirements
  ◦ Any special benefit rules that may apply to services they get outside of the Amerigroup network
  ◦ How to get services covered by fee-for-service Medicaid
  ◦ How to get out-of-area coverage
  ◦ Policies on referrals for specialty and ancillary care
MEMBER RESPONSIBILITIES

Amerigroup members have the responsibility to:

- Let their family doctor know as soon as possible after they get emergency treatment
- Treat their doctors and their staffs and Amerigroup employees with respect and dignity
- Get information and consider treatments before they are done
- Discuss any problems about following their doctor’s directions
- Know what refusing treatment recommended by a doctor can mean
- Help their family doctor get their medical records from the doctor they had before; they should help their doctor fill out their new record as well
- Get permission from their family doctor or the doctor’s associates before seeing a consultant or specialist; they should also get permission from their doctor before going to the emergency room unless they have an emergency
- Call Amerigroup and change their doctor before seeing a new doctor
- Keep following Amerigroup policies and procedures until they are disenrolled
- Make and keep appointments and be on time; always call if they need to cancel an appointment or if they will be late
- State their complaints, concerns and opinions in an appropriate and courteous way
- Learn and follow the policies and procedures outlined in their Member Handbook
- Tell their doctor who they want to be told about their health
- Become involved in their health care; they should work with their doctor about recommended treatment; they must then follow the plans and instructions for care that they have agreed upon with their provider
- Carry their Medicaid and Amerigroup ID card at all times; they should report any lost or stolen cards to Amerigroup as soon as they can; also, contact Amerigroup if information on their card is wrong or if they have changes in name or address
- Provide, to the extent possible, information needed by Amerigroup, their doctor and professional staff in caring for them, including the names of any doctors they are currently seeing

Member Complaint and Grievance Resolution Process and Procedures

Amerigroup will provide members a grievance resolution process. All members or a person acting on behalf of the members have a right to voice dissatisfaction of any aspect of the Amerigroup or a provider’s operations. Providers cannot file a grievance on behalf of a member unless the member has granted the provider permission to act as his or her personal representative in writing.

Member grievances do not relate to medical management actions or interpretation of medically necessary benefits.

Members may file a grievance (complaint) for causes other than adverse action taken by Amerigroup to deny, reduce, terminate, delay or suspend a covered service, as well as any other acts or omissions of Amerigroup which impair the quality, timeliness or availability of such benefits.
Definitions

Appeal: A request for review of an action.

Complaint: A protest by a member as to the conduct of Amerigroup, or an act or failure to act by Amerigroup, or any other matter in which a member feels aggrieved by Amerigroup and/or an Amerigroup agent. Once communicated to Amerigroup, the complaint can be resolved by Amerigroup within five business days, except for urgent situations and as required by the exigencies of the situation.

Grievance: An expression of dissatisfaction about any matter or a complaint that is submitted in writing or that is orally communicated and cannot be resolved within five business days of receipt.

Note: Complaints and grievances do not relate to adverse determinations (decisions to deny or limit medical services); these are called appeals and are addressed in Member Medical Appeals Process and Procedures section.

Member Complaint Resolution

Amerigroup has procedures for receiving, responding to and documenting resolution of member complaints. Member complaints may be oral or written. A provider may initiate a complaint on the member’s behalf with the member’s written consent. A member or provider will not be penalized for filing a complaint. At no time will Amerigroup cease care pending a complaint investigation. A member may telephone Amerigroup Member Services at 1-800-600-4441 or write to the following address:

Quality Management Department
Amerigroup Community Care
399 Thornall Street, Ninth Floor
Edison, NJ 08837

A member may receive assistance with a complaint by writing to the following address:

NJ FamilyCare/Medicaid
P.O. Box 712
Trenton, NJ 08625-0712

Member complaints will be resolved within five business days; however, if not resolved within five business days, the complaint becomes a grievance on the sixth day. Complaints of an emergent nature will be resolved within 24 hours, and complaints of an urgent nature will be resolved within 48 hours. A member may file a grievance if the resolution to the complaint is unsatisfactory.

Medicaid and NJ FamilyCare A and some D members have the right to a Medicaid Fair Hearing. NJ FamilyCare B, C and D members, except D members with a PSC 380, are not permitted the opportunity to access a Medicaid Fair Hearing.
Member Grievance Resolution Nonutilization Management

Amerigroup has procedures for receiving, responding to and documenting resolution of member grievances. A member or provider on behalf of a member with the member’s written consent may file a grievance. A member or provider will not be penalized for filing a grievance. At no time will Amerigroup cease care pending a grievance investigation.

A member or provider on behalf of a member with the member’s written consent may file a grievance by fax, mail, telephone or in-person. Any supporting documentation should accompany the grievance. A member or provider on behalf of a member with the member’s written consent may file a grievance in writing or by calling the following:

Quality Management Department  
Amerigroup Community Care  
399 Thornall Street, Ninth Floor  
Edison, NJ 08837

Member Services at 1-800-600-4441  
Provider Services at 1-800-454-3730

All member grievances will be kept confidential to the extent permissible under federal or state laws, regulations and/or contractual requirements.

A member may receive assistance with a grievance by writing to the following address:

NJ FamilyCare/Medicaid  
P.O. Box 712  
Trenton, NJ 08625-0712

Level I Grievance Review

A Level I Grievance is dissatisfaction with the resolution or outcome of a complaint or a complaint that was not resolved within five business days of receipt. Upon receipt of a Level I grievance request, supporting documentation may be requested by Amerigroup. It may include consultation with the member and/or providers, review of medical records, or other relevant documents and discussions with other persons having knowledge of the issue. A Level I Grievance Acknowledgement Letter will be sent to the member within five business days of the initiation of the Level I Grievance. A resolution letter will be sent to the member and provider if the provider requests the grievance on the member’s behalf within 30 calendar days from the time of the initiation of the grievance. Also, the member is notified in writing of his or her right to a Level II Grievance review.

Level II Grievance Review

If the member or provider on behalf of a member expresses dissatisfaction with the Level I Grievance resolution, he or she can send a letter by mail or fax or call Amerigroup Member Services to request a Level II Grievance review. A Level II Grievance review consists of a committee review. A committee meets as necessary to investigate the grievances. The committee comprises the department heads from QMC, Provider Services and the health plan medical director and any additional senior staff
members necessary to address the member’s concern who have not been involved in the original complaint or grievance.

A member may choose to attend a grievance meeting or choose someone else as a representative to attend. A member and/or member’s representative may participate in meetings in person or through another means of available technology (e.g., telephone conference). A meeting will be set up at a reasonable time and location for the member. A Level II Grievance Resolution Letter is sent to the member and provider if the provider requests the grievance on the member’s behalf within 30 days of receipt of the request.

**Medicaid Fair Hearing**

The member will be notified in writing of his or her right to a Medicaid Fair Hearing. A Medicaid Fair Hearing may be initiated at any time during the complaint and grievance process but is limited to 20 days from the date of the notice of decision. Medicaid/NJ FamilyCare A and specific D (i.e., members with a PSC 380 only) members may also request a hearing at any time during the appeal process through the DMAHS Fair Hearing Section. NJ FamilyCare B, C and D (except D members with a PSC 380) are not permitted the opportunity to access a Medicaid Fair Hearing. The member has a right to represent him or her at the state hearing or to be represented by legal counsel, friend or other spokesperson. The Department’s Medicaid Fair Hearing decision is binding.

Medicaid Fair Hearing submissions are made in writing to:

Department of Human Services  
Division of Medical Assistance and Health Services  
Fair Hearing Section  
P.O. Box 712  
Trenton, NJ 08625-0712

**Dissatisfaction with Grievance Decisions**

**Level II Grievance Review**

If a member expresses dissatisfaction with an adverse grievance decision, he or she may either send a letter by mail or fax it to Amerigroup within 90 days of receipt of the written grievance resolution (20 days in the case of a Medicaid Fair Hearing). Oral requests for review of the decision are followed up with a written request from the member or the member’s representative.

Amerigroup provides the member with an opportunity to express dissatisfaction with an adverse grievance decision which is described below.

The Quality Management staff will attempt to gather as much information as possible, including any aspects of clinical care involved to assist Amerigroup in making an informed decision.

A grievance meeting comprised of the Amerigroup associate vice president of Quality Management, director of Provider Services, medical director, any additional senior staff members and participating providers not previously involved in the grievance decision is scheduled. The member or person acting on behalf of the member may also attend.
A meeting is scheduled at a reasonable time and location for the member. The member is notified at least seven days in advance of the meeting date and given the time and location.

The Amerigroup total time for acknowledgement, investigation, resolution and decision notice of the entire grievance process (Level I and II) will be within 90 calendar days of the initial request.

If delays are outside of Amerigroup control (e.g., the result of a third party’s failure to provide documentation in a timely manner or awaiting response from the complainant for additional information), Amerigroup may extend the time for resolution an additional 14 business days. Amerigroup will notify the member in writing of the cause for the extension and issue a written decision regarding the grievance within the extended time frame.

The member will be notified in writing of the Amerigroup resolution containing the following information:

- The decision reached by Amerigroup
- The reason and policies or procedures that were the basis for the decision
- The right to further remedies allowed by law
- The department’s address and telephone number that a member may contact a Quality Management representative to obtain more information about the decision or the right to an appeal

**Tracking and Reporting**

Grievances will be tracked and trended by the Quality Management department. Records will include, but information is not limited to:

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

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

**First Line of Defense Against Fraud and Abuse**

**General Obligation to Prevent, Detect and Deter Fraud, Waste and Abuse**

As a recipient of funds from state and federally sponsored health care programs, we each have a duty to help prevent, detect and deter fraud, waste and abuse. Amerigroup commitment to detecting, mitigating and preventing fraud, waste and abuse is outlined in our Corporate Compliance Program. As part of the requirements of the federal Deficit Reduction Act, each Amerigroup provider is required to adopt the Amerigroup policies on detecting, preventing and mitigating fraud, waste and abuse in all the federally and state-funded health care programs in which Amerigroup participates.
The Amerigroup policy on New Jersey Fraud, Waste and Abuse Prevention and Detection is part of the Amerigroup Corporate Compliance Program. Electronic copies of this policy and the Amerigroup Code of Business Conduct and Ethics are available at www.amerigroupcorp.com/providers.

Amerigroup maintains several ways to report suspected fraud, waste and abuse. As an Amerigroup provider and a participant in government-sponsored health care, you and your staff are obligated to report suspected fraud, waste and abuse. These reports can be made anonymously at amerigroup.silentwhistle.com. In addition to anonymous reporting, suspected fraud, waste and abuse may also be sent via email to corpinvest@amerigroupcorp.com. Suspected fraud may also be reported by calling Amerigroup Customer Service at 1-800-600-4441 or reaching out directly to the Amerigroup Chief Compliance Officer at 757-473-2711 or via email to ethics@amerigroupcorp.com.

In order to meet the requirements under the Deficit Reduction Act, you must adopt the Amerigroup fraud, waste and abuse policies and distribute them to any staff members or contractors who work with Amerigroup. If you have questions or would like to have more details concerning the Amerigroup fraud, waste and abuse detection, prevention and mitigation program, please contact the Amerigroup Chief Compliance Officer.

Importance of Detecting, Deterring and Preventing Fraud, Waste and Abuse
Health care fraud costs taxpayers increasingly more money every year. There are state and federal laws designed to crack down on these crimes and impose strict penalties. Fraud, waste and abuse in the health care industry may be perpetuated by every party involved in the health care process. There are several stages to inhibiting fraudulent acts, including detection, prevention, investigation and reporting. In this section we educate providers on how to help prevent member and provider fraud by identifying the different types, so you can be the first line of defense.

Many types of fraud and abuse have been identified, including the following:

Provider Fraud, Waste and Abuse
- Billing for services not rendered
- Billing for services that were not medically necessary
- Double billing
- Unbundling
- Upcoding

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

Member Fraud, Waste and Abuse
- Benefit sharing
- Collusion
- Drug trafficking
- Forgery
- Illicit drug seeking
- Impersonation fraud
- Misinformation and/or misrepresentation
Subrogation and/or third-party liability fraud
Transportation fraud

To help prevent member fraud, waste and abuse, providers can educate members about the types of fraud and the penalties levied. Also, spending time with patients and reviewing their records for prescription administration will help minimize drug fraud and abuse. One of the most important steps to help prevent member fraud is as simple as reviewing the Amerigroup member identification card. It is the first line of defense against fraud. Amerigroup may not accept responsibility for the costs incurred by providers rendering services to a patient who is not a member even if that patient presents an Amerigroup member identification card. Providers should take measures to ensure the cardholder is the person named on the card.

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

Amerigroup believes that awareness and action are vital to keeping the state and federal programs safe and effective. Understanding the various opportunities for fraud, waste and abuse and working with members to protect their Amerigroup identification card can help prevent fraud, waste and abuse. We encourage our members and providers to report any suspected instance of fraud, waste or abuse by calling Customer Service at 1-800-600-4441, by emailing corpinvest@amerigroupcorp.com or by contacting the Amerigroup Chief Compliance Officer. An anonymous report can also be made by visiting amerigroup.silentwhistle.com. No individual who reports violations or suspected fraud, waste or abuse will be retaliated against; Amerigroup will make every effort to maintain anonymity and confidentiality.

HIPAA

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

Amerigroup strives to ensure that both Amerigroup and contracted participating providers conduct business in a manner that safeguards patient and member information in accordance with the privacy regulations enacted pursuant to HIPAA. Effective April 14, 2003, contracted providers shall have appropriate administrative, physical and technical safeguards in place to demonstrate compliance with the HIPAA privacy regulations.

Amerigroup recognizes its responsibility under the 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, please note that the 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, to make a precertification determination, to develop a comprehensive plan of care in
conjunction with the PCP, to resolve a payment appeal or to verify compliance with mandatory screenings, and participating standards as determined by the New Jersey Medicaid program. 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 that the receiving fax number is correct, notify the appropriate staff at Amerigroup and verify that 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 a specific Amerigroup department.

Amerigroup voicemail system is secure and password-protected. When leaving messages for Amerigroup associates, providers should only leave 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.
Welcome Call

As part of our member management strategy, Amerigroup offers a welcome call to new members. During the welcome call, new members who have been identified through their health risk assessment as possibly needing additional services are educated regarding the health plan and available services. Additionally, Member Services representatives offer to assist the member with any current needs, such as scheduling an initial checkup.

Appointment Scheduling

Through its participating providers, Amerigroup ensures that members have access to primary care services for routine, urgent and emergency services and to specialty care services for chronic and complex care. Providers will respond to an Amerigroup member’s needs and requests in a timely manner. The PCP should make every effort to schedule Amerigroup members for appointments using the guidelines outlined in Section 7 – PCP Access and Availability.

Nurse HelpLine

The Amerigroup Nurse HelpLine is a service designed to support the provider by offering information and education about medical conditions, health care and prevention to members after normal physician practice hours. The Nurse HelpLine provides triage services and helps direct members to appropriate levels of care. The Amerigroup Nurse HelpLine telephone number is 1-800-600-4441; the deaf or hard of hearing telephone number is 1-800-855-2880. Both are listed on the member’s ID card. This ensures that members have an additional avenue of access to health care information when needed. Features of the Nurse HelpLine include:
- Availability 24 hours a day, 7 days a week
- Information provided is based upon nationally recognized and accepted guidelines
- Free translation services for 150 different languages and for members with difficulty hearing
- Education for members about appropriate alternatives for handling nonemergent medical conditions
- A nurse faxes the member’s assessment report to the provider’s office within 24 hours of receipt of the call

Interpreter Services

Interpreter services are available if needed. Over-the-telephone interpreter services are available 24 hours a day, 7 days a week. For in-office interpreter services, call Amerigroup Provider Services at the National Customer Care Department at 1-800-454-3730 to arrange for the service.

Health Promotion

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

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

- Annual member newsletter
- Creation and distribution of AMERITIPS, Amerigroup health education tools used to inform members of health promotion issues and topics
- Health Tips on Hold (educational telephone messages while the member is on hold)
- A monthly calendar of health education programs offered to members
- Development of health education curricula and procurement of other health education tools (e.g., breast self-exam cards)
- Relationship development with community-based organizations, faith-based organizations, schools, local businesses, special needs organizations and health centers to enhance opportunities for members

**Case/Care Management**

Case/care management is designed to proactively respond to a member’s needs when conditions or diagnoses require coordination of services. When a member is identified (usually through precertification, admission review, and/or provider or member request), the Amerigroup nurse helps identify medically appropriate alternative methods or settings in which care may be delivered. The purpose of the Amerigroup Case/Care Management Program is to provide a coordinated comprehensive approach to ensure that members receive efficient and cost-effective services at the appropriate level of care through the development of individualized, innovative programs and coordination with community services.

A provider, on behalf of the member, may request participation in the program. The case/care manager will work with the member, provider and/or the hospital to identify the necessary:

- Intensity level of case/care management services needed
- Appropriate alternate settings where care may be delivered
- Health care services required
- Equipment and/or supplies required
- Community-based services available
- Communication required (i.e., between member and PCP)

The Amerigroup nurse will assist the member, utilization review team and PCP/hospital in developing the discharge plan of care, ensuring that the member’s medical needs are met and linking the member with community resources and Amerigroup programs for outpatient case and/or disease management.

**Disease Management Centralized Care Unit**

Disease Management Centralized Care Unit (DMCCU) programs are based on a system of coordinated care management interventions and communications designed to assist physicians and others in managing members with chronic conditions. The programs include a holistic, member-centric care
management approach that allows care managers to focus on multiple needs of members. Disease Management (DM) Programs:

- Behavioral Health
  - Bipolar disorder
  - Schizophrenia
- Cardiac
  - Coronary artery disease
  - Congestive heart failure
- Diabetes
- HIV/AIDS
- Pulmonary
  - Asthma
  - Chronic obstructive pulmonary disease

Additional DM programs may be available for members in your area. (Please call the number provided to learn if these programs apply to your members.)

- Hypertension
- Bipolar disorder
- Obesity

Program Features:

- Proactive population identification processes
- Evidence-based national practice guidelines
- Collaborative practice models to include physician and support-service providers in treatment planning for members
- Continuous patient self-management education, including primary prevention, behavior modification programs and compliance/surveillance, as well as home visits and case/care management for high-risk members
- Ongoing process and outcomes measurement, evaluation and management
- Ongoing communication with providers regarding patient status

Amerigroup Disease Management programs are based on national approved clinical practice guidelines located at www.amerigroupcorp.com/providers. Simply access the New Jersey page and log in to the secure site by entering your Login Name and Password. On the Online Inquiries page, scroll down to Resources, click on the Clinical Practice Guidelines link and select New Jersey. A copy of the guidelines can be printed from the website or you can contact Provider Services at the National Customer Care Department at 1-800-454-3730 to receive a printed copy.

Who Is Eligible?

All Amerigroup members with the above diagnoses are eligible for DMCCU services. Members are identified through continuous case finding efforts to include early case finding welcome calls, claims mining and referrals. As a valued provider, you can also refer patients who can benefit from additional education and care management support.

Members identified for participation in any of the programs are assessed and risk stratified, based on the severity of their disease. Once enrolled in a program, they are provided with continuous education
on self-management concepts, which include primary prevention, behavior modification and compliance/surveillance, as well as case/care management for high-risk members. Program evaluation, outcome measurement and process improvement are built into all the programs. Providers are given updates regarding patient status and progress.

**Disease Management Provider Rights and Responsibilities:**
As a participating provider with members enrolled in the disease management program, you have additional rights and responsibilities. You have the right to:

- Obtain information about Amerigroup, including programs and services, our staff, their qualifications and any contractual relationships
- Decline to participate in or work with the Amerigroup programs and services for our members, if contractually possible
- Be informed of how the organization coordinates our disease management-related interventions with treatment plans for individual patients
- Know how to contact the person responsible for managing and communicating with your patients
- Be supported by Amerigroup to make decisions interactively with patients regarding their health care
- Receive courteous and respectful treatment from Amerigroup staff
- Communicate complaints to Amerigroup regarding disease management as outlined in the Amerigroup Provider Complaint and Grievance Procedure

**Hours of Operation**
Amerigroup case/care managers are licensed nurses/social workers and are available from 8:30 a.m. to 5:30 p.m. Eastern Time, Monday through Friday. Confidential voicemail is available 24 hours a day. The Nurse HelpLine is available 24 hours a day, 7 days a week for our members.

**Contact Information**
Please call 1-888-830-4300 to reach an Amerigroup case manager. Additional information about disease management can be obtained by visiting www.amerigroupcorp.com/providers. Select New Jersey, scroll down to Patient Support and click on the link titled Disease Management Centralized Care Unit (DMCCU). Members can obtain information about our DMCCU program by visiting www.myamerigroup.com or calling 1-888-830-4300.

**Health Education Advisory Committee**
The Health Education Advisory Committee provides advice to Amerigroup members regarding health education and outreach programmatic development. The committee strives to ensure that materials and programs meet cultural competency requirements and are both understandable to the member and address the member’s health education needs.

The Health Education Advisory Committee’s responsibilities are to:
- Identify health education needs of the membership based on review of demographic and epidemiologic data
- Identify cultural values and beliefs that must be considered in developing a culturally competent health education program
- Assist in the review, development, implementation and evaluation of the member health education tools for the outreach program
- Review the health education plan and make recommendations on health education strategies
- Identify barriers to obtaining appropriate health care services and develop ways to address those barriers

**WIC Program**

Under New Jersey state law, Medicaid recipients eligible for WIC benefits include the following classifications:

- Pregnant women
- Women who are breast feeding their infant up to one year postpartum
- Women who are nonbreast feeding up to six months postpartum
- Infants under age one
- Children under age five

Please use the New Jersey WIC form located in Appendix A – Forms of this manual if any of your Amerigroup members meet these criteria.

The referral includes information needed by WIC programs to provide appropriate services. The referral must be completed with the current (within 60 days) height, weight, hemoglobin or hematocrit, and any identified medical/nutritional problems for the initial WIC referral and for all subsequent certifications.

Members may apply for WIC services at their local WIC agency service. Please call Provider Services at 1-800-454-3730 for the agency nearest to the member.

Network providers are expected to coordinate with the WIC Program. Coordination includes the referral of potentially eligible women, infants and children and the reporting of appropriate medical information to the WIC Program.

**Vaccines for Children Program**

**Participation Requirement:** The state of New Jersey requires all providers who see Medicaid members and administer vaccines to children to enroll with the Department of Health and Senior Services’ Vaccines For Children (VFC) Program. Additionally, providers must use the free vaccines for Medicaid patients if the vaccine is covered by VFC. Amerigroup reimburses providers an $11.50 administration fee for all VFC covered vaccines. Amerigroup will reimburse providers for the administration and the cost of non-VFC vaccines.
**PROVIDER RESPONSIBILITIES**

**Medical Home**

The PCP is the foundation of the Medical Home, responsible for providing, managing and coordinating all aspects of the member’s medical care and providing all care that is within the scope of his or her practice. The PCP is responsible for coordinating member care with specialists and conferring and collaborating with the specialists, using a collaborative concept known as a Medical Home.

Amerigroup promotes the Medical Home concept to all of its members. The PCP is the member’s and family’s initial contact point when accessing health care. The PCP’s relationship with the member and family, together with the health care providers within the Medical Home and the extended network of consultants and specialists with whom the Medical Home works, have an ongoing and collaborative contractual relationship. The providers in the Medical Home are knowledgeable about the member’s and family’s special, health-related social and educational needs and are connected to necessary resources in the community that will assist the family in meeting those needs. When a member is referred for a consultation or specialty/hospital services or health and health-related services by the PCP through the Medical Home, the Medical Home provider maintains the primary relationship with the member and family. He or she keeps abreast of the current status of the member and family through a planned feedback mechanism with the PCP who receives them into the Medical Home for continuing primary medical care and preventive health services.

**Responsibilities of the PCP**

The PCP is a licensed Medical Doctor (MD) or Doctor of Osteopathy (DO) or certain other licensed medical practitioner who, within the scope of practice and in accordance with state certification/licensure requirements, standards and practices, is responsible for providing all required primary care services to enrollees, including periodic examinations, preventive health care and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, and maintaining continuity of patient care. A PCP shall include general/family practitioners, pediatricians and internists and may include specialist physicians, Physician Assistants (PAs), certified nurse midwives or certified nurse practitioners, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with these contract provisions and licensure requirements. Providers who practice in FQHCs and RHCs may be included as PCPs. Below are highlights of the PCP’s responsibilities.

The PCP shall:

- Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers, including Fee-For-Service (FFS); provide coordination necessary for referrals to specialists and FFS providers (both in and out-of-network); and maintain a medical record of all services rendered by the PCP and other providers
- Provide 24-hour-a-day, 7-day-a-week coverage; regular hours of operation should be clearly defined and communicated to members
• Provide services ethically and legally, provide all services in a culturally competent manner and meet the unique needs of members with special health care needs
• Participate in any system established by Amerigroup to facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements
• Make provisions to communicate in the language or fashion primarily used by his or her membership
• Participate and cooperate with Amerigroup in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by Amerigroup. This includes providing information or documentation as needed to administer health care operations or to verify compliance with mandatory screenings/participating standards as determined by the New Jersey Medicaid program.
• Participate in and cooperate with the Amerigroup complaint and grievance procedures. Amerigroup will notify the PCP of any member grievance.
• Not balance bill members. However, the PCP is entitled to collect applicable copayments for certain services.
• Continue care in progress during and after termination of his or her contract for up to four months until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations
• Comply with all applicable federal and state laws regarding the confidentiality of patient records
• Develop and have an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens
• Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act
• Support, cooperate and comply with the Amerigroup Quality Improvement Program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner
• Inform Amerigroup if a member objects to provision of any counseling, treatments or referral services for religious reasons
• Treat all members with respect and dignity; provide members with appropriate privacy and treat member disclosures and records confidentially, giving the members the opportunity to approve or refuse their release
• Provide to members complete information concerning their diagnosis, evaluation, treatment and prognosis and give members the opportunity to participate in decisions involving their health care, except when contraindicated for medical reasons
• Advise members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program; and advise members on treatments which may be self-administered
• When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings
Have a policy and procedure to ensure proper identification, handling, transport, treatment, and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.

Agree to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide quality patient care.

Agree that any notation in a patient’s clinical record indicating diagnostic or therapeutic intervention as part of the clinical research shall be clearly contrasted with entries regarding the provision of nonresearch related care.

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

PCP Access and Availability

All providers are expected to meet the federal and state accessibility standards and those defined in the Americans with Disabilities Act of 1990. Health care services provided through Amerigroup must be accessible to all members.

Amerigroup is dedicated to arranging access to care for our members. Amerigroup is able to provide quality access dependent upon the accessibility of network providers. Providers are required to adhere to the following access standards:

- Emergency services immediately upon presentation at a service delivery site
- Urgent care within 24 hours
- Symptomatic acute care within 72 hours
- Routine care within 28 days
- Specialist care within four weeks or less as medically indicated
- Urgent specialty care within 24 hours of referral
- Baseline physicals for new adult members within 180 calendar days of enrollment
- Baseline physicals for new child members or adult members of the DDD within 90 days of enrollment or according to the EPSDT guidelines
- Prenatal care within three weeks of a positive pregnancy test, within three days of identification of high risk, within seven days of request in first and second trimester, and within three days of first request in third trimester
- Routine physicals within four weeks for routine physicals needed for school, camp, work or similar
- Lab and radiology within three weeks for routine care and within 48 hours for urgent care
- Waiting time in the physician’s office less than 45 minutes
- Initial pediatric appointments within three months of enrollment
- Behavioral health care immediately upon presentation at a service delivery site for emergency services, within 24 hours of the request for urgent care and within 10 days of the request for routine care
- Maximum number of intermediate/limited encounters are four per hour for adults and four per hour for children
- Emergency dental treatment no later than 48 hours or earlier as the condition warrants, urgent dental care appointments within three days of referral and routine nonsymptomatic dental care appointments within 30 days of referral; if the member does not have dental benefits, Amerigroup
will not pay for emergency dental services unless a doctor other than a dentist gives medical
treatment, and the doctor also needs to perform emergency dental work during treatment; if the
member does have dental benefits and is in need of emergency care, he/she must contact his/her
dentist right away. If the dentist’s office is closed, the member should leave a message with
his/her name and telephone number and will receive a call back within one hour for instruction; if
the dentist is not able to see the member, the member should call Healthplex at 1-800-720-5352
(TTY: 1-800-662-1220) for help in scheduling an appointment or finding another dentist; if the
member is out of town and in need of emergency dental care, he/she can go to any dentist for care
or call Healthplex for help to find a dentist

Amerigroup will ensure each new member (for SSI and New Jersey Care — ABD elderly and disabled
members) or authorized person is contacted to offer an initial visit to the member’s PCP within 45 days
of enrollment or according to the needs of the member. Those members identified with special needs
will be contacted within 10 days of enrollment and offered an expedited appointment.

Amerigroup routinely monitors providers’ adherence to the access to care standards.

Member Missed Appointments

Amerigroup members may sometimes cancel or not appear for necessary appointments and fail to
reschedule the appointment. This can be detrimental to their health. Amerigroup requires providers to
attempt to contact members who have not shown up for or canceled an appointment without
rescheduling the appointment. The contact must be by telephone and should be designed to educate
the member about the importance of keeping appointments and to encourage the member to
reschedule the appointment.

Amerigroup members who frequently cancel or fail to show up for an appointment without
rescheduling the appointment may need additional education in appropriate methods of accessing
care. In these cases, please call Provider Services at our National Customer Care Department at 1-800-
454-3730 to address the situation. Amerigroup staff will contact the member and provide more
extensive education and/or case/care management as appropriate. The Amerigroup goal is for
members to recognize the importance of maintaining preventive health visits and to adhere to a plan
of care recommended by their PCP.

Noncompliant Amerigroup Members

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

A Member/Provider Services representative will contact the member by telephone, or an Outreach
associate will visit the member to provide the education and counseling necessary to address the
situation and will report the outcome of any counseling efforts to you.

Amerigroup must first approve any reassignments of a member from a provider’s panel. Amerigroup
requires documentation of the reasons for the request for reassignment before the provider notifies
the member that he or she is being removed from the provider’s panel.
To remove a member from your panel, you must send a certified letter to the member or head of household and indicate that the member must select a new PCP within 30 days of the notice. A copy of the letter must be sent to:

Amerigroup Community Care  
399 Thornall Street, Ninth Floor  
Edison, NJ 08837

You must continue to provide care until the effective date for assignment to the new PCP.

In extreme situations in which a member consistently refuses to cooperate with Amerigroup and/or network providers, Amerigroup may request DMAHS to disenroll the member. In no event may a member be disenrolled due to health status, need for health services or a change in health status. Members may be disenrolled in any of the following circumstances:

- Amerigroup determines that the willful actions of the member are inconsistent with membership in the Amerigroup plan, and Amerigroup has made and provides DMAHS with documentation of at least three attempts to reconcile the situation. Examples of inconsistent actions include: persistent refusal to cooperate with any participating provider regarding procedures for consultations or obtaining appointments (this does not preclude a member’s right to refuse treatment), intentional misconduct, willful refusal to receive prior approval for nonemergency care; willful refusal to comply with reasonable administrative policies of Amerigroup, fraud or making a material misrepresentation to Amerigroup. In no way can this provision be applied to individuals on the basis of their physical condition, utilization of services, age, socio-economic status, mental disability, or uncooperative or disruptive behavior resulting from his/her special needs.

- Amerigroup becomes aware that the member falls into an aid category, has become ineligible for enrollment or has moved to a residence outside of the covered enrollment area.

- Amerigroup learns that the member is residing outside the state of New Jersey for more than 30 days. This does not apply to situations when the member is out of state for care provided and/or authorized by Amerigroup. This does not apply to full-time students.

Prior to recommending disenrollment of a member, Amerigroup will make a reasonable effort to identify for the member those actions that have interfered with effective provision of covered medical care and services and to explain what actions or procedures are acceptable. Amerigroup must allow the member sufficient opportunity to comply with acceptable procedures prior to recommending disenrollment. Amerigroup will provide at least one oral and at least one written warning to the member regarding the implications of his or her actions. An authorized person may be able to act on behalf of a member in the above situations.

If the member fails to comply with acceptable procedures, Amerigroup will give at least 30 days’ prior written notice to the member of its intent to recommend disenrollment. The notice will include a written explanation of the reason Amerigroup intends to request disenrollment and will advise the member of his or her right to file a disenrollment grievance. Amerigroup will give DMAHS a copy of the notice and advise DMAHS immediately if the member files a disenrollment grievance. An authorized person may be able to act on behalf of a member in the above situations.
In addition, the member may initiate a Medicaid Fair Hearing at any time during the complaint and grievance process but is limited to 20 days after the notice. Medicaid and NJ FamilyCare A and D members (i.e., members with a program status code 380 only) have the right to a Medicaid Fair Hearing. NJ FamilyCare B, C and D members (except D members with a program status code of 380) are not permitted the opportunity to access a Medicaid Fair Hearing.

Amerigroup and network providers will not request a member’s disenrollment based on an adverse change in the member’s health status or utilization of services which are medically necessary for treatment of a member’s condition.

**Members with Special Needs**

Adults with special needs include those members with complex/chronic medical conditions requiring specialized health care services, including persons with physical, mental, substance abuse and/or developmental disabilities, including such persons who are homeless. Children with special health care needs are those members who have or are at an increased risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required generally by children.

Amerigroup has developed methods for:
- Well-child care
- Health promotion and disease prevention
- Specialty care for those who require such care
- Diagnostic and intervention strategies
- Home therapies
- Ongoing ancillary services
- Long-term management of ongoing medical complications
- Care management systems for assuring children with serious, chronic and rare disorders receive appropriate diagnostic work ups on a timely basis
- Access to specialty centers inside and outside of New Jersey for diagnosis and treatment of rare disorders

We have policies and procedures to allow for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member. Our policies and procedure can be found on the Amerigroup website and are available in hard copy upon request.

Amerigroup with the assistance of network providers will identify members who are at risk of or have special needs. The identification will include the application of screening procedures (Complex Needs Assessment) for new members. These will include a review of hospital and pharmacy utilization. Amerigroup will develop care plans that address the member’s service requirements with respect to specialist physician care, durable medical equipment, medical supplies, home health services, social services, transportation, etc. The care management system is designed to ensure that all required services are furnished on a timely basis and that communication occurs between network and non-network providers (if applicable).

Amerigroup works to ensure that a new member with complex/chronic conditions receives immediate transition planning. The planning will be completed within a time frame appropriate to the member’s
condition, but in no case later than 10 business days from the effective date of enrollment when indicated on the Plan Selection form or within 30 days after special conditions are identified by a provider. The transition plan will include the following:

- Review of existing care plans
- Preparation of a transition plan that ensures continual care during the transfer to the plan
- Coordination and follow-through to ensure that the member receives the necessary DME if it was ordered prior to the member’s enrollment with Amerigroup and it was not received by the date of enrollment with Amerigroup

Outreach and enrollment staff is trained to work with members with special needs, to be knowledgeable about their care needs and concerns, to be able to converse in the different languages common among the members, and to be able to converse using different means of communication common among the members, including AT&T Relay Service and American Sign Language, if necessary.

If a new member upon enrollment or a member upon diagnosis requires very complex, highly specialized health care services over a prolonged period of time, the member may receive care from a participating specialist or a participating specialty care center with expertise in treating the life-threatening disease or specialized condition. The specialist or specialty care center will be responsible for providing and coordinating the member’s primary and specialty care. The specialist or specialty care center, acting as both primary and specialty care provider, will be permitted to treat the member without a referral from the member’s PCP and may authorize such referrals, procedures, tests and other medical services. If approval is obtained to receive services from a non-network provider, the care will be provided at no additional cost to the member.

Amerigroup will arrange for the provision of dental services to members with developmental disabilities. At a minimum, these will include the following:

- Providing consultations and assistance to the member’s caregivers
- Providing adequate time for members with developmental disabilities; initial and follow-up dental visits may require up to 60 minutes on average to allow for a comprehensive dental examination and other services; standards allow for up to four visits annually without prior authorization
- Providing home visits when medically necessary and where available
- Providing adequate support staff to meet the needs of the members
- Providing for the use and replacement of fixed, as well as removable prosthetic devices as medically necessary and appropriate
- Providing a reimbursement system for the cost of preoperative and postoperative evaluations associated with dental surgery
- Providing a dental management plan
- Coordinating authorizations for dental required hospitalizations by consulting with Amerigroup dental and medical consultants in an efficient and time-sensitive manner

Training sessions/materials and after-hours protocols for provider’s staff will address members with special needs. Protocols must recognize that a nonurgent condition for an otherwise healthy member may indicate an urgent care need for a member with special needs.
Case/care managers, providers and Member Services staff are able to serve members with behavior problems associated with developmental disabilities, including the extent to which these problems affect the member’s level of compliance.

**PCP Transfers**

In order to maintain continuity of care, Amerigroup encourages members to remain with their PCP. However, members may request to change their PCP for any reason by contacting our Member Services department at 1-800-600-4441. The member’s name will be provided to the PCP on the membership roster.

Members can call to request a PCP change any day of the month. PCP change requests will be processed generally on the same day or by the next business day. Members will receive a new ID card within 10 days.

**Covering Physicians**

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

**Specialist as a PCP**

Under certain circumstances, when a member requires the regular care of the specialist, a specialist may be approved by Amerigroup to serve as a member’s PCP. The criteria for a specialist to serve as a member’s PCP include the member having a chronic, life-threatening illness or condition of such complexity whereby:

- The need for multiple hospitalizations exists.
- The majority of care needs to be given by a specialist.
- The administrative requirements arranging for care exceed the capacity of the nonspecialist 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/Care 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 its 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 outlining the reasons for the denial of the request within one day of the decision. Specialists serving as PCPs will continue to be paid FFS while serving as the member’s PCP. The designation cannot be retroactive. For further information, see the Specialist as PCP Request Form located in the Appendix A – Forms section of the Manual.

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

Any status changes are to be reported to:

Amerigroup Community Care  
399 Thornall St., Ninth Floor  
Edison, NJ 08837

**Specialty Referrals**

In order to reduce the administrative burden on the provider’s office staff, Amerigroup has established procedures that are designed to permit a member with a condition that requires ongoing care from a specialist physician or other health care provider to request an extended authorization when required.

The provider can request an extended authorization by contacting Amerigroup. The provider must supply the necessary clinical information that will be reviewed by Amerigroup.

On a case-by-case basis, an extended authorization will be approved. In the event of termination of a contract with the treating provider, the continuity of care provisions in the provider’s contract with Amerigroup will apply. The provider may renew the authorization by submitting a new request to Amerigroup. Additionally, Amerigroup requires the specialist physician or other health care provider to provide regular updates to the member’s PCP (unless acting also as the designated PCP for the member).

If the specialist or other health care provider needed to provide ongoing care for a specific condition is not available in the Amerigroup network, the referring physician shall request authorization from Amerigroup for services outside the network. Access will be approved to a qualified non-network health care provider within a reasonable distance and travel time at no additional cost if medical necessity is met.

If a provider’s application for an extended authorization is denied, the member (or the provider on behalf of the member) may appeal the decision through the Amerigroup medical appeals process.

**Non-network Specialist Referrals**

Precertification is required for all admissions made by PCPs and specialists. Failure to obtain precertification for a procedure or admission requiring such precertification may result in denial of benefit payment. The medical director will review any appeal of such a denial.

If the member has a medical need that cannot be met by a network provider, a case/care manager will arrange access to needed services by a non-network provider within the service area, including coordination of transportation. Amerigroup will provide for review by a specialist of the same or similar specialty as the type of PCP or provider to whom a referral is requested before denying any request for
non-network care. Amerigroup reimburses non-network providers at rates comparable to network providers; an amount negotiated between the non-network provider and Amerigroup or the FFS Medicaid amount.

**Second Opinions**

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

The second opinion must be obtained from a network provider (see Provider Referral Directory) or a non-network provider if there is not a network provider with the expertise required for the condition. Once approved, the PCP or specialist will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The PCP or specialist will notify the member of the outcome of the second opinion.

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

- Whenever there is a concern about care expressed by the member or the provider
- Whenever potential risks or outcomes of recommended or requested care are discovered by Amerigroup during its regular course of business
- Before initiating a denial of coverage of service
- When denied coverage is appealed
- When an experimental or investigational service is requested

When Amerigroup requests a second opinion, Amerigroup will make the necessary arrangements for the appointment, payment and reporting. Amerigroup will inform the member and the PCP of the results of the second opinion and the consulting provider’s conclusion and recommendations regarding further action.

**Specialty Care Providers**

To participate in the Medicaid managed care model, the provider must be a licensed provider by the state before signing a contract with Amerigroup.

Amerigroup contracts with a network of provider specialty types to meet the medical specialty needs of members and provide all medically necessary covered services. The specialty care provider is a network physician who has the responsibility for providing the specialized care for members (See Role and Responsibility of the Specialty Care Providers). In addition to sharing many of the same responsibilities to members as the PCP (See Responsibilities of the PCP), the specialty care provider provides services that include:

- Allergy and immunology services
- Burn services
- Community behavioral health (e.g., mental health and substance abuse) services
- Cardiology services
- Clinical nurse specialists, psychologists, clinical social workers – behavioral health
• Critical care medical services
• Dermatology services
• Endocrinology services
• Gastroenterology services
• General surgery
• Hematology/oncology services
• HIV/AIDS services
• Neonatal services
• Nephrology services
• Neurology services
• Neurosurgery services
• Ophthalmology services
• Orthopedic surgery services
• Otolaryngology services
• Pediatric services
• Perinatal services
• Psychiatry (adult) assessment services
• Psychiatry (child and adolescent) assessment services
• Trauma services
• Urology services

**Role and Responsibility of the Specialty Care Providers**

Specialist providers will treat members and will render covered services only to the extent and duration that is medically necessary. Examples of obligations of the specialists include the following:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program
- Accepting all members referred to them
- Submitting required claims information including source of referral to Amerigroup
- Arranging for coverage with network providers while off-duty or on vacation
- Verifying member eligibility and precertification of services (if required) at each visit
- Providing consultation summaries or appropriate periodic progress notes to the member’s PCP on a timely basis, following a referral or routinely scheduled consultative visit
- Notifying the member’s PCP when scheduling a hospital admission or scheduling any procedure requiring the PCP’s approval
- Coordinating care, as appropriate, with other providers involved in providing care for members especially in cases where there are medical and behavioral health comorbidities or co-occurring mental health and substance abuse disorders

The specialist shall:

- Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers, including those engaged on a FFS basis; provide coordination necessary to refer to other specialists and FFS providers (both in and out-of-network); and maintain a medical record of all services rendered by the specialist and other providers
- Provide 24-hour-a-day, 7-day-a-week coverage and maintain regular hours of operation that are clearly defined and communicated to members
• Provide services ethically and legally and in a culturally competent manner and meet the unique needs of members with special health care requirements
• Participate in the systems established by Amerigroup that facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements
• Participate and cooperate with Amerigroup in any reasonable internal or external quality assurance, utilization review, continuing education or other similar programs established by Amerigroup. This includes providing information or documentation as needed to administer health care operations or to verify compliance with mandatory screenings/participating standards as determined by the New Jersey Medicaid program.
• Make reasonable efforts to communicate, coordinate and collaborate with other specialty care providers, including behavioral health providers, involved in delivering care and services to consumers
• Participate in and cooperate with the Amerigroup complaint and grievance processes and procedures. Amerigroup will notify the specialist of any member grievance brought against the specialist.
• Not balance bill members. However, the specialist is entitled to collect applicable copayments for certain services.
• Continue care in progress during and after termination of his or her contract. Please see Section 9 – Continuity of Care for more information.
• Comply with all applicable federal and state laws regarding the confidentiality of patient records
• Develop and have an exposure control plan regarding blood-borne pathogens in compliance with OSHA standards
• Make best efforts to fulfill the obligations under the Americans with Disabilities Act applicable to his or her practice location
• Support, cooperate and comply with the Amerigroup Quality Improvement Program initiatives and any related policies and procedures designed to provide quality care in a cost-effective and reasonable manner
• Inform Amerigroup if a member objects for religious reasons to the provision of any counseling, treatment or referral services
• Treat all members with respect and dignity; provide members with appropriate privacy; and treat member disclosures and records confidentially, giving the members the opportunity to approve or refuse their release as allowed under applicable laws and regulations
• Provide to members complete information concerning their diagnosis, evaluation, treatment and prognosis and give members the opportunity to participate in decisions involving their health care, except when contraindicated for medical reasons
• Advise members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program, and advise members on treatments that may be self-administered.
• When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings
• Have a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection
• Agree to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide quality patient care
Agree that any notation in a patient’s clinical record indicating diagnostic or therapeutic intervention that is part of a clinical research study is clearly distinguished from entries pertaining to nonresearch related care.

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

**Specialty Care Providers Access and Availability**

Amerigroup will maintain a specialty network to ensure access and availability to specialists for all members. A provider is considered a specialist if he or she has a provider agreement with Amerigroup to provide specialty services to members.

Specialist must adhere to the following access guidelines:

<table>
<thead>
<tr>
<th>Service</th>
<th>Access Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent, nonemergency visits</td>
<td>Within 24 hours of referral</td>
</tr>
<tr>
<td>Routine visits</td>
<td>Within four weeks</td>
</tr>
<tr>
<td>Prenatal care</td>
<td>Members will be seen within the following time frames:</td>
</tr>
<tr>
<td></td>
<td>1. Three weeks of a positive pregnancy test (home or laboratory)</td>
</tr>
<tr>
<td></td>
<td>2. Three days of identification of high risk</td>
</tr>
<tr>
<td></td>
<td>3. Seven days of request in first and second trimester</td>
</tr>
<tr>
<td></td>
<td>4. Three days of first request in third trimester</td>
</tr>
</tbody>
</table>

**Cultural Competency**

Cultural competency is a set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance of and respect for cultural differences and similarities within, among and between groups and the sensitivity to how these differences influence relationships with enrollees. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse enrollee needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications and other supports.

The quality of the patient-provider interaction has a profound impact on the ability of a patient to communicate symptoms to his or her provider and to adhere to recommended treatment. Some of the reasons that justify a provider’s need for cultural competency include:

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

Cultural barriers between the provider and member can impact the patient-provider relationship in many ways, including:
- The member’s level of comfort with the practitioner and the member’s fear of what might be found upon examination
- The differences in understanding on the part of diverse consumers in the U.S. health care system
- A fear of rejection of personal health beliefs
- The member’s expectation of the health care provider and of the treatment

To be culturally competent, Amerigroup expects providers serving members within this geographic location to demonstrate the following:

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

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

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

**Member Records**

Using nationally recognized standards of care, Amerigroup works with providers to develop clinical policies and guidelines of care for its membership. The Medical Advisory Committee (MAC) oversees and directs Amerigroup in formalizing, adopting and monitoring guidelines. 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. In addition, the New Jersey Department of Human Services/Division of Medical Assistance and Health Services has contracted with The Michigan Peer Review Organization (MPRO) to perform federally required outside medical record audits. Amerigroup understands the problems that providers encounter with the multitude of entities that currently perform medical record audits and will try to schedule reviews as conveniently as possible.

Amerigroup uses the New Jersey Practitioner Clinical Medical Record Audit Form, included in the Forms Section of this manual. In addition, Amerigroup audits include Amerigroup-specific tools designed to collect information to support quality improvement focus studies and HEDIS reporting. Amerigroup will report the findings to its network providers.

Providers are required to maintain medical records that conform to good professional medical practice and appropriate health management. A permanent medical record will 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 follows:

**Medical Record Standards**

The records reflect all aspects of patient care, including ancillary services. Documentation of each visit must include:

- Date of service
- Grievance or purpose of visit
- Diagnosis or medical impression
- Objective finding
- Assessment of patient’s findings
- Plan of treatment, diagnostic tests, therapies and other prescribed regimens
- Medications prescribed
- Health education provided
- Signature and title or initials of the provider rendering the service. If more than one person documents in the medical record, there must be a record on file as to what signature is represented by which initials.
These standards will, 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 patient ID number.

2. **Personal/biographical data.** The record must include: age, sex, address, employer, home and work telephone numbers, and marital status.

3. **Date and corroboration.** All entries must be dated and author identified.

4. **Legibility.** Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.

5. **Allergies.** Medication allergies and adverse reactions must be prominently noted on the record. Absence of allergies, No Known Allergies (NKA) must be noted in an easily recognizable location.

6. **Past medical history** (for patients seen three or more times). Past medical history must be easily identified, including serious accidents, operations and illnesses. For children, the history must include prenatal care of the mother and birth.

7. **Immunizations.** For pediatric records age 13 and under, a completed immunization record or a notation of prior immunization must be recorded, including vaccines and their dates of administration when possible.

8. **Diagnostic information.**

9. **Medication information** (includes medication information/instruction to patient).

10. **Identification of current problems.** Significant illnesses, medical and behavioral health conditions and health maintenance concerns must be identified in the medical record.

11. **Instructions.** Record must include evidence that the patient was provided with basic teaching/instructions regarding physical and/or behavioral health condition.

12. **Smoking/alcohol/substance abuse.** A notation concerning cigarettes, tobacco products, alcohol use and substance abuse must be stated if present for patients age 12 and older. Abbreviations and symbols may be appropriate.

13. **Consultations, referrals and specialist reports.** Notes from any referrals and consultations must be in the record. Consultation, lab and X-ray reports filed in the chart must have the ordering physician’s initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results must have an explicit notation in the record of follow-up plans.

14. **Emergencies.** 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 patient is part of the PCP’s panel must be noted.

15. **Hospital discharge summaries.** Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the patient is enrolled and for prior admissions, as appropriate. Prior admissions pertaining to admissions that may have occurred prior to the patient being enrolled may be pertinent to the patient’s current medical condition.

16. **Advance directive.** For medical records of adult patients, the medical record must document whether or not the individual has executed an advance directive. An advance directive is a written
instruction such as a living will or durable power of attorney that directs health care decision making for individuals who are incapacitated.

17. Security. Providers are required to maintain a written policy to ensure that medical records are safeguarded against loss, destruction or unauthorized use.

18. Release of information. Written procedures are required for the release of information and obtaining consent for treatment.

19. Documentation. Documentation is required setting forth the results of medical, preventive and behavioral health screening and of all treatment provided and results of such treatment.

20. Multidisciplinary teams. Documentation is required of the team members involved in the multidisciplinary team of a patient needing specialty care.

21. Integration of clinical care. Documentation of the integration of clinical care in both the physical and behavioral health records is required. Such documentation must include:
   • Screening for behavioral health conditions (including those which may be affecting physical health care and vice versa) and referral to behavioral health providers when problems are indicated
   • Screening and referral by behavioral health providers to PCPs when appropriate
   • Receipt of behavioral health referrals from physical medicine providers and the disposition and/or outcome of those referrals
   • At least quarterly (or more often if clinically indicated), a summary of the status/progress from the behavioral health provider to the PCP
   • A written release of information that will permit specific information sharing between providers
   • Documentation that behavioral health professionals are included in primary and specialty care service teams described in this contract when a patient with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder

Medical Record Management and Confidentiality

Amerigroup will release medical records of the member and/or facilitate the release of medical records in the possession of network providers. Release of medical records will be consistent with the provisions of confidentiality.

Amerigroup will maintain and requires network providers to maintain appropriate records relating to performance under this agreement, including records related to services provided to members. The medical records will include separate comprehensive medical records for each member as are necessary to record all clinical information pertaining to members, including notations of personal contacts, primary care visits and diagnostic studies. Each member’s medical records will be kept in detail consistent with federal and state requirements and good medical and professional practice, based on the services required and provided. Medical records must be available at each encounter with a medical professional. Records will also include appropriate financial records to document fiscal activities and expenditures, including records relating to the sources and applications of funds determination of amounts payable under the contract and the capacity of the members or network providers, if relevant, to bear the risk of potential financial losses. Financial records will be consistent with applicable state and federal regulations.
Amerigroup requires that duly authorized representatives be granted access to all records relating to its subcontractors’ performance under this agreement for the purposes of examinations, audit, investigation and copying of such records. The provider will give access to such records upon prior written notice during normal business hours, unless otherwise provided or permitted by applicable laws, rules or regulations.

Amerigroup requires network providers to maintain an appropriate record keeping system for services to members. Such system will collect all pertinent information relating to the medical management of each member and make that information readily available to appropriate health professionals and agencies. All records will be retained in accordance with applicable law for five years from the date of service or three years after final payment, whichever is later. All records relating to complaints must be maintained for at least three years and also require the permanent archiving of all major files for a period of no less than seven years. Medical records will be kept for 10 years following the member’s most recent service or until the member reaches age 23.

Medical records of members will be sufficiently complete as to permit subsequent peer review, medical audit or investigation. All required records, either originals or reproductions thereof, will be maintained in legible form and be readily available to appropriate state professional or investigative staff upon request for review and evaluation by professional medical, nursing and investigative staff.

If Amerigroup members disenroll from Amerigroup, network providers are required to release medical records of members as may be directed by the member, Amerigroup and/or authorized representatives of the appropriate agencies of the state and federal government. Release of records will be consistent with confidentiality provisions expressed in this manual and at no cost to members. All records will be retained in accordance with the confidentiality requirements cited in this manual.

Medical records and management information data concerning members enrolled in Amerigroup are confidential and will be disclosed to other persons within Amerigroup only as necessary to provide medical care and quality, peer or grievance review of medical care and other necessary administrative duties.

The provider and Amerigroup both agree and understand that all information, records, data and data elements collected and maintained for the operation of Amerigroup and pertaining to members will be protected from unauthorized disclosure. Access to such information, records, data and data elements will be limited to those who perform their duties in accordance with provisions of this contract and in accordance with applicable law.

**Minor Members**

Amerigroup policy on treatment of minors is designed to comply with federal, state and NCQA requirements and guidelines. Amerigroup communicates the policy to staff, members and providers.

No minor member will need to have parental permission for services such as family planning, prenatal care or substance abuse counseling. Only the minor member, not the member’s parents or any other individual, may consent to the provision of services. However, counseling should be offered to adolescents to encourage them to discuss their needs with a parent, an adult family member or other trusted adult. Minor members may also be treated for life-threatening conditions without parental permission.
Patient Visit Data

Documentation of individual encounters must provide adequate evidence of at a minimum:

1. A history and physical exam that includes appropriate subjective and objective information obtained for the presenting complaints
2. For patients receiving behavioral health treatment, documentation that includes at-risk factors (danger to self/others, ability to care for self, affect, perceptual disorders, cognitive functioning and significant social health)
3. An admission or initial assessment that must include current support systems or lack of support systems
4. For patients receiving behavioral health treatment, a documented assessment that is done with each visit relating to client status/symptoms to the treatment process and that may indicate initial symptoms of the behavioral health condition as decreased, increased or unchanged during the treatment period
5. A plan of treatment that includes activities/therapies and goals to be carried out
6. Diagnostic tests
7. Documented therapies and other prescribed regimens for patients who receive behavioral health treatment and that include evidence of family involvement as applicable and include evidence that the family was included in therapy sessions, when appropriate
8. Regarding follow-up care encounter forms or notes with a notation indicating follow-up care, a call or a visit that must note in weeks, months or as needed (PRN) the specific time to return with unresolved problems from any previous visits being addressed in subsequent visits
9. Results including all other aspects of patient care, such as ancillary services

Amerigroup will systematically review medical records to ensure compliance with the standards. Amerigroup will institute actions for improvement when standards are not met.

Amerigroup maintains an appropriate record keeping system for services to members. This system will collect all pertinent information relating to the medical management of each member and make that information readily available to appropriate health professionals and appropriate 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.

Clinical Practice Guidelines

Using nationally recognized standards of care, Amerigroup works with providers to develop clinical policies and guidelines for the care of its membership. The MAC oversees and directs Amerigroup in formulating, adopting and monitoring guidelines.

Amerigroup selects at least four evidence-based clinical practice guidelines that are relevant to the member population. Amerigroup will measure performance against at least two important aspects of each of the four clinical practice guidelines annually. The guidelines must be reviewed and revised at least every two years or whenever the guidelines change.

Clinical Practice Guidelines are located online at www.amerigroupcorp.com/providers. Simply access the New Jersey page and log in to the secure site by entering your Login Name and Password. On the
Online Inquiries page, scroll down to Resources, click on the Clinical Practice Guidelines link and select New Jersey. A copy of the guidelines can be printed from the website, or you can contact Provider Services at the National Customer Care Department at 1-800-454-3730 to receive a printed copy.

**Advance Directives**

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

Amerigroup adheres to The Patient Self-Determination Act and maintains written policies and procedures regarding advance directives. Advance directives are documents signed by a competent person giving direction to health care providers about treatment choices in certain circumstances. There are two types of advance directives. A Durable Power of Attorney for health care (durable power) allows the member to name a patient advocate to act on behalf of the member. A living will allows the member to state his or her wishes in writing but does not name a patient advocate.

Member Services and Outreach associates encourage members to request an advance directive form and education from their PCP at their first appointment.

Members over age 18 and emancipated minors are able to make an advance directive. His or her response is to be documented in the medical record. Amerigroup will not discriminate or retaliate based on whether a member has or has not executed an advance directive.

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

Member Services and Outreach associates will assist members regarding questions about advance directives; however, no associate of Amerigroup may serve as witness to an advance directive or as a member’s designated agent or representative.

Amerigroup notes the presence of advance directives in the medical records when conducting medical chart audits. A Living Will and Durable Power of Attorney are located in Appendix A – Forms.
Medical Review Criteria

Amerigroup uses review criteria based on InterQual Criteria, Apollo Guidelines and Milliman Care Guidelines as guidelines in medical decision making. Amerigroup works with network providers to develop clinical guidelines of care for its membership. The MAC assists Amerigroup in formalizing and monitoring guidelines.

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

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

Clinical Criteria

Amerigroup uses InterQual, Milliman, Aetna’s Clinical Policy Bulletins and Apollo criteria for clinical decision support for medical management coverage decisions. The criteria provide a system for screening proposed medical care based on member-specific, best medical care practices and rule-based systems to match appropriate services to member needs based upon clinical appropriateness. Criteria include:

- Acute care
- Rehabilitation
- Subacute care
- Home care
- Surgery and procedures
- Imaging studies and X-rays

Amerigroup utilization reviewers use these criteria as part of the precertification of scheduled admission, concurrent review and discharge planning process to determine clinical appropriateness and medical necessity for coverage of continued hospitalization.

Amerigroup as a corporation and individual persons involved in Utilization Management (UM) decisions are 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.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

**Precertification/Notification Process**

Preauthorization (also known as prior authorization or approval) is defined as authorization granted in advance of the rendering of a service after appropriate medical/dental review. Notification is defined as: Prior to rendering covered medical services to a member, the provider must notify Amerigroup by telephone, fax or online submission 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, PCPs must coordinate all specialist care in accordance with managed care principles. Members may self-refer for specialty care; some examples include obstetrical, gynecological, family planning and outpatient behavioral health services (mental health and substance abuse) without PCP coordination. Participating specialists are not required to submit referral forms with claims.

The contractor shall authorize provision of a drug not on the formulary and requested by the PCP or referral provider on behalf of the member if the approved prescriber certifies medical necessity for the drug for a determination. If the formulary includes generic equivalents, the contractor shall provide for a brand-name exception process for prescribers to use when medically necessary.

Amerigroup will notify providers of approved prior authorization determinations for nonurgent services by telephone or in writing. Prior authorization denials and limitations will be provided in writing in accordance with the Health Claims Authorization Processing and Payment Act, P.L. 2005, c.352.

**Member Medical Appeal Process and Procedures**

Amerigroup establishes and maintains a system for the resolution of appeals initiated by members or by providers, acting on behalf of a member and with the member’s written consent, with respect to the denial, termination or other limitation of covered health care services. This is referred to as a UM determination. Appeals received from a provider without a member’s written consent will not qualify for this process and will be processed as a provider medical appeal. For further information see Provider Medical Appeal Process and Procedures.

The internal member medical appeal process will consist of two reviews (Stage 1 Appeal and Stage 2 Appeal). The external review (Stage 3 Appeal) under the Independent Health Care Appeals Program (IHCAP) will be conducted by an Independent Utilization Review Organization (IURO) which is chosen by the New Jersey Department of Banking and Insurance (DOBI).

No member or provider who exercises the right to file an appeal will be subject to disenrollment or otherwise penalized due to such an appeal. Services will be continued by Amerigroup during the appeal investigation according to contractual requirements.

An oral filing for an appeal must be followed with a written, signed appeal, except when the request is for expedited resolution.
If a member initiates an appeal without additional clinical information, Amerigroup will assist the member by requesting pertinent medical records.

Members wishing to appeal may call or write, and providers wishing to appeal must write to:

Quality Management Department
Amerigroup Community Care
399 Thornall St., Ninth Floor
Edison, NJ 08837
Members Services: 1-800-600-4441

**Stage 1 – Appeal**
A member or provider acting on behalf of the member with the member’s written consent can initiate an appeal to Amerigroup within 60 days of the date of denial.

Any member or any provider acting on behalf of a member with the member’s written consent who is dissatisfied with an Amerigroup UM determination will have the opportunity to speak with the Amerigroup medical director and/or the physician designee who rendered the determination. The Stage 1 Appeal will be reviewed, and a decision will be made by a physician who was not involved in the initial determination and is not a subordinate of the original reviewer.

A Stage 1 Appeal will be resolved as soon as possible in accordance with the medical exigencies of the case. For emergent and urgent appeals, see the Expedited Appeal section. All other Stage 1 Appeals will be resolved within five business days. If a Stage 1 Appeal is denied, the denial will be communicated in writing to the member and the providers. Amerigroup will also provide to the member and/or provider a written explanation of his or her right to proceed to a Stage 2 Appeal, including the applicable time limits and to whom the appeal should be addressed.

Upon request, the member and/or provider acting on behalf of the member with the member’s written consent will be provided with the clinical criteria relied upon to make the determination.

**Stage 2 – Appeal**
A member or provider acting on behalf of the member with the member’s written consent may initiate a Stage 2 Appeal within 60 days of the receipt of the Stage 1 denial letter. Any member, member representative or provider acting on behalf of a member who is dissatisfied with the results of the Stage 1 Appeal will have the opportunity to pursue his or her appeal before a panel of physicians and/or other health care professionals. Amerigroup will select the panel.

The appeal panel will include at least one consultant practitioner who is trained or practices in the same specialty as would typically manage the case at issue or such other licensed health care professionals as mutually agreed upon by the parties. Panel members will not have been previously involved in the UM determination.

Members have a right to appear before the panel. If unable or unwilling to appear before the panel in person, the member has the right to communicate by conference call or other available appropriate technology.
The Stage 2 Appeal will be acknowledged in writing to the member or provider who is filing the appeal within 10 business days of receipt.

The Stage 2 Appeal will be resolved as soon as possible in accordance with the medical exigencies of the case. For emergent and urgent appeals, see the Expedited Appeal section. All other Stage 2 Appeals will be resolved within 20 business days. Amerigroup may extend the time frames by 14 calendar days if the member requests the extension or Amerigroup shows (to the DMAHS’ satisfaction upon its request) that there is need for additional information and the delay is in the member’s interest.

Amerigroup will provide the member and/or provider with written notification of the appeal determination and the reasons for the decision. In the case of a denial, Amerigroup will provide the member and the provider a written notification of his or her right to proceed to an external (Stage 3) appeal.

If Amerigroup fails to comply with any of the deadlines for completion of the internal UM determination appeals or in the event that Amerigroup for any reason expressly waives its rights to an internal review of any appeal, then the member and/or provider will be relieved of his or her obligation to complete the Amerigroup internal review process and may at his or her option proceed directly to the Independent Health Care Appeals Program (IHCAP) process.

**Stage 3 – External Appeal**

A member or provider acting on behalf of a member and with the member’s written consent must comply with the internal appeals process of Amerigroup before appealing to the IHCAP. The only exceptions to this requirement may occur if Amerigroup does not comply with the required deadlines or if Amerigroup expressly waives its right to an internal review.

An appeal to the IHCAP must be in writing and made within 60 days following the date of receipt of the Stage 2 Appeal determination from Amerigroup. IHCAP submissions must include the following information:

- A copy of the Stage 1 and/or Stage 2 final written decision from Amerigroup
- A copy of the summary health coverage from the Amerigroup Member Handbook
- For providers who are filing on behalf of a member, attach a copy of the signed and dated Consent to Representation in Appeal of a UM determination and Authorization of Release of Medical Records for Appeal and Arbitration of Claims form
- Attach a copy of the Notice of Intent to Appeal an Adverse UM Determination-Stage 3 sent to the member
- A copy of all medical records and correspondence to be reviewed by the IURO
- The state filing form. The form is included with the member letter. Providers who are appealing on behalf of a member must obtain the form from the member or the New Jersey DOBI website at www.state.nj.us/dobi/managed.htm.
- The filing fee for Medicaid/NJ FamilyCare members is $2.00. The fee is payable to the New Jersey DOBI. Any additional costs of an IURO review are assumed by Amerigroup.
- IURO submissions are sent to the New Jersey Department of Banking and Insurance, Office of Managed Care, P.O. Box 329, Trenton, NJ 08625-0329
The IURO will complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case. The IURO will complete its review within 30 business days from receipt of all documentation necessary for the review. The IURO may extend its review for a reasonable period of time (but not to exceed 90 days from the receipt of the completed submission) due to circumstances beyond its control. If this is necessary, the IURO will notify the member and/or provider, DOBI and Amerigroup in writing prior to the conclusion of the review, specifying the reasons for the delay.

Amerigroup will promptly provide coverage for the health care services found to be medically necessary by the IURO. The IURO’s determination is binding. The IURO will convey its decision to both the member and Amerigroup. Within 10 business days of receipt of the IURO’s determination, Amerigroup will submit a letter to the IURO, member and/or provider who filed the appeal and DOBI, indicating acceptance of the decision.

**Expedited Appeal**

Stage 1 and Stage 2 Appeals are resolved as soon as possible in accordance with the medical exigencies of the case, which in no event will exceed 72 hours in the case of appeals from determinations regarding urgent or emergent care (including all situations in which the member is confined as an inpatient). Investigation and resolution of Stage 1 and Stage 2 Appeals involving emergent care will be concluded within 24 hours. Investigation and resolution of Stage 1 and Stage 2 Appeals involving urgent care will be concluded within two calendar days of receipt.

Initial notice of the decision to the member and provider will be delivered orally by Amerigroup within 24 hours for emergent care and within two calendar days for urgent care. Written notice of the determination will be given to the member and/or provider acting on behalf of the member with the member’s written consent within two business days of the decision.

**Medicaid Fair Hearing**

A Medicaid fair hearing may also be requested at the member’s discretion. Medicaid and NJ FamilyCare A and specified D members (i.e., members with a program status code of 380 only) have the right to a Medicaid fair hearing. NJ FamilyCare B, C and D members (except D members with a program status code of 380) are not permitted the opportunity to access a Medicaid fair hearing.

Members have access to the Medicaid fair hearing process at any time during the appeal process but must initiate a request within 20 days after the date of the notice of decision. The member has a right to represent himself or herself at the state hearing or to be represented by legal counsel, friend or other spokesperson. The department’s Medicaid fair hearing decision is binding.

Medicaid fair hearing submissions are made in writing to:

Department of Human Services  
Division of Medical Assistance and Health Services  
Fair Hearing Section  
P.O. Box 712  
Trenton, NJ 08625-0712
Provider Medical Appeal Process and Procedures

Amerigroup has established and maintains a system for the resolution of medical appeals initiated by providers without the member’s written consent with respect to the denial of payment for services based on medical necessity. This is referred to as a UM determination.

Amerigroup has established and maintains a procedure, approved by DMAHS, for internal review and resolution of complaints such as timely access and coverage issues, drug utilization review and claim management based on standards of drug utilization review. The procedure can be found on the Amerigroup website or a hard copy can be requested.

The internal provider medical appeal process will consist of two reviews (Stage 1 Appeal and Stage 2 Appeal). Appeals must be submitted in writing by the provider to:

Quality Management Department
Amerigroup Community Care
399 Thornall St., Ninth Floor
Edison, NJ 08837

Stage 1 Appeal
A provider can initiate a medical appeal to Amerigroup in writing within 60 days of the date of denial. Any provider who is dissatisfied with an Amerigroup UM determination will have the opportunity to speak and appeal that determination with the Amerigroup medical director and/or the physician designee who rendered the determination. A physician who was not involved in the initial determination will make the decision regarding the Stage 1 Appeal.

Stage 1 Appeals will be resolved as soon as possible in accordance with the medical exigencies of the case. All other Stage 1 Appeals will be resolved within 30 calendar days. Amerigroup will provide the provider with written notification of the appeal determination and the reasons for the decision.

Upon request, the provider will be provided with the clinical criteria relied upon to make the determination.

Stage 2 Appeal
A provider may initiate a Stage 2 Appeal in writing within 30 days of the receipt of the Stage 1 denial letter. A physician who was not involved in the initial determination or the Stage 1 Appeal will make the decision regarding the Stage 2 Appeal.

Stage 2 Appeals will be resolved as soon as possible in accordance with the medical exigencies of the case. All other Stage 2 Appeals will be resolved within 30 calendar days. Amerigroup will provide the provider with written notification of the appeal determination and the reasons for the decision.

Upon request, the provider will be given the clinical criteria relied upon to make the determination.
Continuation of Benefits

To ensure continuation of currently authorized services, the member or person acting on behalf of the member must file a medical appeal on or before the latter of 10 calendar days following Amerigroup mailing of the Notice of Action or the intended effective date of the action.

Amerigroup shall continue the member’s coverage of benefits if the following conditions are met:
- The member or the provider files the appeal in a timely manner.
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment.
- The services were ordered by an authorized provider (e.g., a network provider).
- The original period covered by the original authorization has not expired, unless inadequate notice was given to allow a member a timely appeal.

Amerigroup shall continue or reinstates the member’s benefits while the appeal is pending. The benefits will be continued until one of the following occurs:
- The member withdraws the medical appeal or request for the state fair hearing.
- Ten calendar days pass after Amerigroup mails the medical appeal determination letter, unless the member has within the 10 calendar days requested a state fair hearing with continuation of benefits until a state fair hearing decision is reached.
- The state fair hearing office issues a hearing decision adverse to the member.
- The time period or service limits of a previously authorized service has been met.

If the final determination of the medical appeal is in the member’s favor, Amerigroup will authorize coverage of and arrange for disputed services promptly and as expeditiously as the member’s health condition requires. If the final determination is in the member’s favor and the member receives the disputed services, Amerigroup will pay for those services.
Amerigroup requires precertification of all inpatient elective admissions. The referring primary care or specialist physician is responsible for precertification.

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

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

The hospital can confirm that an authorization is on file by calling the Amerigroup automated Provider Inquiry Line at 1-800-454-3730. If coverage of an admission has not been approved, the facility should call Amerigroup at 1-800-454-3730. Amerigroup will contact the referring physician directly to resolve the issue.

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

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

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with InterQual Criteria and Milliman Care Guidelines Criteria, an Amerigroup reference number will be issued to the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member’s needs and medical history.

If medical necessity criteria for the admission are not met on the initial review, the medical director will contact the requesting physician to discuss the case.

If the precertification documentation is incomplete or inadequate, the precertification nurse will not approve coverage of the request but will notify the referring provider to submit the additional necessary documentation.

If the medical director denies coverage of the request, the appropriate denial letter (including the member’s appeal rights) will be mailed to the requesting provider, member’s PCP and member.
Emergent Admission Notification Requirements

Amerigroup prefers immediate notification by network hospitals of emergent admissions. Network hospitals must notify Amerigroup of emergent admissions within one business day. Amerigroup Medical Management staff will verify eligibility and determine benefit coverage.

Amerigroup is available 24 hours a day, 7 days a week to accept emergent admission notification at our National Customer Care Department at 1-800-454-3730.

Coverage of emergent admissions is authorized based on review by a concurrent review nurse. When the clinical information received meets InterQual Criteria, an Amerigroup reference number will be issued to the hospital.

If the notification documentation provided is incomplete or inadequate, Amerigroup will notify the hospital to submit the additional necessary documentation.

If the medical director denies coverage of the request, the appropriate denial letter will be mailed to the hospital, member’s PCP and member.

Nonemergent Outpatient and Ancillary Services – Precertification and Notification Requirements

Amerigroup requires precertification for coverage of selected nonemergent outpatient and ancillary services (see chart) when performed by a participating provider. All nonemergent outpatient and ancillary services referred to a nonparticipating provider require precertification by the referring provider. To ensure timeliness of the authorization, the expectation of the facility and/or provider is that the following must be provided:

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

The table below contains precertification and notification requirement guidelines.

<table>
<thead>
<tr>
<th>Service</th>
<th>Requirement</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Behavioral Health/Substance Abuse</td>
<td>Self-referral</td>
<td>• Behavioral/mental health services, substance abuse services (diagnosis, treatment and detoxification) and costs for Methadone and its administration are managed by the state for non-Division of Developmental Disabilities (DDD) enrollees, including NJ FamilyCare enrollees. Amerigroup retains responsibility for covering</td>
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<tr>
<td>Service</td>
<td>Requirement</td>
<td>Comments</td>
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<td>services, excluding the cost of drugs, to Medicaid enrollees who are clients of the DDD.</td>
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<td>• Refer to Section 5- Behavioral Health</td>
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<tr>
<td>Cardiac Rehabilitation</td>
<td>Precertification</td>
<td>Coverage is limited to specific provider types. Coverage is limited to members with a history of acute myocardial infarction within the preceding 12 months and/or previous coronary surgery and/or stable angina pectoris.</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td></td>
<td>No precertification is required for coverage of chemotherapy procedures when performed in an outpatient setting by a participating facility, provider office, outpatient hospital or ambulatory surgery center. <strong>For information on coverage of chemotherapy drugs, please see Pharmacy section.</strong> Note: Precertification is required for coverage of inpatient services.</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Precertification</td>
<td>• Precertification is required for the coverage of all services and procedures.</td>
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<td>• <strong>NJ FamilyCare D:</strong> Services performed by a chiropractor are excluded.</td>
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<tr>
<td>Dental Services</td>
<td>Self-referral</td>
<td><strong>Dental Services- for all A, B, C and D members under 19.</strong> Preventive dental services (exams, cleanings, space maintainers, sealants and fluoride):</td>
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<td></td>
<td></td>
<td>• Every 6 months until age 18</td>
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<td></td>
<td>• Once a year for people 18 or older</td>
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<td>• Fluoride is not covered for those 21 and over</td>
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<td>Sealants:</td>
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<td>• One time for those under age 17</td>
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<td></td>
<td>• Not covered for those age 17 or older</td>
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<td>Restorative (fillings and crowns):</td>
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<td>• As medically appropriate to restore the natural tooth</td>
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<td>• Prior authorization needed for crowns</td>
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<td>Endodontic (root canal, etc.): Need prior authorization</td>
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<td>Prosthodontic (removable dentures): Need prior authorization</td>
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<td>Exodontic (extractions and oral surgery): For oral surgery, prior authorization is required for inpatient and outpatient facilities</td>
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<td></td>
<td></td>
<td>Orthodontic: Limited to children under age 19 when medically necessary</td>
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<td></td>
<td>Periodontic (supporting structures, gums,)</td>
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<tr>
<td>Service</td>
<td>Requirement</td>
<td>Comments</td>
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<td>Fee-for-service Medicaid to provide and pay for certain dental services</td>
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<td>by a Medicaid non-Amerigroup provider that are started 60 to 120 days</td>
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<td>prior to a member’s first-time enrollment in managed care</td>
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<td>For D Members-Limited to children under the age of 19</td>
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<tr>
<td>Dermatology Services</td>
<td>No precertification is required for network provider for E&amp;M, testing</td>
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<td></td>
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<td>and procedures.</td>
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<td>Services considered cosmetic in nature are not covered. See Diagnostic</td>
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<td></td>
<td></td>
<td>Testing.</td>
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<tr>
<td>Diagnostic Testing</td>
<td></td>
<td>• No precertification required for routine diagnostic testing</td>
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<td></td>
<td>• Precertification is required for coverage of MRA, MRI, CAT scans,</td>
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<td>nuclear cardiac, PET scans and video EEG.</td>
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<td>• No precertification is required for tests performed in conjunction</td>
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<td></td>
<td>with a precertified inpatient stay.</td>
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<td>• Precertification through National Imaging Associates (NIA) is</td>
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<td></td>
<td>required for coverage of MRA, MRI, CAT scans, nuclear cardiac and PET</td>
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<td>scans. Contact NIA at 1-800-642-7565. NIA will locate an imaging facility</td>
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<td>from the Amerigroup network of radiology service providers.</td>
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<td>• Outpatient radiology services excluded from the precertification</td>
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<td>requirement (which may be provided at a hospital without precertification)</td>
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<td></td>
<td>include: radiation oncology services, services provided in association</td>
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<td>with an emergency room visit, observation stays and services associated</td>
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<td>with and on the same day as a precertified outpatient surgery performed</td>
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<td>at a hospital.</td>
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<td></td>
<td>• <strong>NJ FamilyCare D:</strong> No coverage for thermography and thermograms</td>
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<tr>
<td>Dialysis</td>
<td></td>
<td>• No precertification is required for coverage of dialysis procedures</td>
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<td>performed at a participating provider.</td>
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<td>• Precertification is required for medications related to dialysis</td>
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<td></td>
<td></td>
<td>treatment.</td>
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<tr>
<td>Service</td>
<td>Requirement</td>
<td>Comments</td>
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</tbody>
</table>
| Durable Medical Equipment | Precertification and Certificate of Medical Necessity   | • No precertification is required for coverage of glucometers and nebulizers, dialysis and end-stage renal disease equipment, gradient pressure aids, infant photo/light therapy, sphygmomanometers, walkers and orthotics for arch support, heels, lifts, shoe inserts and wedges by network provider.  
  • All DME billed with an RR modifier (rental) requires precertification.  
  • Precertification is required for coverage of certain prosthetics, orthotics and DME. For code-specific precertification requirements for DME, prosthetics and orthotics ordered by network provider or network facility, please refer to www.amerigroupcorp.com/providers and click on the Precertification Lookup Tool.  
  • See Medical Supplies for guidelines relating to disposable medical supplies.  
  • Precertification may be requested by completing a Certificate of Medical Necessity (CMN) — available at www.amerigroupcorp.com/providers — or by submitting a physician order and 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 mechanism, power operated vehicle, external infusion pumps, parenteral nutrition devices, enteral nutrition devices and oxygen. Amerigroup and provider must agree on HCPCS and/or other codes for billing covered services. All custom wheelchair precertifications require medical director’s review.  |

**NJ FamilyCare D**: Durable Medical Equipment (DME)/Assistive Technology Devices in accordance with existing Medicaid regulations

**Plan D Covered Durable Medical Equipment**
- Alternating pressure pads
- Bed pans
- Bladder irrigation supplies
- Blood glucose monitors and supplies
- Canes
<table>
<thead>
<tr>
<th>Service</th>
<th>Requirement</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Commodes</td>
<td></td>
<td>• Note: Bathroom devices permanently attached are not covered</td>
</tr>
<tr>
<td>• Crutches and related attachments</td>
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<tr>
<td>• Fracture frames</td>
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<tr>
<td>• Gastrostomy supplies</td>
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<tr>
<td>• Hospital beds (e.g., manual, semi-electric, full electric) and Related Equipment</td>
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<tr>
<td>• Ileostomy supplies</td>
<td></td>
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<tr>
<td>• Infusion pumps</td>
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<tr>
<td>• Intermittent Positive Pressure Breathing (IPPB)</td>
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<tr>
<td>• Treatments and related supplies</td>
<td></td>
<td></td>
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<tr>
<td>• IV poles</td>
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<tr>
<td>• Jejunostomy supplies</td>
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<tr>
<td>• Lancets and related devices</td>
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<tr>
<td>• Loop heels/loop toes devices</td>
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<tr>
<td>• Lymphedema pumps</td>
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<tr>
<td>• Manual wheelchairs and related equipment</td>
<td></td>
<td>• Note: Motorized wheelchairs are not covered</td>
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<td></td>
<td></td>
<td>• Note: Types of covered wheelchairs include:</td>
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<tr>
<td></td>
<td></td>
<td>▪ Full-reclining</td>
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<tr>
<td></td>
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<td>▪ High-strength lightweight</td>
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<td>▪ Heavy duty</td>
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<td></td>
<td></td>
<td>▪ Semi-reclining</td>
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<tr>
<td>• Mattress overlays</td>
<td></td>
<td>• Note: Low air loss and air fluidized bed systems not covered</td>
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<tr>
<td>• Nasogastric tubing</td>
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<tr>
<td>• Nebulizers and related supplies</td>
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<tr>
<td>• Needles</td>
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<tr>
<td>• Ostomy supplies</td>
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<tr>
<td>• Over-bed tables</td>
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<tr>
<td>• Oxygen and related equipment and supplies</td>
<td></td>
<td>• Note: Liquid and gas systems and oxygen concentrators are covered</td>
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<td></td>
<td></td>
<td>• Note: Ventilation systems are not covered</td>
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<tr>
<td>• Pacemaker monitors</td>
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<td>• Parenteral nutrition</td>
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<td>• Patient lifts</td>
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<td>• Pneumatic appliances</td>
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<td>• Sitz bath</td>
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<td>Service</td>
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<tr>
<td>Early and Periodic Screening, Diagnosis</td>
<td>Self-referral</td>
<td>• Use EPSDT schedule and <strong>document</strong> visits/ encounters on a CMS-1500 claim form to receive incentive payments. Copays do not apply to EPSDT services. NJ FamilyCare D members are covered for well-child care, including immunizations and lead screenings, and treatment. <strong>NJ FamilyCare D</strong> members receive limited coverage of EPSDT services.</td>
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<tr>
<td>and Treatment Visit</td>
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<tr>
<td>Educational Consultation</td>
<td></td>
<td>No notification or precertification is required. No coverage for smoking cessation.</td>
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</tbody>
</table>
| Emergency Room                               | Self-referral | • No notification is required for emergency care provided in the emergency room. If emergency care results in admission, notification to Amerigroup is required within 24 hours or the next business day.  
• For observation precertification requirements, see **Observation**. |
| Ear, Nose and Throat Services (Otolaryngology) | No precertification is required for E&M, testing and procedures. | Precertification is required for tonsillectomy and/or adenoidectomy for members 12 years and older, as well as for nasal/sinus and cochlear implant surgery and services. See **Diagnostic Testing**.  |
| Family Planning/ Sexually Transmitted Disease Care | Self-referral | • Infertility treatment is not covered. Covered services include pelvic and breast exams, lab work, drugs and biological devices, and supplies related to family planning (e.g., intrauterine device). |

- NJ-PM-0001-10  
- June 2011
## Precertification /Notification Coverage Guidelines

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<tr>
<td></td>
<td></td>
<td>No coverage outside network for FamilyCare D members. All other members may receive services from an appropriate Medicaid participating family planning provider.</td>
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<td></td>
<td>No precertification or notification is required for coverage of primary sterilization procedures. Member must be over age 21.</td>
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<td></td>
<td><strong>Sterilization consent form is required for claims submission of primary sterilization procedures.</strong></td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>No precertification is required for network provider E&amp;M, testing and procedures.</td>
<td>Precertification is required for bariatric surgery, including insertion, removal and/or replacement of adjustable gastric restrictive devices, and subcutaneous port components. See Diagnostic Testing.</td>
</tr>
<tr>
<td>Gynecology</td>
<td>Self-referral</td>
<td>No precertification is required for E&amp;M, testing and procedures.</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td></td>
<td><strong>Medicaid and NJ FamilyCare A, B and C:</strong> No precertification is required for coverage.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>NJ FamilyCare D:</strong> Hearing aid services and audiology services are limited to members age 15 and younger but limited to $1,000 per ear every 24 months.</td>
</tr>
<tr>
<td>Hearing Screening</td>
<td></td>
<td>No notification or precertification is required for coverage of diagnostic and screening tests, hearing aid evaluations or counseling. Medically necessary hearing aids will be provided to children 15 years of age and younger. This coverage will be provided every 24 months and provide coverage up to $1,000 per hearing aid.</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Precertification</td>
<td><strong>Medicaid and NJ FamilyCare A, B and C:</strong> Covered services are limited to skilled nursing, home health aide and medical social services which require precertification for coverage.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>NJ FamilyCare D:</strong> Covered services are limited to skilled nursing homebound beneficiary who is supervised by a registered nurse and home health aide, when the purpose of the treatment is skilled care and social services that are required for the treatment of the member’s medical condition.</td>
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<td><strong>NJ Aged, Blind and Disabled:</strong> Home Health Services are covered under NJ Medicaid FFS.</td>
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<td></td>
<td><strong>NJ FamilyCare A, B, C and D:</strong> Private duty nursing covered for all members until their 21st birthday.</td>
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<td>Service</td>
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| Hospice Care                  | Precertification /Notification | • Precertification is required for coverage of inpatient hospice services.  
• Notification is required for coverage of outpatient hospice services. |
| Hospital Admission            | Precertification              | • Elective admissions require precertification for coverage.              
• Emergency admissions require notification within 24 hours or the next business day.  
• For preadmission lab testing, see Provider Referral Directory for a complete listing of participating vendors.  
• Same-day admission is required for surgery. |
| Laboratory Services (Outpatient) |                             | • Precertification is required for genetic testing.                       
• All laboratory services furnished by non-network providers require precertification by Amerigroup, except for hospital laboratory services provided for an emergency medical condition.  
• For offices with limited or no office laboratory facilities, lab tests may be referred to one of the Amerigroup lab vendors. FamilyCare D members receive laboratory services also.  
• See Provider Referral Directory for a complete listing of participating lab vendors.  
• **Medicaid and NJ FamilyCare A, B, C and D:** Laboratory services are covered except for routine testing related to administration of Clozapine and the other psychotropic drugs listed in Article 4.1.4.B for non-DDD clients. |
| Medical Supplies              |                              | • No precertification is required for coverage of disposable medical supplies.  
• **NJ FamilyCare D:** No coverage for medical supplies except diabetic supplies (See DME list above). Hearing aid supplies are covered for members age 15 and younger but limited to $1,000 per ear every 24 months. |
<p>| Observation                   |                              | No precertification or notification required for in-network observation. If billed with CPT/HCPCS code, authorization requirement should follow the requirement of the CPT/HCPCS code. If observation results in admission, |</p>
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<tr>
<td>Obstetrical Care</td>
<td></td>
<td>• No precertification is required for coverage of obstetrical services when performed by a participating provider.</td>
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<td>• Notification to Amerigroup is required at the FIRST prenatal visit.</td>
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<td>• Notification is required for coverage of emergency and obstetric admissions within 24 hours or the next business day. See Diagnostic Testing.</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>No precertification is required for E&amp;M, testing and procedures.</td>
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<tr>
<td></td>
<td></td>
<td>Precertification is required for repair of eyelid defects. Services considered cosmetic in nature are not covered. See Plastic/Cosmetic/Reconstructive Surgery.</td>
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<tr>
<td>Oral Maxillofacial</td>
<td></td>
<td>• No precertification is required for coverage of E&amp;M-level office visits.</td>
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<td></td>
<td>• Precertification is required for coverage of all other services. See Plastic/Cosmetic/Reconstructive Surgery.</td>
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<tr>
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<td></td>
<td>• NJ FamilyCare D: No coverage for TMJ treatment, including treatment performed by prosthesis placed directly on teeth.</td>
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<tr>
<td>Otolaryngology (Ear, Nose and Throat Services)</td>
<td></td>
<td>See Ear, Nose and Throat Services (Otolaryngology).</td>
</tr>
<tr>
<td>Out-of-area/Out-of-plan Care</td>
<td>Precertification</td>
<td>Precertification is required except for coverage of emergency care (including self-referral) and OB delivery. See related services for precertification. Emergency admissions to an out-of-area/out-of-network facility require notification within one business day.</td>
</tr>
<tr>
<td>Outpatient/ Ambulatory Surgery</td>
<td>Precertification</td>
<td>Precertification requirements are based on the services being performed. Visit <a href="http://www.amerigroupcorp.com/providers">www.amerigroupcorp.com/providers</a> to look up specific service codes for precertification/notification requirements.</td>
</tr>
<tr>
<td>Pain Management</td>
<td>Precertification</td>
<td>• Non-E&amp;M-level testing and procedures require precertification for coverage.</td>
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<td></td>
<td>• Medicaid and NJ FamilyCare A, B and C: A maximum of seven days is allowed for epidural management.</td>
</tr>
<tr>
<td>Perinatology</td>
<td>Notification</td>
<td>See Diagnostic Testing and Laboratory Services.</td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
<td>• The pharmacy benefit covers medically necessary prescription and OTC medications prescribed by a licensed provider. Exceptions and restrictions exist as the benefit is</td>
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<td>Service</td>
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<tr>
<td>Physiatry</td>
<td>Precertification is required for coverage of all non-E&amp;M services and procedures related to pain management.</td>
<td></td>
</tr>
<tr>
<td>Physical Medicine and Rehabilitation</td>
<td>Precertification is required for coverage of all non-E&amp;M services and procedures related to pain management. Outpatient PT, OT and ST are covered by Medicaid FFS.</td>
<td></td>
</tr>
<tr>
<td>Plastic/Cosmetic/Reconstructive Surgery (including Oral Maxillofacial Services)</td>
<td>• No precertification is required for coverage of E&amp;M codes. All other services require precertification. • Services considered cosmetic in nature are not covered. Services related to previous cosmetic procedures are not covered. Reduction mammoplasty requires medical director’s review. • No precertification is required for coverage of oral maxillofacial E&amp;M services. • Precertification is required for coverage of trauma to the teeth and oral maxillofacial medical and surgical conditions including TMJ. See Oral Maxillofacial and Diagnostic Testing.</td>
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## Precertification/Notification Coverage Guidelines

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<tr>
<td><strong>NJ FamilyCare D</strong></td>
<td></td>
<td>• No coverage for TMJ treatment, including treatment performed by prosthesis placed directly on teeth.</td>
</tr>
<tr>
<td>Podiatry</td>
<td></td>
<td>The benefit excludes routine hygienic care of the feet in the absence of a pathological condition.</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td></td>
<td>No precertification 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. Precertification is required for coverage of services rendered on an inpatient basis. <strong>Please note that CAT scans, nuclear cardiology, MRA, MRI and PET scans require precertification for coverage.</strong> See Diagnostic Testing.</td>
</tr>
<tr>
<td>Radiology</td>
<td></td>
<td>See Diagnostic Testing.</td>
</tr>
<tr>
<td>Rehabilitation Therapy (Short-Term):</td>
<td></td>
<td>• Medicaid and NJ FamilyCare A: Outpatient therapy services are covered by NJ Medicaid FFS.</td>
</tr>
<tr>
<td>OT, PT, RT and ST</td>
<td></td>
<td>• NJ FamilyCare B and C: Outpatient therapy services are covered by NJ Medicaid FFS for 60 days per therapy per year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• NJ FamilyCare D: Outpatient physical therapy, occupational therapy and speech therapy services for nonchronic conditions and acute illness and injuries are covered under NJ Medicaid FFS.</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Precertification</td>
<td>• Medicaid and NJ FamilyCare A: Skilled nursing care is limited to the first 30 days of admission to a nursing facility. <strong>Exception:</strong> this covered benefit is limited to rehabilitation services for NJ FamilyCare B and C enrollees.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• NJ FamilyCare B, C and D: Services are covered in a skilled nursing facility only through the first 30 days when the member is admitted for rehabilitative services, PT, OT and ST.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Precertification is required for coverage of all care and services provided in a skilled nursing facility.</td>
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<tr>
<td>Sterilization</td>
<td></td>
<td>• Sterilization is a covered benefit for members age 21 and older.</td>
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<td>• No precertification or notification is required for sterilization procedures, including tubal ligation and vasectomy.</td>
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<td>• Sterilization consent form is required for claims submission for primary sterilization procedures.</td>
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<td>• Reversal of sterilization is not a covered benefit.</td>
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<td>• Sterilization services from a nonparticipating provider are not covered.</td>
</tr>
<tr>
<td>Termination of Pregnancy</td>
<td></td>
<td>Elective, induced abortion and related services are covered by the New Jersey Medicaid FFS program. For benefit questions, members can call the New Jersey Medicaid Hotline at 1-800-356-1561. For NJ Medicaid FFS claims information, providers can call UNISYS at 1-800-776-6334.</td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td>• For all cities and counties, members are directed to the County Board of Social Services.</td>
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<td></td>
<td>• <strong>NJ FamilyCare B, C and D</strong>: Ineligible for routine transportation generally.</td>
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<tr>
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<td></td>
<td>• <strong>NJ FamilyCare D</strong>: Coverage is limited to ambulance services for medical emergencies only. Transportation related to emergency room visits does not require precertification.</td>
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<tr>
<td></td>
<td></td>
<td>• <strong>Medicaid and NJ FamilyCare A, B and C</strong>: Medically necessary transportation (ambulance, medical intensive care units and invalid coach) is covered for any managed care or nonmanaged care covered benefit.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>Medicaid and all NJ FamilyCare Members</strong>: Lower-mode transportation is available to any member requesting transportation to any provider for a medically necessary covered benefit if the location is greater than 30 miles from the member’s residence when there is no network provider available closer.</td>
</tr>
<tr>
<td>Vision Care (Medical)</td>
<td>No precertification is required for testing and procedures.</td>
<td>Precertification is required for repair of eyelid defects. Services considered cosmetic in nature are not covered. See Diagnostic Testing.</td>
</tr>
<tr>
<td>Vision Care (Routine)</td>
<td>Self-referral</td>
<td>• <strong>NJ FamilyCare A, B and C</strong>: Coverage is limited to one routine eye exam per year. Members may contact Block Vision at 1-800-428-8789.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>NJ FamilyCare A, B and C</strong>: Coverage is provided for one pair of eyeglass lenses once every 12 months for members under age 19 and age 60 and older.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>NJ FamilyCare A, B and C</strong>: Coverage is provided for one pair of eyeglass lenses once every 24 months for members age 19 through 59 as medically necessary.</td>
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<tr>
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<td></td>
<td>• <strong>NJ FamilyCare D</strong> members are eligible for a new pair of eyeglass lenses once every 4 years.</td>
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Precertification /Notification Coverage Guidelines

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<td>eyeglass lenses every 24 months or as medically necessary.</td>
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<td>• Coverage is provided for contact lenses once every 24 months for specific pathological conditions, vision correction that cannot be improved to at least 20/70 or better with regular lenses. Members not meeting the medical necessity benefit can opt for contact lenses as a value-added benefit. Amerigroup will reimburse the lesser of usual and customary or up to $100.</td>
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<td></td>
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<td>• Lenses may be replaced more frequently than once every two years for persons 19 through and including 59 years of age or more frequently than once every year for persons less than 19 years of age or 60 years of age and older, providing there is a prescription change of at least 0/75 diopter in spherical and/or cylindrical power or a change in axis of eight degrees or more.</td>
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<td>• For additional details regarding vision services, please refer to N.J.A.C. 10:6202.4.</td>
</tr>
<tr>
<td>Well-woman Exam</td>
<td>Self-referral</td>
<td>Well-woman exams are covered one per calendar year when performed by a PCP or in-network GYN. Exam includes routine lab work, sexually transmitted disease screening, Pap smear and mammogram (age 35 or older).</td>
</tr>
<tr>
<td>Revenue Codes</td>
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<td>To the extent the following services are covered benefits, precertification or notification is required for all services billed with the following revenue codes:</td>
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<td>• All inpatient and behavioral health accommodations</td>
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<td>• 0023 – Home health prospective payment system</td>
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<td></td>
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<td>• 0240 through 0249 – All-inclusive ancillary psychiatric</td>
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<td>• 0632 – Pharmacy multiple source</td>
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<td>• 3101 through 3109 – Adult day care and foster care</td>
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</table>

For services that require precertification, Amerigroup uses InterQual Clinical Decision Support and Milliman Care Guidelines Criteria.

Amerigroup is staffed with clinical professionals who coordinate services provided to members and are available 24 hours a day, 7 days a week to accept precertification requests. When a request for medical services is received from the physician via fax, the precertification assistant will verify eligibility and benefits and will forward the request to the nurse reviewer.

The nurse will review the request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. When appropriate, the nurse will assist the physician in identifying alternatives for health care delivery as supported by the medical director. All determinations to deny or limit an admission, service procedure or extension of stay shall be rendered by a physician.
When the clinical information received meets medical necessity criteria, an Amerigroup reference number will be issued to the referring physician.

If the request is a stat/urgent request (expedited service authorizations), the decision will be made within 24 hours of receipt of the necessary information but no later than three business days after receipt of the request for services.

If the precertification documentation is incomplete or inadequate, the nurse will not approve coverage of the request but will instead notify the provider to submit the additional necessary documentation.

If the medical director denies the request for coverage, the appropriate notice of proposed action will be mailed to the requesting provider, the member’s PCP, the facility and the member.

**Inpatient Reviews**

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

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

When an Amerigroup UM clinician reviews the medical record at the hospital, he or she also attempts to meet with the member and family to discuss any discharge planning needs and verify that the member or family is aware of the member’s PCP’s name, address and telephone number. The UM clinician will conduct continued stay reviews daily and review discharge plans, unless the patient’s condition is such that it is unlikely to change within the upcoming 24 hours and discharge planning needs cannot be determined.

When the clinical information received meets medical necessity criteria, approved days and bed-level coverage will be communicated to the hospital for the continued stay.

If the discharge is approved, the Amerigroup UM clinician will help coordinate discharge planning needs with the hospital utilizations review staff and attending physician. The attending physician is expected to coordinate with the member’s PCP regarding follow-up care after discharge. The PCP is responsible for contacting the member to schedule all necessary follow-up care. In the case of a behavioral health discharge, the attending physician is responsible for ensuring that the member has secured an appointment for a follow-up visit with a behavioral health provider to occur within seven calendar days of discharge.
Amerigroup will authorize the covered length of stay one day at a time based on the clinical information that supports the continued stay. Exceptions to the one-day length of stay authorization are made for confinements when the severity of the illness and subsequent course of treatment are likely to be several days or are predetermined by state law. Examples of confinement and/or treatment include the following: ICU, CCU, behavioral health rehabilitation and C-section or vaginal deliveries. Exceptions are made by the medical director.

If, based upon appropriate criteria and after attempts to speak to the attending physician, the medical director denies coverage for an inpatient stay request, the appropriate notice of action will be mailed to the hospital, member’s PCP and member.

**Inpatient Retrospective Review**

Inpatient admissions that were not notified or authorized (as applicable) will be reviewed retrospectively, if appropriate utilization management protocols have been followed. Please note that Amerigroup requires notification within one business day following an emergent or urgent admission. Elective admissions need to be authorized 72 hours prior to admission.

Medical records requested for the purpose of quality improvement audits are also reviewed retrospectively. Providers’ Medical Records departments will be contacted to determine the procedure for securing access to medical records. The Amerigroup authorized coordinator reviews the charts, obtaining copies of pertinent records for review by the medical director. If quality improvement criteria are not met, the case is referred to the medical director, who evaluates the case and renders a decision for hospitalization.

**Discharge Planning**

Discharge planning is designed to assist the provider in the coordination of the member discharge when acute care (hospitalization) is no longer necessary.

When long-term care is necessary, Amerigroup works with the provider to 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
- Convalescent facility
- Home health care program (e.g., home intravenous antibiotics)

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

Discharge plan authorizations follow InterQual Criteria and Milliman Care Guidelines. Authorizations include and are not limited to transportation, home health, DME, pharmacy, follow-up visits to practitioners or outpatient procedures.
Continuity of Care

If a member’s physician is terminated from the network for any reason, he or she may, under certain circumstances, continue to provide medically necessary services to the member for four months or longer for certain types of treatment. A member will continue care with the treating physician under the following conditions:

- A pregnancy that requires the treating physician to continue the postpartum evaluation of the member for up to six weeks after delivery
- Postoperative care that requires the treating physician to continue care for a period up to six months
- Oncology treatment that requires the treating physician to continue care for a period up to one year
- Psychiatric treatment that requires the treating physician to continue care for a period up to one year

Confidentiality of Information

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

Emergency Services

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

Amerigroup does not discourage members from using the 911 emergency systems or deny access to emergency services. Emergency services are provided to members without requiring precertification. Any hospital or provider calling for an authorization for emergency services will be granted one immediately upon request. Emergency services coverage includes services that are needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

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

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
Emergency response is coordinated with community services, including the police, fire and Emergency Medical Services departments, juvenile probation, the judicial system, child protective services, chemical dependency, emergency services, and local mental health authorities, if applicable.

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

Emergency services will include an examination at an emergency room for suspected physical/child abuse and/or neglect. A medical examination at an emergency room is required by N.J.A.C. 10:122D-2.5(b) when a foster home placement of a child occurs after business hours.

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

For NJ FamilyCare D members, no copayment is required if the member was referred to the emergency room by his or her PCP for services that should have been rendered in the PCP’s office or if the member is admitted into the hospital. The PCP should notify Amerigroup to ensure appropriate adjudication of the claim.

If the member is admitted, the Amerigroup concurrent review nurse will implement the concurrent review process to ensure coordination of care.

**Urgent Care**

Amerigroup requires its members to contact their PCP in situations where urgent, unscheduled care is necessary. Precertification with Amerigroup is not required for a member to access a participating urgent care center.
Quality Management Program

Overview
Amerigroup maintains a comprehensive quality management program to objectively monitor and systematically evaluate the care and service provided to members. The scope and content of the program reflects the demographic and epidemiological needs of the population served. Members and providers have opportunities to make recommendations for areas of improvement. The Quality Management Program goals and outcomes are available upon request to providers and members (Contact Provider Services at the National Contact Center: 1-800-454-3730). Studies are planned across the continuum of care and service with ongoing proactive evaluation and refinement of the program.

The initial program development was based on a review of the needs of the population served. Systematic re-evaluation of the needs of the Amerigroup-specific population occurs on an annual basis. This includes not only age/sex distribution, but also a review of utilization data — inpatient, emergent/urgent care and office visits by type, cost and volume. This information is used to define areas that are high volume or that are problem prone.

Amerigroup adheres to the New Jersey modified Quality Assessment and Performance Improvement (QAPI) program. The QAPI objectively and systematically monitors and evaluates the quality and appropriateness of care and service to members through quality-of-care studies and related activities and pursues opportunities for improvement on an ongoing basis. Opportunities to promote and improve patient safety are inherent in the Quality Management Program.

There is a comprehensive committee structure in place with oversight from the Amerigroup governing body. Not only are the traditional MAC and Credentialing Committees in place, but a Community/Member Advisory Committee and a Health Education Advisory Committee are also integral components of the Quality Management Committee structure.

Quality of Care
All physicians, advanced registered nurse practitioners and Physician Assistants (PAs) are evaluated for compliance with pre-established standards as described in Amerigroup credentialing program.

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

Reviews are accomplished by Quality Management (QM) Coordinators and Associate Professionals who strive to develop relationships with providers and hospitals that will positively impact the quality of care and services provided to our members.

Results are submitted to the Amerigroup QM department and incorporated into a profile.
Amerigroup quality program includes review of quality of care issues identified for all care settings. QM staff uses member complaints, reported adverse events and other information to evaluate the quality of service and care provided to our members.

Quality Management Committee

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

The QMC’s responsibilities are to:
• Establish strategic direction and monitor and support implementation of the quality management program
• Establish processes and structure that ensure NCQA compliance
• Review planning, implementation, measurement and outcomes of clinical/service quality improvement studies
• Coordinate communication of quality management activities throughout Amerigroup
• Review HEDIS data and action plans for improvement
• Review and approve the annual quality management program description
• Review and approve the annual work plans for each service delivery area
• Provide oversight and review of delegated services
• Provide oversight and review of subordinate committees
• Receive and review reports on utilization review decisions and take action when appropriate
• Analyze member and provider satisfaction survey responses
• Monitor Amerigroup operational indicators through Amerigroup senior staff

Medical Advisory Committee

Amerigroup MAC has multiple purposes. The MAC assesses levels and quality of care provided to members and recommends, evaluates and monitors standards of care. The MAC identifies opportunities to improve services and clinical performance by establishing, reviewing and updating clinical practice guidelines based on review of demographics and epidemiologic information to target high-volume, high-risk and problem-prone conditions. The MAC oversees the peer review process that provides a systematic approach for the monitoring of quality and the appropriateness of care. The MAC conducts a systematic process for network maintenance through the credentialing/recredentialing process. The MAC advises to Amerigroup administration in any aspect of Amerigroup policy or operation affecting network providers or members. The MAC approves and provides oversight of the peer review process, the Quality Management Program and the Utilization Review Program. It oversees and makes recommendations regarding health promotion activities.

The MAC’s responsibilities are to:
• Use an ongoing peer review system to monitor practice patterns, to identify appropriateness of care and to improve risk prevention activities
• Approve clinical protocols and guidelines which help ensure the delivery of quality care and appropriate resource utilization
• Review clinical study design and results
• Develop action plans and recommendations regarding clinical quality improvement studies
• Consider and act in response to provider sanctions
• Provide oversight of Credentialing Committee decisions to credential and recredential providers for participation in Amerigroup
• Approve credentialing and recredentialing policies and procedures
• Oversee members’ access to care
• Review and provide feedback regarding new technologies
• Approve recommendations from subordinate committees

**Credentialing**

Amerigroup credentialing policies and procedures incorporate the current NCQA Standards and Guidelines for the Accreditation of MCOs, as well as the New Jersey Division of Medical Assistance and Health Services (DMAHS) requirements for the credentialing and recredentialing of licensed independent providers and organizational providers with whom it contracts.

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

**Credentialing Requirements**

Each provider, applicable ancillary, facility and hospital will remain in full compliance with all Amerigroup credentialing criteria as set forth in its Credentialing Policies and Procedures and all applicable laws and regulations. Each provider, applicable ancillary, facility and hospital will complete an Amerigroup application form upon request by Amerigroup. Individual physicians may use the Council for Affordable Quality Healthcare Application, New Jersey Universal Physician Application and the New Jersey Physician Recredentialing Application in lieu of Amerigroup applications if they so choose. Each provider will comply with such other credentialing criteria as may be established by Amerigroup.

Amerigroup adheres to the QAPI provisions regarding credentialing and recredentialing.

Recredentialing is performed every three years.

**Credentialing Procedures**

Amerigroup is committed to operating an effective, quality credentialing program. Amerigroup credentials the following provider types: Medical Doctors (MDs), Doctors of Osteopathy (DOs), doctors of dental surgery, doctors of dental medicine, doctors of podiatric medicine, doctors of chiropractic, physician assistants, optometrists, nurse practitioners, certified nurse midwives, licensed professional counselors/social workers, psychologists, speech/language therapists and other applicable or appropriate mid-level providers, as well as hospitals and allied services (ancillary) providers.

During recredentialing, each provider must show evidence of satisfying these policy requirements and must have satisfactory results relative to Amerigroup measures of quality of health care and service.
Amerigroup will establish a Credentialing Committee and a Medical Advisory Committee for the formal determination of recommendations regarding credentialing decisions. The Credentialing Committee will make decisions regarding participation of initial applicants and their continued participation at the time of recredentialing. The oversight rests with the Medical Advisory Committee.

Amerigroup credentialing policy is revised periodically based on input from several sources, including the Credentialing Committees, the Amerigroup medical director, the Amerigroup chief medical officer and state and federal requirements. The policy will be reviewed and approved as needed, but at a minimum annually.

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

Each provider has the right to inquire about the status of his or her application. He or she may do so by the following methods: (1) telephone; (2) facsimile; (3) contact through his or her Provider Relations representative; or (4) in writing.

As an applicant for participation with Amerigroup, each provider has the right to review information obtained from primary verification sources during the credentialing process. Upon notification from Amerigroup, the provider has the right to explain information obtained that may vary substantially from that provided and to provide corrections to any erroneous information submitted by another party. The provider must submit a written explanation or appear before the Credentialing Committee, if deemed necessary.

Currently, the following verifications are completed as applicable prior to final submission of a practitioner file to the Amerigroup medical director or Credentialing Committee. To the extent allowed under applicable law or state agency requirements, per NCQA Standards and Guidelines, the medical director has authority to approve clean files without input from the Credentialing Committee. All files not designated as a clean file will be presented to the Credentialing Committee for review and decision regarding participation.

In addition to the submission of an application and the execution of a Participating Provider Agreement, the following must be reviewed and approved by the Credentialing Committee or the medical director.

1. **Board Certification.** Verification by referencing the American Medical Association (AMA) Provider Profile, American Osteopathic Association, the American Board of Medical Specialties, American Board of Podiatric Surgery and/or American Board of Podiatric Orthopedics and Primary Podiatric Medicine.
2. **Verification of Education and Training.** Verification by referencing board certification or the appropriate state-licensing agency.

3. **Verification of Work History.** The practitioner must submit a curriculum vitae documenting work history for the past five years. Any gaps in work history greater than six months must be explained in writing and brought to the attention of the medical director and Credentialing Committee, as applicable.

4. **Hospital Affiliations and Privileges.** To the extent allowed under applicable law or state agency requirements, verification of clinical privileges in good standing at an Amerigroup network hospital may be accomplished by the use of an attestation signed by the provider. If an attestation is not acceptable, hospital admitting privileges in good standing are verified for the practitioner. This information is obtained in the form of a written letter from the hospital, roster format (multiple practitioners), Internet access or by telephone contact. The date and name of the person spoken to at the hospital are documented.

5. **State Licensure or Certification.** Verification of state license information to ensure that the practitioner maintains a current legal license or certification to practice in the state. This information can be verified by referencing data provided to Amerigroup by the state via roster, telephone or the Internet.

6. **DEA Number.** Verification of the Drug Enforcement Administration (DEA) number to ensure that the practitioner is currently eligible to prescribe controlled substances. This information is verified by obtaining a copy of the DEA certificate or by referencing the National Technical Information Service (NTIS) data. If the practitioner is not required to possess a DEA certificate but does hold a state controlled substance certificate, the Controlled Dangerous Substance (CDS) certificate is verified to ensure the practitioner is currently eligible to prescribe controlled substances. This information is verified by obtaining a copy of the CDS certificate or by referencing CDS online or Internet data if applicable.

7. **Professional Liability Coverage.** To the extent allowed under applicable law or state agency requirements, verification of malpractice coverage may be accomplished by the use of an attestation signed by the provider, indicating the name of the carrier, policy number, coverage limits and the effective and expiration dates of such malpractice coverage. If attestation is not acceptable, the practitioner’s malpractice insurance information is verified by obtaining a copy of the professional liability insurance face sheet from the practitioner or from the malpractice insurance carrier. Practitioners are required to maintain professional liability insurance in specified amounts.

8. **Professional Liability Claims History.** Verification of an applicant’s history of professional liability claims, if any, reviewed by Amerigroup Credentialing Committee to determine whether acceptable risk exposure exists. The review is based on information provided and attested to by the applicant and information available from the National Practitioner’s Data Bank (NPDB). The Credentialing Committee’s policy is designed to give careful consideration to the medical facts of the specific cases, total number and frequency of claims in the past five years, and the amounts of settlements and/or judgments.

9. **CMS Sanctions.** Verification that the practitioner’s record is clear of any sanctions by Medicare/Medicaid. This information is verified by accessing the NPDB. The Excluded Parties Listing Service (EPLS) website is also reviewed to further ensure there are no sanctions that would prevent the provider from participating in any federal program.
10. **Disclosures – Attestation and Release of Information.** The Amerigroup Provider Application will require responses to the following:

- Physical or mental health reasons for the inability to perform the essential functions of the position with or without accommodation
- Any history or current problems with chemical dependency, alcohol or substance abuse
- History of license revocations, suspension, voluntary relinquishment, probationary status, or other licensure conditions or limitations
- History of conviction of any criminal offense other than minor traffic violations
- History of loss or limitation of hospital privileges or disciplinary activity, including denial, suspension, limitation, termination or nonrenewal of professional privileges
- History of complaints or adverse action reports filed with a local, state, or national professional society or licensing board
- History of refusal or cancellation of professional liability insurance
- History of suspension or revocation of a DEA or CDS certificate
- History of any Medicare/Medicaid sanctions
- Attestation by the applicant of the correctness and completeness of the application

Any issue identified must be explained in writing. These explanations are presented with the provider’s application to the Credentialing Committee.

11. The NPDB is queried against applicants and Amerigroup contracted providers. The NPDB will provide a report for every practitioner queried. These reports are shared with the medical director and the Credentialing Committee for review and action as appropriate. The Federation of State Medical Boards for MDs, DOs and PAs is queried to verify any restrictions and/or sanctions made against the practitioner’s license. The appropriate state-licensing agency is queried for all other providers. All sanctions are investigated and documented, including Amerigroup decision to accept or deny the applicant’s participation in the network.

12. **Location Review** is no longer required in state contract.

13. **Recredentialing.** At the time of recredentialing (every three years), information for PCPs from quality improvement activities, performance indicators, utilization management, member complaints, member satisfaction surveys and reverification of work history, hospital privileges, and current licensure is also presented for the Credentialing Committee’s review.

The provider will be notified by telephone or in writing if any information obtained in support of the assessment or reassessment process varies substantially from the information submitted by the providers. Providers have the right to review the information submitted in support of the credentialing and recredentialing process and to correct any errors in the documentation. This will be accomplished by submission of a written explanation or by appearance before the Credentialing Committee, if so requested.

The decision to approve or deny initial participation will be communicated in writing within 60 days of the Credentialing Committee’s decision. To the extent allowed under applicable law or state agency requirements per NCQA Standards and Guidelines, the medical director may render a decision regarding the approval of clean files without benefit of input from the Credentialing Committee. In the event the provider’s continued participation is denied, the provider will be notified by certified mail. If continued participation is denied, the provider will be allowed 30 days to appeal the decision.
Credentialing Organizational Providers

The provider application contains the provider’s actual signature that serves as an attestation that the health care facility agrees to the assessment requirements. Providers requiring assessments are as follows: hospitals, home health agencies, skilled nursing facilities, nursing homes, ambulatory surgical centers and behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting.

Currently, the following steps are completed in addition to the application and Network Provider Agreement before approval for participation of a hospital or organizational provider.

State licensure is verified by obtaining a current copy of the state license from the organization or by contacting the state-licensing agency. Primary source verification is not required. Any restrictions to a license are investigated and documented, including the decision to accept or deny the organization’s participation in the network.

Amerigroup contracts with facilities that meet the requirements of an unbiased and recognized authority. Hospitals (e.g., acute, transitional or rehabilitation) should be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Healthcare Facilities Accreditation Program or the American Osteopathic Association. The Commission on Accreditation of Rehabilitation Facilities may accredit rehabilitation facilities. Home health agencies should be accredited by JCAHO or the Community Health Accreditation Program. Nursing homes should be accredited by JCAHO. JCAHO or the Accreditation Association for Ambulatory Health Care should accredit ambulatory surgical centers. If facilities, ancillaries or hospitals are not accredited, Amerigroup will accept a copy of a recent state or CMS review in lieu of performing an on-site review. If accreditation or copy of a recent review is unavailable, an on-site review will be performed.

- A copy of the malpractice insurance face sheet is required. Organizations are required to maintain malpractice insurance in the amounts specified in the provider contract and according to Amerigroup policy.
- Amerigroup will track a facility’s or ancillary’s reassessment date and reassess every 36 months as applicable. Requirements for recredentialing of organizational providers are the same for reassessment as they are for the initial assessment.
- Medicare and Medicaid sanctions are reviewed by accessing the Office of the Inspector General website.
- The EPLS website is reviewed to further ensure there are no sanctions that would prevent the provider from participating in any federal program.

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

Organizations have the right to review the information submitted in support of the assessment process and to correct any errors in the documentation. This will be accomplished by submission of a written explanation or by appearance before the Credentialing Committee, if so requested.

The decision to terminate an organization’s participation will be communicated in writing via certified mail.
Delegated Credentialing
Amerigroup will ensure the quality of its credentialing program through direct verification and through delegation of credentialing functions to qualified provider organizations. Where a Provider Group is believed to have a strong credentialing program, Amerigroup may evaluate a delegation of credentialing and recredentialing. A Provider Group must have a minimum of 150 participating providers.

The Credentialing department will review the written credentialing policy of the Provider Group for adequacy. Steps, if any, are identified where the Provider Group’s credentialing policy does not meet Amerigroup standards. Amerigroup will perform or arrange for the Provider Group to perform the Amerigroup credentialing steps not addressed by the Provider Group.

Amerigroup will perform a predelegation audit of the Provider Group’s credentialing practices. A passing score is considered to be an overall average of 90 percent compliance. The Provider Group is expected to submit an acceptable corrective action plan within 30 days of receipt of the audit results. If there are serious deficiencies, Amerigroup will deny the delegation or will restrict the level of delegation. Amerigroup may waive the need for the predelegation on-site audit if the delegated entity’s credentialing program is NCQA certified to include all credentialing and recredentialing elements. Amerigroup is responsible for oversight of any delegated credentialing arrangement and schedules appropriate reviews. The reviews are held at least annually.

Peer Review
The peer review process provides a systematic approach for monitoring the quality and appropriateness of care.

Peer Review responsibilities are:
- Participate in the implementation of the established peer review system
- Review and make recommendations regarding individual provider peer review cases
- Work in accordance with the executive medical director

Should investigation of a member grievance result in concern regarding a physician’s compliance with community standards of care or service, all elements of peer review will be followed.

Dissatisfaction severity codes and levels of severity are applied to quality issues. The medical director assigns a level of severity to the grievance. Peer review includes investigation of physician actions by or at the discretion of the medical director. The medical director takes action based on the quality issue and the level of severity, invites the cooperation of the physician and consults and informs the Medical Advisory Committee and Peer Review Committee. The medical director informs the physician of the Committee’s decision, recommendations, follow-up actions and/or disciplinary actions to be taken. Outcomes are reported to the appropriate internal and external entities which include the Quality Management Committee.

The peer review process is a major component of the Medical Advisory Committee monthly agenda.

The peer review policy is available upon request.
Amerigroup has a formal grievance and appeal process for the handling of disputes pertaining to administrative issues and nonpayment related matters. For payment disputes, see Provider Payment Appeals in Section 12. Providers may access this process by filing a written grievance. Provider grievance will be resolved fairly, consistent with Amerigroup policies and covered benefits.

If a provider is dissatisfied with Amerigroup policies and procedures, Amerigroup will furnish providers access to a complaint resolution process. Amerigroup will respond to provider complaints in a timely manner and attempt to resolve all provider complaints to the provider’s satisfaction. If a provider is dissatisfied with a complaint resolution, Amerigroup will provide a grievance process for further appeal.

Amerigroup has an informal complaint process, which network providers can use to make verbal complaints, ask questions and resolve problems without going through the formal, written grievance process.

A provider will not be penalized for filing a complaint. Providers have unlimited access to file any and all complaints to Provider Services to initiate a complaint. Provider Services can be reached by calling 1-800-454-3730. Any Amerigroup representative can accept a provider complaint.

When Amerigroup receives a complaint via the telephone, they will attempt to resolve the provider complaint at that time according to Amerigroup policies and procedures. If a complaint cannot be resolved within five days of receipt, Amerigroup acknowledges receipt of a provider complaint by sending a Complaint Acknowledgement Letter to the provider within five business days of the initial complaint.

Complaints of an emergent nature will be resolved immediately. Complaints of an urgent nature will be resolved within 48 hours. All other provider complaints will be resolved and responded to in writing within 30 days of receipt.

If the provider expresses dissatisfaction with the complaint resolution, he or she can either write a grievance letter or call Amerigroup Provider Services at 1-800-454-3730.

**Provider Grievance Resolution**

Amerigroup has a formal grievance and appeal process, which network providers and non-network providers can use to complain in writing. A grievance is a written expression of dissatisfaction with the resolution of a provider complaint. Provider grievances will be fairly resolved, consistent with Amerigroup policies and covered benefits.

All provider grievances will be kept confidential. A provider will not be penalized for filing a grievance. Any supporting documentation should accompany the grievance.

A provider can file a grievance in writing addressed to:
At no time will Amerigroup cease care pending a grievance investigation.

**Level I Grievance Review**
Upon receipt of a Level I Grievance Review with supporting documentation, Amerigroup immediately informs the appropriate Amerigroup department head, medical director and/or CEO. Grievances of an emergent nature will be resolved immediately. Grievances of an urgent nature will be resolved within 48 hours from the time of receipt. All other provider grievances will be resolved and responded to in writing within 30 days of receipt.

**Level II Grievance Review**
If the provider expresses dissatisfaction with the Level I grievance resolution, he or she can either send a letter by mail or fax or call Amerigroup Provider Services to request a Level II Grievance Review.

A Level II Grievance Review consists of a committee review. A committee meets as necessary to investigate and resolve grievances unresolved to a provider’s satisfaction during the Level I Grievance Review. The committee is comprised of the vice president of Quality Management, vice president of Provider Services, medical director and any additional members of senior staff, network providers and/or consultants of the same or similar specialty as the provider’s concern who have not been involved with the original complaint or grievance.

A provider may choose to attend a grievance meeting or participate in meetings through another means of technology (e.g., telephone conference). The meeting will be set up at a reasonable time and location for the provider. Emergent grievances will be resolved immediately. Urgent grievances will be resolved within 48 hours of initiation. A Level II Grievance Resolution Letter will be sent to a provider within 30 days of receipt of the request.
Electronic Submission

Amerigroup encourages the submission of claims electronically through Electronic Data Interchange (EDI). Providers must submit claims within 180 days from the date of discharge for inpatient services or from the date of service for outpatient services. Electronic claims submission is available through:

- Emdeon (formerly WebMD) – Claim Payer ID 27514
- Capario (formerly MedAvant) – Claim Payer ID 28804
- Availity (formerly THIN) – Claim Payer ID 26375

Providers have the option of submitting claims electronically through EDI.

The advantages of electronic claims submission are as follows:

- Facilitates timely claims adjudication
- Acknowledges receipt and rejection notification of claims electronically
- Improves claims tracking
- Improves claims status reporting
- Reduces adjudication turnaround
- Eliminates paper
- Improves cost effectiveness
- Allows for automatic adjudication of claims

The guide for EDI claims submission is located at www.amerigroupcorp.com/providers. The EDI claim submission guide includes additional information related to the EDI claim process.

To initiate the electronic claims submission process or obtain additional information, please contact Amerigroup EDI Hotline at 1-800-590-5745.

Paper Claims Submission

Providers also have the option of submitting paper claims. Amerigroup uses Optical Character Recognition (OCR) technology as part of its front-end claims processing procedures. This technology is provided through software called MACESS. OCR technology is coupled with an imaging module to furnish providers with a more responsive claims processing interface. The benefits include the following:

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

In order to use OCR technology, claims must be submitted on original red claim forms (not black and white or photocopied forms) laser printed or typed (not handwritten) in a large, dark font. Providers must submit a properly completed UB-04 CMS-1450 or CMS-1500 (08-05) 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 (COB)/subrogation or in cases where a member has retroactive eligibility. For cases of COB/subrogation, the time frames for filing a claim will begin on the date that the third-party documents resolution of the claim.

Amerigroup is requiring the use of the new CMS-1500 (08-05) and new UB-04 CMS-1450 for the purposes of accommodating the National Provider Identifier (NPI) in accordance with the NPI implementation timelines set by the state of New Jersey, CMS and National Uniform Claim Committee.

CMS-1500 (08-05) or UB-04 CMS-1450 must include the following information (HIPAA compliant where applicable):
- Patient’s ID number
- Patient’s name
- Patient’s date of birth
- ICD-9 diagnosis code/revenue codes
- Date of service
- Place of service
- Description of services rendered CPT-4 codes/HCPC codes/DRGs
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- Amerigroup provider number
- NPI of billing provider when applicable
- State Medicaid ID number
- COB/other insurance information
- Authorization/precertification number or copy of authorization/precertification
- Name of referring physician
- NPI of referring physician when applicable
- Any other state-required data

Amerigroup cannot accept claims with alterations to billing information. Claims that have been altered will be returned to the provider with an explanation of the reason for the return. Amerigroup will not accept claims from those providers who submit entirely handwritten claims.

**Paper claims** must be submitted within **180 days** of the last date of service of the course of treatment and must be submitted to the following address:

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

**Web Portal Submissions – (Participating Providers Only)**

Participating providers have the option to use the claim submission utilities available on the Amerigroup website. Providers can enter claims on a preformatted CMS-1500 and UB-04 claim template. Provider offices and facilities that are able to create HIPAA compliant ANSI 837 4010A1 claim
transactions will have the ability to upload their claims on Amerigroup website. To take advantage of the direct submission of ANSI 837 claims files, contact Amerigroup EDI Hotline at 1-800-590-5745.

**Encounter Data**

Amerigroup has established and maintains a system to collect member encounter data. Due to reporting needs and requirements, network providers who are reimbursed by capitation must send encounter data to Amerigroup for each member encounter. Encounter data can be submitted through EDI submission methods or on a CMS-1500 (08-05) claims form, unless other arrangements are approved by Amerigroup. Data will be submitted in a timely manner, but no later than 90 days from the date of service.

The encounter data will include the following:
- Member ID number
- Member name (first and last name)
- Member date of birth
- Provider name according to contract
- Amerigroup provider number
- COB information
- Date of encounter
- Diagnosis code
- Types of services provided (using current procedure codes and modifiers if applicable)
- Provider TIN and state Medicaid ID number
- Any other state-required data

**Encounter data** should be submitted to:

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

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

Compliance is monitored by Amerigroup utilization and quality improvement staff, coordinated with the medical director and reported to the Quality Management Committee on a quarterly basis. The PCP is monitored for compliance with reporting of utilization. Lack of compliance will result in training and follow-up audits and could result in termination.

**Claims Adjudication**

Amerigroup is dedicated to providing timely adjudication of provider claims for services rendered to members. All network and non-network provider claims that are submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. These guidelines
comply with industry standards as defined by the CPT-4 and ICD-9 Manuals. Institutional claims should be submitted using EDI submission methods or the UB-04 CMS-1450 and provider services using the CMS-1500.

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

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

For claims payment to be considered, providers must adhere to the following time limits:
- Submit claims within 180 days from the last date the service is rendered in a course of treatment or for inpatient claims filed by a hospital within 180 days from the date of discharge
- Submit the claim within 180 days of receiving a response from the third-party payer in cases of other insurance
- Submit claims for members whose eligibility has not been added to the state’s eligibility system within 180 days from the date the eligibility is added and Amerigroup is notified of the eligibility/enrollment
- Submitted claims after the 180-day filing deadline will be denied

After filing a claim with Amerigroup, review the weekly Explanation Of Payment (EOP). If the claim does not appear on an EOP within 30 business days as adjudicated or you have no other written indication that the claim has been received, check the status of your claim at www.amerigroupcorp.com/providers or the telephonic Provider Inquiry Line at 1-800-454-3730. If the claim is not on file with Amerigroup, resubmit your claim within 180 days from the date of service. If filing electronically, check the confirmation reports for acceptance of the claim that you receive from your EDI or practice management vendor.

Amerigroup adjudicates claims in accordance with the New Jersey regulatory requirements.

**Clean Claims Payment**

A clean claim is a request for payment for a service rendered by a provider that:
- Is submitted in a timely manner by provider
- Is accurate
- Is submitted on a HIPAA compliant standard claim form including a CMS-1500 (08-05) or UB-04 CMS-1450 or successor forms thereto or the electronic equivalent of such claim form
- Requires no further information, adjustment or alteration by provider or by a third party in order to be processed and paid by Amerigroup

Clean claims are adjudicated within 30 business days of receipt. If Amerigroup does not adjudicate the clean claim within the time frames specified above, Amerigroup will pay all applicable interest as required by law.
Amerigroup produces and mails an EOP on a weekly basis, which delineates for the provider the status of each claim that has been adjudicated during the previous week. Upon receipt of the requested information from the provider, Amerigroup must complete processing of the clean claim within 30 business days.

Paper claims that are determined to be unclean will be returned to the billing provider along with a letter stating the reason for the rejection. Electronic claims (i.e., EDI) that are determined to be unclean will be returned to the Amerigroup-contracted clearinghouse that submitted the claim.

Amerigroup will adjudicate and pay clean claims appropriately from practitioners, either in individual or group practice or who practice in shared health facilities, in accordance with state requirements. Days are calculated from receipt date to date of payment. The date of receipt is the date Amerigroup receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

**Claims Status**

Providers should use www.amerigroupcorp.com/providers or call the automated Provider Inquiry Line at 1-800-454-3730 to check claims status.

**Provider Reimbursement**

**Electronic Funds Transfer and Electronic Remittance Advice**

Amerigroup offers Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) with online viewing capability. Providers can elect to receive Amerigroup payments electronically through direct deposit to their bank account. In addition, providers can select from a variety of remittance information options, including:

- Electronic remittance advice presented online and printed in your location
- HIPAA-compliant data file for download directly to your practice management or patient accounting system
- Paper remittance printed and mailed by Amerigroup

Some of the benefits providers may experience include:

- Faster receipt of payments from Amerigroup
- Ability to generate custom reports on both payment and claim information based on the criteria specified
- Online capability to search claims and remittance details across multiple remittances
- Elimination of the need for manual entry of remittance information and user errors
- Ability to perform faster secondary billing

To register for ERA/EFT, please visit our website at www.amerigroupcorp.com/providers.

**PCP Reimbursement**

Amerigroup reimburses PCPs according to their contractual arrangement.
Specialist Reimbursement
Reimbursement to network specialty care providers and network providers not serving as PCPs is based on their contractual arrangement with Amerigroup.

Specialty care providers will obtain PCP and Amerigroup approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized by the PCP’s referral or beyond the scope of self-referral permitted under this program.

Specialty care provider services will be covered only when there is documentation of appropriate notification or precertification, as appropriate, and receipt of the required claims and encounter information to Amerigroup.

Overpayment Process
Refund notifications may be identified by two entities, Amerigroup Cost Containment Unit (CCU) or the provider. The CCU researches and notifies the provider of an overpayment requesting a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified by Amerigroup, the CCU will notify the provider of the overpayment. The provider will submit a Refund Notification Form along with the refund check. If a provider identified the overpayment and returns the Amerigroup check, please include a completed Refund Notification Form specifying the reason for the return. This form can be found on the Provider Web Portal at www.amerigroupcorp.com/providers. The submission of the Refund Notification Form will allow the CCU to process and reconcile the overpayment in a timely manner. Once the CCU has reviewed the overpayment, you will receive a confirmation letter explaining the details of the reconciliation. For questions regarding the Refund Notification procedure, please call Provider Services at the National Customer Care Department at 1-800-454-3730 and select the appropriate prompt.

Provider Payment Disputes
Providers may access a timely payment dispute process. A payment dispute is any dispute between the health care provider and Amerigroup for reasons including: lost or incomplete claim forms or electronic submissions, requests for additional explanation as to services or treatment rendered by a health care provider, inappropriate or unapproved referrals initiated by the providers, billing disputes, timely filing, notification/precertification issues, and service already provided where the provider does not agree with the results of Amerigroup claim adjudication. No action is required by the member.

Providers will not be penalized for filing a payment dispute. Stage 1 and Stage 2 Disputes must be submitted in writing to Amerigroup Payment Dispute Unit. The letter must detail the reason for the dispute and be accompanied by supporting documentation, such as the EOP or medical records. The Payment Dispute Unit will receive, distribute and coordinate all payment disputes. A separate address has been established for this purpose:

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

- 140 -
An internal review shall be conducted and its results communicated in a written decision to the provider within 30 calendar days of the receipt of the dispute.

**Stage 1 – Payment Dispute**
The provider must submit a written dispute to Amerigroup with all applicable documentation supporting the provider’s position regarding the adjudication of the claim. The Stage 1 written dispute must be received within 90 calendar days of the provider’s EOP.

The Payment Dispute Unit will acknowledge receipt of the dispute in writing within five business days.

Amerigroup Payment Dispute Unit will render a written determination within 30 calendar days of the receipt of the dispute.

If additional information is requested, the provider must submit the additional information within 30 calendar days. If the information is not received within 30 calendar days, the dispute will be denied and closed due to incomplete information with no further recourse on behalf of the provider.

**Stage 2 Dispute**
The provider must submit a written dispute to Amerigroup with any additional documentation or information supporting the provider’s position regarding the dispute determination. The Stage 2 Dispute must be received within 30 calendar days of the determination of the Stage 1 Dispute.

The Payment Dispute Unit will acknowledge receipt of the dispute in writing within five business days.

Amerigroup Payment Dispute Unit will render a written determination within 10 business days of the receipt of the dispute.

If additional information is requested, the provider must submit the additional information within 30 calendar days. If the information is not received within 30 calendar days, the dispute will be denied and closed with no further recourse on behalf of the provider.

Examples of appropriate documentation to support provider payment disputes:
- Letter stating the reasons why the provider believes the claim reimbursement is incorrect
- Copy of the original claim
- Copy of the Amerigroup EOP
- EOP or EOB from another carrier
- Evidence of eligibility verification (e.g., copy of ID card, panel report, call log record with date of the name of the person you spoke with at Amerigroup when you verified eligibility)
- Medical records
- Approved referral and authorization forms from Amerigroup indicating the authorization number
- Contract rate sheets indicating evidence of payment rates
- Evidence of previous dispute submission or timely filing:
  - Certified mail receipt with claim/dispute log if more than one claim/dispute was submitted
  - Overnight mail receipt with claim/dispute log if more than one claim/dispute was submitted
  - EDI claim transmission reports indicating that the claim was accepted; rejection reports are not accepted as proof of timely filing.
- A statement specifying the line items the provider is disputing
• Information Amerigroup previously requested that the provider has not yet submitted, if available
• Itemization of the contract provisions the provider believes Amerigroup is not complying with, if any
• Pertinent correspondence between the provider and Amerigroup on this matter
• A description of pertinent communications between the provider and Amerigroup on this matter that were not in writing
• Relevant sections of the National Correct Coding Initiative or other coding support the provider relied on if the dispute concerns the disposition of billing codes
• Other documents the provider may believe supports the provider’s position in this dispute

Questions regarding Amerigroup provider payment dispute process should be directed to the dedicated Amerigroup Provider Relations representative, or the provider can call Provider Services at 1-800-454-3730.

Independent Arbitration
If the provider is dissatisfied with the result to the Stage 2 payment dispute resolution, the provider may file for independent arbitration pursuant to New Jersey P.L. 2005, c.35. In order to file for independent arbitration, certain conditions must be met, including:
• The claims amount in dispute must be $1,000 or more. Claims that are aggregated to meet the $1,000 threshold must fulfill the aggregation criteria as specified by the New Jersey Department of Banking and Insurance, which includes the following:
  o All disputed claim amounts aggregated for arbitration must be from claims that have been submitted to the internal Stage 2 claims payment dispute process and the dispute process has been exhausted.
  o All claims in the aggregation of disputed claims MUST be timely. Untimely claims will be removed from the aggregation, and if the remaining claims do not meet the threshold amount, none of the claims will be considered for arbitration at that time.
  o Disputed claim amounts should be aggregated by carrier and covered person, or by carrier and CPT code.
• The provider must complete the State-developed Health Care Provider Application to Dispute a Claims Determination Form. Copies of the form are available on our website at www.amerigroupcorp.com or through the New Jersey Department of Banking and Insurance website.
• Although not required by law, the provider should strongly consider obtaining a completed Consent to Authorization of Release of Medical Records for Arbitration of Claims Form from the member for whom the services were provided. In the absence of this authorization, no personal health information can be shared with the arbiter. Copies of the form are available on our website at www.amerigroupcorp.com or through the New Jersey Department of Banking and Insurance website.
• The claim must not be eligible for dispute under the IHCAP.
• The provider must include the fee for Arbitration as required by the Department of Banking and Insurance. Please check with the Department of Banking and Insurance for the most current information as to the appropriate fee.
• The request for arbitration must be made within 90 days of the most recent adverse determination regarding the claim.
Coordination of Benefits

If a member is covered by more than one health care plan, Amerigroup will administer Coordination Of Benefits (COB). Under COB, the primary payer of benefits is identified in order to eliminate duplication of reimbursement.

If Amerigroup is identified as the primary payer of benefits, Amerigroup will reimburse the provider up to the contracted fee. If Amerigroup is identified as the secondary payer of benefits and the primary coverage is Medicare, Amerigroup will cover the full deductible for in-Patient services and Out-Patient Hospital Services. For Out-Patient services, Amerigroup will cover the primary health plan’s deductible, coinsurance and noncovered services if those services are covered under the Amerigroup scope of benefits up to the Medicare/Medicaid contracted fee, not to exceed the amount Amerigroup would have paid if it had been the primary carrier. In addition, providers and members must abide by all Amerigroup policies and procedures, including notification or precertification of services.

Amerigroup will notify the state within 30 days after it learns that a member has health insurance coverage that is not reflected in the state’s file or casualty insurance coverage or if there is a change in a member’s health insurance coverage. In addition, Amerigroup requires its providers to notify Amerigroup of this information.

Any questions or inquiries regarding paid, denied or pended claims should be directed to Provider Services at 1-800-454-3730.

Billing Members

Overview
Before rendering services, providers should always inform members that the cost of services not covered by Amerigroup will be charged to the member.

A provider who chooses to provide services not covered by Amerigroup:
• Understands that Amerigroup only reimburses for services that are medically necessary, including hospital admissions and other services
• Obtains the member’s signature on the Client Acknowledgment Statement specifying that the member will be held responsible for payment of services
• Understands that he or she may not bill for or take recourse against a member for denied or reduced claims for services that are within the amount, duration and scope of benefits of the Medicaid program

Amerigroup members must not be balance billed for the amount above which is paid by Amerigroup for covered services.

In addition, providers may not bill a member if any of the following occurs:
• Failure to timely submit a claim, including claims not received by Amerigroup
• Failure to submit a claim to Amerigroup for initial processing within 180 days of the last date of service in the course of treatment
• Failure to submit a corrected claim within the same 180-day filing resubmission period
• Failure to dispute a claim within the 45-day administrative dispute period
• Failure to dispute a utilization review determination within 30 days of notification of coverage denial
• Submission of an unsigned or otherwise incomplete claim
• Errors made in claims preparation, claims submission or the dispute process

**Client Acknowledgment Statement**

A provider may bill an Amerigroup member for a service that has been denied as not medically necessary or not a covered benefit only if both of the following conditions are met:

• The member requests the specific service or item
• The provider obtains and keeps a written acknowledgement statement signed by the member and the provider stating:

I understand that, in the opinion of (provider’s name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under Amerigroup as being reasonable and medically necessary for my care or that are not a covered benefit. I understand that Amerigroup has established the medical necessity standards for the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined to be inconsistent with the Amerigroup medically necessary standards for my care or not a covered benefit.

Signature: ____________________________________________

Date: ____________________________________________
APPENDIX A – FORMS

The following forms are included as sample reference materials.
# Referral and Claim Submission Forms

## WIC Form

**New Jersey State Department of Health**  
**WIC/Maternity Services**

**REFERRAL/NUTRITION ASSESSMENT FOR WOMEN**  
Please see instructions on last page

<table>
<thead>
<tr>
<th>NAME OF CLIENT</th>
<th>TELEPHONE NUMBER</th>
<th>DATE OF BIRTH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| ADDRESS OF CLIENT | CHECK ONE:  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Pregnant</td>
</tr>
</tbody>
</table>

**REFERRAL** *(To be completed by health professional, including second page)*

**ANTHROPOMETRIC AND LABORATORY DATE (One Blood Test is Required)**

<table>
<thead>
<tr>
<th>First Prenatal</th>
<th># Weeks</th>
<th>Weight</th>
<th>Pre-Preg</th>
<th>Usual Wt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check-up: Date: <em><strong>/</strong></em>/____ Gestation _____ (pounds) ______ (pounds) ______ (pounds) ______</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current</th>
<th># Weeks</th>
<th>Weight</th>
<th>Height</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check-up: Date: <em><strong>/</strong></em>/____ Gestation _____ (pounds) ______ (inches) ______</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Blood Test:** Date: ___/___/____ Hb(mg/dl) ______ Hct ______% EP(ug/dl) ______ Lead ______ Other ______

**MEDICAL HISTORY**

Gravida _______ Para _______ Ab/Misc ________ Stillbirth ________ EDC _________ ADC __________ ☐ Vag ☐ C-section

Past Med/Surg History ________________________________________________________________

Current Medical Problem(s) _____________________________________________________________

Previous Preg Complications ___________________________________________________________

Date Last Preg Ended ______/_____/______

Physician/Clinic __________________________ Phone ______________________

Signature of Health Professional __________________________ Date: _______/_______/_______

**WIC APPOINTMENT:** Date: __________/__________/__________ Time: __________________

**ASSESSMENT** *(To be completed by Client or Health Professional)*

1) Are you taking any of the following?
   - Vitamins/Minerals ☐ Yes ☐ No Amount: ____________ Type: ____________
   - Iron ☐ Yes ☐ No Amount: ____________ Type: ____________
   - Over-the-counter Medicines ☐ Yes ☐ No Amount: ____________ Type: ____________
   - Special Medicines ☐ Yes ☐ No Amount: ____________ Type: ____________
   - Street Drugs ☐ Yes ☐ No Amount: ____________ Type: ____________

2) How much did you smoke before you were pregnant? Amount: ____________
   How much do you smoke now? Amount: ____________

3) How much beer, wine cooler or liquor do you drink per week? Amount: ____________

4) Are you on a special diet now? ☐ Yes ☐ No Prior to pregnancy? ☐ Yes ☐ No

5) Are you experiencing?
   - Nausea ☐ Yes ☐ No Heartburn ☐ Yes ☐ No
   - Frequent Vomiting ☐ Yes ☐ No Fatus (Gas) ☐ Yes ☐ No
   - Diarrhea ☐ Yes ☐ No Dental Problems ☐ Yes ☐ No
   - Constipation ☐ Yes ☐ No Bleeding Gums ☐ Yes ☐ No

6) Do you eat?
   - Paint Chips ☐ Yes ☐ No Dirt ☐ Yes ☐ No
   - Laundry Starch ☐ Yes ☐ No Clay ☐ Yes ☐ No
   - Corn Starch ☐ Yes ☐ No Plaster ☐ Yes ☐ No
   - Ice ☐ Yes ☐ No Other Cravings ☐ Yes ☐ No

7) Do you have a working?
   - Stove ☐ Yes ☐ No Sink with water supply ☐ Yes ☐ No
   - Refrigerator ☐ Yes ☐ No
8) Are you on any program?  
<table>
<thead>
<tr>
<th>Program</th>
<th>Yes</th>
<th>No</th>
<th>Maternity Services/</th>
<th>Presumptively Eligible</th>
<th>AFDC/Medicaid</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>WIC</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Support Enf</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food Stamps</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9) How do you plan to or presently feed your baby?  
<table>
<thead>
<tr>
<th>Method</th>
<th>Yes</th>
<th>No</th>
<th>Undecided?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast milk</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10) Do you do the following daily?  
<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
<th>Type: _________________________</th>
<th>How Many: ____________________</th>
<th>Type: _________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work Care for Children</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exercise</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11) If pregnant, how much weight (pounds) do you plan to gain? _____________________________________________

12) Where do you plan to or presently take your child for medical care? ________________________________
Referral Section (Complete by Health Professional)
1) Fill in client’s name, address, phone number and date of birth; or use addressograph stamp.
2) Check status of woman being referred.
3) Fill in data on first prenatal check-up and current check-up, if applicable.
4) One blood test is required prior to submitting this form to WIC. Pregnant women need blood test that was done during pregnancy. Postpartum women (breastfeeding and nonbreastfeeding) need blood test that was done after delivery.
5) Complete Gravida, Para, Abortions, Miscarriages.
6) Fill in EDC (Estimated Date of Confinement) for prenatal clients.
7) Fill in ADC (Actual Date of Confinement), vaginal or C-section delivery for postpartum clients.
8) Complete past medical/surgical history based on client’s record.
9) Fill in any pertinent current medical problems diagnosed.
Information in this section should NOT include most recent pregnancy for postpartum women.
10) Complete previous pregnancy complications, referring to list below:
   Write approximate letter or letters on space provided.
   a. Hx of low birth weight infant(s) [<5.5 pounds]
   b. Hx of premature infant(s) [<37 weeks gestation]
   c. Hx of infant(s) > 10 pounds at birth
   d. Hx of or planned C-section
   e. Multiple pregnancy or recent multiple birth
   f. Medical problems (e.g., diabetes, hypertension, pre-eclampsia, eclampsia)
   g. Disability that may compromise adequacy of diet
   h. Social or environmental condition that may compromise adequacy of diet
   i. Substance use (e.g., alcohol, drugs, cigarettes, pica)
   j. Vitamin/mineral supplement or medicine prescription
   k. Special formula prescription and medical reason for its necessity
   l. Other pertinent health/medical data
1) Fill in physician’s name or clinic and phone number.
2) Signature of referring health professional IS REQUIRED, with current date.
Assessment Section/Food Frequency (Page 1 and 2)
1) This section may be completed by the client or a health professional.
2) If completed by client, it must be reviewed by the health professional for accuracy and completeness. Check the appropriate answer for questions 1-18. Any responses that do NOT meet WIC standards demand further clarification.
3) The health professional should compare the food frequency with the recommended servings needed daily for pregnant/postpartum women and formulate a nutrition plan of care accordingly.
4) The Nutrition Assessment and Plan of Care must be written according to the hospital/ WIC State policy and procedure.
5) Upon completion of nutrition education, the health professional must circle the appropriate Nutrition Education Topics and record the date. (More topics below) If materials are provided, write the appropriate Topic Code in the space labeled Other.

<table>
<thead>
<tr>
<th>Code</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>05</td>
<td>Child Nutrition</td>
</tr>
<tr>
<td>06</td>
<td>Dental Health</td>
</tr>
<tr>
<td>07</td>
<td>Fat in Diet</td>
</tr>
<tr>
<td>08</td>
<td>Food Budget/Consumer</td>
</tr>
<tr>
<td>09</td>
<td>Fruit and Vegetables</td>
</tr>
<tr>
<td>10</td>
<td>Medical problems (e.g., diabetes, hypertension)</td>
</tr>
<tr>
<td>11</td>
<td>Mealtimes Psychology</td>
</tr>
<tr>
<td>12</td>
<td>Nutrients in WIC Foods</td>
</tr>
<tr>
<td>13</td>
<td>Salt in Diet</td>
</tr>
<tr>
<td>14</td>
<td>Smoking and Pregnancy</td>
</tr>
<tr>
<td>15</td>
<td>Snacking</td>
</tr>
<tr>
<td>16</td>
<td>No Show</td>
</tr>
<tr>
<td>17</td>
<td>Vitamin A in Diet</td>
</tr>
<tr>
<td>18</td>
<td>Vitamin C in Diet</td>
</tr>
<tr>
<td>19</td>
<td>No Show</td>
</tr>
<tr>
<td>20</td>
<td>Food in Diet</td>
</tr>
<tr>
<td>21</td>
<td>No Show</td>
</tr>
</tbody>
</table>

Name and Address of WIC Program, Physician or Clinic: 
Telephone Number
INSTRUCTIONS

Assessment Section/Food Frequency (Page 1 and 2)

1) This section may be completed by the client or a health professional.

2) If completed by the client, it must be reviewed by the health professional for accuracy and completeness. Check the appropriate answer for questions 1 through 18. Any responses that do NOT meet WIC standards demand further clarification.

3) The health professional should compare the food frequency with the recommended servings needed daily for pregnant/postpartum women and formulate a nutrition plan accordingly.

4) The Nutrition Assessment and Plan of Care must be written according to the hospital/ WIC State policy and procedure.

5) Upon completion of nutrition education, the health professional must circle the appropriate Nutrition Education Topic Code and write the date education was provided.

6) Listed below is continuation of nutrition Education Topics. If materials are provided, write the appropriate Topic Code in the space labeled Other.

   05 – Child Nutrition
   06 – Dental Health
   07 – Fat in the Diet
   08 – Food Budgeting/Consumer Awareness/Meal Planning
   09 – Fruit and Vegetables
   11 – Mealtime Psychology
   12 – Nutrients in WIC Foods
   15 – Salt in the Diet
   16 – Smoking and Pregnancy
   17 – Snacking
   18 – Sugar in Diet
   19 – Vitamin A in Diet
   20 – Vitamin C in Diet
   44 – No Show
   45 – Client Refused
Specialist as PCP Request Form

Date: ______________________________________________________

Member’s Name: ____________________________________________

Member’s ID #: ____________________________________________

PCP’s Name (if applicable): __________________________________

Specialist/Specialty: ________________________________________

Member’s Diagnosis: ________________________________________

Describe the medical justification for selecting a specialist as PCP for this member.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

The signatures below indicate agreement by the specialist, Amerigroup and the member for whom the specialist will function as this member’s PCP, including providing to the member access 24 hours a day, 7 days a week.

Specialist’s Signature: ___________________________ Date: ____________

Medical Director’s Signature: _________________________ Date: ____________

Member’s Signature: _______________________________ Date: ____________

HIV Antibody Blood Forms
Counsel for HIV Antibody Blood Test

Name: ____________________________________________________________

In accordance with Chapter 174, P.L. 1995:

I acknowledge that ________________________________ has counseled
(Name of physician or other provider)
and provided me with:

A. Information concerning how HIV is transmitted
B. The benefits of voluntary testing
C. The benefits of knowing if I have HIV or not
D. The treatments which are available to me and my unborn child should I test positive
E. The fact that I have a right to refuse the test and I will not be denied treatment

I have consented to be tested for infection with HIV.  □

I have decided not to be tested for infection with HIV.  □

This record will be retained as a permanent part of the patient’s medical record.

____________________________________  ______________________________
Signature of Patient                    Date

____________________________________
Signature of Witness
Consent for the HIV Antibody Blood Test

I have been told that my blood will be tested for antibodies to the virus named HIV (Human Immunodeficiency Virus). This is the virus that causes AIDS (Acquired Immunodeficiency Syndrome), but it is not a test for AIDS. I understand that the test is done on blood.

I have been advised that the test is not 100 percent accurate. The test may show that a person has antibodies to the virus when they really don’t—this is a false positive test. The test may also fail to show that a person has antibodies to the virus when they really do—this is a false negative test. I have also been advised that this is not a test for AIDS and that a positive test does not mean that I have AIDS. Other tests and examinations are needed to diagnose AIDS.

I have been advised that, if I have any questions about the HIV antibody test, its benefits or its risks, I may ask those questions before I decide to agree to the blood test.

I understand that the results of this blood test will only be given to those health care workers directly responsible for my care and treatment. I also understand that my results can only be given to other agencies or persons if I sign a release form.

By signing below, I agree that I have read this form or someone has read this form to me. I have had all my questions answered and have been given all the information I want about the blood test and the use of the results of my blood test. I agree to give a tube of blood for the HIV antibody tests. There is almost no risk in giving blood. I may have some pain or a bruise around the place that the blood was taken.

___________________________________  ______________________________
Date                                Patient’s/Guardian’s Signature

___________________________________  ______________________________
Witness Signature                   Patient’s/Guardian’s Printed Name

____________________________________
Physician Signature

Amerigroup recognizes the need for strict confidentiality guidelines.
Results of the HIV Antibody Blood Test

A. EXPLANATION

This authorization for use or disclosure of the results of a blood test to detect antibodies to HIV, the probable causative agent of Acquired Immunodeficiency Syndrome (AIDS), is being requested of you to comply with the terms of Confidentiality of Medical Information Act, Civil Code Section 56 et seq. and Health and Safety Code Section 199.21(g).

B. AUTHORIZATION

I hereby authorize _______________________________________________ to furnish
(Name of physician, hospital or health care provider)

________________________________________________________________________

to ________________________________________________________ the results of the blood
test for antibodies to HIV.

C. USES

The requester may use the information for any purpose, subject only to the following limitation:
________________________________________________________________________.

D. DURATION

This authorization shall become effective immediately and shall remain in effect indefinitely or until ______________________, 20____, whichever is shorter.

E. RESTRICTIONS

I understand that the requester may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

F. ADDITIONAL COPY

I further understand that I have a right to receive a copy of this authorization upon my request. Copy requested and received: ☐ Yes ☐ No ______________ Initial

Date: ______________, 20____

________________________________________

Signature

________________________________________

Printed Name

Note: this form must be in at least eight-point type.
Blood Lead Risk Forms

Verbal Blood Lead Risk Assessment

Member Name: ________________________________
Date: ________________________________________
ID #: ________________________________________
Person Interviewed/Relationship: ________________

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your child live in or regularly visit a house built before 1960? Does the house have chipping or peeling paint?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was your child’s day care center/preschool/babysitter’s home built before 1960? Does the house have chipping or peeling paint?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child live in or regularly visit a house built before 1960 with recent, ongoing or planned renovation or remodeling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have any of your children or their playmates had lead poisoning?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child frequently come in contact with an adult who works with lead? Examples include construction, welding or pottery, or other trades practiced in your community.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you give your child home or folk remedies that may contain lead?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Blood Lead Testing for High-risk Children

Member Name: _______________________________
Date: _______________________________________
ID #: _______________________________________
Person Interviewed/Relationship: _________________

<table>
<thead>
<tr>
<th>Has your child’s blood been tested for lead?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>When was your child last tested?</td>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>What was the result?</td>
<td>Result:</td>
<td></td>
</tr>
<tr>
<td>Has the child seen the pediatrician since his or her last blood test?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>When?</td>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Was the child tested for lead poisoning?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

- If the PCP has not seen the child, encourage and help arrange a visit.
- If it has been over one year since the child’s last visit, encourage and help arrange a visit.
- If the child has been/is being treated for lead poisoning, apply risk assessment and encourage continuation of follow-up. Assist member through any barriers identified.
New Jersey Maternity Notification

Fax: 1-800-964-3627

Telephone: 1-800-454-3730

This referral is valid only for services authorized by this form. Only completed referrals will be processed. If the consultant/provider recommends another service or surgery, additional authorization is required. Certification does not guarantee that benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions.

Incomplete forms will not be processed.

OB emergencies do not require this form to be filled out.

All payments for approved procedures are subject to claims adjudication and member eligibility at the time that the service is rendered. Notification of pregnancy is required after the first prenatal visit.

Member Name: ___________________________  Amerigroup ID #: ____________________
Address: ____________________________________________________________
Telephone: ____________________  SSN #: _________-_______-_______
Date of Birth: ____________________  Work Telephone: ____________________

Member receiving care:
Address of Facility/OB Office Providing Care: _______________________________________
Date of WIC referral: _______/______/_______

EDC: _______/_______/_______
Gravida _____  Parity _____
Term _____  Preterm _____
Living _____  Spont AB _____  Elect AB _____

Blood Type: __________  Pre-pregnancy Weight: _____
Blood Pressure: __________  Height: _____
MSAFP/triple/quad Screen: _______________________________________________________

Allergies: ___________________________________________________________________
Medication Other Than Vitamins: __________________________________________________

HIV:
Date of HIV Counseling: _______/_______/_______  Date of first office visit: _______/_______/_______
Date HIV Test Offered: _______/_______/_______  Gestational Age at First Visit: __________________
Date HIV Consent Signed: _______/_______/_______  Date of WIC referral: _______/_______/_______
Date HIV Test Drawn: _______/_______/_______  **Please contact OB Case Manager for coordination and authorization of high-risk members. **
HIV Results: __________________________________________________________________

Substance Use:
Alcohol (drinks per day): ____________________
Tobacco (cigarettes per day): ____________________
Illegal substance use: ____________________

**For Amerigroup use only**
Reference #: ___________________________  Initials: ___________________________

Member Name: ___________________________ Member ID #: ____________________ Date _____/____/____
Please check all that apply to the member.

<table>
<thead>
<tr>
<th>Medical History</th>
<th>Member</th>
<th>Obstetrical History</th>
<th>Current</th>
<th>Previous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>Y N NA</td>
<td>Excessive weight loss</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Vision problem</td>
<td>Y N NA</td>
<td>Excessive weight gain</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Hearing problem</td>
<td>Y N NA</td>
<td>Gestational diabetes</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Thyroid disease</td>
<td>Y N NA</td>
<td>If yes, specify medication/diet</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>Y N NA</td>
<td>First trimester bleeding</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Member taking insulin?</td>
<td>Y N NA</td>
<td>Incompetent cervix</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Heart murmur</td>
<td>Y N NA</td>
<td>If yes, did member have cerclage</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Heart disease</td>
<td>Y N NA</td>
<td>Group B strep</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Y N NA</td>
<td>Preterm labor</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>If yes, specify medication</td>
<td>Y N NA</td>
<td>Preterm delivery</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Seizures/epilepsy</td>
<td>Y N NA</td>
<td>Preterm rupture of membranes</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>If yes, specify medication</td>
<td>Y N NA</td>
<td>Placenta previa</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>Y N NA</td>
<td>Placental abruption</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Y N NA</td>
<td>Eclampsia</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Eating disorder</td>
<td>Y N NA</td>
<td>Stillborn</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Kidney disease</td>
<td>Y N NA</td>
<td>Twins, triplets, etc.</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Frequent bladder infections</td>
<td>Y N NA</td>
<td>Rh negative</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Liver disease</td>
<td>Y N NA</td>
<td>If yes, date rhgam was given</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>Y N NA</td>
<td>Infections</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Lupus</td>
<td>Y N NA</td>
<td>If yes, what?</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Phlebitis</td>
<td>Y N NA</td>
<td>Obesity</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td>Y N NA</td>
<td>Hepatitis</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Sickle cell disease</td>
<td>Y N NA</td>
<td>IUGR</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td>Y N NA</td>
<td>Oligo/polyhydramnios</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Genetic disorder</td>
<td>Y N NA</td>
<td>No prenatal care/ late treatment</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>If yes, what?</td>
<td>Y N NA</td>
<td>Adolescent &lt; 16 y/o</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Uterine fibroid</td>
<td>Y N NA</td>
<td>Macrosomia</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Abnormal pap smear</td>
<td>Y N NA</td>
<td>AMA</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>If yes, specify procedure</td>
<td>Y N NA</td>
<td>Previous c-section</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>STD/HIV+/AIDS</td>
<td>Y N NA</td>
<td>List any surgery</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>If yes, specify treatment</td>
<td>Y N NA</td>
<td>List other previous OB complications</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Mental health problems</td>
<td>Y N NA</td>
<td>Date</td>
<td>Y N NA</td>
<td></td>
</tr>
<tr>
<td>Signature</td>
<td>Y N NA</td>
<td>Date</td>
<td>Y N NA</td>
<td></td>
</tr>
</tbody>
</table>
HMO – EPSDT Worksheet

A standardized EPSDT form was jointly developed by the Medicaid HMOs, the New Jersey Division of Medical Assistance and Health Services (DMAHS) and the Michigan Peer Review Organization. The new worksheet was developed in response to the call for a uniform system for recording child health services rendered at each visit. The worksheet is envisioned to facilitate recording and reporting of services rendered to pediatric beneficiaries.

The worksheet is an office tool to collect all necessary EPSDT data for reporting to the HMOs. The data should then be transferred to the CMS-1500 (08-05) form for submission to the HMO. Do not submit the EPSDT worksheet to the HMO – only the completed CMS-1500 (08-05) claim form is necessary. This process will replace any existing EPSDT forms for all HMOs participating in the NJ FamilyCare program.

10 Tips for Completing the EPSDT Worksheet and CMS-1500 (08-05) Claim Form
1. Never mail the EPSDT form to the health plan. The form must stay in the medical record.
2. Complete the top section of the EPSDT form. Make sure that the child’s health plan is checked off and that you have entered all demographic information.

EPSDT Screening Codes
3. Check off only one preventive visit code. The code you choose should correspond to the child’s age and status as a new or established patient.
4. If you refer a child for EPSDT services, select the correct Z code and enter the appropriate diagnosis.

Vaccines, Lead and Other In-office Screenings
5. Check the appropriate procedure codes for drawing blood. If you are performing a capillary stick or venipuncture for lead testing, make sure to record the correct code.

<table>
<thead>
<tr>
<th>36406.59</th>
<th>Venipuncture – Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>36415.59</td>
<td>Capillary Stick - Lead</td>
</tr>
</tbody>
</table>

6. Circle the correct procedure codes for immunizations, and circle the dose of the vaccine which is being given (D1, D2, D3 and D4).
7. If a vaccine is contraindicated, circle the appropriate reason (C1, C2, C3).
8. If all vaccines are up-to-date as of the current visit, circle All UTD.

Completing CMS-1500 (08-05) Claim Forms
9. Use the procedure codes identified on the EPSDT form to complete CMS-1500 (08-05). When you are providing well-child care, the primary diagnosis will usually be V20.2.
10. Before mailing CMS-1500 (08-05) to the health plan, make sure you have completed all information required to identify the member, the PCP and the services provided. Each CMS-1500 (08-05) claim form should record procedures and diagnoses for a single date of service.
### EPSDT Form

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name</td>
<td>Provider HMO ID #</td>
</tr>
</tbody>
</table>

**HMO - EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT SERVICES (EPSDT) BILLING WORKSHEET**

**EPSDT SCREENING CODES**

<table>
<thead>
<tr>
<th><strong>PREVENTIVE HEALTH VISITS</strong> one preventive medicine services code</th>
<th><strong>DIAGNOSIS CODES &amp; REFERRALS</strong> Enter diagnosis codes and all applicable referrals for each code.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEW EST.</td>
<td>* REFERRAL</td>
</tr>
</tbody>
</table>

| **NEW** | **EST.** | **Patient (under one year)** | **Mental Health Referral** | **Vision Referral** | **Hearing Referral** | **Dental Referral** | **Refer Lab 4, 5** | **Refer Lab 1-3** | **Refer Other** | **Other Referral** |

**VACCINES, & LEAD & OTHER IN-OFFICE SCREENING**

| **Immunization administration and lead procedure code(s) - if applicable** | **36406 50** Vanquih, 3 yrs (Lead Screening) | **In-Office Screening** |
|---|---|
| | 36406 Vanquih, 3 yrs (Other) | 99173 | Vision |
| 90471 | Immunization Admin, 1st vaccine | 36415 50 | Vanquih (Lead Screening) | 92551 | Aud: |
| 90472 | Immunization Admin, Each Additional Vaccine | 36415 | Vanquih (Other) | 85580 EIA |
| | | 36416 | Capillary (Lead Screening) | 85013 | Itc |
| | | 36416 | Capillary (Other) | 85013 | Itc |

**IMMUNIZATIONS** If all immunizations are up-to-date, please circle: All UTD Check one dosage box OR one contraindication box for each age-appropriate immunization. Indicate if immunizations are up to date. DO NOT SUBMIT DOSAGE CODES [D1, D2, D3, etc.]

<table>
<thead>
<tr>
<th><strong>CODE</strong></th>
<th><strong>DESCRIPTION</strong></th>
<th><strong>DUE / GIVEN DOSAGE</strong></th>
<th><strong>DUE / NOT GIVEN CONTRA-INDICATIONS</strong></th>
<th><strong>NOT GIVEN UP TO DATE</strong></th>
<th><strong>MODIFIER</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>90744</td>
<td>Hepatitis B (pediatric or adolescent dosage)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90748</td>
<td>HepB/Hib</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90700</td>
<td>DTaP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90721</td>
<td>DTaP - Hib, 15 mo. +</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90718</td>
<td>T d</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90647</td>
<td>Hib (3 dose schedule)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90645</td>
<td>Hib (4 dose schedule)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90646</td>
<td>Hib/Dpt, 12 mo. +</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90713</td>
<td>IPV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90669</td>
<td>Pneumococcal (7 valent)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90707</td>
<td>MMR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90657</td>
<td>Influenza, split virus, 6-35 mo.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90658</td>
<td>Influenza, split virus, 35 mo. +</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90655</td>
<td>Influenza, split v., preservative free</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90633</td>
<td>Hepatitis A (2 dose schedule)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90716</td>
<td>Varicella</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90734</td>
<td>DtaP/HepB/IV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90701</td>
<td>DT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90634</td>
<td>Hepatitis A (3 dose schedule)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90705</td>
<td>Measles</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90733</td>
<td>Meningooccal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90734</td>
<td>Mumps</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90732</td>
<td>Pneumococcal (23 valent)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90716</td>
<td>Rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90703</td>
<td>Tetanus / Toxoid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An EPSDT visit consists of a health and developmental history including assessments of both physical and mental health development, a comprehensive unclothed physical examination, vision and hearing screening, dental inspection and nutritional assessment, age-appropriate immunizations, lead screenings and lab tests. The information not included on this form should be documented in the medical record. THIS FORM IS A PERMANENT PART OF THE MEDICAL RECORD.

Return for next visit: EPSDT visit: Follow-up: Immunizations: #1501 rev. 9/04
# Diabetes Information Form

Name: ____________________________________  Birth Date: ___________________________

Allergies: _________________________________  Phone #: _____________________________

<table>
<thead>
<tr>
<th>Examination/Test</th>
<th>Schedule</th>
<th>Date of Onset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory HgA1c &lt; 7.0% acceptable</td>
<td>Every 3-6 Months</td>
<td>Date</td>
</tr>
<tr>
<td>Fasting Lipid Profile:</td>
<td>Annual</td>
<td>Result</td>
</tr>
<tr>
<td>HDL 50 mg/dL (women)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LDL: 100 mg/dL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Triglycerides: 175 mg/dL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urine Microalbumin</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>Serum Creatinine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History and Physical Examination</td>
<td>Annual</td>
<td>Date</td>
</tr>
<tr>
<td>Interval History with Depression Screening</td>
<td></td>
<td>Comment</td>
</tr>
<tr>
<td>Diabetic Retinal Eye Exam</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>Foot Exam</td>
<td>Each Visit</td>
<td></td>
</tr>
<tr>
<td>Blood Pressure 130/80 mmHg</td>
<td>Each Visit</td>
<td></td>
</tr>
<tr>
<td>Weight/Height</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EKG (&gt; Age 30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Education and Therapy</td>
<td>Date</td>
<td>Comment</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diet/Exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Adherence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-monitored Blood Glucose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preconception/Pregnancy Counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACE Inhibitors/ARB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspirin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight Loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunization</td>
<td>Annual</td>
<td>Date</td>
</tr>
<tr>
<td>Influenza Vaccine</td>
<td></td>
<td>Comment</td>
</tr>
<tr>
<td>Pneumococcal Vaccine once, repeat after five years for age &gt; 65 if first dose was &lt; 65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Date</td>
<td>Comment</td>
</tr>
</tbody>
</table>

Advance Directives
Living Will
You can make a living will by filling out this form. You can choose another form or use the one your doctor gives you, too. If you make a living will, give it to your PCP. If you need help in understanding or filling out 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 say here followed. I am writing this for when 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 (say what it is here)
___________________________________________________________________

TREATMENT I DO WANT. I want (put your initial by the services you do want):

_____ No medical services
_____ Pain relief
_____ All treatment to keep me alive as long as possible
_____ Other (say what it is here)
_________________________________________________________________

What I say 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 any time I wish. I just have to let my doctor know I want to change it or not have it at all.

Signature: _______________________________________________________
Date: ___________________
Address: _________________________________________________________
Durable Power of Attorney

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, too. If you name a durable power of attorney, give it to your PCP. If you need help in understanding or filling out this form, call Member Services at 1-800-600-4441.

I (Name) _______________________________________, want
__________________________________________________
(Name of person I want to carry out my wishes) and (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) and (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 (say what it is here)

TREATMENT I DO WANT. I want (put your initial by the services you do want):

_____ No medical services
_____ Pain relief
_____ All treatment to keep me alive as long as possible
_____ Other (say what it is here)

What I say 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 any time 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: ________________________________________________________
A woman who has a hysterectomy can never again get pregnant. When you have a hysterectomy, the doctor removes your uterus (womb). You cannot have a baby after your uterus is removed, and you will not have menstrual periods anymore.

I received the above information orally and in writing from _______________________________

Name of clinic or physician

________________________ before my operation was performed.

I talked to _______________________________ about a hysterectomy. ____________________

Name of responsible person(s) She/he/they discussed it with me and gave me a chance to ask questions and answered them for me before the operation.

I have read all of this notice. I agree that it is a true description of what was explained to me by _______________________________

Name of staff member of _______________________________

Clinic/hospital/physician and that all my questions were answered to my satisfaction.

I, ________________________________, hereby consent or did consent of my own free will to have ________________________________

Name of recipient a hysterectomy done by ________________________________ and/or associates or assistants

Physician

of his or her choice.

I consent or did consent to any other medical treatment that the doctor thinks is (was) necessary to preserve my health.

I also consent to the release of this form and other medical records about the operation to the representatives of the United States Department of Health and Human Services or employees of programs or projects funded by that department, but only for purposes of determining if federal laws were observed.

________________________________________

Recipient’s signature

Date: Month/Day/Year

FD-189 (REV 7/83) 7472 M ED 7/83
Item-by-item Instructions for Completing the
Hysterectomy Receipt of Information Form FD-189 (Rev 3/91)

1) **Name of Clinic or Physician:** Enter the name of the clinic or physician who provided the information.

2) **Name of Responsible Persons:** Enter the name of the individual who discussed the procedure with the recipient.

3) **She/He/They:** Enter appropriate selection.

4) **Name of Staff Member:** Enter the name of the individual who explained the procedure to the recipient.

5) **Clinic/Hospital/Physician:** Enter the name of the clinic/hospital or physician’s office in which the individual who explained the procedure is affiliated.

6) **Recipient’s Name:** Copy the recipient’s name as printed on the Medicaid Eligibility Identification Card. First name must be entered first.

7) **Name of Physician:** Enter the physician’s name.

8) **Recipient’s Signature and Date:** Recipient must personally sign and date the completed form.
Sterilization Consent Form – 7473 M ED

Federally prescribed documentation regulations for sterilization procedures are extremely rigid. Specific Medicaid requirements must be met and documented on the Consent Form prior to the sterilization of an individual.

The Consent Form is a replica of the form contained in the Federal Regulations and must be used by providers when submitting claims for sterilization procedures. Any claim (hospital, operating physician, anesthesiologist, clinic, etc.) involved in a sterilization procedure must have a properly completed Consent Form attached when it is submitted for payment. Sterilization claims are hard copy restricted; electronic billing is not permitted.

Providers may obtain additional copies of the Consent Form from the Fiscal Agent; however, photocopies of the Consent Form are acceptable.

A sample of the Consent Form and instructions for the form’s proper completion are provided for reference.
CONSENT FORM

Notice: YOUR DECISION, AT ANY TIME, NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

☐ CONSENT TO STERILIZATION ☐
☐ STATEMENT OF PERSON OBTAINING CONSENT ☐

I have asked for and received information about sterilization from __________________________.

doctor or clinic
When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _________________. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs. I am at least 21 years of age and was born on ________________, month/day/year. I, ________________, hereby consent of my own free will to be sterilized by ________________, doctor on _________________________________, by a method called _______________________________. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:
Representatives of the Department of Health, Education, and Welfare or Employees of programs or projects funded by that Department but only for determining if Federal Laws were observed.

_________________________________ signature
_________________________________ Date:________________

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)
☐ American Indian or ☐ Black (not Hispanic origin)
☐ Alaska Native ☐ Hispanic
☐ Asian or Pacific Islander ☐ White (not of Hispanic origin)

☐ INTERPRETER'S STATEMENT ☐

Before ____________________________ signed the consent _________________.

name of individual
form, I explained to him/her the nature of the sterilization operation ________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_________________________________ signature of person obtaining consent ________________ date

facility

________

address

☐ PHYSICIAN'S STATEMENT ☐

Shortly before I performed a sterilization operation upon _________________. 

name of individual to be sterilized

on ____________________________, I explained to him/her the nature of the sterilization operation ________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual’s signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

1) At least 30 days have passed between the date of the individual’s signature on this consent form and the date the sterilization was performed.

2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual’s signature on this consent form because of the following circumstances (check applicable box and fill in information)
If an interpreter is provided to assist the individual to be sterilized:
I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in ____________ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

__________________________________________________________________________

interpreter  date

 requested:
  ___ Premature delivery
  ___ Individual’s expected date of delivery
  ___ Emergency abdominal surgery
 (describe circumstances): __________________________ Date____________________

 investigator  month/day/year
Item-by-item Instructions for Completing the
Sterilization Consent Form Section 1 Consent to Sterilization

1) **Doctor or Clinic:** Enter the name of the physician or clinic.

2) **Sterilization Procedure:** Enter the name of the sterilization procedure.

3) **Recipient's Date of Birth:** Enter recipient’s date of birth in month, day and year sequence (mm/dd/yy).

4) **Recipient's Name:** Copy the recipient’s name as printed on the Medicaid Eligibility Identification Card. First name must be entered first.

5) **Doctor:** Enter physician’s name who is performing the procedure.

6) **Type of Sterilization:** Enter the method of sterilization chosen.

7) **Recipient’s Signature and Date:** Recipient must personally sign and hand date form at least 30 days, but not more than 180 days prior to surgery.

Section II Race and Ethnicity Designation:
8) **Race and Ethnicity Designation:** Optional information requested by the federal government, but is NOT required.

Section III Interpreter’s Statement: To be used only when the recipient does not speak English
9) **Language Used:** Enter language used.

10) **Interpreter’s Signature:** Interpreter must sign and date form at least 30 days, but not more than 180 days prior to the sterilization procedure.

Section IV Statement of Person Obtaining Consent:
11) **Name of Individual:** Enter the name of the recipient as it appears in Section I, item 4.

12) **Sterilization/Operation:** Enter the name of the sterilization procedure.

13) **Signature of Person Obtaining Consent:** Signature and date of the person who explains the procedure to the recipient and obtains the recipient’s consent. Must be completed at least 30 days, but not more than 180 days prior to the sterilization procedure.

14) **Facility’s Name and Address:** Enter the name and address of the facility or physician’s office with which the person obtaining the consent is affiliated.

15) **Name of Individual to be Sterilized:** Enter the recipient’s name as it appears in Section I, item 4.

16) **Date of Sterilization:** Enter the date of the sterilization in month, day and year sequence (mm/dd/yy).

17) **Specify Type of Operation:** Enter the name of the sterilization procedure.

18) **Paragraphs 1) and 2):** The physician must indicate the paragraph that applies to recipient’s situation. Paragraph 1) states that at least 30 days have passed between the date of the individual’s signature on the consent form and the date the sterilization was performed. Paragraph 2) states that the sterilization was performed less than 30 days, but more than 72 hours after the date of the
individual’s signature on the consent form. The circumstances are premature delivery (state the expected date of delivery) or emergency abdominal surgery (describe the emergency).

19) **Physician’s Signature and Date:** Physician must sign and date form after the surgery has been performed.
Practitioner Evaluation and Audit Tools

Practitioner Clinical Medical Record Audit

Physician Name: ______________________________ Office Manager: ______________________________

Office Address: _______________________________________________________________________

Specialty: _________________________ Date: ___________ Reviewer Name: _________________________

Chart/Member #: _________________________

Due to HIPAA regulations, the use of a Member’s name on this form is prohibited

<table>
<thead>
<tr>
<th>Point</th>
<th>Y</th>
<th>N</th>
<th>N/A</th>
<th>Point Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is chart accessible?</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do all pages contain patient ID (name/ID #)?</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Is there personal/biographical data?</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Is the provider identified on each entry?</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Are all entries dated?</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Is the record legible?</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Are significant illnesses and medical conditions indicated on the problem list? *</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Are allergies and adverse reactions to medications prominently displayed or, if patient has no known allergies or history of adverse reaction, is this appropriately noted in the record? *</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Is there an appropriate past medical history in the record (for patients seen three or more times) which includes serious accidents, operations or illnesses, emergency care and discharge summaries? Age 18 and under should include prenatal care, birth, operations and childhood illnesses. *</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Is there documentation of smoking habits and history of alcohol or substance abuse (age 12 and over) and was the patient counseled if the response was positive?</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Is there a pertinent history and physical exam?</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Are labs and other studies ordered as appropriate and reflect PCP review?</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Are working diagnoses consistent with findings? *</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Is there a date for a return visit or other follow-up plan for each encounter?</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Point Score</td>
<td></td>
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<td>---</td>
<td>---</td>
<td>---</td>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Are problems from previous visits addressed?</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Is there evidence of appropriate use of consultants?</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Is there evidence of continuity and coordination of care between primary and specialty physicians?</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>Do consultant summaries, lab and imaging study results reflect PCP review?</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>Does the care appear to be medically appropriate? (There is no evidence that patient was placed at inappropriate risk by diagnostic or therapeutic procedure.) *</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>Is there a completed immunization record (ages 13 and under)?</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>Are preventive services appropriately used?</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>Does documentation of advance directive include: (3 points total)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Is there evidence advance directive was offered/discussed with patient (21 and older)?</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- If patient desires advance directive, is it present in the chart (21 and older)?</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>Does pediatric documentation include: (4 points total)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Growth chart (1.5 pts.)</td>
<td></td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Head circumference chart (1 pt.)</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Developmental milestones (1.5 pts.)</td>
<td></td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Is there a list of current medications?</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>If a mental health problem is noted was a referral made or did the PCP perform treatment?</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>If a substance abuse problem is noted was a referral made or was treatment or education noted?</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>Are abnormal test results acknowledged?</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>Are copies of any emergency treatment and/or hospital admission (including discharge summaries and/or ancillary services care) present in the chart?</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>Is there evidence of blood lead risk assessment (verbal assessment or blood lead test, ages six months to six years)?</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>31.</td>
<td>Is there evidence that cultural and linguistic needs are being met, including documentation of interpretation services provided?</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

*These critical elements must be met, in addition to receiving an average score of 80 percent, to achieve an acceptable rating on the Clinical Medical Record Review.*
# Minimum Adult Preventive Health Guidelines

<table>
<thead>
<tr>
<th>Screening</th>
<th>Service</th>
<th>Age</th>
<th>Frequency</th>
<th>Recommendation By</th>
<th>Date Recommendation Last Approved</th>
<th>Contract Required</th>
<th>Rating*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>BP Screen</td>
<td>≥21 years old</td>
<td>At least every two years</td>
<td>U.S. Preventive Services Task Force</td>
<td>5/04</td>
<td>Yes</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Periodic screening at clinical discretion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lipid Disorders</td>
<td>Total Cholesterol and high density lipoprotein cholesterol</td>
<td>Males 35-65 years old Females 45-65 years old Males 20-35 years old and Females 20-45 years old with high risk for coronary heart disease</td>
<td>Every five years, shorter intervals for people who have lipid levels close to warranting therapy</td>
<td>U.S. Preventive Services Task Force</td>
<td>5/04</td>
<td>Yes</td>
<td>A</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>Fecal Blood Occult Flexible sigmoidoscopy Combination of fecal occult blood test and flexible sigmoidoscopy Colonoscopy Double-contrast barium enema</td>
<td>≥50 years old, earlier for high-risk patients</td>
<td>Every year Every five years Every 10 years Every five years</td>
<td>U.S. Preventive Services Task Force</td>
<td>5/04</td>
<td>Yes</td>
<td>A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Group</th>
<th>Age Requirements</th>
<th>Recommendations</th>
<th>Approval Date</th>
<th>Coverage</th>
<th>Recommendation Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza Vaccine</td>
<td>Adults</td>
<td>≥ 65 years old</td>
<td>Every year for people ≥ 65 years old. Every year regardless of age for those who are residents of chronic care facilities or suffer from chronic cardiopulmonary disorders, metabolic diseases, hemoglobinopathies, immunosuppression, or renal dysfunction. Immune vaccines once individuals who are immuno-compromised age ≥ 65 years old. High-risk patients ≥ 50 years old who are institutionalized or who have chronic cardiac or pulmonary disease, diabetes mellitus or anatomic asplenia, or who live in special environments or social settings with an identified increased risk of pneumonia. Every 10 years. High-risk adults – persons living in or traveling to where the disease is endemic, men who have sex with men, military personnel, and hospital and laboratory workers.</td>
<td>5/04</td>
<td>Yes</td>
<td>B</td>
</tr>
<tr>
<td>Pneumococcal Vaccine</td>
<td>Adults</td>
<td>≥ 65 years old</td>
<td>U.S. Preventive Services Task Force 5/04</td>
<td>Yes</td>
<td></td>
<td>B</td>
</tr>
<tr>
<td>Td Booster</td>
<td>Adults</td>
<td>≥ 12 years old</td>
<td>U.S. Preventive Services Task Force 5/04</td>
<td>Yes</td>
<td></td>
<td>A</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>Adults</td>
<td>≥ 21 years old</td>
<td>U.S. Preventive Services Task Force 5/04</td>
<td>Yes</td>
<td></td>
<td>B</td>
</tr>
<tr>
<td>Mammography</td>
<td>Breast Cancer Screening</td>
<td>≥ 40 years old and older 65 to 75 years old</td>
<td>Every 1-2 years. Every year.</td>
<td>5/04</td>
<td>Yes</td>
<td>B</td>
</tr>
<tr>
<td>Pap Smear</td>
<td>Cervical Cancer Screening</td>
<td>Within three years of onset of sexual activity or age 21 (whichever comes)</td>
<td>Every three years.</td>
<td>5/04</td>
<td>Yes</td>
<td>A</td>
</tr>
<tr>
<td>Pelvic Exam</td>
<td>first) and has a cervix. Annually</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
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</tr>
<tr>
<td>Prostate Cancer Screening</td>
<td>PSA &amp; DRE</td>
<td>65 to 75 years old</td>
<td>Every two years</td>
<td>Managed Care Contract U.S. Preventive Services Task Force</td>
<td>5/04</td>
<td>Yes</td>
</tr>
</tbody>
</table>


The following forms are also available on our website at www.amerigrouppcorp.com/providers. Select New Jersey to view these forms. You may also download them for your use as needed.

Medicare
- CMS Waiver of Liability
- Medicare Advantage Health Risk Assessment

Referral and Claims Submission Forms
- Authorization Request Form
- Maternity Notification Form
- Specialist as PCP Request
- WIC
- CMS-1500 (08-05)Claim Form
- UB-04 Claim Form

Medical Record Forms
- Clinical Information Form
- Adult Preventive Care Flow Sheet
- Adult Preventive/Diabetes Care Flow Sheet
- EPSDT Worksheet
- Vaccine Administration Form
- Patient Drug Profile
- Problem List 1
- Problem List 2
- Well-care Form – Birth – 15 Months
- Well-care Form – 18 Months – 12 Years
- Well-care Form – 13 Years – 18 Years

Provider Grievance and Appeals
- Provider Payment Dispute & Correspondence Submission
- Grievance Form

Blood Lead Risk Forms
- Blood Lead Testing for High-risk Children
- Verbal Blood Lead Risk Assessment

Behavioral Health Forms
- Behavioral Health Outpatient Treatment Form
- Behavioral Health Outpatient Treatment Report Form C
- Well-being Screening Tool
- Behavioral Health Neuropsychological Testing Form

HIV Antibody Blood Forms
- Consent for HIV Antibody Blood Test
- Counsel for HIV Antibody Blood Test
- Results of HIV Antibody Blood Test

Hysterectomy and Sterilization Forms
- Acknowledgement of Receipt of Hysterectomy Information
- Consent to Sterilization Forms

Practitioner Evaluation and Audit Tools
- New Jersey Practitioner Clinical Medical Record Audit
- New Jersey Practitioner Office Site Evaluation

Pharmacy Synagis Order Form
- CAREMARK Enrollment Forms

Cost Containment Form
- Refund Notification Form
Appendix B – Clinical Practice 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 such 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 (SAMHSA) 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 our 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 preventive and nonpreventive clinical practice guidelines for acute and chronic medical and behavioral health conditions to all affected providers every two years and more frequently if an update has occurred. Preventive health guidelines will be distributed 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 our website at www.amerigrouppcorp.com/providers, and log in to the secure site by entering your Login Name and Password. On the Online Inquiries page, scroll down to Resources, click on the Clinical Practice Guidelines link and select the New Jersey link. A copy of the guidelines can be printed from the website, or you can contact Provider Services at the National Customer Care Department at 1-800-454-3730 to receive a copy.